BHS ED Self-directed learning workbook

Author Jaycen Cruickshank updated 2021 Heather Crook

Ballarat Health Services

Emergency Department
Self directed Learning package

Name: _____

Emergency Department Self-directed workbook

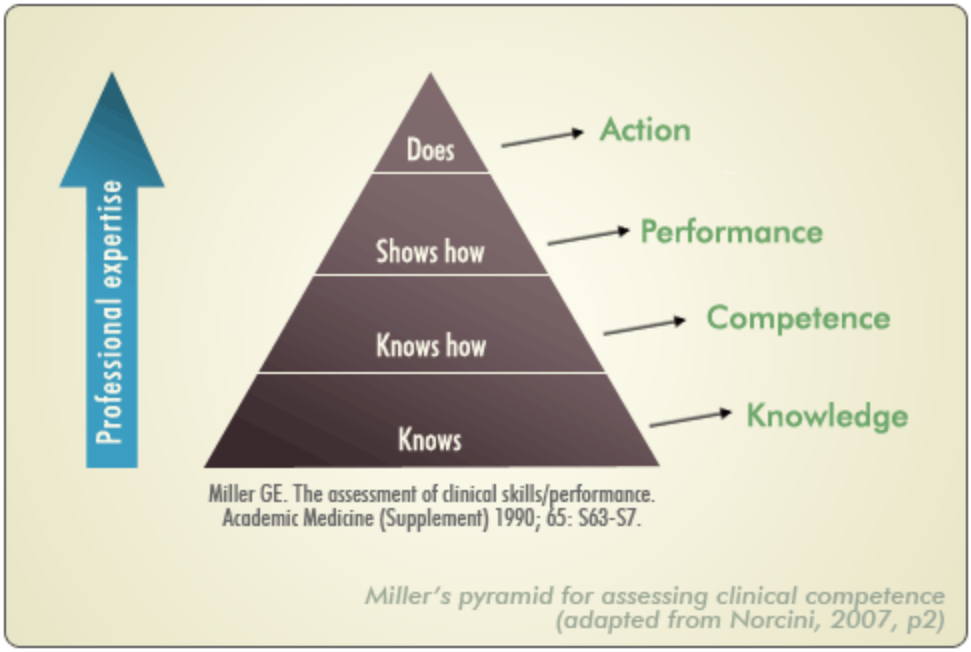
General information

Emergency Medicine is concerned with the management of the broad spectrum of acute illnesses and injury in all age groups. The aim of this self-directed workbook is to assist hospital medical officers to identify the competencies for working in Emergency Medicine in Ballarat.

The emergency department at BHS has for many years run an observership program and we have recruited many excellent doctors as a result. The department has a very multicultural staff mix, and we view with pride our diversity and teamwork. We aim to make your time with us productive within a supportive environment. We have also ensured we have paid training time for registrars but also an above award arrangement with paid training time for HMOs and Interns.

Since 2012 we have been aiming to improve the learning experience for our medical staff. This has involved different types of learning sessions. Any good education program will attempt to assess prior knowledge of the learners before teaching. With a diverse group there will be variation within the group. We have been using this self-directed workbook as a guide for you to assess your knowledge and identify your learning needs by completing the workbook. It is not mandatory, but we would like to continue to use it as it assists with performance appraisals, and to provide some more structure and real learning outcomes. You will know best what type of learning style suits you, so can choose how you use the book.

The following diagram highlights the key objectives, with our aim to see more of “does” and “shows how”



Miller’s pyramid for assessing clinical competence (adapted from Norcini, 2007, p2)

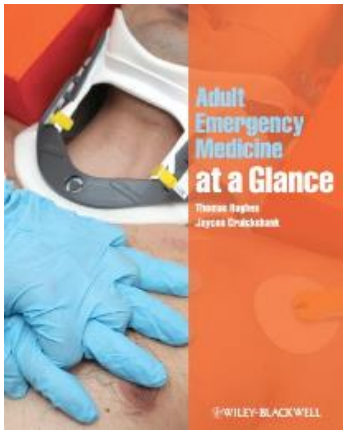
Education

The BHS ED HMO and Observer education series covers the following fifteen topics:

1. Resuscitation
2. Major Trauma
3. Cardiology
4. Respiratory System
5. Neurology
6. Toxicology
7. Psychiatry
8. Surgery
9. Orthopaedic
10. Minor Trauma
11. Obstetrics and Gynaecology
12. Sepsis
13. Paediatrics
14. Eyes, ENT
15. Aged Care

The learning resources in this self-directed workbook covers these topics. The learner should complete the self-directed workbook to enhance their own understanding of their learning needs. Every section does not need to be completed. Use it to reinforce areas where your knowledge is strong, or to identify areas that need some work. In many cases this will mean on the job learning, rather than finding information in books. It will help to revise the cases when you have seen similar patients in the Department, to reinforce your learning.

For brief rotations in the Emergency Department, we recommend Adult Emergency Medicine at a Glance.



There is a potential conflict of interest given Jaycen Cruickshank is one of the authors. The reason for the recommendation relates to the fact that the content of this book reflects the minimum amount of knowledge required regarding Emergency Medicine.

Feedback

Feedback with supervisor to be completed using the self-assessment tool provided.

Complete the self-directed workbook and review with your supervisor.

Add interesting cases to your consults list in BOSSNET, to facilitate discussion. This ensures you do not need to keep lists with patient information, which if taken off site can result in privacy and confidentiality breaches

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1. Resuscitation – Case 1: Anaphylaxis

36 year old female, Anna, from Greece noticed with rapid onset of shortness of breath after having taken an antibiotic. Normally has mild asthma.

Now presents with generalised wheeze and facial swelling. Looks ill.

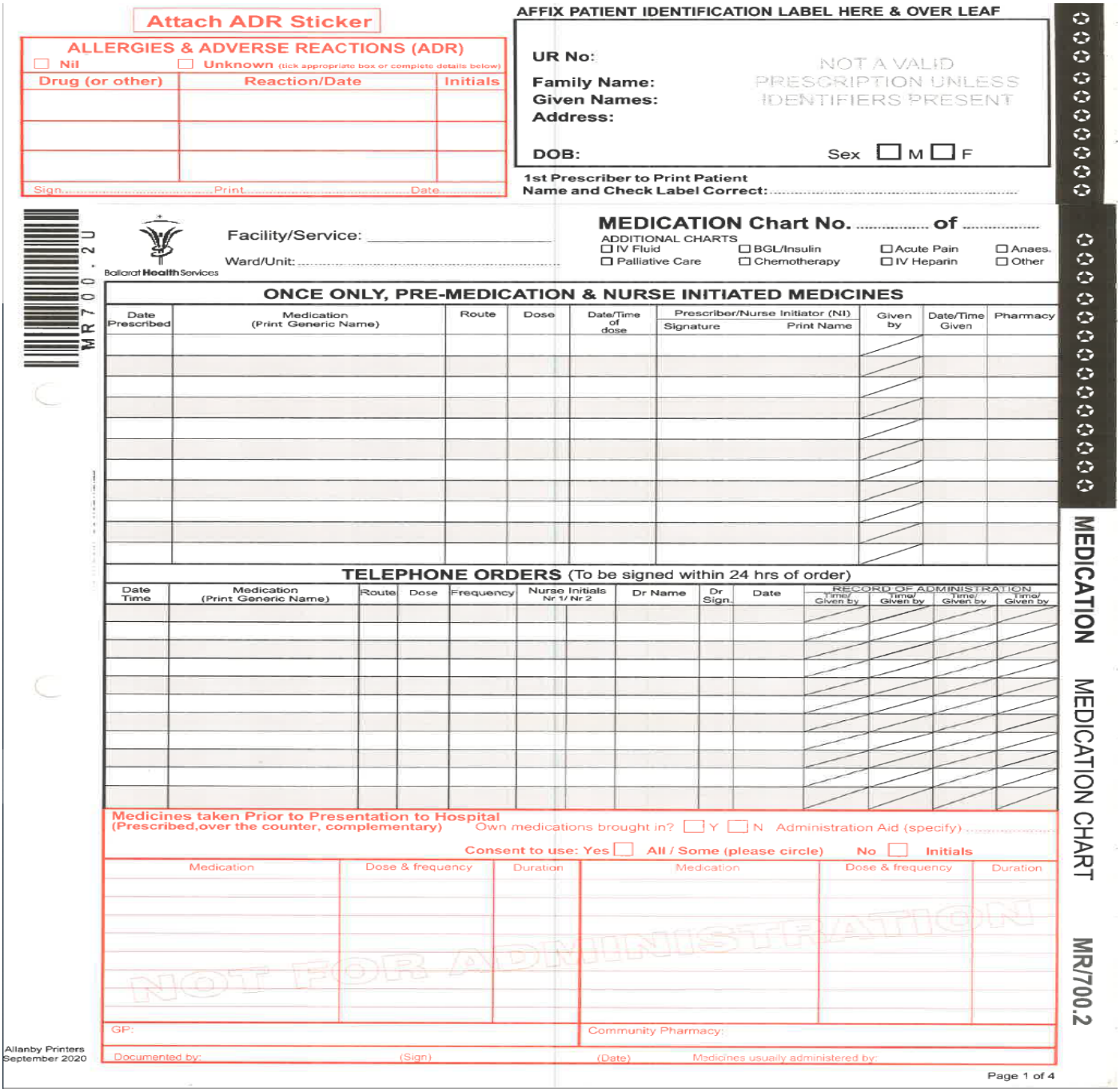
What has Anna got, and what things can cause this condition?

