



Rady Children's Hospital
San Diego, California

Emergency Medicine House Staff Manual

About the ED

General

Welcome to the Emergency Department of Rady Children's Hospital. We are very pleased that you will be spending time with us and hope that your rotation will be a rewarding one. The Emergency Department staff is very committed to housestaff education. Each of us feels that housestaff education is extremely important. We all feel that it is one of the most rewarding aspects of our job. The following guidelines have been established to help orient you to our department. Please take the time to read through this manual.

Patient care is always our number one priority. We will try to provide as much didactic teaching as possible, but there will be times when we get busy and cannot spend as much time teaching about various aspects of emergency medicine.

Housestaff will be the primary care providers in the ED for each patient they see. However, the attending staff will be expected to hear and see about each and every patient you see. When we become comfortable with your assessments, we may ask for abbreviated versions of the presentation. There will be 24-hour attending coverage, with increased attending coverage during busy hours.

Schedule Shifts will be 8-12 hours in length. You will be expected to work 2 to 4 weekend shifts. You will be required to work 4 eight-hour shifts per week and two to four weekend shifts per rotation. All residents will be excused for continuity clinics. UCSD EM residents will be excused for their Tuesday morning lecture series. Residents rotating from an institution other than UCSD that are planning to spend part of the rotation on vacation should have a note from their chief resident or program director confirming this.

Time and Attendance

1. You should be on time for your shift.
 - a) This means out on the floor and starting work at the assigned time of the shift.
 - b) This is not just an expectation, but also a common courtesy to your co-workers.

Personal Business on Work Time

1. Everyone should focus on their assigned duties while on their shift.
2. Reading of medical related material is allowed if there are no patients in the department.

Personal Phone Calls

1. At no time should calls interfere with patient care or the flow of patients through the department.
 - a) At no time should personal calls be made in the view of or hearing of patients or families.
 - b) At no time should a patient or family member know that a Team Member is receiving a personal call.

**Food in the Department/
Breaks and Meals**

1. Food is prohibited in the patient care areas.
2. Food should be kept out of the view of all patients and families.
3. Please do not eat food items which are provided for the patients families.

Sorry, unless your institution provides them, there are no free meals.

Professional Appearance

1. Please ensure all clothing is professional and appropriate for the work environment. We expect housestaff to be dressed in neat clothes or clean scrubs and a white coat. No T-shirts, sweatshirts, jeans, or sandals.
2. Ensure that the clothing and shoes worn provide protection in accordance with hospital, departmental, and infection control policies.
3. Your primary institution photo ID badge and a Rady Children's ID badge must be worn at all times while on the RCHSD campus.
4. Applying of cosmetics or contact lenses within patient care environment is prohibited.

Professional Behavior

1. Our patients and families are valuable to us.
2. When parents are driven with anxiety our goal will be to help them feel more comfortable and educate them on what is happening to their child.
 - a) Treat every interaction with patients and families as you would expect to be treated.
 - b) Do not judge parents. Educate them on the reasons to start treatment early.
 - c) Assist in helping parents that are upset. Communicate with both patients and families regarding what to expect, why things are happening the way they are, what procedures are going to be performed, and why the procedures are necessary to help decrease their anxiety.
 - d) Assist with other patients in the emergency department.
 - e) All patients and visitors are to be treated with respect at all times.

**Quality of Care
and Teamwork**

1. Always place high quality care as the top priority.
2. Always view all the patients in the department as "our" patients, *not* "my patients and your patients."
3. Offer to take patients or assist others as appropriate.
4. Everyone's workload should always be equal. Never sit or stall while others carry the load.

Departmental Cleanliness

1. The cleanliness of the department is the responsibility of the TEAM. The impression that our environment makes to our families and patients is very important in helping to instill confidence in the quality of care that we provide.
2. Be sure to remove sharps from your trays after procedures.

Patient Care

Don't recap needles!

When you start your shift, introduce yourself to the charge nurse and the attending if you have not met. Write your name and resident level on the board with your beeper number along side it.

Order Patients Seen

Patients are seen according to acuity, then in order of time in room. There will be no picking or choosing of patients. Red dot patients or orange triage acuity level I or II patients will always be seen preferentially.

Currently, the sickest patients are not entered immediately into the tracking system. The attendings are usually made aware of these patients' status. They may ask you to be involved in the care of these patients. If you feel that the patient on your initial assessment is toxic-appearing, notify the attending immediately.

Medical students need to check with the attending before seeing red or orange dot patients.

