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1. Policy issues

la. *Notification of Physicians*

Medical Registrars are responsible for notifying Physicians of admissions and any significant alteration in a patient's condition. This responsibility is not to be delegated to more junior members of the medical staff.

Physicians must be notified of:

1. all admissions under their name
2. all deaths, whether expected or not

Urgent notification, during normal work hours and after-hours, must occur when there is:

1. significant change in a patient's condition requiring a substantial change in clinical management
2. any MET call on a patient
3. need for a surgical consultation (regardless of whether the patient goes to theatre)
4. transfer of a patient into or from a high dependency ward (CCU, ICU, HDU)
5. need for an invasive investigation with a risk of morbidity (e.g. angiography)

If the Physician in charge of a patient's care is unable to be contacted, then the On-Call Physician must be notified.

A stamp is used in the ED to record in the notes that a patient has been accepted under a particular Admitting Medical Officer (AMO).

SEEN BY REGISTRAR

NAME ....

ADMIT..

UNDER..

SIGNED..

It is the registrar's responsibility to ensure that the stamped entry appears in the record of all medical patients admitted through ED.

lb. *Sick relief roster*

All Medical Registrars are on the sick relief roster. This is to cover any Medical Registrars who may be ill and unable to work an allocated overtime shifts. Sick relief is for a week at a time, beginning on Monday and extending to Sunday. If the registrar on

call for sick relief is already doing an overtime shift within 24 hours of the sick relief shift, then the second sick relief will be asked to do that shift.

When on sick relief, registrars must be contactable either via hospital page or telephone at all times. You are advised to carry your normal hours page which will work anywhere in the Sydney Metropolitan area.

The sick relief registrar is to act as the contact registrar for JM0s in the absence of the usual registrar. The JM0s are to call the sick relief registrar to assess any acutely unwell patient. If the sick relief registrar is unable to assist the JMO, it is the sick relief registrar's responsibility to make alternative arrangements.

If a registrar becomes ill, it is their responsibility to notify:

a. The relevant consultant physician
b. The Division of Medicine administration clerk and
c. After hours, the on-duty hospital superintendent, the ED communications clerk and switchboard.
d. Office of the Director of Medical Administration

1c. ***Accrued Days Off (AD0s)***

The method of shift work results in the accumulation of sufficient time for one working day per month as leave. This day (an AD0) must be taken as it occurs. Medical Registrars are NOT to allow AD0s to accumulate. When taking AD0s, registrars should ensure that their Consultants and JM0s are aware and that appropriate Registrar cover has been arranged.

2. After-hours handover round

This is an important aspect of continuing medical care of patients after hours. This round is conducted at the change of shift:

10.30 PM every night and
8.30-9 AM on Saturday and Sunday morninngs.

All the relevant medical staff must attend, except when involved in resuscitating patients.

The registrar who is completing the shift is in charge of the handover. The registrar is to describe all medical admissions during the shift and to direct the oncoming JM0s to perform any ongoing clinical assessments or investigations. The JM0s who have completed the shift are to describe any patients with urgent problems and outline the ongoing medical care that is required.

There is a one hour overlap for the evening and night registrars. Evening registrars must not leave more than three patients to be seen by the night registrar at handover!!

3. Rosters

The roster for overtime shifts is issued every 4-6 weeks. If registrars have any particular rostering requirements, please contact the administrative officer in the Division of Medicine well in advance to issuing of the new roster. Once the roster has been completed and distributed, registrars are responsible for making their own swaps. Notify any changes to all of the following:

1. Administrative officer in the Division of Medicine
2. The Communications Clerk in the Emergency Department
3. Director of Medical Services office in Administration
4. Switchboard

When sick, or unable to turn up for a shift, registrars must notify the above people as soon as possible so that alternative arrangements can be made. It is not adequate to notify another member of the team or nursing staff on a ward.

Copies of the roster are available in the Division of Medicine, Emergency Department and Administration.

4. Formal Handover Sessions

Weekdays 8.30 am – 9.00 am in the meeting room on Grimson 2. All registrars are encouraged to attend this every day for both administrative and educational purposes. It is compulsory for all registrars who are in general medicine.

5. Grand Rounds

Grand Rounds is a critical aspect of the Division of Medicine's ongoing medical education and peer review. Medical Registrars and Physicians are expected to make every opportunity to attend these sessions and be involved in this process. All Medical Registrars will be required to present at Grand Rounds during the course of the year. The importance of a successful presentation at Grand Rounds can not be underestimated. With this in mind, Medical Registrars are advised to prepare all material thoroughly and to practice presentation skills. If you need access to a computer or facilities to prepare materials for projection, please contact members of the Division of Medicine.

Grand Rounds are held every Thursday in the Auditorium, Thomas & Rachel Moore Education Centre. Lunch is provided from 12.30, and the meeting commences at 1pm.

6. Clinical Review

While most of the medical departments conduct their own clinical review, the Division conducts a formal review as a mechanism for improving the quality of clinical management of patients in the care of Physicians. Cases of educational value or which illustrate problems in management are selected for presentation at monthly meetings held on the **second Friday of the month at 12.30 PM in Seminar Room 2 in the Education**

Centre. Registrars are required to attend at least 80% of pre-review meetings during the course of the year. A Senior Physician chairs the pre-review meeting. At this meeting all the preceding month's mortality cases are reviewed. The meeting is also a forum for raising areas of concern in clinical management, morbidity issues and the discussion of issues which may lead to a formulation or review of policy. Registrars are expected to participate in the clinical presentation of the case at the Divisional Morbidity and Mortality meetings, and, in conjunction with the reviewing Physician, are expected to critically examine the issues involved. The Divisional Morbidity and Mortality meeting is held in the Education Centre on the fourth Thursday of the month starting at 5.30 pm.

