I. Educational Purpose and Goals

Approximately 60,000 patients per year are evaluated in the Emergency Department (ED) at the University of California, Davis Medical Center. Patients from multiple ethnic, cultural and socioeconomic backgrounds are evaluated with problems ranging from sore throat/minor contusions to life-threatening conditions such as myocardial infarction or critical trauma.

Board certified Emergency Medicine physicians, along with residents from various specialties, evaluate all patients who present to the ED. Residents/attendings from all medical/surgical specialties provide consultation. UC Davis Medical Center serves as a Level I Trauma Center and a tertiary referral center. Due to the vast diversity of patients who present to our ED and excellent resources to care for these patients, the Emergency Medicine rotation provides an excellent learning experience for Internal Medicine residents (IMR).

More precisely, we expect that our residents will gain in the following ways:

1) To become familiar with the expedient evaluation and management of both critical and non-critical medical/surgical conditions as they present to the ED. Focused history and physical exams will be emphasized.
2) To enhance the IMR’s knowledge base, clinical skills, and procedural skills in Emergency Medicine.
3) To learn how to efficiently select appropriate laboratory and radiologic studies in order to diagnosis and treat patients in the Emergency Department.
4) To learn about non-Internal problems and how Internal Medicine conditions may be masked by other special problems.
5) To learn how patient’s medical problems, socioeconomic background, ethical beliefs, occupation, and environmental issues play important roles in evaluating and managing patients in the ED.
6) To improve teaching skills pertaining to medical problems encountered in the Emergency Department.
7) To learn how to triage which patients require hospitalization from those who do not.

II. PRINCIPAL TEACHING METHODS

a. Direct Supervised Patient Care Activity: IMRs primarily learn through direct patient care with attending supervision. Residents will perform a complete patient assessment including
a history and physical, differential diagnosis, and both therapeutic and diagnostic plans. Each patient, along with patient care plans, will be reviewed with an Attending Physician. A discussion at the bedside will focus on the history and key elements of the physical exam. Diagnostic and therapeutic plans will then be finalized. The Emergency Medicine Attending will review the resident’s charting and formulate their own note. The IMR will follow the patient’s progress throughout the ED stay. The IMR will be responsible for procedures, laboratory interpretations, radiology interpretations, discharge instructions, and admission procedures all under the direct supervision of the ED Attending. The IMR will be responsible for calling consults and talking with patient’s family members. In critically ill patients, an attending physician will evaluate the patient with the IMR at the bedside to maximize patient care and teaching.

b. Didactics: Emergency Medicine lectures and/or case reports are presented at 7 AM “board rounds.” Residents from the out-going night shift and in-coming day shift are present for this didactic session.

c. Faculty:
Nathan Kupperman, MD               Edward Panacek, MD
Emily Andrada, MD                    Aman Parikh, MD
Aaron Bair, MD                       John Richards, MD
Jeremy Cooke, MD                     John Rose, MD
Seric Cusick, MD                     Douglas Rudisill, MD
Partick Daubert, MD                  Peter Sokolove, MD
Robert Derlet, MD                    Samuel Turnipseed, MD
Deborah Diercks, MD                  Katren Tyler, MD
Jim Holmes, MD                       Leah Tzimenatos, MD
Donna Kinser, MD                     Cheryl Vance, MD
Douglas Kirk, MD                     Sharon Wilson, MD
Erik Laurin, MD                      Garen Wintemute, MD
Jenny McCormick, MD                  James Montoya, MD
Kerry McMahon, MD

III. EDUCATIONAL CONTENT AND MATERIALS

1) Patient Characteristics and Disease Mix: Approximately 60,000 patients per year are evaluated in the UCD ED. Patients from multiple ethnic, cultural, and socioeconomic backgrounds are evaluated with problems ranging from sore throats/minor contusions to life-threatening conditions such as myocardial infarction or critical trauma. UC Davis serves as a tertiary referral center for a large area of California and also is northern California’s largest Level I trauma center. The above characteristics of our ED guarantee a wide diversity of common and uncommon medical and surgical disease processes which the IMR may encounter.

2) Board Rounds: are held at 7 AM and 7 PM. Teaching cases and topics of interested are presented in morning rounds; evening rounds are brief and may emphasize a few major teaching points.