Initially, discuss the ordering of all lab and x-ray studies with the attending on duty. All lab and x-ray orders should be written on the order sheet and placed in the clerk's rack to be taken off. The lab technician will be able to draw most labs. Nursing orders should be reviewed with the nurse assigned to the patient.

Once the patient is ready for discharge, check the discharge order on the order sheet.

- a. diagnosis
- b. signs and symptoms to return to the ED immediately
- c. follow-up appointment

Check boxes to use prepared discharge instructions in the ED, in addition to your written instructions. These are available for the majority of diagnoses made in the ED. You should be familiar with the content of each.

Educational Responsibilities

During each rotation of your residency training, you should have specific goals that you want to accomplish to further your education and strengthen areas in which you need improvement. Think about what areas you want to learn more about and what skills you would like to become more proficient at. Discuss these goals with the ED attendings, and we will try to help you achieve them.

Scheduled Conferences

A conference schedule is posted on the resident bulletin board in the ED.

Lectures are no longer being offered, due to resident work hour restrictions. Self-paced modules are being developed and will be available on-line. You should download the article and test on fever. Please return tests to Sandy in building 19 or at MC 5075.

Other educational opportunities include pediatric grand rounds (Friday, 8:00 a.m.— 9:00 a.m., Dining Room A/B/C), pediatric case conference, and pediatric trauma conference. A copy of the monthly conference schedule can be obtained from the ED secretary.

Evaluation

Attending/rotation evaluation: Please download a copy of our evaluation form. It is mandatory that this is filled out and turned in to Sandy Ische at the end of your rotation. You may also e-mail it to her at sische@rchsd.org. (See Appendix C.)

Resident evaluation: The ED attendings will fill out the evaluation form that is given to us by your institution. If your institution has not received one in a reasonable amount of time, call Sandy at (858) 966-8036 to make sure we have an evaluation form to fill out.

A to Z Topic Review

Admission Try to decide as early as possible whether your patient will require admission. When the hospital is busy there may be a delay in getting a bed. Decide with the attending: a. location (ward/IMU/ICU); b. diagnosis; c. attending. The following people need to be notified when a patient is admitted to the hospital:

1. **ED charge nurse.**
2. **Patient's primary physician.**
3. **Admitting attending:** may be the primary, a specialist/hospitalist.
4. **The pediatric resident.** Some attendings do not require housestaff coverage.

Animal Bites All animal bites should be reported to the San Diego Animal Control Department (619-236-4250).

BIDS We are participating in a surveillance project which is being conducted by the US and Mexico. All patients are screened for eligibility on the green form on the chart. Patients with fever and rash or hepatitis symptoms may be eligible. Further information is available in the ED.

Charting All ED charts must be dictated before you go home. Use the format provided in Appendix A.

Be sure to document any invasive procedure you perform. (LP's, I&D's, CVP's, art lines, joint reduction or aspiration. Any procedure for which you obtain a written consent for requires a written procedure note).

Also be sure to document all lab results, even if the patient is admitted.

All orders for medications and procedures must have times and be signed.

Chart (Hospital) If the patient was referred, the chart may already be in the ED. If the patient was seen in the ED in the last two months, we will be able to pull the record. If the visit has been in the last few days, the old ED record will usually be on the chart already. Otherwise, just ask the clerk to call medical records for the old chart.

Chart Location The ED chart should be kept in one of the following locations:

1. In the chart rack in the proper slot.
2. In the clerk's rack after orders have been written.
3. In your hands.
4. In the nurses' hands.

Please do not leave it on the counter or patient's room. Your help to keep the chart in the rack when not in use will increase the efficiency of the ED.

Child Abuse You should be aware of the guidelines for managing suspected child abuse here in the Rady Children's ED. There is an excellent guide, written by the Center for Child Protection, which is available for review in the ED. There is a social worker assigned to the ED, 12 hours a day, 7 days a week, and on-call social workers 24 hours a day. If you have any questions as to whether or not you should be concerned about possible child abuse, address this with the attending.

Prior to dictation, review the diagnosis, assessment, and plan with the attending. R/O NAT is not an appropriate diagnosis. Careful documentation of all injuries, assessment of whether the stated mechanism was the likely cause, and an assessment of risk to the child is standard.

Computer Access Call Ramona Travis in Med Staff Services at extension 3435 to obtain a computer access code.

Call Prentice Parish at 2669 or 8056 for tracking board training.

Consulting List A daily list is maintained by the ED clerk for paging numbers for the various consultants on call to the ED. Pages should be placed by the unit secretaries.