7. Physician Training Program

The FRACP examination is a demanding test of a candidate's knowledge and skills in Internal Medicine. Preparation must be extensive. In order to help candidates prepare for this examination, the Division of Medicine provides:

1. Regular lectures
2. Short and long case practice sessions
3. Journal Club.

The Division of Medicine prides itself on being able to meet the individual needs of all physician trainees. The Director of Registrar Training should be notified of any particular requirements. The training program and post-graduate educational activities are outlined in the Divisional publication "Training Program in Basic Post-graduate Medicine".

The Division of Medicine provides a lecture program in Internal Medicine for registrars on Thursday afternoons immediately following Grand Rounds. The program runes from 2-5pm, and is held in the Education Centre. Lecture timetables are available from Jane Beecham in the Division of Medicine.

Journal Club:

Registrars must attend the Journal Club, held every Monday starting at 12.30 pm, in the Grimson 2nd floor tutorial room.

Core reading:

a) Internal Medicine - *Harrison's Principles of Internal Medicine* or the *Oxford Textbook of Medicine*

b) Texts in the sub-specialties - see appendix of suggested further reading in *Examination Medicine* by Talley and O'Connor.

c) Journal Reading - it is important to cover recent major articles, review articles and editorials in the following journals:

New England Journal of Medicine

Lancet
The British Medical Journal
The Australian and New Zealand Journal of Medicine
The Medical Journal of Australia

Trainees are advised to form journal and study clubs to allow coverage of this large volume of reading and to commence MCQ practice. As the written paper is in MCQ format, trainees should be thoroughly familiar with this style of questioning. Past papers, ASAP and MKSAP questions are available from the college, Division of Medicine and the hospital Library.

Courses:
The Coppleson Institute at the University of Sydney runs a biennial cycle of lectures held every Tuesday evening. The lecturers are aware of important areas for the MCQ examination and contain up-to date information that can be difficult to obtain from journals. For further details contact:

Postgraduate committee in Medicine Coppleson Institute
The University of Sydney
Telephone: 9692 3526

Course in Clinical Immunology and HIV infection, organised by Postgraduate Medical School, at the University of New South Wales. This course runs over a weekend in December. For further details contact:

Postgraduate Medical School,
UNSW
Telephone: 9385 3063

Royal Prince Alfred Hospital - ALJESAL review course. Held over 2 weeks in December.

Dunedin Hospital, New Zealand - RACP Revision Course – Contact Mrs. Crosaldo, Department of Medicine.

8. Pharmacy

Hospital policy stipulates the ordering of drugs in their generic format. The Drug Advisory Committee controls the availability of certain drugs. Registrars should familiarise themselves with the Pharmacopoeia available on each ward. Doses should be stated in metric (SI) units (mg., mMol., microgram etc.) rather than a volume or number of tablets or ampoules. Australian formulations may differ in dose from formulations available in other countries. This is particularly true of injections. When writing doses of less than one unit, a leading zero should always be written before the decimal point e.g. **0.5** mg. Failure to follow this convention has resulted in doses 10 times the intended amount being administered.

Pharmacy has an extensive database of drug information which can be accessed through the Department by calling 83354 or 83356.

There is an on-line drug information database available at ward level through the mainframe computer system - HOSLAB Main Menu Item 83. Martindale on-line is the most relevant for Australian conditions. The rest of the databases are U.S. and are excellent cross-references, but they are written for U.S. products and conditions. There are policies regarding the ordering of restricted and authorised drugs, including some antibiotics. Please refer to **Appendix A3** for a detailed list of restricted antibiotics.

9. Library

The Ken Merten Library is situated near the Level One entry to the Auditorium in the Education Building. Services and facilities include loan of materials (excluding journals), access to Medline and the Internet, photocopiers (both colour and black/white), literature searches and interlibrary loans. Lounge and individual study areas are provided, and group rooms may be booked for meetings and tutorials. A South Western Sydney Area Health Service Library card will be issued on completion of a registration form. Access is then available to all libraries in the SWSAHS network.

Hours are generally 8.00am to 6.00 pm, 8.00am to 8.00pm on Tuesdays and Wednesdays, 8.30am to 5.00pm over the Christmas period.

Please phone the circulation desk ext. 83557 for further information or to make a booking. The Librarians are available for computer based resources tuition. Bookings for this service are appreciated.

10. Pathology tests and accessing the computer system

The South Western Area Pathology Service offers a complete pathology service from analytical to consultation services. Phone numbers for pathology can be found on the computer.

SWAPS has three request forms:

1. A cross matching form
2. A general request for all other services - it can be used for multiple departments and specimens
3. An autopsy request form

The specimen and request form must identify the patient accurately and legibly. This is best done in clear handwriting on the request form and container label. Pre-printed labels on request forms should be accompanied by the patient's name in writing. Pre-printed labels should not be used on specimen containers.

Obtaining Results

All pathology information is kept on the mainframe computer system, and is available from the ward terminals. Chemistry and Haematology results are available back to 1983. Results from other departments are available back to approximately 1990. Reports are generated daily by all Pathology departments. Ward or doctor summaries can be printed on ward terminals with attached printers, or can be generated by Haematology and Chemistry on demand.