How does it present?

How do you assess how ill Anna is?

Why is it important?

What is the urgent treatment? Please document it below.



Attach ADR Sticker

ALLERGIES & ADVERSE REACTIONS (ADR)

☐ Nil ☐ Unknown (tick appropriate box or complete details below)

Drug (or other)	Reaction/Date	Initials

Sign..... Print..... Date.....

AFFIX PATIENT IDENTIFICATION LABEL HERE & OVER LEAF

UR No:

Family Name:

Given Names:

Address:

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

DOB: Sex ☐ M ☐ F

1st Prescriber to Print Patient Name and Check Label Correct:.....

MR700.2U

Ballarat Health Services

Facility/Service: _____

Ward/Unit:.....

MEDICATION Chart No. ..... of .....

ADDITIONAL CHARTS

☐ IV Fluid ☐ BGL/Insulin ☐ Acute Pain ☐ Anaes.

☐ Palliative Care ☐ Chemotherapy ☐ IV Heparin ☐ Other

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What other treatment is helpful? Write it above.

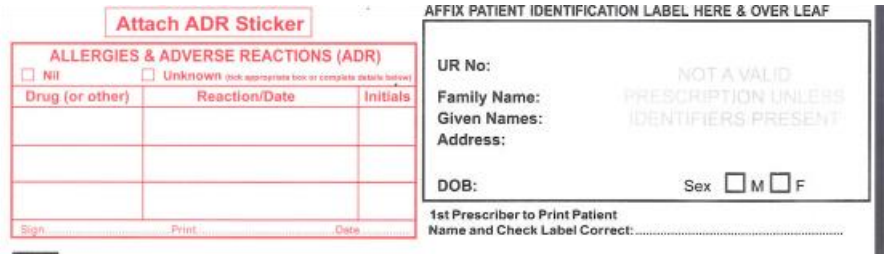
What do you do if she was very sick?

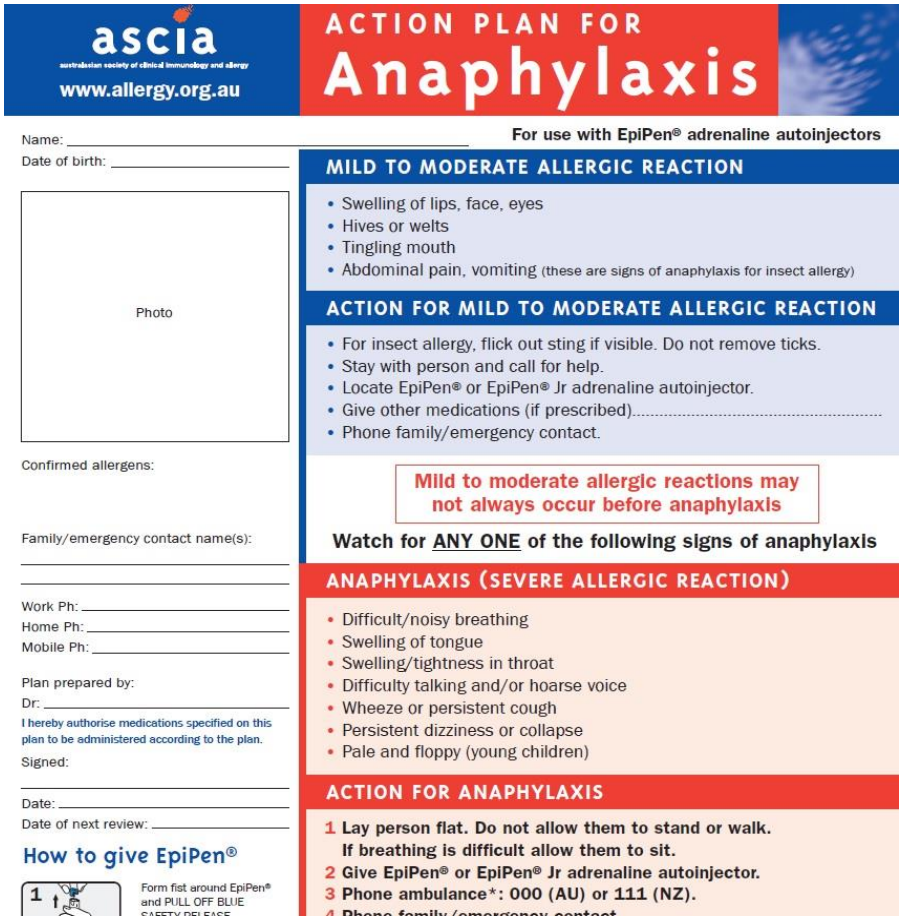
How do you know if she was getting better/worse?

How long should she stay in hospital?

Where in the hospital should she be looked after?

TASK: Complete the following for her prior to discharge.





Patient Alerts; don't forget to add a CAM Alert

2. Major Trauma – Case 1: Vehicle rollover

A patient presents with a high speed rollover at 2am. The vital signs are BP 90/60 HR 120 and normal oxygen sats.

Outline the initial management to be taken by the Admitting Officer and nurse in charge

On arrival outline your initial assessment of this patient in the first 5 to 10 minutes.

What bed-side tests would you like to perform, and what are you looking for?

List life threatening conditions and their immediate treatment

Condition	Immediate treatment

2. Major Trauma – Case 2: Heavy fall, LOC

A patient fell over at the pub and hit their head on concrete with a brief LOC, but is now fine and is here with friends to be checked out.

How will you decide if he needs imaging of neck and or head?

In this situation the patient ended up having a CT head and neck which were normal.

Describe the safe discharge of this patient including appropriate referral

What is the ABI clinic and outline the referral process for this?

3. Cardiology – Case 1: Chest pain ischaemic

You are required to write up two patients with chest pain, one with ischaemic chest pain (Case 1) and one with another diagnosis. Think of cases you have seen yourself for these tasks.

What other signs and symptoms did the patient have?

What features on History were typical of ischaemic cardiac pain?

