Harbor-UCLA Medical Center

Department of Emergency Medicine
Rotation Guide 2015-2016

Last Update: 7/27/2015 Isakson

Introduction

Welcome to our Emergency Department! The Harbor-UCLA Medical Center Emergency Department (ED) has been completely rebuilt and we moved into our brand-new, high-tech, modern space on April 20th, 2014. Our ED sees over 80,000 patients annually and is a Level 1 Trauma Center. Please read this guide to help get the most out of your rotation with us. We look forward to working with you; if you have any questions please do not hesitate to contact the appropriate individual below:

Chief Residents, 2015-2016

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Scheduling

Shift Structure

Purple Team (Team "A")	Green Team (Team "B")
Day A: 7:00 A.M. to 5:00 P.M. Rounds at 7:00 A.M. and 4:00 P.M.	**Day B: 7:30 A.M. to 6:00 P.M.** Rounds at 8:00 A.M. and 5:00 P.M.
Swing A: 3:30 P.M. to 1:00 A.M. Rounds at 4:00 P.M. and midnight	**Swing B: 4:30 P.M. to 2:00 A.M.** Rounds at 5:00 P.M. and 1:00 A.M.
Night A: 11:30 P.M. to 8:00 A.M. Rounds at midnight and 7:00 A.M.	**Night B: 12:30 A.M. to 9:00 A.M.** Rounds at 1:00 A.M. and 9:00 A.M.

- Rounds occur 30 minutes after shift begins (to give individuals time to see patients prior to rounds), ***except*** for "Day A" shift which begins with rounds. Individuals are not expected to see patients prior to rounds on "Day A" shifts.
- Schedules for the Adult ED are available on www.amion.com, password humc or at www.emedharbor.edu/private/ in the Schedules section.

Requesting Days Off and Missing Shifts

- Request days off by attempting to find another intern / resident to cover your shift, and preferably designate the day and shift that you will pay back, then email Christiane (christiane@emedharbor.edu), cc/ Cheyenne (csanderlin@emedharbor.edu) to confirm.
- If you must miss a shift for an acceptable reason, please e-mail the chief who is in charge of your schedule, the program coordinator Christiane, ***and*** call the Emergency Department doctor's work room at (310) 222-3969 once your shift is scheduled to begin to let the team know they will be missing a person.
    - Unexcused shifts will result in failure of the rotation.

Emergency Medicine Philosophy

During the rotation, the most important skill you will learn is the approach to the undifferentiated patient. ED patients rarely present with a label of "diverticulitis," "CHF exacerbation" or "subarachnoid hemorrhage." Instead, they present with broad complaints of abdominal pain, shortness of breath, headache, or vague weakness. You must immediately assess whether the patient is essentially well, somewhat sick, or very sick. Sorting out who is sick versus who is well, who needs critical care versus a ward admission, and who needs urgent medications or other interventions is complex, but the ED curriculum is designed to help you to develop a framework to make those assessments and decisions.

Once an initial game plan for a patient is outlined, even early in the evaluation, one must be willing to amend it as needed. Patients require constant reevaluation, and the plan of action is modified as needed. The Emergency Department is a CRITICAL CARE AREA; treat your patients as though they may crash unexpectedly, and you won't get caught unprepared. Prepare for the worst-case scenario and don't get into the habit of selecting the most likely (and least serious) diagnosis until you have adequately ruled out the potential life threats.

Keep your patients moving and be efficient; you may need the bed very soon for another patient. When you are evaluating one patient, the lab work, EKG, etc., for another patient should be getting done. Something effective is being accomplished for ALL of your patients AT THE SAME TIME. If a patient is to be admitted, and further EMERGENT evaluation is not needed in the ED, every effort should be made to get the patient to the appropriate inpatient area as efficiently as possible.

We use a team approach in the ED including working closely with our nurses and technicians. Please communicate patient plans on all levels. Our team goal is to provide the highest quality of care for our beneficiaries in the most efficient and compassionate manner possible.