OPTION 22 **COMBINED ENQUIRY** Single search routine provides all Pathology, Radiology and Nuclear Medicine results. Contact John Haswell on 85005 for training sessions or documentation.
OPTION 60 **SPECIMEN INFORMATION** This allows you to access the Pathology Handbook which contains information about the specimen required and any other special collection conditions. The program is very easy to run and will find any occurrence of the sequence of letters typed in.
OPTION 7 **MEDICAL MANAGEMENT** Allows specialised enquiries. Graphing available.
OPTION 85 **PHONE DIRECTORY**
OPTION 95 **YOUR COMMENTS** Allows staff to use an electronic mail box to alert Pathology of problems etc. Please type name and phone number so exact problem can be identified and a solution provided.
OPTION(1-4) **SPECIFIC RESULT ENQUIRY** These options allow the user to select the department from which they require information.
OPTION 5 **FAST RESULT REPORTING** New results since last report run.
OPTION 70 **INSTRUCTION MENU** Provides information on how to use the four enquiry options (1-4). The information on how to use the Microbiology enquiry OPTION 10 is held in the new pathology information section OPTION 80**.**
OPTION 80 **PATHOLOGY INFORMATION** offers an information tree which allows you to progressively select the information about a department in pathology.

All these options are very easy to use and the best way to become familiar with the operations is to spend an hour trying them out.

In addition to the options there is an information section on the top and bottom of all ward terminals which will highlight any new information or problems which the laboratory is encountering. **For help with computer *problems*** contact Ext 85005 or Ext 85888.

11. DEATHS

Postmortems

The most senior available member of the Medical Team should make a request for postmortem to the relatives of a deceased patient wherever possible. When consent is

obtained, the next-of-kin must sign the permission for Postmortem contained on the Authorities Form. The Resident Medical Officer should then fill out an autopsy request form and complete a death certificate. The postmortem should be booked through the Pathology Department, ext 83669. Ideally, a member of the medical team should attend any postmortem performed on a patient of that team. The Death Certificate can be modified to reflect the postmortem findings.

Coroner's Cases

A medical practitioner must not issue a death certificate if they are of the opinion that the person died in any of the circumstances listed below. Instead, the medical practitioner should report the death to the police or a Coroner:

(a) the person died a violent or unnatural death;

(b) the person died a sudden death the cause of which is unknown;

(c) the person died under suspicious or unusual circumstances;

(d) the person died having not been attended by a medical practitioner within the period of 3 months immediately preceding his or her death;

(e) the person died while under, or as a result of, or within 24 hours after the administration of, an anaesthetic administered in the course of a medical, surgical or dental operation or procedure or an operation or procedure of a like nature, other than a local anaesthetic administered solely for the purpose of facilitating a procedure of resuscitation from apparent or impending death.,

(f) the person died within a year and a day after the date of any accident to which the cause of his or her death is or may be attributable;

(g) the person died while in or temporarily absent from any of the following establishments and while the person was a resident at the establishment for the purpose of receiving care, treatment or assistance:

- a hospital within the meaning of the Mental Health Act 1990,
- a facility within the meaning of the Community Welfare Act 1987,
- a residential centre for handicapped persons licensed under the Youth and Community Services Act 1973,
- a residential child care centre licensed under the Children (Care and Protection) Act 1987; or

(h) the person died in any of the following circumstances:

* while in the custody of a police officer or in other lawful custody, or while escaping or attempting to escape from the custody of a police officer or other lawful custody; or

* as a result of or in the course of police operations; or

* while in, temporarily absent from, a detention centre within the meaning of the Children (Detention Centres) Act 1987, a prison within the meaning of the Prisons Act 1952 or a lock-up, and of which the person was an inmate; or

* while proceeding to an institution referred to above, for the purpose of being admitted as an inmate of the institution and while in the company of a police officer or other official charged with the person's care or custody.

A medical practitioner may issue a death certificate if the medical practitioner is of the opinion that the person:

(a) was 65 years of age or older, and

(b) died in circumstances other than those referred to in paragraphs (b), (c), (d), (e), (g) or (h), and

(c) died after sustaining an injury from an accident, being an accident, which did not occur in a hospital or nursing home, that was attributable to the age of that person, contributed substantially to the death of the person and was not caused by an act or omission by any other person.

Where a death certificate is issued under this provision, the death certificate must indicate that it issued under section 12B(2) of the Coroners Act.

Where doubt exists as to whether a death should be reported , the Coroner should be contacted for advice.

(2) ANAESTHETIC DEATHS

Deaths which occur during or within 24 hours of the administration of a local anaesthetic which has been administered "solely for the purpose of facilitating a procedure of resuscitation from apparent or impending death" are not examinable by the Coroner, unless they fall within any of the categories listed above.

In circumstances where a patient has died during or within 24 hours of the administration of a local anaesthetic, it will be necessary to determine whether the anaesthetic was administered as part of a resuscitative measure. Further, if the death occurred in any of the other circumstances listed above, then the death will be examinable by the Coroner.

(3) OBLIGATION TO REPORT DEATHS

Hospitals and medical practitioners or any other person, who has reasonable grounds for believing that a death or a suspected death would be examinable by the coroner but has not been reported, must report the death or suspected death to the police or a coroner as soon as possible.

All reports by hospitals should be on the prescribed form as:

Form A -"Report of Death of a Patient to the Coroner" and Form B - "Report of Death Associated with Anaesthesia/Sedation" .