3) Procedures: All procedures performed by IMRs are supervised by an ED attending. Multiple procedures such as placement of nasogastric tubes, suturing, splinting, arthrocentesis,
thoracentesis, paracentesis, chest tube insertion, pacemaker insertion, etc, are performed in the ED. A procedure note is required and must be signed by those performing the procedure including the ED attending.

4) **Conferences:** The IMR is required to attend Monday afternoon IM conferences from noon to 5 PM. IMR are also excused from the ED on Thursday mornings from 8 AM to 9 AM to attend IM Grand Rounds.

5) **Ancillary Teaching Materials:** In the IM Resident Drawer, which is located behind the staff mailboxes below the printer in Area I, is a notebook of basic EM articles for review. Various medical and surgical textbooks (emergency medicine, toxicology, dermatology, etc) are available in the ED. Housestaff have computer access at multiple sites in the ED for on-line literature searches and journal viewing. IM housestaff have access to a medical library 24 hours a day.

6) **Poison Control:** can be called 24 hours a day for help with toxicological problems. On-call physicians for toxicology include an EM resident, the toxicology fellow and the toxicology attending.

### IV. EDUCATIONAL GOALS AND OBJECTIVES

Residents will rotate through the ED in each of their 3 years. As such, they will come to the ED with different skill sets and goals. Due to the vast diversity of medical and surgical diseases which present to the ED, it would be impossible to make a list of all the topics which we desire the IMR to be exposed during their rotation. Our goal is to teach the IMR about each disease as he/she encounters it in the ED. In addition, there are other main teaching competencies that we wish residents to gain in each of the core competencies, as outlined below.

#### Patient Care

- All residents must be able to complete an efficient yet complete patient history and examination appropriate for the presenting complaint.
- All residents should be able to describe the primary and secondary survey as part of the initial ED evaluation in trauma patients.
- PGY1s should be able to come up with an appropriate differential diagnosis and describe a rational initial evaluation for patients with shortness of breath, chest pain, asthma exacerbation, COPD exacerbation, acute abdominal pain, nausea and vomiting, fever, acute headache, acute altered mental status, acute joint pain, gastrointestinal bleeding, syncope, lacerations, dysuria, cough, vaginal bleeding, low back pain, and pelvic pain.
- PGY2 and PGY3 residents should be able to do a rapid evaluation and start therapy on patients who arrive in critically ill condition, with supervision by the attending.
- PGY2 and PGY3 residents should be able to make accurate determinations of which patients are critically ill, and which patients need hospitalization, and which do not.
- PGY2 and PGY3 residents should be able to take appropriate measures to stabilize acutely ill patients in the ED prior to admission.
- By the end of the PGY3 year, residents should be able to describe the indications, contraindications, risks, benefits, and proper technique for lumbar puncture,
• thoracentesis, paracentesis, NG tube placement, central line access, arterial blood sampling, venipuncture, intravenous catheter placement
• PGY2 and PGY3 residents should be able to run codes using ACLS protocol for medical patients in the ED under faculty supervision.

Medical Knowledge
• Describe an appropriate differential diagnosis for the conditions described above.
• PGY1s should be able to describe basic approach to reading ECG and CXRs.
• PGY2 and PGY3 should be able to reliably recognize acute myocardial infarction or ischemic changes on ECGs, and reliably interpret findings on CXR.
• PGY2 and PGY3 Residents should know ACLS protocols for running codes.

Interpersonal and Communication Skills
• Residents at all levels must provide legible, timely records as described in the attached supplement.
• Residents at all levels will be able to concisely and effectively give oral presentations.
• Residents will communicate all important issues to their supervising residents and ED attending.
• Residents will effectively communicate to patients and families regarding their medical condition and treatment plan, including plans for follow-up.

Professionalism
• All residents will demonstrate integrity, accountability, respect, compassion, patient advocacy, and dedication to patient care that supercedes self-interest.
• Residents will treat all ED staff and patients with respect.

Practice Based Learning and Improvement
• Residents will participate in and fully use tools for quality improvement protocols for the ED.
• The resident will use library and internet resources at UC Davis Medical Center to search the medical literature, critically appraise articles, and apply evidence to the care of patients in the ED.
• PGY1 residents, if working with medical students, will facilitate their education.
• PGY2 and PGY3 residents will supervise and teach PGY1 residents and medical students.

