The Emergency Department (ED) attendings work 10 and 8 hour shifts, 7a-4:30p, 1p-10:30p, 4:30p-1a, 10:30p7a. Two attendings are on duty, with the exception of the time period from 2a to 6a when one attending is on duty.

The ED has 3 main areas. The Acute Care area has 24 beds including 2 cardiac rooms and 3 trauma rooms. Minor Trauma is an adjacent area with 8 beds. Minor Trauma is open noon to midnight daily. Pediatric Acute Care is a separate unit staffed by Pediatric attendings and residents. Pediatric Acute Care is open 9a-11p daily. After those hours, pediatric patients (ages 15 and below) are treated in the main ED. During your rotation, you will be assigned shifts in both the Acute Care area of the ED and the Minor Trauma area.

Guidelines for Houseofficers

Introduction and General Principles

Welcome to the Department of Emergency Medicine! During this rotation, you will learn skills that are essential to your medical education. You will be supervised by faculty members who are Board Certified or Board Eligible in Emergency Medicine. Our faculty have practiced in a variety of institutions and settings, and thus, your experience here will be enhanced by exposure to different styles of practice.

Emergency Medicine differs in many respects from the inpatient and clinic settings. During this rotation, you will see a broad spectrum of illness ranging from the most trivial complaints to life-threatening disease. It is important to remember that all patients come to the ED for a reason. Many present to the ED early in the course of their illness, therefore a serious disease may initially present to you as an apparently benign complaint. Many may present with complaints that could best be handled elsewhere. It is our role to ensure our patients receive our best efforts to guide them through the increasingly complex healthcare system as well as to diagnose and treat acute care conditions. Remember the Emergency Department is an important portal of entry into the hospital and provides a strong impression of the institution to patients, their families, and referring physicians from other medical centers.
Houseofficer Requirements for Successful Completion of

Emergency Medicine Rotation

2001-2002 Academic Year

1. Completion of the Online Orientation Module

Each houseofficer must complete the online orientation course and exam before starting their Emergency Medicine rotation. The orientation module is available online at www.med.unc.edu/wrkunits/2depts/emergmed.

2. Assigned Shifts in the Emergency Department

Be prompt for your assigned shifts. If you are ill or must miss an assigned shift, you need to contact:

- **Your chief resident.** Chief residents from each rotating department will be responsible for providing replacement coverage for their individual department residents who are unable to fill an assigned shift.

- **The ED attending physician working at the time your shift begins (966-4721).**

In order to successfully complete the ED rotation as required by your residency, you must complete all assigned shifts. Illnesses are only excused if verified by your personal physician (not a resident physician) or your residency director.

3. Resident Conferences

In order for the Departments of Emergency Medicine, Medicine, Surgery, Family Medicine and OB/Gyn to meet the requirements of the Residency Review Committee, weekly attendance at our Emergency Medicine Conferences is MANDATORY. These conferences are held on Wednesday mornings from 7a to noon. The schedule of topics is available monthly. Emergency Medicine interns/residents are required to attend conferences 5 hours per week. Off-service interns/residents are required attend 3 hours per week. During your rotation, you will likely be scheduled in the ED on one or more Wednesday mornings. **On these mornings you should attend sign out rounds and check in with the ED attending prior to departing for conference.** When you are not scheduled to work in the ED, you should attend at least part of the Wednesday morning conference. Attendance will be taken at these conferences and reported to individual residency directors at the end of each rotation along with your final evaluation.

*If you have questions or concerns, please feel free to contact:*

**Cherri Hobgood, MD**

*Assistant Professor*
Important Items to Keep in Mind:

1. Although you will be quite busy at times, make sure you speak to any family or visitors who may be in the waiting room after you have finished your evaluation. It is important to let them know how well the patient is doing and give them an estimate of the anticipated length of stay. Always overestimate the length of stay. Things take longer than you think.

2. Laboratory studies and X-rays are ordered only if they impact on acute treatment, immediate decision making, or are essential for the provision of follow-up care. The Emergency Department is not the place to begin an extensive workup of non-critical problems.

3. Every patient should be given instructions for follow-up care and referred to a follow-up physician, no matter how trivial the problem may seem. (see documentation and charting guidelines)

4. You should be able to arrive at a reasonable clinical diagnosis on most patients. If you lack a definitive diagnosis, you must have formulated a clear differential diagnosis and have ruled-out all possible life-threatening conditions before the patient can be discharged safely.