Follow-up Appointments As a general rule we do not perform follow-up visits on our patients. Special exceptions include wound checks, patients who require urgent follow-up that do not have a regular physician or do not go to a particular clinic, and suture removal when they prefer to come back here (there are others). Patients without a primary care attending may be followed up in urgent care. Every patient should have a follow-up appointment made or advised at time of discharge.

IVs/Blood Draws Our nurses and lab technicians are very proficient at obtaining blood and rarely require physician assistance. However, venipuncture is a skill you should be able to perform. It is up to you to show interest and ask the nurse or lab tech to help you start an IV or draw blood. All ABG's must be drawn by a MD. However, the rule is, if you make two attempts without success, you are out, and get someone else to try.

Kawasaki study We are participating in a study of Kawasaki patients. Both cases and controls need to be enrolled. Information is posted in the ED. Control patients will only be enrolled during research nurse hours.

Lab Tests We have the ability to do the following labs here in the ED:

1. Bedside glucose
2. Urine dipstick
3. Hemocult stool/gastric
4. Rapid bloodgas analysis

Hemocult developer and documentation slips are found in the soiled utility room.

Always have labs sent by ED staff.

Never send CSF through tube system.

- Medical Students** Fourth year medical students will work in the ED.
1. Patients should be screened initially, to see if they are appropriate for the medical student.
 2. All orders, charts, and discharge instructions must be co-signed by a licensed physician.
 3. Attendings will review each case with the medical student.
 4. Students should identify themselves as student doctors or medical students (the word student must be audibly detected by the parent) . Name-tags must be worn.
- Needles** **BE CAREFUL!** Dispose of sharps in a sharps container as soon as possible. Don't stick them in the mattress. If you stick yourself, let the ED attending know.
- NPO Orders** Remember that whenever you identify a potential surgical candidate or a child that may require sedation, tell the parents, patient, and nurse not to allow the patient to eat or drink anything.
- Ophthalmology** It is imperative that visual acuity testing be attempted on every child that presents with an eye problem and documented in the chart. A slit lamp is available. Make sure you have been checked out on this instrument by one of the attendings before attempting its use.
- Patient Referral** Be sure to check the ED chart to see if a referral form is attached. Don't forget to call referring physicians back, if requested in the referral.
- Phone Numbers** Each counter in the central area has a list of commonly used numbers taped in the center of the counter.
- Poisonings** Poison Control (1-800-876-4766) should be contacted on every suspected poisoning. Consult attending if there are any questions. Micromedex is available on-line.
- Private Physician Notification**
1. Every physician that has referred a patient by phone should be contacted, unless they request specifically not to be contacted.
 2. You should notify the private physician if a parent requests.
 3. Be sure to document attending notification in the ED chart.
 4. The private physician should be notified on any patient that is admitted.
- Spanish Interpreter** Hospital translators are generally available 8am—3am. Try not to tie up our bilingual ED staff when it is not a life threatening emergency and a hospital translator is readily available.
- Suturing** Suture materials are available in the suture cart. Consult attending for suture type. See article in packet by Dr. Kanegaye.
- X-rays** We are responsible for initial interpretation of all x-rays. Be sure to review any x-ray you order with the attending. The radiologists provide "wet reads" when available.

General Objectives

1. Develop a logical, efficient approach to the assessment of the ill pediatric patient.
2. Put into practice the rapid cardiopulmonary assessment learned in PALS.
3. Learn to prioritize and triage patient care.
4. Become adept at procedures necessary to resuscitate and stabilize pediatric patients.
5. Build and expand knowledge base and technical skills regarding pediatric emergencies in a 'hands on' environment.
6. Learn how to deal with families, patients, and medical staff under acute stress.
7. Learn good charting and documentation.
8. Learn the 'safety net' method of the early evaluation and treatment of sick children (i.e., IV, ECG, and Ox monitor and oxygen).
9. Learn how to decide when certain pediatric problems should be admitted and when they can be safely sent home and managed at home.

Educational Objectives

1. Prehospital Care.
 - a. Know the difference between an EMT, paramedic, fireman, and critical care nurse.
 - b. Learn what prehospital care providers can and cannot do for sick children in the field.
 - c. Review the prehospital protocols for pediatric care in San Diego County.
 - d. It is encouraged that each resident spend 1-2 shifts with a paramedic team during their month, if they have not already done so.
 - e. Learn how 911 works, who staffs it, and who determines their protocols.
2. Initial Evaluation.
 - a. Become familiar with how pediatric patients are triaged into the ED.
 - b. Be able to perform the rapid cardiopulmonary assessment.
 - c. Be familiar with the Glasgow Coma Score, the Trauma Score, and the Yale Observation score.
 - d. Be familiar with what vital sign values should trigger an immediate evaluation.
3. Life Support.
 - a. Become proficient in the airway management of the pediatric patient.
 - b. Become proficient at cardiopulmonary assessment and learn to lead a resuscitation effort.
 - c. Evaluate and treat a child with multiple trauma.