Systems Based Practice
• All residents will work to effectively coordinate care with other health care professionals as required for patient needs.
• PGY2 residents will consistently adopt available clinical practice guidelines and recognize the limitations of these guidelines. They will work with case managers, social workers, and discharge coordinators to improve patient care.
• PGY3 residents will consistently model cost-effective therapy.
V. METHODS OF EVALUATION

The IMR will be evaluated by each attending that they work with on a particular shift. These attendings will fill out the ED evaluation cards. Verbal feedback should be given to the IMR at the end of each shift. The IMR’s performance relative to their level of training will always be considered. Residents will evaluate the ED rotation using E-Value at the end of each rotation.

VI. STRUCTURE OF THE ROTATION

IMR rotate through the ED either in two or four week blocks. ED shifts are 12 hours and IMRs have 12 hours off between shifts. In general IMRs work 4-5 shifts each week and have 1-2 days off. IMR will work approximately 50% day shifts and 50% night shifts. No resident works more than 80 hours per week. Each resident has at least one continuous 24-hour period free per week from all clinical, educational, and administrative activities. The IMR will attend his/her continuity clinic during the Emergency Medicine rotation approximately 1-2 times per every 2 weeks. The IMR is always free to attend IM Clinical Conferences on Monday afternoon and IM Grand Rounds on Thursday mornings.

ED shifts are from 7 AM to 7 PM or 7 PM to 7 AM in Areas I or III. On even days, the IMR is assigned to Area I; odd days Area III. In general, Area I is where critically ill patients are evaluated. These patients include chest pain suspicious for acute coronary syndrome, sepsis, hypotensive patients, “critical trauma,” and severe COPD exacerbations. Less critically ill patients are “usually” evaluated in Area III. These include patients with seizures, suspected appendicitis, pelvic pain, pyleonephritis, and minor trauma. However, don’t be misled by which area a patient is triaged. Critically ill patients may present to Area III, be aware.

IMR have first contact responsibilities with both medical and surgical patients who present to Area I or III. An attending physician is assigned to each area to maximize patient care and teaching.

VII. STRENGTHS OF THE ROTATION

PREVENTIVE CARE

Although one might not think of preventive care as a part of Emergency Medicine, the ED evaluation is an important opportunity to educate patients. Examples include: 1) cardiac risk modification in patients evaluated by our Chest Pain Evaluation Unit 2) diet restrictions in patients with renal or hepatic disease 3) tetanus administration 4) diabetic foot care.

INTEGRATED CARE

The Emergency Department is a complex network in which interactions with multiple disciplines takes place. IMRs will have extensive interactions with services such as radiology, pharmacy, psychiatric emergency services, discharge planning, and surgical consultations. Other interactions may include orthopedic cast technicians, PIC line nurses, and dietary services.

FOSTERING INNOVATION
Creative thinking is an important concept in Emergency Medicine and is highly encouraged. Patients present to the ED with extremely uncommon presentations of common diseases and some present with symptoms or situations not encountered by most physicians. Creative thinking may be our best resource in these situations. IMRs are also encouraged to be involved in the research projects which are on-going in the ED. ED based research projects by the IMR are encouraged and ED faculty support is available.
EMERGENCY MEDICINE ROTATION SUPPLEMENT

I. RESPONSIBILITIES

As an Internal Medicine resident in the Emergency Department you have various responsibilities; outlined and then discussed below are four important aspects of your role as the Internal Medicine resident in the Emergency Department. Performance of these roles will satisfy your ACGME requirements for your Emergency Medicine experience. All responsibilities of the IM resident in the ED are under the supervision and direction of the Emergency Medicine attending staff.

A. First-contact patient responsibility
B. Teaching
C. Consultations
D. Admission decisions

A. FIRST-CONTACT PATIENT RESPONSIBILITY

Internal Medicine residents assigned to Emergency Medicine must have first-contact responsibility for a sufficient number of unselected patients...must have meaningful responsibility for patients...broad range of adult patients with medical and surgical illnesses...learn how to discriminate which patients require hospitalization. These tasks can be accomplished by seeing patients as they arrive by ambulance and by working the stacks.