5. Information concerning patients seen or discussed in the ED is confidential. It should not be discussed anywhere else, other than in a medical conference setting. This means you must not discuss patient information in the hallways, nor the elevators, nor in downtown restaurants, etc. You are a professional and must conduct yourself as such.

6. All patients who are seen in the Emergency Department are the ultimate responsibility of the attending emergency physician. Consequently, THE EMERGENCY DEPARTMENT ATTENDING MUST SEE EVERY PATIENT AND SIGN EVERY CHART PRIOR TO THE PATIENT’S DISCHARGE, ADMISSION OR TRANSFER.

7. Some patients have such serious illness at the time of presentation that they may decompensate in a very short period of time. Because of this, there are certain circumstances when it is vital for you to notify the attending physician of the patient’s condition IMMEDIATELY AND POSSIBLY BEFORE YOU HAVE FINISHED YOUR INITIAL EVALUATION. (You will find a list of these circumstances attached in this handout.) If you think a particular patient is unstable, alert the attending on duty.
8. **SMS Informatics System (SMS):** All ED patients are tracked on a computer system called SMS. When you arrive in the ED, you will be instructed how to use this system to sign up as the provider for the patients you are evaluating. In order to access this system, you must have a valid UNC Hospital code and password.

9. As patients enter the Emergency Department, they are triaged by the nursing staff. The **triage designations are:**

<table>
<thead>
<tr>
<th>Stability of vital functions</th>
<th>ESI-1</th>
<th>ESI-2</th>
<th>ESI-3</th>
<th>ESI-4</th>
<th>ESI-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life-threat or organ-threat</td>
<td>Unstable</td>
<td>Stable</td>
<td>Stable</td>
<td>Stable</td>
<td>Stable</td>
</tr>
<tr>
<td>Severe pain or severe distress</td>
<td>Immediately</td>
<td>Sometimes</td>
<td>Seldom</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Expected resource intensity</td>
<td>Maximum: staff at bedside continuously; mobilization of outside resources</td>
<td>High: multiple, often complex diagnostic studies; frequent consultation; continuous (remote) monitoring</td>
<td>Medium: multiple diagnostic studies; or brief observation; or complex procedure</td>
<td>Low: one simple diagnostic study; or simple procedure</td>
<td>Low: exam only</td>
</tr>
<tr>
<td>Med/staff response</td>
<td>Immediate team effort</td>
<td>Minutes</td>
<td>Up to 1 hr</td>
<td>Could be delayed</td>
<td>Could be delayed</td>
</tr>
<tr>
<td>Expected time to disposition</td>
<td>1.5 hr</td>
<td>4 hr</td>
<td>6 hr</td>
<td>2 hr</td>
<td>1 hr</td>
</tr>
<tr>
<td>Examples</td>
<td>Cardiac arrest, intubated/hypotensive trauma patient, acute (&lt;3 hr) MI or stroke</td>
<td>Most chest pain, stable trauma (MOI concerning), elderly pneumonia patient, altered mental status, behavioral disturbance</td>
<td>Most abdominal pain, dehydration, esophageal food impaction, hip fracture</td>
<td>Closed extremity trauma, simple lac, simple cystitis, typical migraine</td>
<td>Sore throat, minor burn, recheck</td>
</tr>
</tbody>
</table>

In general, patients should be seen in the order in which they arrive in the ED, however patients triaged as “1” or “2” should be evaluated before those designated “3-4-5”. If you are unsure which patient you should evaluate next, ask the attending or a senior resident to direct you.

**SCHEDULE**

Housestaff will be assigned to one section of the department and will report ONLY to the attending staffing that section.

**RESPONSIBILITIES**

Role of the Emergency Department Attending

The ED attending is primarily responsible for patient flow and consultation. The ED attending will be responsible for the supervision of all medical students and houseofficers. Housestaff cannot sign student orders.

Role of the PGY-III Resident

The PGY-III Emergency Medicine Resident has three main responsibilities in the ED:
1. Directly evaluate patients as the primary physician, with particular attention to critically ill or injured patients.

2. Ensure that patient flow in the ED is maintained.

3. Supervise one or more PGY-I residents who are working in the ED.

4. Perform or supervise procedures required for patient care.

5. At times, these residents may take a turn at being “in charge” of the ED under the supervision of the attending.

**Role of the PGY-III Medicine Admitting Officer**

The role of the PGY-III Medicine Admitting Officer is to admit patients to the medicine services. This requires “calling the patient in” to bed control and calling the intern or team who will be admitting the patient as well as evaluating the patient for proper placement within the hospital.