4. Allergy.
 - a. Develop a good understanding of presentation, treatment, and complications of asthma.
 - b. Learn to manage a child with anaphylaxis. Be able to say in your sleep, “.2 or .3 cc of 1:1000 SQ epinephrine.”
 - f. Know how to cardiovert, defibrillate, and externally pace a pediatric patient.
 - g. Know how to recognize and treat shock.
5. Child Abuse.
 - a. Know the most common presentations of physical and sexual abuse.
 - b. Know how to differentiate accidental and non-accidental bruising.
 - c. Have a differential diagnosis list of diseases that are misdiagnosed as physical abuse.
 - d. Be familiar with the child abuse reporting laws.
 - e. Know indications for skeletal survey.
6. Dermatology.
 - a. Recognize and treat patients with acute drug reactions and contact dermatitis.
 - b. Treat and manage fungal infections of the skin and hair.
 - c. Recognize and treat scabies and lice.
7. Endocrine.
 - a. Diagnose and manage diabetic ketoacidosis.
 - b. Diagnose and manage hypoglycemia.
 - c. Diagnose and treat a child with hypocalcemia.
 - d. Recognize adrenal failure.
8. Gastroenterology.
 - a. Learn the differential diagnosis for acute abdominal pain.
 - b. Approach to the patient with upper and lower GI bleeding.
 - c. Develop an approach to assessment and treatment of dehydration with oral hydration or IV fluids.
 - d. Evaluate patients with vomiting and diarrhea.
 - e. Diagnose, treat and develop differential diagnosis of intestinal obstruction.
 - f. Manage incarcerated hernia.
9. Gynecology.
 - a. Evaluation and treatment of dysfunctional vaginal bleeding.
 - b. Evaluation of vaginal discharge.
 - c. Diagnosis and management of PID.
10. Hematology.
 - a. Manage a child in sickle cell crisis.
 - b. Evaluation of febrile patients with sickle cell disease.
 - c. Develop approach to the assessment of acute onset bleeding and/or bruising.
 - d. Management of the patient with hemophilia and trauma.
 - e. Recognition and treatment of the child with DIC.

11. Infectious Disease.

- a. Evaluate and treat patients with:
 - * otitis media
 - * cervical adenopathy
 - * impetigo
 - * sinusitis
 - * septic arthritis
 - * facial cellulitis
 - * UTI
 - * epiglottitis
 - * pharyngitis
 - * peritonsillar abscess
 - * periorbital cellulitis
 - * pneumonia
 - * osteomyelitis
 - * meningitis
 - * encephalitis
 - * septicemia
- b. Develop an approach to the assessment and treatment of the febrile infant.
- c. Develop an approach to the assessment and treatment of the febrile toddler.
- d. Manage human and animal bites.

12. Neurology.

- a. Develop and approach the assessment of febrile seizures and first time non-febrile seizures.
- b. Approach to the patient with altered mental status.
- c. Treatment of status epilepticus.
- d. Approach to the patient with a possible VP shunt obstruction or infection.
- e. Recognize and treat a patient with elevated ICP.
- f. Assessment and treatment of headaches.

13. Ophthalmology.

- a. Learn to do vision screening on different age children.
- b. Learn to evaluate and treat patients with the following:
 - * corneal abrasion
 - * hyphema
 - * conjunctivitis
 - * ocular foreign body

14. Orthopedic.

- a. Approach to the evaluation of the limping child.
- b. Management of nursemaid's elbow.
- c. Diagnosis and treatment of extremity fractures.

15. Pain Management.

- a. Approach to non-pharmacological pain and anxiety.
- b. Safe use of conscious sedation.
- c. Selection of a proper analgesic agent.
- d. Effective local anesthesia.

16. Psychiatric.

- a. Learn how to deal with a suicidal patient.
- b. Know how to safely manage a violent patient in the emergency department.

17. Pulmonary.

- a. Learn to recognize and manage a patient with respiratory failure.
- b. Learn how to evaluate patients with:
 - * smoke inhalation
 - * aspiration
 - * foreign body aspiration
 - * spontaneous pneumothorax and pneumomediastinum.