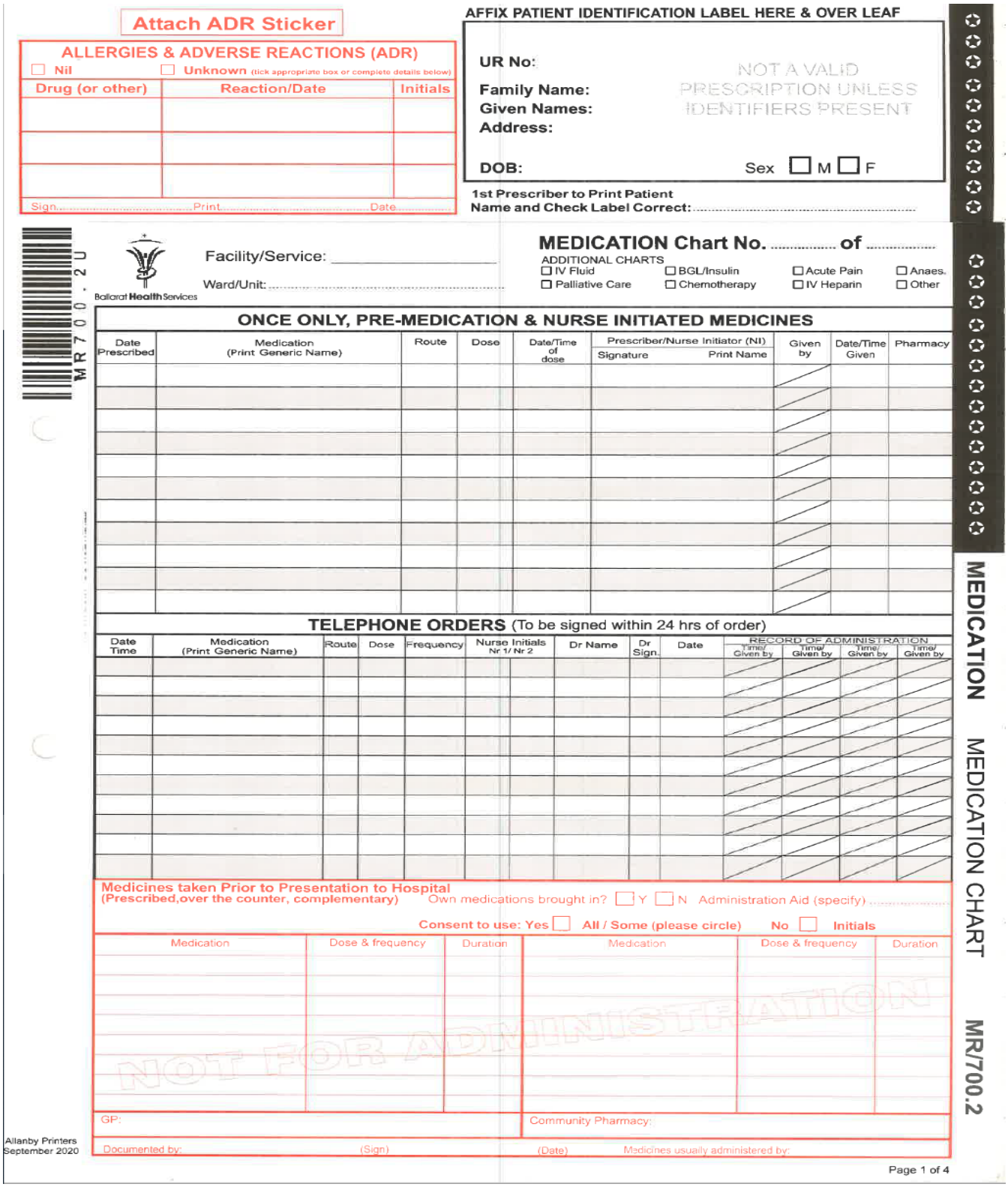
What are the risk factors?

Outline the features of low, intermediate and high-risk acute coronary syndromes

What treatments are available in this hospital?

Where in the hospital should these patients be looked after?

What treatment did the patient receive in the emergency department?



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3. Cardiology – Case 2: chest pain, not ischaemic.

You are required to write up two patients with chest pain, one with ischaemic chest pain (above) and one with another diagnosis (Case 2).

What features on History made this patient's pain UNLIKELY to be cardiac in origin?

What alternate diagnoses were considered in this patient?

What investigations were done to evaluate the alternative diagnosis?

TASK: Collect copies of ECG's from patients (de-identified) you observe which show the following.

1. Acute myocardial Infarction/ acute coronary syndrome
2. A rhythm disturbance

Describe the ECG. Why is it important to write a comment on each ECG you reviewed, including recording initials or writing your name?

4. Respiratory – Case 1: A breathless patient.

22 year old female with increased shortness of breath past 2 days.

Normally uses a brown inhaler and a blue inhaler

Now presents with generalised wheeze and is very short of breath.

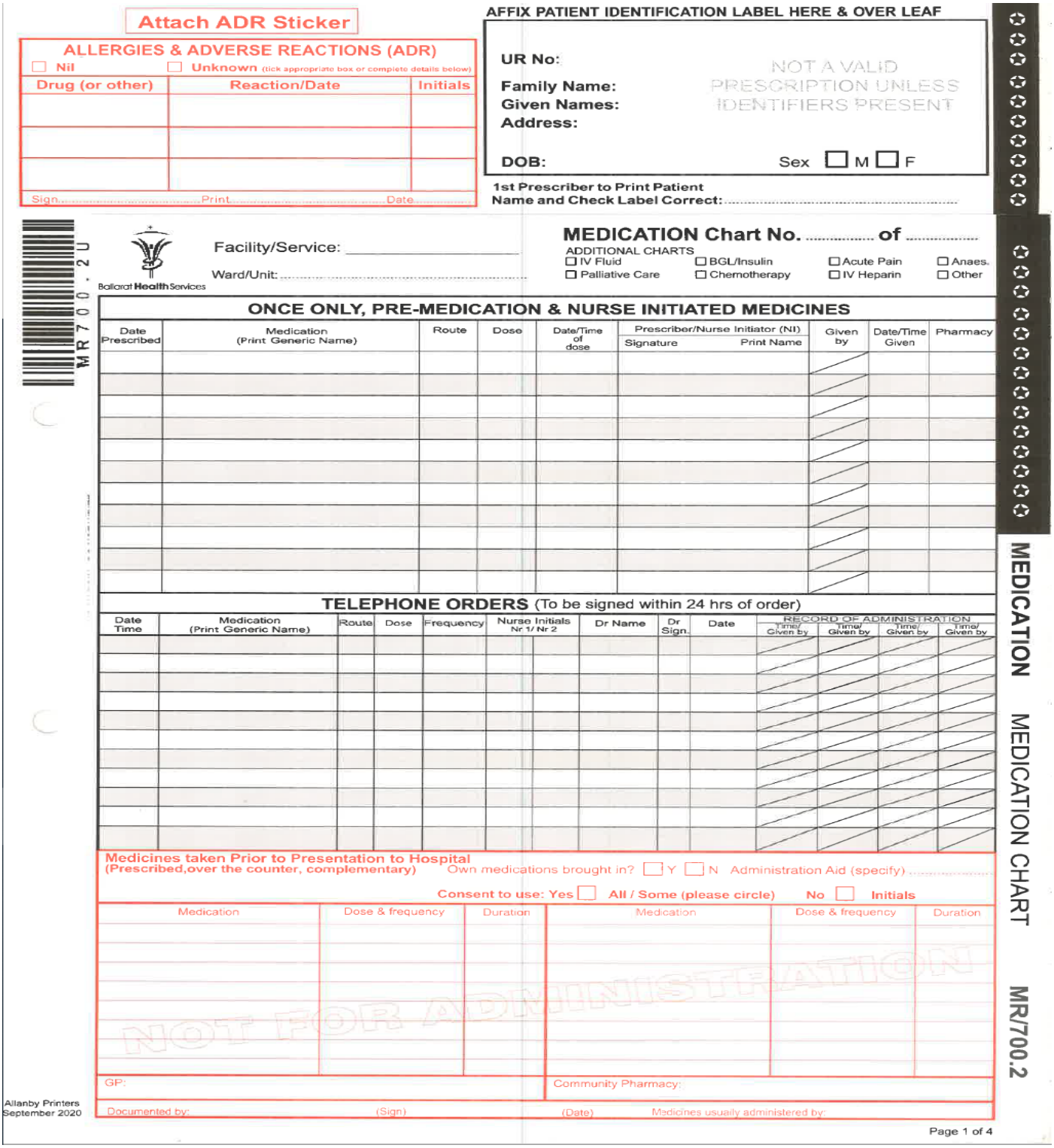
What condition does this patient have?