**Role of the PGY-I and PGY-II Residents and Medical Students**

The PGY-I resident and medical student are primarily responsible for patient evaluation and management. Remember that you are here to learn and that specific questions are expected. **It is better to ask and ask early!**

**PATIENT CARE AND CASE PRESENTATION**

*It will be the responsibility of the EM PGY-III resident, all PGY-I residents, and medical students to pick up new patients as they are added to the board by the triage nurse. Patients are to be seen according to their time of entry into the ED unless another patient with a potentially life-threatening complaint has not yet been evaluated. Patients with life-threatening complaints are designated by a triage classification of “1” (in red) and should be seen promptly. If you are not certain whether a particular patient is to be seen, ask the attending physician or triage nurse.*

The residents will see and evaluate the majority of patients. This initial evaluation is to consist of a history and physical examination, which may be “directed” if the patient has an obviously isolated problem (such as a minor extremity injury). All other patients should have a complete history and physical examination including social and family history, medications and allergies. This evaluation should take no longer than 5 to 10 minutes to complete.

**ANY PATIENT WITH A CONDITION WHICH MAY DETERIORATE PRECIPITOUSLY MUST BE CALLED TO THE ATTENTION OF THE ED ATTENDING IMMEDIATELY, EVEN IF THE INITIAL EVALUATION IS NOT COMPLETED.** A list of such conditions is listed in this handout.

After formulating a differential diagnosis and treatment plan, but before writing orders, the intern is to present the patient to the ED attending. At that time, an evaluation and treatment plan can
be formulated and orders written. All orders written by housestaff must be countersigned by the ED attending. No verbal orders are acceptable.

After all ancillary studies have been completed, the houseofficer is to present the case to the ED attending again, this time noting the results of laboratory values, X-rays, etc. At this time a disposition will be made and the patient will be either discharged, admitted or transferred to a different institution. The attending must countersign the chart at this time.

All admissions to the general medical service are to be referred to the Medicine Admitting Officer for notification of the floor team.

**TYPES OF PATIENTS SEEN**

Adult patients with a wide variety of complaints are seen in the Acute Care area of the ED. In addition to evaluating and treating patients with general medical and surgical problems, you will gain experience with patients whose complaints include the following:

- **Psychiatric** - Our responsibility is medical clearance; be especially careful with elderly patients or those with confounding medical problems; some psychiatric patients will be seen directly by the Psychiatric consultants.

- **OB-Gyn** - Women at 20 weeks or greater gestation are transferred directly to Labor and Delivery. The exceptions to this are if they have any type of trauma or a complaint totally unrelated to pregnancy. All women between 10-60 should be assumed to be pregnant until proven otherwise by a negative urine pregnancy test.

- **Trauma** - Major trauma patients, as determined by criteria, are seen by the Trauma team, EM Attending and Senior Emergency Medicine Residents. Patients with lesser trauma are evaluated and treated by the general ED staff.

- **Pediatrics (ages 15 and below)** - These patients are seen directly by a Pediatric resident, either in Pediatric Acute Care (9a-11p) or in the Acute Care ED at other times.

**ANCILLARY SERVICES**

**Laboratory Studies**

1. Laboratory studies are ordered in writing on the order sheet. Be specific, the ordering of panels is discouraged.

2. Laboratory reports results can be obtained on the computer and hard copies are provided in the ED, although they may take longer. Be sure to check the computer frequently for results so the patient can receive disposition in a timely manner.

3. **All laboratory studies must be documented on the chart**, including those that are pending at the time of disposition.
Radiologic Studies

1. If a patient needs an X-ray, write the order on the order sheet and place in the new order rack. You need to write a reason for the X-ray study, i.e. R/O CHF, R/O free air. After 5pm and weekends, special studies such as IVP’s, CT scans and V/Q scans require the ordering physician to call the radiology resident to arrange the test. The X-ray orders are entered into the computer by the nursing staff.

2. Look at the patient’s X-rays even though the radiologist’s interpretation is written on the X-ray jacket. Remember that you have the advantage of knowing the patient’s clinical presentation and thus may notice something the radiologist might have misses.