1. Direct medical CPR's. The medical resident will direct CPR's according to the American Heart Association ACLS guidelines under the supervision of the Emergency Department Attending. A "code leader" will be designated to run the code; he or she will give all orders and delegate procedures. The "code leader" will be responsible for communicating with the patient's family members regarding the outcome of the CPR.

2. Provide care for critically ill patients. When a critically ill medical patient arrives in the ED, the medical resident should be in immediate attendance to initiate evaluation and therapy. In general, he should be the primary provider of care and fill out the ED blue sheet. An ED attending will be available for assistance in the management of the patient. All critically ill patients should be presented to the ED attending as soon as possible after an initial evaluation - this may be extremely brief in the critically ill or arresting patient.

3. Provide care for non-critically ill patients. The IM resident should diagnose and manage a broad spectrum of adult patients with medical and surgical illnesses. This task can be accomplished by working the stacks.

B. TEACHING

Internal Medicine residents should be a principal resource for medical students, interns, fellow residents, and attendings in the ED.
1. The IM residents should be available to hear case presentations from interns and medical students during his/her twelve-hour shift. The cases should include bedside exam, a discussion of the differential, and diagnostic/therapeutic plans (these cases will also be staffed by an Emergency Medicine Attending).

2. All IM residents should teach physical exam skills to students, interns, and other residents rotating in the ED as they see patients with characteristic physical findings.

3. The IM resident should teach and assist medical students, interns, and fellow residents in the performance of procedures, such as lumbar puncture, thoracentesis, etc. All procedures performed in the ED should be supervised by an EM attending.

C. CONSULTATIONS

The IMR may provide consultations to residents in other disciplines within Emergency Medicine.

1. When requested, the IM resident should assist with diagnosis, triage, and initial management of medical and non-medical patients.

2. Arrange for inpatient medical consultation by the General Medicine consult service when appropriate.

D. ADMISSION DECISIONS

The IMR should participate meaningfully in medical admission decisions.

1. By seeing patients primarily and providing medical consultations, the IM resident will have direct experience in this process.

2. Procedure for Internal Medicine Admissions through the Emergency Department.
   a. **Procedure:** If a patient that the IMR is evaluating requires hospital admission, he/she should call the admitting team directly to make them aware of the patient. The IM "hospitalist" triages all patients admitted to the IM ward service. A call to the admitting resident on the MICU, CIS, or Hematology-Oncology service is appropriate.

   The Internal Medicine Resident rotating in the Emergency Department (IMR-ED) can be an important resource for both medical problems and triage decisions. They are available for medical consultation 24 hours a day. The IMR-ED can also give insight into triage decisions involving MICU vs CIS or IM Ward vs Hem/Onc service.

   b. **Pertinent ED w/u Rule:** Patients are not to be worked up extensively in the Emergency Department by the admitting IM team unless the admission bed is unavailable. A brief evaluation and interim orders are appropriate.
c. **The Grid:** The GRID (Appendix #1) is a list of admission guidelines for patients admitted to UCDMC. The GRID should be followed as closely as possible. However, the GRID is a set of guidelines, not strict criteria which is inflexible. Clinical judgment must be applied regarding admission decisions. As stated previously, the IMR-ED is a valuable resource to aid with triage decisions in the Emergency Department. Final admission decisions lie with the Emergency Medicine Attending physician.

d. **Family Practice:** The Family Practice (FP) inpatient service admits patients to the hospital who are seen primarily in the FP clinic. They do not admit patients directly to the Medical or Cardiac Intensive Care Units. They also alternate admitting “placement problems” with Internal Medicine; FP admits “placement problems” whose last digit of their medical record number is odd.

e. **Complaints/Concerns:** IMRs are encouraged to fill out an Emergency Medicine shift report on all patient care concerns or complaints. The form is found in Area I above the drop box.

f. All medical admissions require an ED attending note.

### III. POLICIES

A. **ED BY-REPORT.** Charting should be concise and to the point. The record should read clearly and should accurately represent the patient's problem to any outside reviewer. Charts may be reviewed by a staff physician; any problems, suggestions, or compliments will be brought to the attention of the primary care provider. Please fill in ALL sections of the by-report such as orders, lab results, follow-up exams; this will make the medical record accurate and also aid with the billing process. Please assess PMH, FH, SH, ROS on all patients. Always write your name (and time you saw the patient) and the attending’s name who saw the patient with you on the by report.