Form A (which is form number MR39), and Form B (which is form number MR40), are kept in stock at the Fast Forms Division of the Government Printing Service (GPS), telephone: (02) 9743 8777, facsimile: (02) 9743 8603, address: PO Box 256, Regents Park, NSW 2143. Item No: 606180 must be quoted when ordering the MR39, and Item No: 601685 when ordering Form B, from the NSW Government Printing Service.

It is departmental policy that deaths associated with the administration of anaesthesia must also to be notified to the Special Committee Investigating Deaths Under Anaesthesia, PO Box M25, Camperdown, 2050 (Circular No. 90/88). This notification is to be made by forwarding the triplicate copy of the Form B.

Where the death has been associated with Anaesthesia, Form B must be completed in addition to form A.

Reports on Form A should be prepared in triplicate, the original and duplicate copies being handed to the police for transmission to the Coroner, the triplicate copy retained by the hospital. Form B is provided in quadruplicate with the original and duplicate copies being handed to the police for transmission to the Coroner, the triplicate copy to the Special Committee Investigating Deaths Under Anaesthesia and the quadruplicate copy being retained by the hospital.

(4) GUIDELINES FOR NURSING STAFF AND MEDICAL OFFICERS ON CORONERS'CASES DYING IN HOSPITAL

These guidelines should be followed by nursing and medical staff in dealing with Coroners' cases dying in hospital.

In general nothing should be done to a body after death if it is a coroner's case.

All IV cannulae, needles, endotracheal and intragastric tubes, all drains and airways should be left insitu. Attached drip bags, bottles and feed lines must accompany the body. All sharps or pieces of equipment left insitu should be firmly taped or secured to the body in such a way that the risk of sharps injury or leakage is minimised. The

immediate area should be checked and any sharps or equipment not required to remain insitu should be removed for disposal or reprocessing.

The body should be placed only in a plastic body bag. The body should not be washed even if the surface is soiled so that all surface contamination can be observed by the forensic pathologist and duly assessed. When, for instance death occurs shortly after injury by impact with a vehicle or by violent assault, washing may remove vital trace evidence such as an offender's blood and hairs or such things as paint flakes, glass chips or other finely divided material which may be matched later against similar material obtained from another source.

Limbs and chins should not be tied and orifices should not be plugged with cotton wool as these activities can leave marks, which cause problems especially about the face and neck.

Any material sucked from the stomach and/or any vomitus from suspected poisoning cases, should be retained and placed in screw-capped container(s), appropriately labelled and forwarded with the body for chemical analysis.

Prior to death, the deceased may have (either definitely or possibly) one of the infectious diseases listed under "List A" or "List B" (see following). If this is the case then a label stating only either "Infectious Disease List A - Handle With Care" or "Infectious Disease List B Handle With Care" should be attached to the body and the body should be placed only in a plastic body bag. The body should then be placed in a second plastic body bag with a second label with the same information affixed outside. Neither label should specify the condition. The body should **not** be washed with antiseptic solution.

Infectious Diseases:

List A

Acquired Immunodeficiency Syndrome (AIDS)
Acute viral hepatitis (unspecified)
Hepatitis B
Hepatitis C
Hepatitis D
Human Immunodeficiency Virus Infection (HIV)
Meningococcal disease
Rabies
Tuberculosis

List B

Anthrax
Diphtheria
Creutzfeldt - Jakob disease
Plague

Smallpox
Yellow fever
Any viral haemorrhagic fever (including Lassa, Marburg, Ebola and Congo-Crimean fevers);

Hospitals are also responsible for the safe custody of bodies until a Coroner's order for burial has been issued or, when directed by the Coroner, bodies are removed by members of the Police Force. This implies safe custody of the correct body in the same condition as when death occurs, ie no interference with incisions, dressings etc. Further, customary treatment of the body such as plugging the orifices, shall not be carried out.

If a Teaching Hospital wishes to take the opportunity with regard to a particular case for the specific purpose of teaching students, written consent must be obtained from the senior next of kin. Written application must then be made by a senior medical practitioner or hospital administrator to the Coroner for permission in each case and approval obtained.

If a hospital desires to remove surgical apparatus, written application for permission to do so must be made by a senior medical practitioner or hospital administrator to the Coroner *in* each case and approval obtained.

Relatives are at times caused distress because they are questioned by police and asked to carry out the necessary identification formalities without having been advised in advance of the reason for police enquiries. Where deaths are reported to the Coroner, a Senior Hospital Officer should, where possible, interview relatives immediately and explain to them the formalities required by the Coroner's Act.

Access to bodies for identification purposes should be appropriately authorised and supervised by the police.

Access to bodies for any other reason including compassionate reasons should be appropriately authorised and supervised by a senior medical officer who had cared for the deceased or the Nurse Unit Manager or Acting Nurse Unit Manager in that ward.

(5) TRANSFER OF MEDICAL RECORDS TO FORENSIC PATHOLOGISTS FOR POST MORTEM

Where a post mortem is to be conducted under the direction of the coroner, the pathologist or medical officer conducting the post mortem should have access to the medical records. The hospital should assume responsibility for the safe delivery and collection from the coroner's court of these medical records. A circular dealing with the confidentiality of medical records was issued in February 1999 (99/18). The following procedure is recommended for the handling of records:

(a) The release of all medical records should be handled by the Medical Records Section or designated responsible officer of the hospital. All hospitals must maintain a Register of Deceased Persons. It is recommended that the movement

of medical records of deceased persons be recorded either in a specific register or in the Register of Deceased Persons. If a separate register is kept it should contain the following information:

* **Unit Number/ Medical Record Number.** This is a registered number given to the patient.
* **Patient's full name**
* **Date of death**
* **Hospital autopsy.** This column should be notated if the medical staff of the hospital are seeking to conduct a post mortem within the hospital.
* **Report to Coroner complete.** This column should be notated to signify that all the statutory forms of report to the coroner have been completed. There are two main
  forms:
  (I) the "report of a death of the patient to the coroner (Form A) and
  (II) "notes of death reported to have arisen from or during anaesthesia" (Form B).
* **Police informed.** The nearest police station should be informed of all deaths falling within Part 3 of the Coroners Act, 1980. The dispatch and receipt of medical records to and from the Coroner should also be noted.