4. If you cannot find the radiologist’s interpretation in the radiology reading room, you can dial the dictated report on RTAS. (x66831).

5. If you have any questions regarding the interpretation of a particular radiograph, you may consult the ED attending, the PGY-III resident or the radiology resident, whose name and beeper number are posted in the X-ray reading room.

6. **All radiologic studies must be documented on the chart!**

7. On the discharge sheet, there is a box to check to let the patient know that the X-ray interpretation is preliminary until the attending radiologist has reviewed the films. All films after 5pm on weekdays and on weekends are preliminary readings. If there is a change in the reading, the patient will be contacted.

**INSURANCE DESIGNATIONS**

Patients with Medicare, Medicaid, or Carolina Access should be called to the attention of the attending. The attending MUST specifically see these patients in order to bill for our services.

**MEALS**

Housestaff may briefly leave the ED for nutrition breaks as patient flow permits, but only after notifying the attending that they are leaving.

**DOCUMENTATION STANDARDS**

It is your responsibility to see that these standards are met on every chart. Charts will be returned to you for completion if documentation standards are not met.

**DISCHARGE INSTRUCTIONS AND FOLLOW-UP**
All patients are to receive a discharge instruction sheet prior to leaving the Emergency Department. There are specific items that must be included on the discharge form.

**CONSULTATIONS**

Consultation for admission to the General Medicine Services should be directed to the PGY-III medicine resident. Any patient who requires surgical evaluation or possible admission to the surgery services must be referred to the senior surgery resident on call (Beeper #1111). The beeper numbers of the other on-call consultation residents can be found on the SMS computer call list, by calling the hospital operator or by asking the ED clerk. It is usually best to discuss the calling of consultants with the attending or a senior resident before seeking consultation from other services.

**PATIENTS LEAVING THE EMERGENCY DEPARTMENT AGAINST MEDICAL ADVICE (AMA)**

All patients who threaten to leave the Emergency Department against medical advice (AMA) must be seen by the ED attending immediately. The patient is required to sign an AMA form on the back of the chart and must be properly informed of the risks of departing AMA.

**SECURITY AND PARKING**

 Escorts to the parking decks are available 24 hours a day. **USE THEM!!** Use the Point to Point Service (962-7867) or have hospital security accompany you! You cannot park in the ED patient parking lot.

**DRESS CODE AND IDENTIFICATION**

Name badges must be worn at all times. Housestaff are expected to look and act like professionals at all times. Scrubsuits are acceptable for wear in the Emergency Department provided they are clean and in good condition. Jeans, shorts, sweats and T-shirts are not permitted.

**ROUNDS AT THE MONITORS**

At 7a, 3p, 7p and 11p “Rounds” are held at the monitors on A side in the Acute Care Area. All interns, residents, students and attendings working in the ER briefly present their patient’s medical condition and the status of their evaluation.

**WHEN YOUR SHIFT ENDS**

You must turn your patients over to an intern or resident on duty in the ED. If your patient is nearing completion of their evaluation – please fill out the paperwork completely including the discharge form if appropriate. If the evaluation is in progress, please have a clear plan to pass on to the next doctor.
Medical Conditions Requiring Immediate Attending Physician Notification

The following is a list of conditions that require immediate notification of the Emergency Department attending physician, regardless of your level of training. This list does not cover all possible situations, and you should feel free to notify the attending immediately if you have a patient you feel may deteriorate precipitously or if you are uncomfortable given your present level of training.

1. Any patient who presents with or develops acute cardiopulmonary arrest.

2. Any patient with a complete or partially obstructed airway.

3. Any patient who presents with or develops a significant cardiac arrhythmia, whether stable or not.

4. Any patient with acute onset Alteration of Mental Status (AOMS). This includes any patient presenting with this as the chief complaint or any patient whose mental status deteriorates while in the ED.

5. Any patient with significant hypotension or hypertension. For these purposes, significant hypotension will be defined as blood pressure of less than 100 mmHg systolic and significant hypertension will be defined as a blood pressure of greater than or equal to 180 mmHg or hypertension associated with acute alteration of mental status.

6. Any patient with severe respiratory distress. For these purposes, significant respiratory distress will be defined as a respiratory rate greater than 30 breaths/minute, any patient with a pulse oximeter reading of less than or equal to 90 mmHg, any patient with an acute elevation of pCO2 greater than or equal to 60 mm Hg, any patient with a complaint of shortness of breath accompanied by diaphoresis, use of accessory muscles of respiration, cyanosis, alteration of mental status, bradycardia, or any other signs consistent with imminent respiratory failure.