Ground Rules for the Emergency Department

General Ground Rules for PGY-1 Residents

- You may see any patient you would like if it is on your team, **except** for traumatic injury patients
  - Lower-level traumatic injury presentations are called "Trauma Consult" or "TC" and are seen by the junior EM resident
  - Higher-level traumatic injury presentations are called "Trauma Team Activations" or "TTA" and are seen by the senior EM resident
- If the patient is "sick" and requires active resuscitation or immediate orders, please notify the senior resident immediately.
- All cases that a PGY-1 initially sees are initially presented to the senior resident on your team – this is a chance for you to get teaching, guidance, and to start honing your presentation, exam, and plan. Afterward, you will present the patient to the attending.
- **Please do not write orders on patients without first consulting your senior resident.**
- Emergency Department policy is that **all admissions and consultations** must be performed by a **junior or senior resident**.
- Sign up for patients immediately if they are available to maximize your experience and to see the widest variety of patients.
- Everything you order must be followed up on, or clearly document who has agreed to follow up on testing (e.g., "Dr. John Smith from neurology requested a vitamin B_{12} level which he states he will follow up on the result for.)

Meals in the Emergency Department

- If your patients are stable, ask the senior resident if you can go to the cafeteria to pick up food. Food should be picked up in the cafeteria and brought into the Resident Work Room (Lounge) to eat.
- Snacks and drinks with lids are acceptable in the Doctor Work Rooms, meals are not.

Rounding

Rounding is a time to safely transfer patient care and provide teaching for the residents. Please pay attention during rounds. Common terms you will hear are provided below:

- **Pickup**: This is a patient who does not yet have a disposition (e.g., is not definitely discharged or admitted to a service) and has things pending. The junior resident will take these patients from the team that is going home during rounds.
- **Follow**: This is a patient who has a disposition (e.g., is already admitted or discharged), but is not yet off of our board in the Emergency Department yet. Patients must be admitted for a minimum of two hours and have admission orders from the admitting team for us to remove our names from the board. The senior resident will take these patients from the team that is going home during rounds.

Documentation

Documentation is critical to providing appropriate patient care and having other providers understand your thought process. Please go over all your charts with your senior resident to ensure appropriate documentation, as it is too complex to summarize here.

Consultations

All consultations must be performed by a PGY-2 resident or above. The consultant's name should always be documented, as should the timing of the page, first contact, and recommendations. Consultants are important and their job is to (1) answer a focused question we have for them, (2) provide a procedure or service we do not have access to (e.g., cardiac catheterization, dialysis), or (3) create a follow-up that we do not have access to (e.g., expedited outpatient endoscopic appointment). Ensure that you have all the appropriate information prior to consulting another service, and have approval of the attending physician responsible for that patient. In general, consultations should have the following format:

- Introduction, obtaining name.
- Providing patient identifying information (e.g., John Doe, medical record #, location).
- Focused reason for consultation (e.g., "Reason for consultation is for hemodialysis in a patient with a potassium of 9, has a left AV fistula in place.")
- Brief presentation of the patient and important lab/imaging/diagnostic testing.

Radiology

- **X-rays**: All X-rays must have a note placed in on Synapse reflecting your read of the X-ray. This is important because unless specifically requested to do so, radiology does not read X-rays by the time the patient is discharged from the ED. Therefore, when the radiologist reads the X-ray they can see what you felt the findings were. If their opinion differs, they can call the resident running the board to ensure the patient gets contacted if necessary.
- **CT**: CT scans must have an order in Orchid, and (if applicable) the consent for contrast. These can be left in the patient's nursing chart.
- **Ultrasound**: Ultrasound requests must have an order in Orchid

Discharging Patients

- All patients should have a complete in Orchid filled out. This includes diagnoses, prescriptions (note that controlled substances require a separate controlled substances prescription paper), follow up information (including intrafacility referral forms or specialty forms if necessary), and discharge instructions with return precautions.
- Low-acuity follow-up can be done via a community health clinic (CHC) referral, which is a list of clinics in the area. The patient must call for an appointment.
- **Check the patient's insurance status** as they may have a primary doctor already – do not book these patients who cannot be seen at Harbor into our appointment spots, because (1) it wastes the patient's time when they show up and cannot be seen, (2) delays the patient's appropriate care, and (3) uses one of our appointment spots that could have been used for someone else.
- Ask your senior resident what the follow-up options are for each individual patient if you are unsure.