(b) Medical records may be sent with the deceased but should be collated and packaged prior to dispatch. The records should be forwarded in a sealed envelope to the coroner.

(c) A signed receipt should be obtained for all records from the coroner's court. The receipt may be a simple card bearing the following:

Received from Hospital

Package Number:

.... signed
.... date
The Coroner,
Coroner's Court

(c) Records should be forwarded within 24 hours of the death.

(e) Records should be forwarded and collected by the hospital courier where practical.

Records will generally be available for collection within seven (7) days of delivery to the coroner's court.

(6) DISCHARGE TYPE SUMMARIES FOR CORONIAL CASES IN HOSPITALS

For coronial cases involving deaths in hospitals, it is the responsibility of hospitals to provide the Coroner's Office with originals or copies of the deceased person's medical records and completed Forms A, or B.

Hospitals should provide a discharge type summary upon the written request of the Coroner. This summary should outline the care and treatment received by the deceased person at the hospital and specifically answer the questions raised by the Coroner's Office in its request. This will enable any issues of concern to be addressed in the first instance without the intervention of the police.

(7) OBJECTIONS TO A POST MORTEM EXAMINATION

This section provides information that should be given to the relatives of a deceased person whose death has been referred to the Coroner.

1 . The Coroners Amendment Act 1997 commenced on February 2 1998. The Act amends the Coroners Act 1980 to allow for an objection to an autopsy examination to be made.

2. The amendments allow a senior next of kin of a deceased person whose death has been referred to a coroner to request the coroner not to direct a post mortem examination. If the coroner decides that a post mortem examination is necessary or desirable in the public interest, the coroner must notify the senior next of kin of this decision. The post mortem examination will usually be delayed for 48 hours to enable the senior next of kin to apply to the Supreme Court for an order that the post mortem examination not proceed, or that only a partial post mortem examination proceed.

3. The "senior next of kin" are defined in the Coroners Act as:

* a spouse of the deceased (ie a person living with the deceased immediately before their death as their spouse on a bona fide domestic basis)
* if there is no-one in the above category or they are not available, any child of the deceased aged over 18 years
* if there is no-one in the above categories or they are not available, either parent of the deceased
* if there is no-one in the above categories or the are not available, any brother or sister of the deceased over the age of 18
* if there is no-one in the above categories or they are not available, an executor of the deceased person's will or the deceased person's personal representative immediately before their death.

4. A person other than the senior next of kin may object to the performance of a post mortem examination, and the objection will be referred to the Coroner. However,

the special provisions regarding a right of appeal to the Supreme Court (outlined in paragraph 2 above) apply only to senior available next of kin.

5. If a senior next of kin or other person is considering making an objection to the post mortem examination, they should ring the Clerk of the relevant Coroner’s Court immediately to notify them of their intention, as time will be of the essence in making an objection prior to the post mortem examination taking place. They should also make their intention known to the police officer completing the relevant police form (P79A) for the Coroner.

6. The Coroner's Court and the Institute of Forensic Medicine have produced information leaflets. The leaflet provides information about the coronial system and informs next of kin of their right to object to a post mortem examination. Copies of the brochure can be obtained from the State Coroner s Court at Glebe on (02) 9552 4066 or the Institute of Forensic Medicine on (02) 9660 5977.

7. Grief counsellors are employed on a fulltime basis at the NSW Institute of Forensic Medicine at Glebe on (02) 9660 5977 and at the Department of Forensic Medicine at Westmead on (02) 9845 6907. The counsellors are available to assist relatives of the deceased person. They provide the bereaved with information, support and counselling.

APPENDIX

Al. Division of Medicine Contact Numbers.