7. Any patient with significant tachycardia or bradycardia. For these purposes, significant tachycardia is defined as a heart rate greater than or equal to 150 beats/minute and significant bradycardia is defined as a heart rate less than or equal to 60 beats/minute.

8. Any patient with a significant cardiac arrhythmia.

9. Any patient with either clinical or EKG evidence of acute myocardial infarction.

10. Any patient with a fever greater than 105 degrees Fahrenheit, any patient with significant alteration of mental status associated with a fever, or any patient with a fever and a potentially immunocompromised state (e.g. HIV disease, cancer patients, transplant patients, etc.)
11. Any patient with significant hypothermia. For these purposes, significant hypothermia is defined as a rectal temperature less than or equal to 95 degrees Fahrenheit.

12. Any patient with severe abdominal pain or abdominal pain associated with peritoneal signs.

13. Any female with abdominal pain and a positive pregnancy test.

14. Any patient with significant upper or lower GI bleeding (whether hypotensive or not).

15. Any patient who develops seizure activity while in the Emergency Department.

16. Any patient with significant abnormality of any laboratory value (e.g. hypo/hypernatremia, hypo/hyperkalemia, symptomatic hypercalcemia, hematocrit less than 28, etc.).

17. Any patient with a history of significant trauma.


19. Any patient with an overdose of prescription or over-the-counter medications.

20. Any patient or visitor who gives evidence of becoming significantly agitated, violent, or suicidal.

21. Any patient with a blood sugar of less than 70 mg/dL.

22. Any patient with a snakebite.

23. Any patient with significant bleeding, or bleeding associated with hemophilia (blood dyscrasias).

24. Any patient with a significant allergic reaction.

25. ANY PATIENT WHO YOU FEEL IS BEYOND YOUR PRESENT CAPABILITIES AS A RESIDENT, OR WHO YOU THINK MAY DETERIORATE SUDDENLY.

Documentation Standards

The following information is required on all charts for all Emergency Department patients for legal and billing purposes. Please review this in conjunction with the copy of the chart included in this packet.

1. Fill in the vital signs at the top of the doctors note. Alternately, you can write them at the beginning of your physical exam.
2. At the top of the chart or at the bottom the chart, under where it says “Attending Signature” write the name of the attending with whom you are seeing the patient. YOU MUST DO THIS!

3. Fill in the time at the top, left-hand corner of the chart, the time you began seeing the patient, which is not necessarily the time you are writing in the chart.

4. Use history/present illness to include information on the Past Medical History (PMH), Social History (SH) and Family History (FH), even if all you write is noncontributory. Important and pertinent social history in the ED settings includes uses of tobacco or alcohol and with whom the patient lives.

5. You need to list the medications the patient is taking and any drug allergies the patient has. If the patient has no allergies, write none; if no medications, write none. If you don’t write anything, others will not know if there are none or you don’t know or you didn’t ask.

6. The history of the present illness and physical exam should be limited to what is pertinent to the patient’s main complaint.

7. All laboratory studies, EKG, and X-rays are recorded along the right side of the chart.

8. Fill in the review of systems as pertinent to the patient. If you have described this in the HPI, note that. Keep in mind, for complex patients (basically any patient ill enough to be admitted) you must include 10 (ten) different ROS - even if the comment is “no change” or “0” null sign.

9. Fill in the Physical Examination. For complex or critically ill patients you have to be complete. These patients are required to have 8 (eight) body systems examined.

10. After you record the history and physical, write a short assessment including differential. Alternately, you can make a problem list (acute problems). In the differential, include what you believe is the patient’s problem, as well as the worst case scenario. For example:

   Pt. #1: Young man with diffuse abdominal pain, nausea and vomiting –

   Pt. #2: Young female with reproducible sternal pain -- probable musculoskeletal chest wall pain / costochondritis, doubt cardiac chest pain
Based on the differential problem list that you have established, it should be obvious by reviewing the chart how you distinguished among the possibilities and came to your final diagnosis. Some examples: GI cocktail given, patient with complete relief; Phenergan 25mg IV given, nausea relieved and patient tolerating PO well.