How does this condition usually present?

How do you assess how ill she is?

Why is it important?

What is the treatment? – Please complete below



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How do you know if she is getting better/worse?

What do you do if she is very sick?

When is it safe to discharge her? Where do you find the asthma action plans?

TASK: There are two asthma stickers found in the Emergency Department. Affix them below with an example of them completed correctly

5. Neurology – Case 1: Headache and Nausea and Vomiting

A patient presents with a severe headache, and nausea and vomiting for the last six hours, which has not settled with the usual oral medication that she tried at home.

She suffers from migraines as did her mother, and is not on medications normally

List the differential diagnosis in addition to migraine.

A physical examination is normal

What are the three most import differential diagnoses? List the features you would look for.

Please order some medication on the chart

Please complete a SSU pathway for this patient and describe the process for requesting an admission to SSU

5. Neurology – Case 2: Sudden Headache

The patient is reviewed on the SSU ward round and on further questioning; the patient admits that the headache came on suddenly during sexual intercourse.

The headache was severe but has now settled…

Does this change your management? Would you order any tests, and if so, outline below

5. Neurology – Case 3: Seizure

17 year old female brought in by ambulance.

Was witnessed to collapse at The Railway Hotel, one of the less salubrious nightclubs nearby.

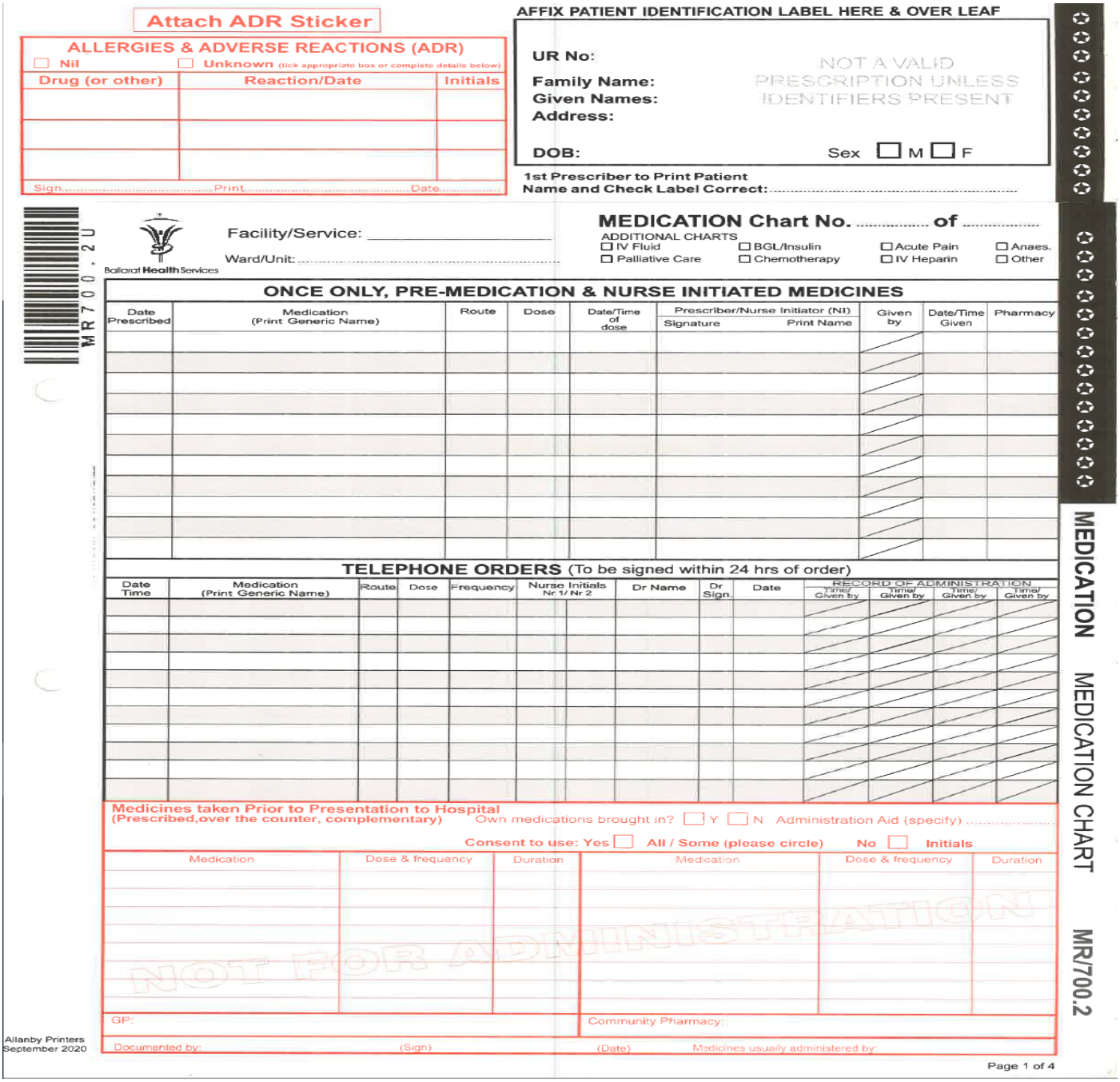
Is having rhythmic contractions of all limbs when brought in by the ambulance staff.

What are the top priorities in her treatment?

How does this condition present to the ED?

What might have caused her condition?

What is the treatment? Document this below



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What would you do if she is not getting better?

What investigations may need to be carried out to help with her management?

What follow up may be appropriate?

6. Toxicology – Case 1: Patient with Suspected Overdose

27 year old female found on floor semi-conscious.

The ambulance crew found empty packets of amitriptyline, and diazepam around her.

On being brought into the department she is talking, but confused.

What other signs and symptoms might she have?

What general supportive treatment does she need?