Professor Bruce Hall
Medical Director
Secretary – Terry Manaton
Tel: 84172

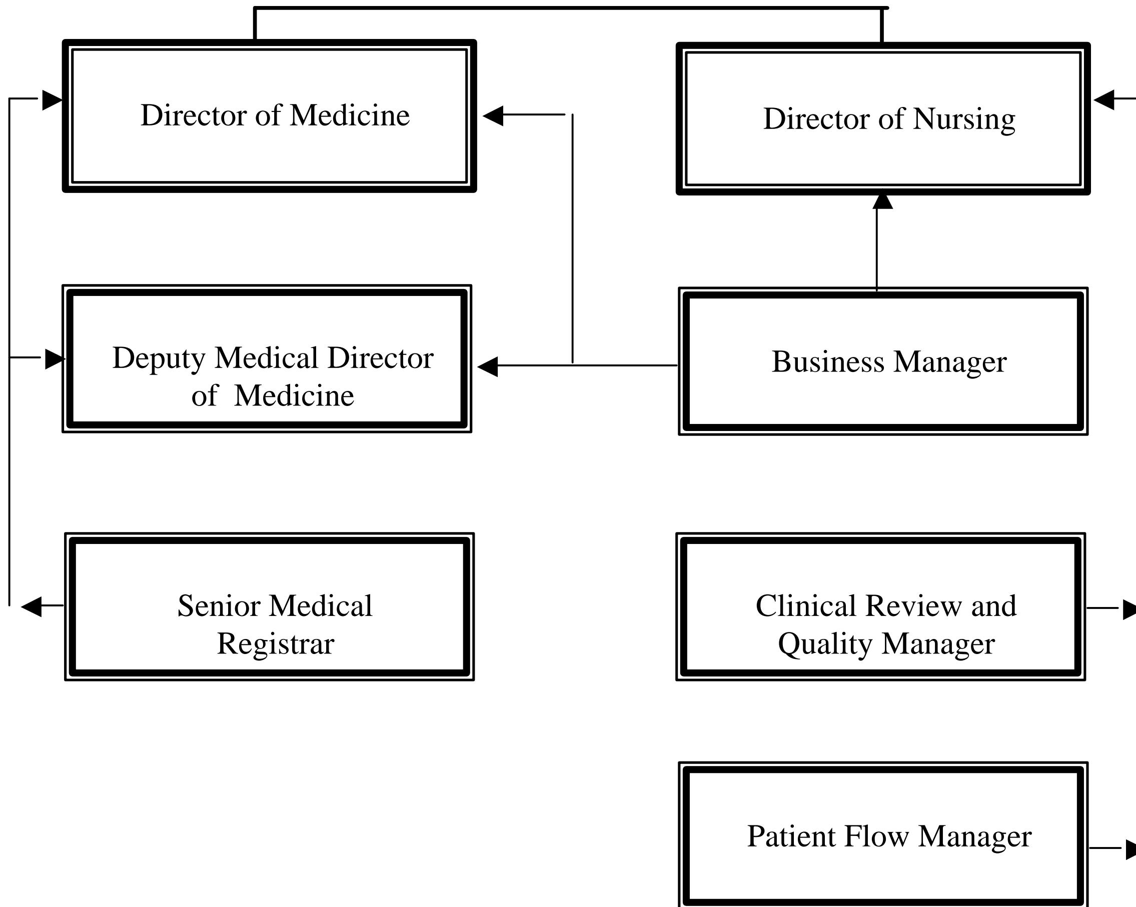
Ms Leanne Mills
Nursing Director
Secretary – Krishna Narayan
Tel: 84175

Professor Hugh Dickson
Deputy Medical Director
Secretary – Robyn Shipley
Tel: 84180

Dr Ken Howlin
Director of Physician Training
Tel: 83714

Senior Medical Registrar
Administration Assistant – Jane Beecham
Tel: 84181

DIVISIONAL EXECUTIVE STRUCTURE



A2. Introduction to the Emergency Department

STRUCTURE AND FUNCTION OF THE EMERGENCY DEPARTMENT

Staff

The Liverpool Hospital Emergency Department is an independent clinical department, within the Division of Critical Care. The Medical Director is Dr Sue leraci and the Nursing Manager is Mr Brett Clarke. The Staff Specialists are Drs Alan Giles, Jennie Martin, John Sammut, Sally McCarthy and Peter Wyllie.

There is at least one ED Registrar (Accredited trainee) on duty 24 hrs a day, 7 days a week, and at least two in the afternoon. The Staff Specialists work an extended hours roster (some evenings and weekends).

Admitting Officer

One of the Staff Specialists (Emergency Physicians) or Registrars acts as Admitting Officer each shift (direct phone no 83961).

Arranging Admissions (from Clinics, VMO rooms or other Hospitals)

The Admitting Officer in ED co-ordinates bed placement together with the Bed Management ADON. They are aware of the capacity, and the patients waiting for beds in ED.

To arrange a direct admission, contact the Admitting Officer on 83961. They will liaise with the Senior Nurse Manager Bed Management (Sue Whitby) or After Hours Hospital Manager. Where possible, we will try to get the patient directly to the ward, (unless resuscitation is required). The Bed Manager may be contacted directly if there is no need for ED involvement.

Please do not arrange for patients to turn up at the ED without discussing with the Admitting Officer first.

Role

The primary role of the Emergency Department is the initial assessment, stabilisation, investigation and initial treatment of patients presenting with acute illness and injury. We do not run any clinics and we try to minimise ED follow-up visits (patients are referred to their LMO, Physician's rooms or Outpatients). We cannot act as an admission processing centre for patients sent in by Physicians, as this impairs our capacity to see new patients promptly.

Bed Management
As bed access block (patients banking up waiting for beds) makes the department unworkable and unsafe, we try to move patients to the wards as soon as possible.

Sometimes we may need your help to find beds or we may ask you to see new admissions on the ward (as is hospital policy when the ED is full).

Inpatients in the ED

Remember that, once you have accepted an admission under your unit, their care is your responsibility. While they are waiting for a bed, they belong to your team and you should include them in your regular rounds.

Consent for Surgery

Our staff are asked not to document consent for operation for surgical patients, as it is our policy (and hospital policy) that the team intending to do the procedure should explain and obtain consent. Please don't ask *the junior* staff to do this task for you.

Telephone and Paging (ED Communications Clerk)

In order to streamline communications within the ED, we have a Communications Clerk who takes all incoming calls on 83961. They also handle paging and patient enquiries. Our internal extensions are diverted to that number.

If you phone any of the other ED extensions during these hours, the call will be diverted to 83961 and answered by the Clerk.