Curriculum

The curriculum emphasizes the core emergency medicine topics based on which patients you evaluate. The ED staff has chosen 15 core clinical presentations and 4 procedural competencies based on important presenting complaints. Of these, it is expected that you will see at least 10 during your ED rotation. Try to see a patient with one of these presenting complaints on every shift. Make sure your

supervising staff or resident knows which ones you are aiming to see on a given day so that they can steer those patients your way. These complaints have been selected either because they are considered key ED presentations or are unique to emergency medicine. Return the documentation of these encounters to the attending ED coordinator.

After seeing a patient with one of these presenting complaints, you will present the patient to the staff or senior resident as usual, and then have a focused discussion that revolves around the assessment and management options. The intent is to help you develop a roadmap or approach for future problem solving, not simply to fill your head with facts. These discussions are meant to be interactive, not an interrogation. Feel free to ask questions of your own and to challenge your staff/resident as to why one approach might be preferred over another, or what evidence supports that approach.

You will be expected to have formulated an overall assessment, a differential diagnosis with emphasis on immediate life/limb/vision/fertility threats, a diagnostic strategy, the likely disposition for the patient (ward admit, critical care admit, observation, discharge), which (if any) consultations might be required, and management options prior to presenting the patient. It is fine to be "wrong" (i.e. have your supervising staff/resident disagree with you) about any of these assessments or plans. The staff does not expect you to know everything about emergency medicine – if you did, there would be little point in doing the rotation! The staff will be assessing your knowledge base to some degree, but enthusiasm, rigor of your thought processes, dedication to your patients, ability to take criticism, and good communication with all parties (patients, other physicians, and ED nursing/clerical staff) are at least as important to your success on this rotation as your "book smarts."

Core Presenting Complaints

1. Abdominal pain
2. Altered mental status
3. Back pain
4. Chest pain
5. Dyspnea
6. Fever in children under age 2
7. GI bleeding (hematemesis, melena, or hematochezia)
8. Headache & head injury
9. Laceration
10. Red and/or painful eye
11. Seizure
12. Shock/hypotension (hypovolemia, sepsis, anaphylaxis, neurogenic, cardiogenic)
13. Soft tissue redness/swelling/pain
14. Suicidality/psychosis
15. Toxic ingestion/overdose

Additional Important Presentations

1. Burns/electrical injuries
2. Cardiac rhythm disturbance (especially a-fib and SVT)
3. Glucose related emergencies (hypoglycemia, DKA, hyperosmolar nonketotic state)
4. Heat emergencies/rhabdomyolysis
5. Mammalian bites (dogs, cats, rodents, human)

6. Scrotal/testicular pain
7. Snake bites
8. Syncope
9. Trauma
10. Vaginal bleeding

Evaluation Process

In addition to attending all scheduled shifts and educational activities and completing required documentation, you will be evaluated during your shifts. Throughout your rotation you should choose 4 attendings and 4 residents to complete an evaluation form. By the end of your rotation, you should have a minimum of 8 evaluations. Additional evaluations are always welcomed. Once the evaluation is complete it will be returned to the evaluation box in the ED and used to complete your overall evaluation for the rotation. A copy of the evaluation is attached and copies can be found in the ED.

If at any time during your rotation you need remediation based on poor performance, this will be handled on a case by case basis with the attending rotation coordinator.

There may be requirements for patients seen and procedures performed during your rotation. These will be provided to you on your first day of the rotation.