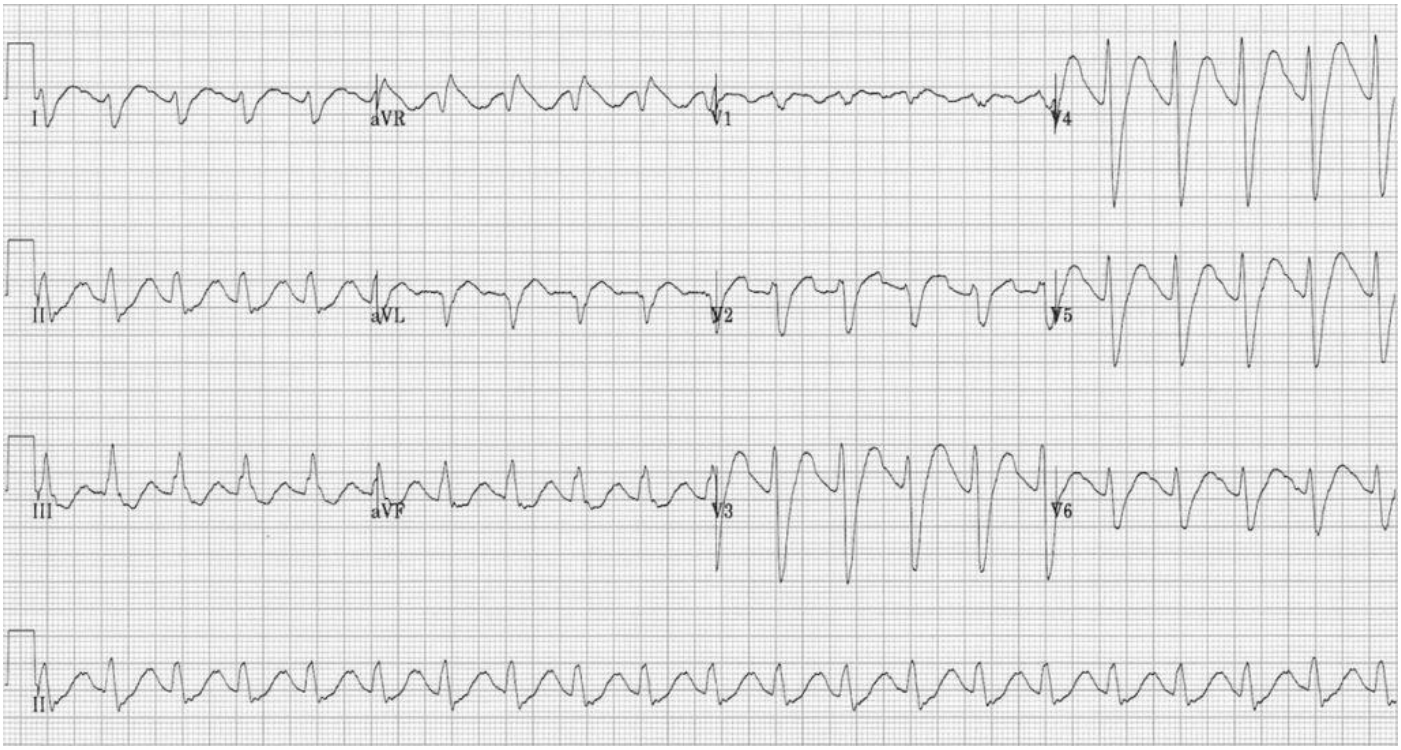
How do you assess how ill she is?

What is the treatment?

What sort of ward care will she need in the first 12 hours?

What follow up should she have?

Interpret the patient's ECG. What features do you look for in patients with tricyclic overdose?



What features do you look for in SSRI overdose?

What are the dangers of each?

What is the management of each?

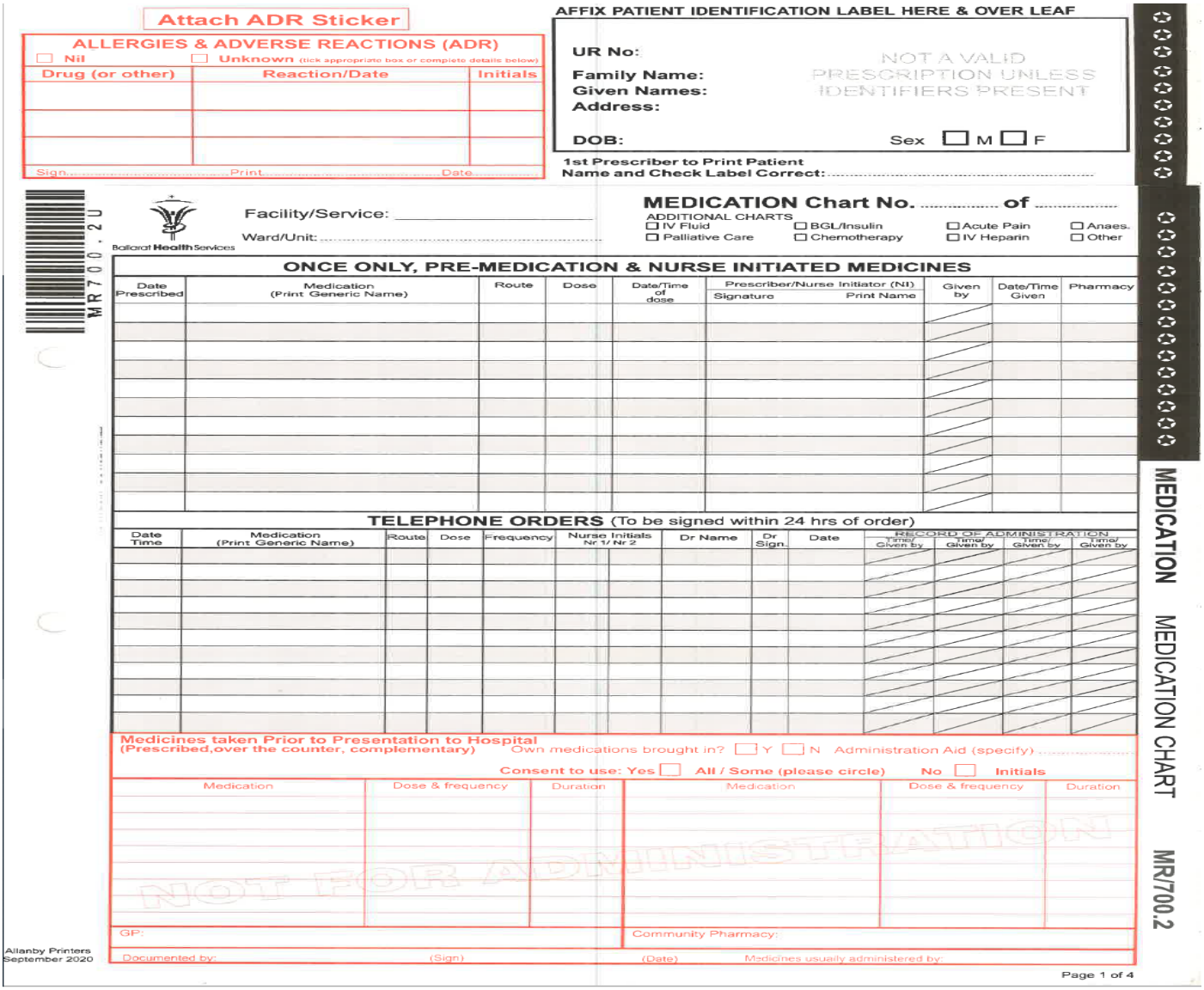
6. Toxicology – Case 2: Patient with Coma

20 year old male – well known to the ED with multiple past visits.

Found at home unconscious with 3 empty boxes of paracetamol and an empty syringe. He was seen by his housemates 1 hour previously, and had seemed fine.

He is brought in still unconscious, with small pupils and slow breathing.