If you need to page someone while you are in the ED, ask the Communications Clerk to page them for you. They will get back to you (by phone or overhead announcement) when they have the person on the line.

Rosters

If you swap your admitting day or on-call roster, or if your pager is malfunctioning, please let the ED know (particularly the Communications Clerk or the Admitting Officer).

Advice and Assistance

The ED Staff Specialists and Registrars are used to problem-solving and dealing with most other departments of the hospital and all the clinical disciplines. If you need any advice or explanation, whether clinical, administrative, or organisational, don't hesitate to ask one of us.

We have a body of expertise and a collection of good references on toxicology, envenomation, arrhythmias, trauma and many other aspects of acute medicine.

Feedback

We are always keen to hear feedback about what happened to our patients, or any other information that can add to our knowledge or service provision.

A3. Restricted Antibiotics

Antibiotics are one of the most commonly prescribed categories of drugs in any hospital. Unlike most medications, their use can affect the treatment of other patients in the hospital by inducing drug resistance in organisms inappropriately treated. For instance, MRSA outbreaks are usually an artifact of inappropriate drug use. MRSA nosocomial infection is currently a serious problem in this hospital.

For this reason, and because antibiotics constitute **a** major expense in all hospital budgets, most hospitals (including Liverpool) have guidelines placing restrictions on their use.

These guidelines are based on the ANTIBIOTIC GUIDELINES prepared by the VICTORIAN MEDICAL POSTGRADUATE FOUNDATION and endorsed by all States. They are available from Liverpool Hospital Pharmacy. Our guidelines may differ from these due to local antibiotic sensitivity patterns.

Their purpose is to prevent bacterial drug resistance, avoid toxicity and reduce costs. In addition, some specialised antibiotics should only ever be used for the treatment of infections caused by resistant bacteria.

Except where indicated below, the Pharmacy is not permitted to dispense the following antibiotics unless Microbiology/infectious Diseases clinicians have agreed with usage. The following antibiotics are on this restricted list:

Aciclovir *	Clarithromycin	Miconazole injection
Amikacin *	Clindamycin	Rifampicin
Amphotericin B	Didanosine	Rifabutin
Antituberculous drugs +	Fluconazole	Tazocin
Aztreonam *	Flucytosine	Timentin
Capreomycin	Foscamet	Tobramycin
Cefotaxime	Fusidic acid	Teicoplanin
Cefpodoxime	Gancyclovir	Vancomycin
Ceftazidime	lmipenem *	Zalcitabine
Cephalothin	Ketoconazole	Zidovudine

Ciprofloxacin

* These drugs are **<u>not</u>** restricted for use by Haematology, Oncology and Intensive Care Units.

** These drugs are restricted for use in infections caused by methicillin resistant Staphylococcus aureus (MRSA) - Rifampicin, Fusidic acid.

\+ Antituberculous drugs should be administered under the supervision of the Chest Clinic, Chest Physician, or Microbiologist/infectious Disease Physician.

Topical antibiotic use:

The use of topical antibiotics is actively discouraged except for indications covered in the Guidelines in relation to infections of the eye, ear, vagina and perianal.

FOR THE COMPLETE GUIDE TO ANTIBIOTICS THERAPY PLEASE USE THE MAINFRAME TERMINALS.

A4. Benzodiazepine Usage

Benzodiazepines should not be prescribed as a routine for new admissions into hospital.

Benzodiazepines must not be prescribed for more than five days maximum for patients who do not use them regularly. After five days of use the Physician in charge of the patient must prescribe further drug usage.

Benzodiazepines when prescribed for night sedation should be on a PRN basis only.

Benzodiazepines cannot be prescribed to patients with organic brain syndrome e.g. dementia, delirium unless recommended by the Physician in charge of the patient.

Benzodiazepines must not be prescribed to patients with respiratory disease unless recommended by the Physician in charge.

Patients who were first prescribed Benzodiazepines during their hospital stay should be warned of the withdrawal side effects expected on cessation of medication and their lack of effectiveness if used for prolonged periods (greater than 1-2 weeks). These people should not be prescribed Benzodiazepines on discharge and they should be asked to consult their LMO if they require ongoing sedation.

Patients who have been on long-standing Benzodiazepines should also be advised concerning the consequences of Benzodiazepines. In hospital they should be gradually reduced to help minimise withdrawal reaction.

NB: Please contact the Drug and Alcohol Unit Consultation Service, ext. 83311 (page 460) should you require further information and assistance on the prescription of Benzodiazepines.

A5. Prescribing Methadone to Addicts

Clients of Methadone programs should have their regular dose continued during their stay in hospital.

The patient should be asked the name and address of their methadone program and/or dispenser as it is essential to establish independently whether they are on a program.

The Drug & Alcohol team should then be consulted to establish their dose, and whether they have received the dose due for the day of admission. Contact Jacaranda House on extension 83745 or page the Drug & Alcohol Registrar on duty.

Out-of-hours, the Drug & Alcohol Physician will advise on the correct course of action if the client's program cannot be contacted.

Narcotic abusers who are not registered with a Methadone program should be referred to the Drug & Alcohol Physician.

A6. Staff Counselling

The hospital provides a confidential counselling service for all staff, for any sort of work or personal problem.

The Counsellor, Tony Homer, is a psychologist with over 25 years experience in hospitals and the Health Service.

Staff counselling enables people to identify and clarify the difficulty, decide on a solution and develop all the skills necessary to put that solution into effect.

Problems commonly encountered by the medical staff, for which assistance is provided, include time and stress management, study skills, exam and viva anxieties, interpersonal issues with patient's relatives, colleagues and nurses, and the demands presented by dealing with death and disability.