18. Radiology.

- a. Learn to read a pediatric chest film.
- b. Learn how to tell fracture lines from normal epiphysis.
- c. Learn indications for various x-ray studies.

19. Urology.

- a. Approach the patient with a painful scrotum.
- b. Develop an approach to the evaluation of hematuria.
- c. Treat balanitis and phimosis.
- d. Evaluate and manage a patient with acute renal failure.

20. Toxicology.

- a. Manage the child with ingestion of an unknown substance.
- b. Assessment and management of carbon monoxide poisoning.
- c. Recognize and treat these ingestions:
 - * iron
 - * tricyclics
 - * ethanol
 - * cocaine
 - * hydrocarbons
 - * aspirin
 - * acetaminophen
 - * theophylline
 - * acids/alkali

21. Trauma.

- a. Become familiar with the primary and secondary survey in the evaluation of the trauma patient.
- b. Learn to evaluate and treat the child with the following injuries:
 - * chest
 - * liver
 - * spine
 - * extremity fractures
 - * dental
 - * open and closed head
 - * spleen
 - * urogenital
 - * lacerations
 - * eye

Procedures

Residents will be able to learn and perform the following procedures in the ED as long as the attending is aware and agrees with your plan. Some of these procedures are rare and you may not see any patients to learn how or actually perform them. The attending can discuss any of the procedures you would like instruction on.

1. Arterial puncture.
2. Arterial line.
3. Aspiration of abscess.
4. Administration of local anesthesia.
5. Digital block.
6. Foreign body removal from soft tissue, ear, nose, mouth, and eye.
7. Simple suturing.
8. Paronychia drainage.
9. I & D of abscess.
10. NG placement.
11. Gastric lavage.
12. Burn dressing.
13. Wound irrigation and debridement.
14. Intubation.
15. Administration of nebulized medication.
16. Peripheral IV's: you are encouraged to try as many as you want. A maximum 2 attempts, no matter who you are.
17. Lumbar puncture (sitting recumbent).
18. Central line placement.
19. Conscious sedation.
20. Nursemaid's elbow reduction.
21. Slit lamp use.
22. Fluorescein staining of the cornea.
23. Eye irrigation with a Morgan lens.
24. C-spine immobilization.
25. Trager traction device use.
26. Orthopedic splinting.
27. Ring and fishhook removal.
28. Pelvic exam.
29. Incarcerated hernia reduction.

Objectives: by Level

PL-1

1. Develop skills of pediatric emergency assessment and management through direct patient care.
 2. Learn to obtain a problem oriented history and physical appropriate for the ED setting.
 3. Develop a differential diagnosis based on the information available.
 4. Formulate a treatment plan.
 5. Expand knowledge through managing a variety of patients.
 6. Develop interpersonal skills needed to deal with families under stress.
 7. Become comfortable with basic suturing, wound care, and splinting.
 8. Become proficient at starting an IV and drawing blood.
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PL-2

1. Refine technical and diagnostic skills needed to care for patients in the ED.
 2. Increase efficiency and independence in evaluating patients.
 3. Learn to prioritize patient care and to manage several patients simultaneously.
 4. Strengthen cognitive, technical, and interpersonal skills in managing seriously ill or injured patients including those who require resuscitation.
 5. Be comfortable with 2-layer closure wound repair, know how to start central lines, be able to start intraosseous lines, and know how to run a resuscitation.
-

PL-3

1. Become more skilled in the role of leader, supervisor, and teacher of the housestaff and the students working in the ED.
2. Learn how to establish and maintain an efficient flow of patients through the ED. Be able to teach others how to do so.
3. Refine communication skills in dealing with referring and consulting physicians.
4. Be comfortable leading resuscitations in the ED.
5. Continue to expand knowledge and skills.

Objectives:

Other Rotating Residents

1. Develop skills of pediatric emergency assessment and management through direct patient care.
2. Learn to obtain a problem-oriented history and physical appropriate for the PED.
3. Expand knowledge through seeing as many patients as possible.
4. Become more comfortable in dealing with families and ill children.
5. Get a sense of the difference between pediatric and adult ED patients.
6. Get experience taking care of difficult children with lots of medical problems that you may not see often in your residency training.
7. Learn as much as you can about pediatric pain management and sedation, trauma management, and how and why we manage febrile patients the way we do.