What treatment(s) does he need?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Palliative Care Chemotherapy IV Heparin Other

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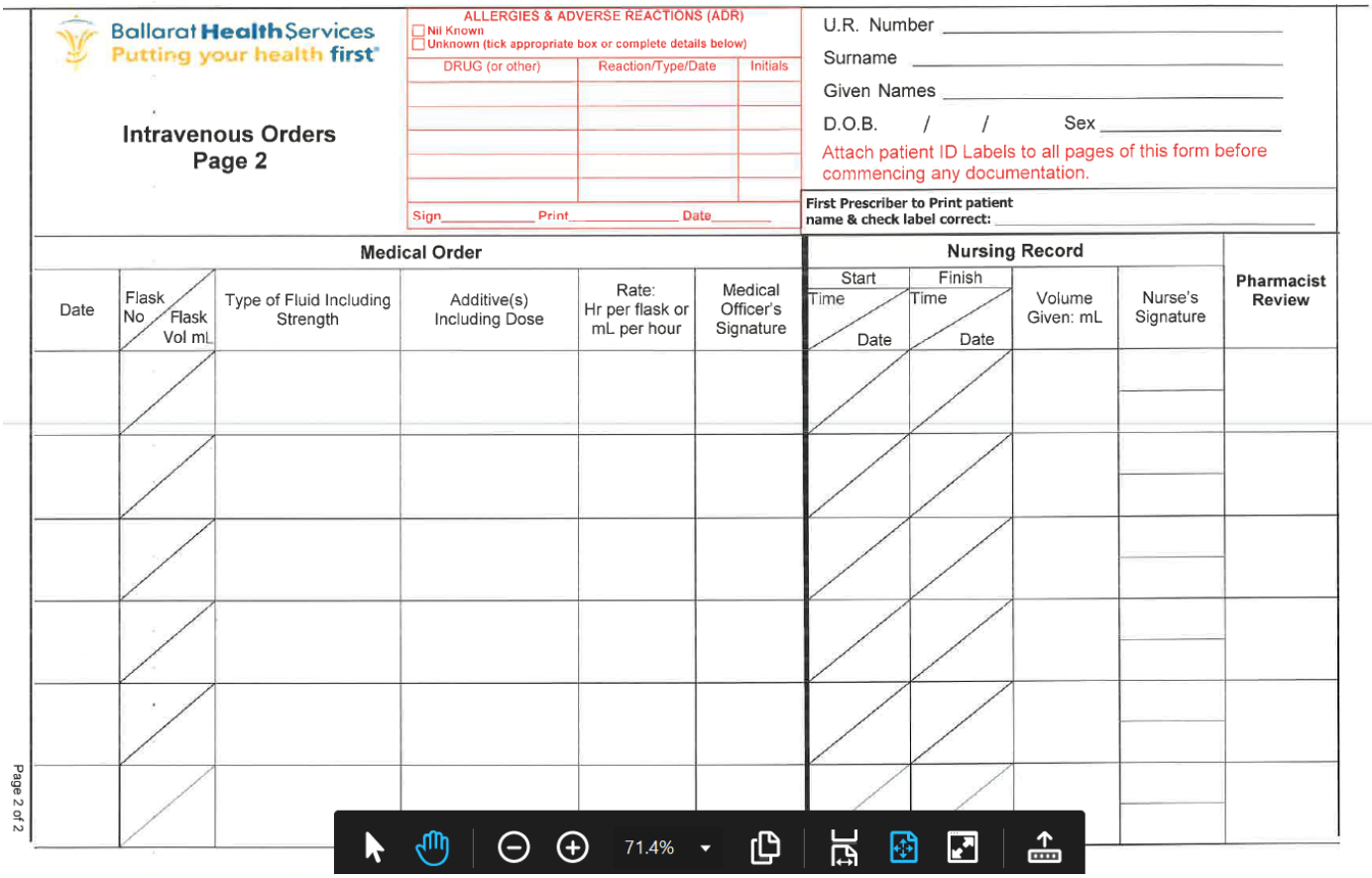
What general treatment should overdose patients have?

What investigations do you need to do? When? Why?

His investigations show he needs specific treatment. Why does he need this treatment?

What is the treatment? How does it work? You estimate he weighs roughly 80kg. How will you work out the doses? Write it below



Ballarat Health Services
Putting your health first

Intravenous Orders
Page 2

ALLERGIES & ADVERSE REACTIONS (ADR)
☐ Nil Known
☐ Unknown (tick appropriate box or complete details below)

DRUG (or other)	Reaction/Type/Date	Initials

Sign_____ Print_____ Date_____

U.R. Number _____
Surname _____
Given Names _____
D.O.B. / / Sex _____
Attach patient ID Labels to all pages of this form before commencing any documentation.

First Prescriber to Print patient name & check label correct: _____

Medical Order						Nursing Record				Pharmacist Review
Date	Flask No / Flask Vol mL	Type of Fluid Including Strength	Additive(s) Including Dose	Rate: Hr per flask or mL per hour	Medical Officer's Signature	Start Time / Date	Finish Time / Date	Volume Given: mL	Nurse's Signature	

Page 2 of 2

71.4%

How do you know if they are getting better/worse?

What follow-up is necessary?

7. Psychiatry – Case 1: Behaviour Problem

Observe 1 patient who is bought to emergency for assessment or management of a psychiatric problem.

In order to gain an understanding of the management of psychiatric patients in the emergency department you may wish to spend some time with the ECAT (Emergency Crisis and Assessment Team) worker. The Admitting Officer can identify this person for you.

How did the patient get to emergency?

Who referred the patient to the emergency department?

How do we make referrals to psychiatric services?

Describe a safe environment to assess the patient.

Who assessed the patient and what were they assessing?

What follow-up arrangements were made for this patient?

What is a “code grey?”

Who attends when a code grey is called?

Who may call a code grey?

8. Surgery – Case 1: Abdominal pain - Renal Colic

A 55 year old man presents with right sided renal colic, this is his first episode of the same, he spoke to his GP who appropriately directed the patient to the ED for analgesia and assessment.

List the diagnosis/differential diagnoses.

Outline the investigations that should be performed (list them in order of importance, i.e. what is done first etc)

Prescribe appropriate analgesia for this patient

Attach ADR Sticker

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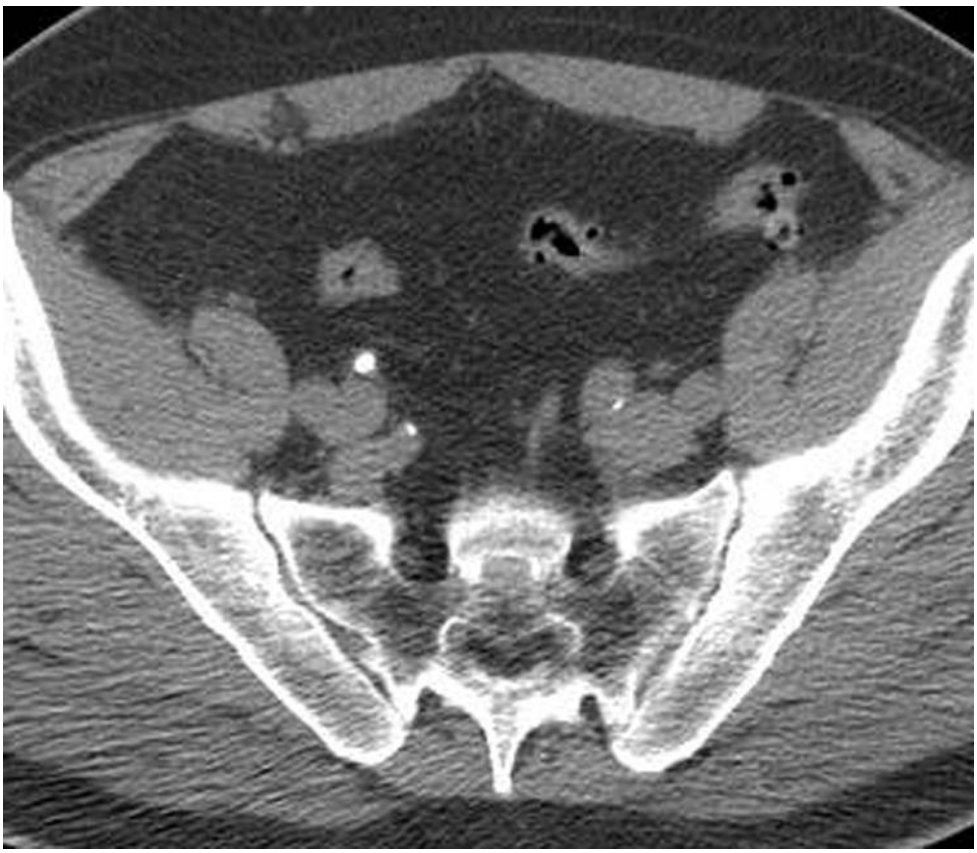
Comment on this CT



Outline the discharge plan including advice given when discharging a patient who has a 2mm renal stone in the ureter, who is now pain free and without complications

9. Orthopaedic – Case 1: Back pain management.

Observe a physiotherapist evaluate a patient with back pain.