If you make a clinical diagnosis without any work-up, you need to explain that. For example: 20 year old white female with reproducible chest wall pain, no risk factors for CAD and no associated symptoms, likelihood of cardiopulmonary disease as the underlying etiology is very low. We will treat her with NSAID’s. Patient knows to return if symptoms change or worsen.

11. If the patient is in the Emergency Room for a significant length of time waiting for disposition or a bed, you need to make note that you reevaluated the patient during this time. For example: 2:45 pm Patient now afebrile and tolerating oral fluids well. Many conditions such as respiratory distress, chest pain and abdominal pain require frequent reevaluation, and you need to document it.

12. If you counseled the patient about a health problem (i.e. diet, importance of taking HTN meds, need to drink less ETOH), write on the chart that you did this. All patients evaluated for STD’s must be counseled about HIV, and you must write this down.

13. If you call a consultant to see the patient, write down the time and who you talked with at the bottom of the Attending note box. For example: 6 pm Discussed case with Dr. Smith (General Surgery) who will evaluate patient. “Curbside” consultations are not official. If there is really a question, the patient must be seen by the consultant.

14. Write a procedure note for all procedures done on the patient: Lumbar puncture, thoracentesis central lines, etc. You need to write this in the procedure box bottom left corner of chart.

15. For lacerations, you need to include the following information by filling out the box in the lower left corner of the chart.

- location on body (make drawing if you are so inclined).
- size (must be in cm) and is it dirty? Describe wound.
- you need to describe the repair (irrigation solution and amount, type of suture material, type of sutures (interrupted, subcutaneous, etc.), how many layers, anesthesia (solution, how much, local vs. digital vs regional).
- Remember to ask about tetanus status for all wounds and document this.
16. Diagnosis: The first written down pertains to why they are here today, but if they have underlying disease that is pertinent to what is going on, you need to write that down as well. For example:

   Pt #1: Chest pain, rule out MI
   
   HTN
   
   Type II DM
   
   Pt. #2: R/O cryptococcal meningitis
   
   AIDS
   
   Severe Hemophilia A without inhibitor

17. Attending Note – The attending evaluating the patient with you will need to write a detailed note in the area designated “Attending Note” – so please leave that space open. At the bottom right of the chart under “Evaluation and Management” is the patient charge as determined by the Attending physician – leave that blank.

18. Injury Assessment (bottom right of chart) – please fill this area in if your patient has been injured. Check the appropriate boxes to answer the questions if you have the information available.

19. Signatures at the bottom of the chart: You need to sign as the examining physician with your physician code. The attending will sign at the bottom right of the chart.

20. Condition on Discharge - Be honest but statements such as “Good” or “Improved” are best. “Stable” is also acceptable. If the condition is “poor”, “serious” or “critical” – the patient should usually be admitted.

**DISCHARGE INSTRUCTIONS**

These are very important and reviewed in detail. This is a common source of legal problems in Emergency Medicine – so take the time to do it thoroughly.

**You must include on this sheet:**

1. Your name at the top as the physician; interns need to put the attending’s name also.
2. List any new medications you have prescribed for the patient.
3. On the blank lines, write specific instructions for the patient:
   a. **Diagnosis:** This will sometimes be vague, such as “viral syndrome”
b. **Medication Instructions**: Detailed, understandable instructions about any new medications you give the patient and what they should do with their other medications (either continue them as before or discontinue them, etc.)

c. **Reasons to return**: What exactly to return to the ED for: i.e. temp >101.5 despite Tylenol; unable to keep fluids down; redness of effected area; etc. **You need to be specific**. The patients are often medically unsophisticated and might not know when something is wrong. **DO NOT USE MEDICAL TERMS!**

d. **Follow up plans**: Specific plan for follow up: who to call, their phone number, when to call, what to be seen for. **Every patient**, even those with the most minor complaint should be given some follow up instructions, if even just the phone number to call for an appointment. (UNC Healthlink is 966-7890)

All patients should receive Follow-Up. Follow-up options include but are not limited to:

1. Follow-up with their own doctor (**MUST BE NAMED**) for a specific period of time. If the patient is unable to identify an MD, a referral should be given.

2. **UNC Clinic Appointment**:

   Options for obtaining this are:

   * You can call and get an appointment for the patient (Mon-Fri 8a-5p)

   * Fill out a clinic referral sheet available in the ED, these are faxed to a central office where appointments are made,

   * You can give the patient the phone number for a specific clinic (some are listed on the discharge sheet) BUT, keep in mind, it may be several months before a patient can get an appointment.