B. **ATTENDING SUPPORT.** All patients seen by residents, medical students, and nurse practitioners should be presented to an ED attending. When possible, this should be done immediately after the initial history and physical is taken to permit maximal teaching and supervision benefits. All charts must have an attending note and signature.

C. **ILLNESS.** If you become ill while on your ED rotation, call your CHIEF RESIDENT promptly. The Chief will then arrange coverage for you by another Internal Medicine resident. Please notify the ED Charge Physician and tell him you have notified your Chief Resident.

D. **ATTENDANCE.** In general, you are to remain on the premises except for a meal, personal break or a scheduled conference. When you leave the ED, notify a staff physician, and carry your pager. Work closely with the EM residents; take
breaks/meals opposite the EM residents so one of you will always be available to see patients in the ED.

E. BOARD ROUNDS. Rounds are held at 7:00 a.m. and 7:00 p.m. At these times, checkouts will occur between oncoming and outgoing shifts. Teaching cases are presented in morning rounds; evening rounds are brief and may emphasize a few major teaching points. Update the triage board regularly: who you are seeing, which attending saw the case, notes, disposition, etc.

F. ORIENTATION. An orientation will be held in the Main ED at 9:00 a.m. on the first day of the rotation, please make a genuine effort to be present. If you cannot be present, have any questions or problems, call and let the EM Director for Resident Rotations (Samuel Turnipseed) know. Dr. Turnipseed can be reached at the following: EM ADMINISTRATION 734-5016 OR PAGER 762-6429.

G. CONCERNS. If an IM resident has any concerns (personal matters, patient care problems, attending conflicts, etc) during the rotation, he/she should contact Dr. Turnipseed. If appropriate, the IM resident may discuss the matter with the Attending present at the time of the concern.

MISCELLANEOUS

A. RESEARCH. A bulletin board above the reference books in Area I alerts housestaff/faculty to various research projects underway. Be alert to the cases needed as your input is vital to completing this research.

B. CHEST PAIN EVALUATION UNIT (CPEU). Please read Appendix 3, 4, 5 for “Guidelines for Admitting CPEU Patients Overnight”.

C. SEPSIS. All patients with a diagnosis of sepsis should receive immediate antibiotics in the ED after appropriate cultures have been obtained. EM staff recommends that all patients diagnosed with an infectious process requiring antibiotics receive prompt antibiotics in the ED after appropriate cultures have been obtained.

D. RADIOLOGY. X-Rays may be viewed on computers in the ED or in the ED X-Ray Reading Room. Please review all x-rays with the ED attending or the Radiology resident/attending in the reading room. A Radiology resident is available 24 hours a day.

V. DOCUMENTATION

A. The Chart

1. Should have your name printed at the top along with the time you went to interview the patient, this is extremely important medicolegally!

2. In Emergency Medicine the interaction with a patient is usually a one-time experience from which all care is based. Therefore, it is of utmost importance that our record of this patient be accurate and complete.
"The chart can either be a friend or an enemy in court." An emergency department medical record must be concise, must contain the major findings that rule out high-risk diagnoses given the patient's presenting complaint, and must provide appropriate discharge instructions and referral for a follow-up.

3. Always sign your charts!

4. Standard abbreviations are acceptable.

B. Vital signs

1. All adult patients require 4 vital signs: BP, P, RR, T. (consider pulse oximetry)

2. All pediatric patients require 5 vital signs: BP, P, RR, T, Wt. (consider pulse oximetry)

3. All diabetic patients, who are in the ED for a diabetes related problem and are required to wait to be seen, should have an Accuchek™ performed at triage.

4. If there are no vital signs on the chart have the nurse obtain them immediately.

5. The majority of patients, especially if they have been in the ED for a prolonged time, will need at least another set of vital signs.

C. Chief Complaint

1. Address the patient's complaint, as well as the triage complaint (they are often times not the same).

2. All the complaints should be addressed.
   a. Urgent/emergent complaints must be assessed and dealt with in the ED.
   b. Chronic complaints that do not have an acute component may be deferred to the patient's primary care provider using your medical judgment.