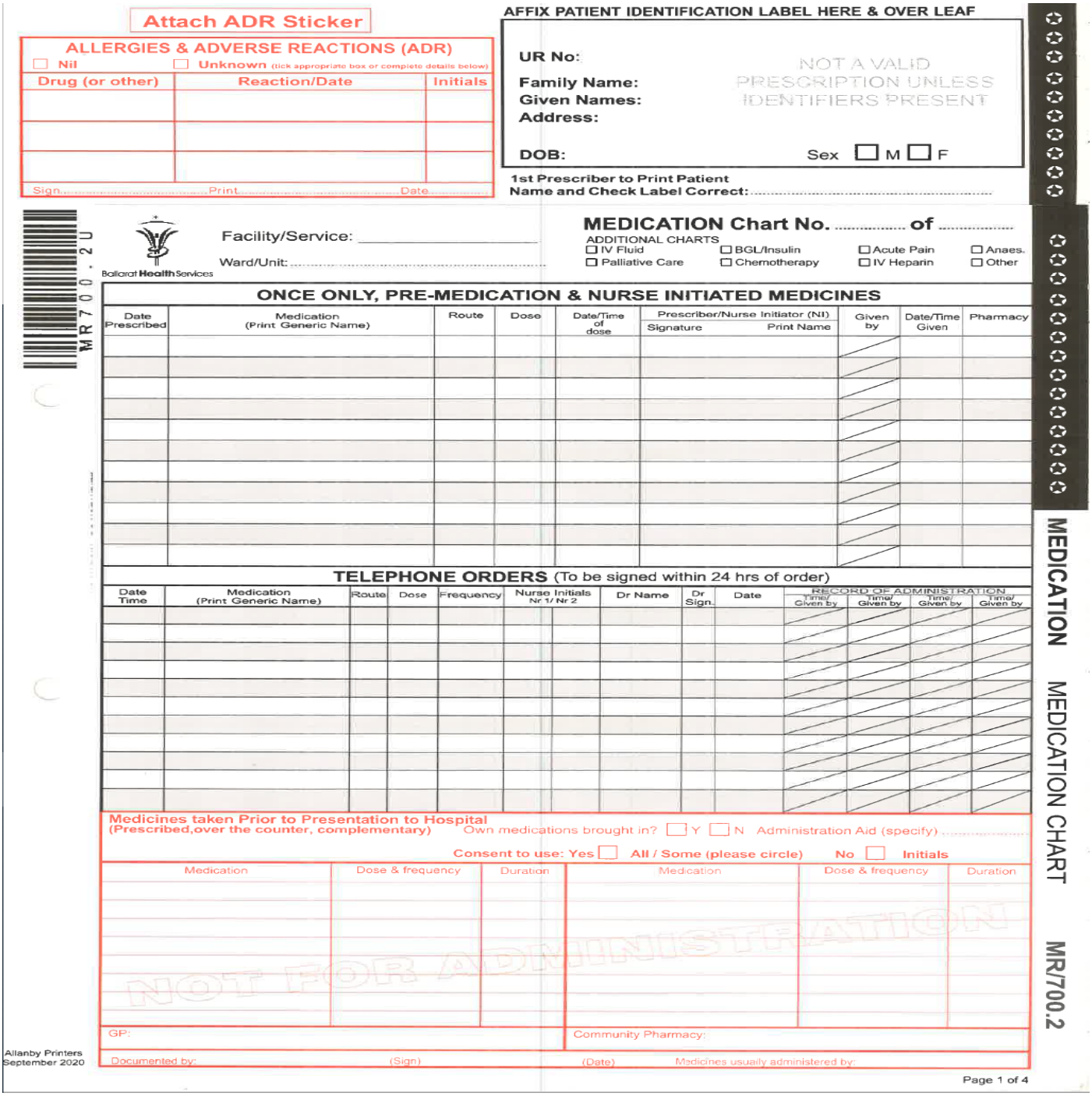
What is the physiotherapist assessing?

In broad terms, what advice does the physiotherapist give the patient?

List serious medical or surgical causes of back pain that should be excluded prior to physiotherapy referral, and how they are excluded.

Clue: red flags

TASK: Write an appropriate analgesia prescription for a patient with their first episode of severe back pain, no current medications, medical history or allergies.



Attach ADR Sticker

ALLERGIES & ADVERSE REACTIONS (ADR)
☐ Nil ☐ Unknown (tick appropriate box or complete details below)

Drug (or other)	Reaction/Date	Initials

Sign..... Print..... Date.....

AFFIX PATIENT IDENTIFICATION LABEL HERE & OVER LEAF

UR No:
Family Name:
Given Names:
Address:
DOB: Sex ☐ M ☐ F

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

1st Prescriber to Print Patient Name and Check Label Correct:.....

MR700.2U

Ballarat Health Services

Facility/Service: _____
Ward/Unit:.....

MEDICATION Chart No. ..... of .....

ADDITIONAL CHARTS
☐ IV Fluid ☐ BGL/Insulin ☐ Acute Pain ☐ Anaes.
☐ Palliative Care ☐ Chemotherapy ☐ IV Heparin ☐ Other

ONCE ONLY, PRE-MEDICATION & NURSE INITIATED MEDICINES

Date Prescribed	Medication (Print Generic Name)	Route	Dose	Date/Time of dose	Prescriber/Nurse Initiator (NI) Signature	Prescriber/Nurse Initiator (NI) Print Name	Given by	Date/Time Given	Pharmacy

TELEPHONE ORDERS (To be signed within 24 hrs of order)

Date Time	Medication (Print Generic Name)	Route	Dose	Frequency	Nurse Initials Nr 1/ Nr 2	Dr Name	Dr Sign	Date	RECORD OF ADMINISTRATION Time/ Given by	Time/ Given by	Time/ Given by	Time/ Given by

Medicines taken Prior to Presentation to Hospital
(Prescribed,over the counter, complementary) Own medications brought in? ☐ Y ☐ N Administration Aid (specify).....

Consent to use: Yes ☐ All / Some (please circle) No ☐ Initials

Medication	Dose & frequency	Duration	Medication	Dose & frequency	Duration

NOT FOR ADMINISTRATION

GP: Community Pharmacy:

Documented by: (Sign) (Date) Medicines usually administered by:

MEDICATION MEDICATION CHART MR/700.2

Allanby Printers September 2020

Page 1 of 4

Demonstrate accurate completion of the following form for a patient who is say, the Director of ED, who is right handed, has a left clavicle fracture after falling off his bike on a road.

This form is now available on BOSSNET (Discharge Summary eForms). A guide on how to complete it is available on the Orientation Resources page of the ED intranet.

CERTIFICATE OF CAPACITY

TAC TRANSPORT ACCIDENT COMMISSION

VWA Victorian WorkCover Authority

- A valid Certificate of Capacity must be provided if you are claiming compensation for loss of income because of a transport accident or work-related injury or illness.
- The certifier will use this Certificate of Capacity to communicate with your employer and your case manager about your work capacity (refer to the TAC or Victorian WorkCover Authority (VWA) website for who can certify). **Note:** The first medical certificate for a work-related injury/condition VWA claim must be issued by a medical practitioner.
- Certifiers – Please type or use block letters and **ensure that all relevant sections are complete**. Incomplete forms may be returned.