The Counsellor is available on ext 84641. Out of hours appointments can be easily arranged.

A7. How to PAGE and other general information

The Hospital provides a page. Replacement batteries are available from the switchboard. If you answer your page promptly, you will be popular with your colleagues. The pages are not waterproof, so don't drop them in basins, baths or toilets. They also break if you drop them. They need to be turned on to work (see sentence number three).

How to page

Dial 5# . The phone will ring then connect to a high pitched tone. Immediately dial in page number then *. The tone will change to a deeper note. Immediately dial in phone number of extension you are using followed by **. A beeping sound will be heard. Hang up and wait for page to be answered.

Switchboard

Dial 9.
The telephone number of the Hospital is 9828 3000. The facsimile number of the Division of Medicine is 9828 4170.
The area code for long distance calls within Australia is 02. For international calls, the number is 61 2 9828 3000.

Dress

The atmosphere of the Hospital is relaxed. Most of the senior staff wear coats and ties. For registrars, a neat casual style of dress is encouraged. Needless to say, clothes should be clean. Safety concerns oblige the wearing of robust footwear, not sandals. While white coats are favoured by some staff, the Hospital does not provide them. Interestingly, research in children has shown that doctors who wear white coats are usually seen as cold, unfriendly and competent, whereas casually dressed doctors are seen as warm, friendly and less competent!
Hospital ID badges are issued on the first day of work and should be worn at all times during working hours.

MET calls

MET stands for Medical Emergency Team. The MET call system was developed in Liverpool Hospital. Rather than have a team that would respond only to cardio-respiratory arrests, the MET responds to these, plus it provides a response for patients whose physiological parameters indicate that they are at risk of requiring an urgent response in the near future. The MET team consists of:

- ICU senior registrar or resuscitation registrar
- ICU resident
- ICU nurse
- Medical registrar

The MET responds to calls prompted by the following:

• Airway	Threatened
• Breathing	All respiratory arrests Respiratory rate <5 Respiratory rate >36
• Circulation	All cardiac arrests Pulse rate <40 Pulse rate >140 Systolic blood pressure <90
• Neurology	Sudden fall in level of consciousness (Fall in GCS of >2 points) Repeated or prolonged seizures
• Other	Any patient who does not fir the criteria above that you are seriously worried about

The medical registrar on take carries a MET page. There is always a medical officer on the team from ICU who is skilled in intubation, including paediatric intubation. Backup for paediatrics is also available via the Intensive Care Nursery staff. Paediatric crises are stabilised and transferred to a Children's Hospital. Paediatric patients whose condition is deteriorating are similarly transferred.

Leave

Registrars are eligible for 4 weeks of annual leave per year. Only two registrars can be absent at any one time, as relief will not allow cover otherwise. There is a system of accrued days off. Every month, a day off is accrued. This leave should not accumulate. It should be taken regularly. Registrars should let their AMO know and their junior staff know when they are taking leave. Registrars cannot escape overtime shifts by taking an ADO.

Leave is allocated on a first come – first served basis. Leave forms are in the Division.

Leave has to be approved by the Senior Medical Registrar.

Leave relief can present difficulties, particularly if more than on registrar is absent at a time. It is important to consult fully with the Senior Medical Registrar and the Department Head to ensure that leave cover arrangements are satisfactory.

Meals

Free meals are available for staff working overtime shifts. Vouchers for these are available from switchboard. During normal working hours, meals may be purchased from the Hospital canteen. A staff discount is available to those who are wearing a hospital ID badge.

Interns

These doctors have just finished their undergraduate training. Training of interns is an important responsibility of the registrar. Registrars should treat interns as they would have been wanted to be treated by their registrars when they were at an equivalent stage of their training.

Resident Medical Officers

They are extraordinarily valuable, very rare in the South West of Sydney, and should be persuaded to continue their medical training at Liverpool Hospital.

AMC doctors or AMECs

These are Australian Medical Council graduates. They are doctors who performed their training overseas, and so are not registerable in Australia. In order to be registered, they have to pass a written and clinical examination, and work for a year in a Hospital.

Students

Students should be carefully trained and nurtured, and integrated into the activities of the Unit. The students attached to SWSAHS Clinical School are students of UNSW. They do the majority of their clinical rotations at Liverpool Hospital. The curriculum of UNSW prescribes that students are integral members of clinical teams, participating and contributing to the function of the team. They can assist in admissions, follow-up rounds and need to learn practical skills such as cannulation, blood taking etc. They only have 6 hours formal teaching a week so should attend with the registrar and consultants on all rounds. Teaching of students, interns and RMOs is a major function of registrar activities.

Other sources of useful information

The Liverpool Hospital RMO Manual is essential reading for registrars.

A8. Positive Blood Cultures

The technical staff in the Microbiology Department will call medical registrars working at nights and weekends if there are positive blood culture results reported. It is hospital policy that the medical technologist should call the registrar associated with the appropriate team. Occasionally, surgical registrars and obstetric registrars are not contactable because they are in operating theatres. The fallback position is that they contact the medical registrar.

A positive blood culture is an important clinical finding that must be acted upon at nights and weekends. If the registrar is notified about a positive blood culture on a non-medical patient is not a medical patient, the registrar should assume an immediate consultation from the surgical or other team. It is then the medical registrar's responsibility to see the patient, or to make arrangements for other medical staff to see the patient to assess whether the patient is receiving appropriate treatment.