3. Since the patient's chief complaint(s) may change during their stay in the ED it is imperative that you evaluate the patient in an area that is appropriate to the acuity of his complaint expressed to you, i.e. you don't workup myocardial ischemia in the hall.

D. Medicines / Allergies / Last Tetanus / Last Menstrual Period
1. Every chart, where appropriate, should have this data recorded. It is advisable to verify this information when you interview the patient.

2. If the triage nurse has not filled in this data, you fill it in.

3. Tetanus status must be addressed in medical patients; e.g. the patient who bites his tongue during a seizure, the IVDA patient with phlebitis and cellulitis of the antecubital fossa.

4. Women of child bearing age should have LMP recorded on the chart, especially if radiographic studies are contemplated (consider UPT).

E. History

1. The history should be brief but must contain all pertinent data needed to address the chief complaint(s), including the pertinent negatives.

2. Remember when taking a history and formulating a diagnosis in the ED your role is to be highly sensitive (minimizing the false negatives), you do not want to miss the high-risk diagnoses. The role of the consultant is to be highly specific (maximizing the true negatives).

   a. High-risk diagnoses (not exhaustive)
      (1) Failure to diagnose fractured extremities
      (2) Failure to diagnose a foreign body in a wound
      (3) Myocardial infarction
      (4) Failure to diagnose laceration to tendon or nerve
      (5) Meningitis
      (6) Ectopic pregnancy

3. Family History, Review of Systems, Social History should be commented on with pertinent positives and negatives; e.g. in the evaluation of chest pain that may be ischemic, cardiac risk factors should be addressed.

F. Physical Exam

1. A thorough physical examination should be documented, emphasizing pertinent organ systems from the chief complaint.

2. WNL, negative, NA are not appropriate.

3. Remember NSR is an electrocardiographic diagnosis not a physical finding.

4. In seemingly straightforward physical findings the high-risk diagnoses must guide your evaluation. Example:

   An 18 month old child with a dull retracted immobile tympanic membrane may well have an otitis media, but the physical exam needs comments about adenopathy, nuchal rigidity, toxicity of appearance, and hydration to
be complete. This indicates that you were cognizant of the possibility of meningitis and that your exam ruled it out.

5. Avoid judgmental statements in the record, e.g. EtOH on breath is preferable to "drunk" and disheveled is preferable to "bum", "street-person", or "filthy."

G. Studies

1. It is important for you in this rotation and in your future practice to order diagnostic studies rationally. Your history and physical examination should give you the majority of your diagnoses. If you are ordering studies because they are available, or the attending may want them, or the admitting team may need them on rounds in the morning - these are all wrong. You order tests because the results will influence the diagnosis, treatment, or follow up. If you will do the same thing whether the test result is normal or abnormal then you probably do not need to do the test at all.

2. There is a subset of diagnostic studies that are high-yield (tests highly likely to detect pathology), i.e. digoxin or theophylline, etc. Examples:
   a. A patient on theophylline presenting with nausea, vomiting, and abdominal pain absolutely needs a theophylline level as part of his workup.
   b. A patient on digoxin experiencing palpitations absolutely needs a digoxin level.

3. If a study is ordered, the results must be recorded on the chart, this signifies that you were aware of the results. Many a lawyer will say, "Doctor, it wasn't on the chart, you must not have done it." Also, for reimbursement purposes it indicates that the result was necessary in the evaluation process and therefore eligible for reimbursement.

4. Studies with results that will not be available prior to discharge of the patient from the ED are dangerous.
   a. They require that you arrange explicit follow-up, e.g. for the results of your Chlamydia test go to ____________________________, or go to Employee Health in 72 hours to have your PPD read.
   b. Mammograms, PAP smears, and other health care maintenance studies should not be ordered in the ED. These studies should be ordered by their primary care providers.
   c. Patient should wait in the ED for all high-yield study results, e.g. the patient with a digoxin level of 6.5 is better off waiting 5 hours in the ED than going home to bed.
H. Orders

1. Always time your orders.

2. All orders must be written!
   a. Legally required for the nursing staff.
   b. Required for reimbursement from Third Party Payors and Medi-Cal. If an order was done without documentation that it was ordered by a physician, even though the nurse may chart the order being completed, it stands a good chance of having payment denied.
   c. Documented orders by physicians are a way of tracking and justifying usage of items, especially costly items such as pulse oximeters and Dinamaps.