Appendix A: Dictation Format

- 1) Enter "dictate" or x8000
 - From outside hospital (858) 874-7154
 - For assistance (858) 874-7120
- 2) Enter Rady Children's Hospital ID Number: 88 + #
- 3) Enter your unique 6 digit Dictator ID Number + #
- 4) Enter "99 #" for dictation type
- 5) Enter 7 digit unit number (include leading zero) + #

Please note that you will need to press the # key after every prompt.

**** SPELL ALL NAMES WHEN DICTATING ****

This is (your name) dictating an ED record for (attending) on:

- **Patient Name**
- **Medical Record Number**
- **Date of Birth**
- **Date of Service**
- **Primary Care Physician**
- **Referral Source** (MD, hospital, telephone triage, nurse connection, urgent care, paramedics, self) - - **See the referral/intake sheets**
- **Time Initially Seen (by you)**
- **Chief Complaint**
- **History** - Include four or more of the following:
 - Location, Timing
 - Quality, Context
 - Severity, Duration
 - Associated sign/symptoms
 - Modifying factors
- **Gyne Hx** (if applicable) LMP, sexual activity, etc.
- **Review of Symptoms** (list of positive and negative systems, a minimum of five, and then add, "all other systems are negative")
 - Examples:**
 - General:** Fever, weight change, activity level, travel, TB exposure
 - Eyes:** Visual change, pain, discharge, photophobia
 - Ears, Nose, Throat:** discharge, pain, bleeding, dysphagia
 - Pulm:** cough, SOB, hemoptysis, wheezes
 - CV:** chest pain, palpitations, syncope
 - GI:** N/V/D, pain, hematochezia
 - GU:** frequency, dysuria, hematuria, swelling, pain
 - Musculoskeletal:** pain, swelling, discoloration, limp
 - Neuro:** change mental status, LOC, ataxia, sz's
 - Skin:** rash, petechiae, ecchymoses, pruritis
 - Psychiatric:** hallucinations, suicidal ideation, mood disturbance
 - Hematologic/Lymphatic:** easy bruising/bleeding, edema
 - Allergic/Immunologic:** hives, frequent serious infections, HIV
 - Endocrine:** polyuria, polydipsia, polyphagia
- **Medications with doses**
- **Allergies**
- **Immunization Status**
- **PMH/Surg Hx**

Keyboard Control Codes:

1 = Pause
2 = Resume dictation
3 = Rewind & listen to last phrase
5 = Disconnect
8 = Begin next report
(Remember to write job # on clinical record.)

- **SH** (lives with; smokers?, etc.)
- **FH**
- **Physical Exam:**
 Vital signs/wgt/FOC (HC)/sat (from triage).
 General appearance/activity level/interaction
 Brief general head-toe PEx *plus* problem focused exam
 Special Consideration
 Lacerations: exploration, palpation
 Ortho, extremity: perfusion; sensation; motor, tendon fx
 Presedation: airway, jaw/neck mobility
- **Medical Course/Decision Making:**
“The history and physical exam were obtained by myself and _____ (attending physician).”
Document the thought process. What was done and why or why not. Note differential Dx considered and how related diagnosis were excluded. Include lab results and interpretation/implications. Document reevaluations over what period of time!!! Document conversations with PMD and consultants. Document review of past visits/records and old x-rays.
- **Procedure notes** (see format below)
- **IMPRESSION**
- **Disposition** (D/C; admitted to _____; transfer to _____; left AMA).
- **Condition on D/C** (Stable or improved for most D/C's).
- **D/C Plan** (Rx, F/U, indications for return).
- **CC COPIES TO PMD AND RELEVANT SUBSPECIALISTS.** (Spell 1st name.) (Transcription may “forget” if not mentioned here.)

Procedure Note (Examples)

1. Lumbar Puncture:

After obtaining informed consent from the parent/guardian an LP was performed under the supervision of (attending). The patient was prepped and draped in sterile fashion. Landmarks were identified. (The area was infiltrated with 1% Lidocaine.) A (22) gauge spinal needle was inserted between L4 and L5. Approximately (3) cc of (clear) CSF was obtained on the (first) attempt. The needle was withdrawn and bandage applied. There were no complications and the patient tolerated the procedure well.

2. Cerumen Removal:

The patient had cerumen removed from the (left/right) ear canal in order to visualize the tympanic membrane. This was accomplished with a cerumen loop. There were no complications. The tympanic membrane was subsequently visualized.

3. Reduction Of Subluxated Radial Head: (two choices)

A) The procedure was explained to the parents who consented. Under the supervision of (attending), the child's (right) arm was grasped at the distal forearm with counter traction at the elbow. Gentle traction was applied and the forearm was fully supinated and flexed. There was a palpable pop over the radial head. After a few minutes the patient was using the arm normally. There were no complications.