   * Some clinics will see patients on a “walk-in” basis, examples are: Urgent Care (medical problems) adjacent to ED; Dermatology (ACC); Ophthalmology (ACC); ENT (Ground Floor Neurosciences); OB/GYN (ACC).

   * Family Medicine will usually see new patients in 7-10 days.

3. **Appointments at Urgent Care Clinic**: This is for follow-up of medical conditions, usually or a specific problem. The ED clerks can schedule this appointment through the computer system.
4. Follow-up at Minor Trauma. This is for minor surgical/traumatic injuries such as suture removal, wound rechecks, minor orthopedic injuries. The patient does not get a specific appointment. Determine what day the patient needs to return – write on a discharge form for them to return to Minor Trauma between 12 noon and 8 p that day.

5. Healthlink (966-7890) – appointment will be arranged for patient but not necessarily soon.

6. Return to ER. (Not a great choice, but sometimes necessary if you can’t figure out any other follow-up)

7. **PRN is not an option.** DO NOT write it on the chart.

*These instructions need to be legible and reviewed with the patient at least one time. We have instruction sheets available (English and Spanish) for back pain, head injury, diarrhea, etc. Spanish interpreters can translate instructions which are not pre-printed. The resident or student physician should verbally review the discharge instructions with the patient and/or family. The written discharge instructions are placed in the “New Orders” file. A nurse will review the instructions with the patient and have them (or their representative) sign that they understand the instructions. The patient leaves with the top copy of the discharge instruction sheet.*

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**Welcome!**

From the Nurses in the Emergency Department

*The following handout details survival skills for your emergency department rotation. We hope that it may be helpful to you.*

The ED is divided into several sections:

- Triage
- Acute Area
- Intermediate Area (Urgent Care Center)
- Minor Trauma
- Pediatric Acute Care

The nursing staff is assigned by “team.” One or two nurses are assigned to the triage area. These nurses are responsible for screening all patients and prioritizing their care.
The Acute Area is divided into Team A and Team B. Two or more nurses are assigned to cover each of these teams.

There are three trauma bays, including a pediatric resuscitation bay. There are two cardiac resuscitation rooms. The Team A consists of beds four through nine, and beds 23 through 27. Team B consists of beds ten through twenty-two, as well as the ortho suite. A nurse is assigned to cover Minor Trauma during its hours of operation -- usually noon to midnight. Minor Trauma is staffed by an assigned intern or resident in consultation with the ED attending.

There is a pediatric float nurse on evening shift and a nurse assigned only to the pediatric acute care area. The pediatric area is staffed by MD’s from the Department of Pediatrics.

A charge nurse is assigned to coordinate the care of the ED patients. At various times, the charge nurse will also have a patient care assignment. Two nurses are assigned to the trauma team. If there is a trauma in progress and the nurse assigned to a certain area becomes unavailable, refer all questions to the charge nurse.

Remember, if you are busy, so is the nursing staff!
This is a team-oriented department. Help us and each other!

General Information

It is mandatory that you wear your name tag!

Familiarize yourself with the clean and dirty utility rooms on your first day. You will find this invaluable. Most of the equipment you need is located in these areas. Equipment is secured in the PYXIS.

Tidy up after yourself after completing an exam or procedure. There are trash cans located at each patient care bedside. (This includes the lounge!)

The ED staff is a lifeform in itself. The nursing assistants, clerks, nurses, and social worker can be great resources for the inside scoop on usual routines, community resources, etc.

Clerks can help you with phone calls and paging. Clerks answer the phones, even if you have paged someone. Listen to the intercom for your name or the person you have paged. The key staff in the ED have assigned intercom cell phones.

Nursing Assistants can perform the following:
• simple wound preps
• crutch set-up
• lab transport
• patient transport (excluding monitored patients)
• room set-up
• assist with procedures

*Remove all needles and sharps from trays and dispose of them in the sharps box!*

If a laceration needs sutures, anesthetize the wound prior to wound prep. The department’s infection rate has been consistently 0% because the NA’s do an excellent job.

RN’s

1. Unless the patient is acutely ill, please allow the RN to triage the patient prior to beginning your exam or gathering information.

2. ED nurses will assess the acuity of patients and institute treatment and diagnostic procedures prior to your seeing the patient. For example: monitoring, IV access. Orders still need to be written for the patient.