3. As a general rule, do not order tests that you are not going to personally follow up on, e.g. in your clinic.

4. Do not order health care maintenance studies in the ED, e.g. PAP smears (unless specifically asked to by OB/GYN, where the consultant is going to follow up on the results).

I. Progress

1. There is space on the ED by-report for you to record the patient's progress in the ED. Observation notes, new clinical findings, response to therapy, disposition plans, etc. should be discusseddocumento here.

2. The nurses routinely record serial VS, response to therapy, etc. We should do no less - it is absolutely necessary for you to document in the chart the patient's response to your therapy.
   a. An asthmatic should have documentation on the chart providing a chronology of improvement in symptoms and exam over the course of several breathing treatments. Or conversely, further worsening of the condition to the point of needing intubation.

3. Also it would be good practice to indicate on the chart that the case was discussed with attending X at time Y with the following suggestions....

4. When caring for patients in the ED, always document discussions with family members, primary physicians, or other caretakers (including name, phone #, time).

J. Dispositions
1. **Where:**
   a. Home
   b. Admission to Service X
   c. Checked out to Physician Y
   d. Death

2. **When:**
   a. Always indicate time!

3. **Who:**
   a. Patient went home by self, with mother, with adult male friend, etc.
   b. Patient admitted to Physician A of Service B.
   c. Patient checked out to Physician C (when receiving patients in checkout - document on the chart the time and who checked out to you).
   d. Patient dead at time D, clerk notified the coroner at time E, family arrived at time F (or family in the ED at expiration), etc.

4. **How:**
   a. Ambulatory
   b. Gurney to floor
   c. Gurney to ICU with monitor, RT, etc.
   d. Wheelchair

5. **Instructions:**
   a. All patients should receive instructions that are pertinent for their chief complaint, diagnosis, treatment, follow-up, etc. There are a limited number of preprinted discharge instructions available in the ED.
   
   b. Return to the ED PRN is *unacceptable and dangerous*, they must receive definite guidelines as to when and why they should return to the ED or to seek follow up with their PMD. Examples:

   (1) Return to the ED if the wound becomes more red, painful, you develop a fever or have draining pus.

   (2) Return to the ED if you are unable to take your medicine, nausea and vomiting develops.

   (3) Return to the ED if you are soaking, with blood, 1 pad/hour for 4 hours continuously.

   c. Instructions should be written in English (or in patient's own language if available) without any Latin symbols or medical shorthand. Always include the medication name, dosage, dosing intervals, and duration of treatment course. Include common side-affects (where applicable); i.e. the Tylenol® #3 may make you nauseated, or do not take the Flagyl® with alcohol-containing beverages, etc.
6. **Dangers:**

   a. Always be wary of checkouts!

   b. The checking-out physician should heed the following recommendations:

   (1) Name and times on chart.

   (2) Pertinent history and physical on the chart.

   (3) Diagnosis written on the chart, may only be preliminary (pending laboratory or imaging studies).

   (4) Plan written on the chart, again may only be preliminary.

   (a) If test X is normal patient may go home.

   (b) If test Y is positive then call consultant Z.

   (5) Disposition and instructions (including prescriptions), if known, written on the chart.

K. **Follow-up**

1. Always refer back to the primary doctor, if the patient has one.

2. Patients without a primary doctor must be referred to the appropriate clinic on the back of the ED sheet.

3. Always indicate a time frame, again PRN is not acceptable.

4. Indicate on the chart that if they are unable to see the specified physician and their condition worsens, they may return to the ED.

5. It is against both State and Federal law to tell a patient to follow up at another ED if not improved, this will be construed as *patient dumping*.

6. **Transfers:**

   (a) Transfers of patients to other facilities should only be for medical indications, i.e. facility X has a higher level of care than we do.

   (b) Other indications, i.e. financial, should be initiated by the patient or the patient's family and should be documented so on the chart.

   (c) Please consult the attending staff on the proper documentation of interfacility transfers - there are extremely stiff fines if not handled appropriately and are not covered by malpractice insurance policies.