B) The procedure was explained to the parents who consented. Under the supervision of (attending), the child's (right) arm was grasped at the distal forearm with counter traction at the elbow. Gentle traction was applied and the forearm was hyperpronated. There was a palpable pop over the radial head. After a few minutes the patient was using the arm normally. There were no complications

4. Sedation: [Note: this “macro” is available pre-typed. Tell transcriptionist to insert “sedation macro” and just give content for each numbered blank.]

Procedure: Sedation. Indication: [1] (fx reduction). Presedation history and examination revealed: ASA physical status [2] (I); fasting duration [3] () hours; family history [4] (negative) for adverse anesthetic/sedative reactions; airway class [5] (I); normal dentition/neck mobility; and no contraindications to sedation. Risks, benefits and alternatives were discussed with [6] (mother), who desired to proceed. With ECG and saturation monitors, constant nursing observation, and direct attending supervision, the patient received [7] (drug/route/dose) mg/kg, achieving an appropriate level of sedation. The procedure was completed by [8] (ortho). The ED attending was at bedside continuously for [9] (15) minutes during the deep portion of the sedation. The patient was subsequently observed with serial examinations until the return of presedation mental status. The patient remained hemodynamically stable, with normal oxygen saturations and VS and no complications during procedure or recovery.

5. Laceration Repair:

The patient's wound was prepped and draped in sterile fashion. Anesthesia was achieved with (2) cc of (1% lidocaine with epinephrine). (If nerve block please mention specifically). The wound was irrigated (with 500cc NS) and explored. There were no foreign bodies (tendon injuries etc). The wound was reapproximated in (1,2,3) layers. (three 5-0 vicryl sutures were placed sub q and the epidermis was closed with six 6-0 ethilon interrupted sutures). There was excellent reapproximation of the wound edges. The patient tolerated the procedure without complication.

SAVE JOB #'S ON CLINICAL RECORD. THIS IS OUR BEST WAY OF TRACKING “LOST” DICTATIONS.

Appendix B: Selected Caveats for Emergency Medicine: A Grief Reduction Syllabus John T. Kanegaye, MD

GENERAL

1. ALWAYS introduce yourself (name, title) to the patient/family (consider brief apology if family has been waiting long).
2. Make a point of letting the patient see you wash your hands before exam.
3. DO try to sit when taking the history (proven to convince families that you're being thoughtful and taking plenty of time with them).
4. ALWAYS convey your orders and general plan to the assigned RN.
5. NEVER forget to address the patient (and not just the parent).
6. Keep families updated through the ED course, even if only waiting for labs.

ABDOMEN/GI

1. DO rectals in abdominal pain, vomiting without diarrhea, and other acute presentations (except in neutropenic host).
2. ALWAYS consider need to make NPO.
3. DON'T forget pelvic exam and pregnancy tests.
4. Re-examine frequently.

ADOLESCENTS

1. Remember the value of having parents out of room.
2. Do not expect entirely frank discourse of sexual activity, drug use, etc.
3. Get hCG's liberally (over age 10 or so).
4. Consider strongly chaperone for GU/pelvic/rectal exams (for all male MDs examining females).

ATTENDINGS IN THE ED (a strange beast)

1. What they want to know:
 - a. General appearance
 - b. Vitals
 - c. Pertinent positives and negatives
2. What they don't need to know:
 - a. Extensive birth history in reasonably well or older kids (>3-4 mo).
 - b. Social/Family history or race, except as extremely pertinent (e.g. NAT, RAD, SS dis)
3. Talk to them before getting consults, tests.

DENTAL

1. Account for all traumatized tooth fragments (x-ray if necessary).
2. Chin lac is a jaw fx til proven otherwise.

ENT

1. DO NOT irrigate in presence of TM perforation or absorbent foreign body.
2. Look out for facial nerve and parotid duct injury in facial lacs.
3. Avoid cortisporin solution in the presence of perforation (suspension OK).
4. Avoid cautery on both sides of nasal septum.
5. Ensure adequate visualization, lighting, and immobilization before instrumentation (Curette wax carefully).

EYE

1. NEVER prescribe steroids for ophthalmic use (unless negative for dendrites and has ophtho follow-up).
2. Do not dispense topical anesthetics for home use.
3. Consider formal referral within 24 hours for conjunctivitis, abrasion in contact lens wearers.
4. Minimize examination, disturbance for the suspected open globe. Hard shield, not patch.
5. Don't forget to check visual acuity.
6. Suspect nasolacrimal duct injury with lacerations to medial lid.

FEVER

1. CBC is a poor substitute for excellent documentation of child's well-being, activity, response to therapy, etc.
 - a. The only real screen for bacteremia is a blood culture, not the CBC.
 - b. Ditto meningitis and LP's.
2. Have a low threshold for catheterized urines, esp. if no other source in girls < 24 mo and boys < 6 mo (it would be hard to fault getting these in older pts. as well).

GU

1. Don't be the cause of paraphimosis.
 - a. Put it back the way you found it (post-exam or post-catheterization).
 - b. Ill advised foreskin care
2. Steroids under occlusion (foreskin, diaper) have increased potency and may promote skin atrophy.
3. In trauma, don't catheterize if suspected urethral transection (blood at meatus high riding prostrate, subcutaneous urinary extravasation, suspected pelvic fracture).
4. Scrotal masses
 - a. Painful acute scrotal mass is torsion until proven otherwise.
 - b. Painless scrotal mass is cancer until proven otherwise.
5. Beware use of lidocaine with epinephrine or TAC at tip of penis.
6. Vaginal bleeding is an ectopic until proven otherwise.
7. Consider strongly chaperone for GU/pelvic/rectal exams.

LABORATORY

1. Before ordering any test:
 - a. Know the likelihood of a clinically significant abnormality.
 - b. Understand how or if the result will influence management.
 - c. Be certain that meaningful follow-up of results can occur.
2. Bagged urine samples are useful for hematuria in trauma (never use in fever workup).
3. Keep family updated on results, interpretation as they become available.

LEGAL ISSUES

1. Beware change of shift!
 - a. Reassess patients signed out to you, and document it.
 - b. Document your sign out and tentative plan.
 - c. Every patient needs a note, even if all you did was to check labs and discharge.
2. When in doubt, consult. Document it (even phone calls or failed phone contact).
3. Document discussion of risks/benefits/alternatives (R/B/A) and guardian consent/patient assent—BEFORE the procedure.
4. Document response to ED treatment(s).
5. Enlist the PMD (notify of visit, tests, consults, need for follow-up as appropriate) in aftercare. BUT leave the option open to RT ED.
6. Review RN notes and VS, and be sure to address/refute any concerns accordingly. (Document in your note.)
7. The patient signing out AMA after waiting only 10 min may be victim of NAT or other hidden trap (CO poisoning?).

8. Frequent flyers are not always ED abusers.
9. Terms such as “WNL,” “WDWN,” and “nontoxic” are meaningless without supporting documentation. “VS stable” only true if monitored over a period of time.
10. Consider NAT if the story changes, is inconsistent between historians, or doesn’t fit the clinical picture.

ORTHOPEDICS

1. “Joint above, joint below” for all x-rays and immobilization.
2. Neurovascular exam before sending to x-ray, before and after any manipulation.
3. No fracture on x-ray ≠ no fracture on patient.
4. Err on the side of immobilizing. Some fractures should be treated on clinical grounds: Salter I at distal fibula (lat malleolar tenderness rarely “just a sprain”); scaphoid fx (snuffbox tenderness); toddler’s fx (tibial tenderness).

PHARMACOLOGIC MISADVENTURES

1. Steroids with: VZ, HSV, DM, HTN, untreated TB.
2. Erythromycin and other macrolides with: carbamazepine, digoxin, terfenadine, cyclosporin.
3. Ketamine with: HTN, psych.

SEDATION

1. ALWAYS check NPO status.
2. ALWAYS check airway status (could you ventilate, intubate in case of respiratory depression/arrest?).
3. ALWAYS check anesthetic, sedation history.
4. ALWAYS check suction, O₂ availability.

TOXICOLOGY

1. Don’t forget hCG, ASA, APAP—even if the history is not suggestive.
2. Consider neglect, abuse esp <1 yr, >5 yr.

WOUND MANAGEMENT

1. ALWAYS be alert for non-accidental trauma.
2. DO a full nerve function exam before giving anesthetics.
3. ALWAYS explore/palpate.
4. DON’T miss a foreign body. Consider them radio-opaque until proven otherwise (esp glass).
5. The solution to pollution is dilution (you can never irrigate too much).
6. No lido with epi in fingers, nose, penis, toes (and maybe tips or ears).
7. Ditto TAC. Add also: burns, road rash, mucous membranes and conjunctive (near or on).