This certificate has been issued in relation to a:

☐ **Transport accident related injury (TAC Claim)** ☐ **Work related injury/condition (VWA claim)**

This certificate has been issued to confirm attendance only *Complete sections 1, 2, 5 & 6 only* ☐

1. Worker Details

Worker First Name

Worker Last Name

Claim Number (if known)

Date of Injury (if Claim number not known) D D / M M / Y Y Y Y

Date of Birth D D / M M / Y Y Y Y

Worker Address

Postcode

2. Diagnosis

I examined you on D D / M M / Y Y Y Y

If this certificate refers to a period prior to the date of examination, please provide details in Additional Comments (Section 3) below

My Clinical Diagnosis/es *based on my examination of you and other available information is:*

3. Capacity Assessment

***Note:** If capacity is affected further details MUST be provided in this section – if fields are blank this indicates limitations are not applicable. • Continue to Section 4 if capacity is unaffected*

Your work capacity is affected by your injury/condition as follows:

Physical Function *Select applicable – blank fields indicate that limitations are not applicable*	CAN	WITH MODIFICATIONS	CANNOT
Sit	☐	☐	☐
Stand/Walk	☐	☐	☐
Bend	☐	☐	☐
Squat	☐	☐	☐
Kneel	☐	☐	☐
Reach above shoulder	☐	☐	☐
Use injured arm/hand	☐	☐	☐
Lift	☐	☐	☐
Neck movement	☐	☐	☐

Physical Function – Additional Comments *eg. limits on durations, weight-handling capacity, repetitive or sustained postures, movements or forces:*

Mental Health Function *Select applicable – blank fields indicate that limitations are not applicable*	NOT AFFECTED	AFFECTED
Attention/Concentration	☐	☐
Memory *(short and/or long term)*	☐	☐
Judgement *(ability to make decisions)*	☐	☐

Mental Health Function – Additional Comments *eg. effects of mental health symptoms, cognitive function:*

Other Functional Considerations – not listed above

Other Functional Considerations – Additional Comments *eg. effects of medication:*

Work Environment Considerations *eg. physical (temperature, noise, space, light) or mental health considerations that affect work capacity*

4. Certification

Note: Certificate durations for a work-related injury/condition (VWA claim), unless special reasons apply are up to:
• 14 days for the first certificate (must be issued by a medical practitioner), • 28 days for a subsequent certificate.

Taking into account the effects of your injury/condition, as outlined in section 3, you:

☐ **Have a capacity for pre-injury employment from** D D / M M / Y Y Y Y

☐ **Have a capacity for suitable employment from** D D / M M / Y Y Y Y to D D / M M / Y Y Y Y

☐ **Have no capacity for employment from** D D / M M / Y Y Y Y to D D / M M / Y Y Y Y

Estimated timeframe to return to work ☐☐ *days or* ☐☐ *weeks*

An estimated timeframe will assist with planning for a return to safe work

5. Treatment Plan

Your treatment plan including injury management, strategies to increase capacity for work, address return to work barriers and/or prevent recurrence/aggravation of injury:

6. Certifier Declaration

I certify that I have clinically examined this patient. The information and medical opinions I have provided in this certificate are, to the best of my knowledge, true and correct.

Provider name, address and phone no. *(or practice stamp)*

Postcode ☐☐☐☐

Telephone (☐☐) ☐☐☐☐☐☐☐☐

Signature of Certifier

Provider number or hospital name

Date issued D D / M M / Y Y Y Y

7. Worker Declaration – WORKER TO COMPLETE

MANDATORY unless this is the first certificate or an attendance certificate only

At any time since the last Certificate of Capacity was provided, have you engaged in:
- voluntary work, or
- any form of employment or in self-employment for which you have received or been entitled to receive payment in money or otherwise?

☐ No, I have not

☐ Yes, I have

Please provide details of any voluntary work, employment or self-employment you have engaged in (other than with your pre-injury employer as part of your return to work):

I declare that the details I have given on this certificate are true and correct. I understand that it is an offence under the legislation to provide false or misleading information.

Signature of Worker

Date D D / M M / Y Y Y Y

Further Information

Returning to work

If you have a work capacity for suitable employment your employer and case manager will use the information provided by your certifier on the Certificate of Capacity to assess suitable options for you to safely stay at or return to work. They will take into account what you can do safely and any limitations that apply to your individual circumstances. A capacity for suitable employment could mean working reduced hours while you recover or working modified or different duties until you can return to your normal work with your pre-injury employer or another employer.

Privacy

The TAC and VWA (VWA Agents and Self-Insurers) will handle your personal and health information in accordance with their privacy policies and legislation. You can access privacy policy information at the TAC and VWA websites.

http://www.vwa.vic.gov.au/__data/assets/pdf_file/0011/139655/ADV-Certificate-of-Capacity-FAQs-for-health-professionals-02092014-1.0.pdf

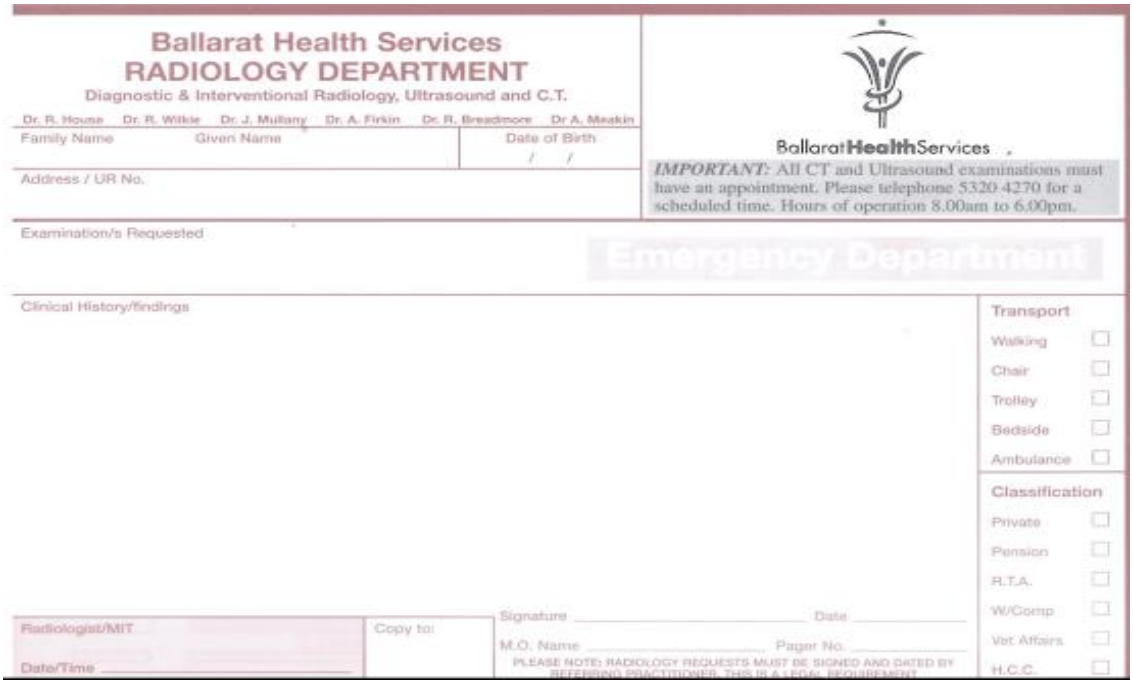
10. Minor Trauma – Case 1: Patient with wrist pain post fall.

Mr Clem See is from New Zealand and fell over. He has a painful wrist.

Describe the clinical signs that may be evident, and how they will help you determine what x-rays to order.

The XR is normal, but he was tender in anatomical snuff box. What do you do now?

TASK: Complete the radiology form below



Ballarat Health Services
RADIOLOGY DEPARTMENT
Diagnostic & Interventional Radiology, Ultrasound and C.T.

Dr. R. House Dr. R. Wilkie Dr. J. Mullany Dr. A. Firkin Dr. R. Breadmore Dr A. Meakin

Family Name Given Name Date of Birth / /

Address / UR No.

BallaratHealthServices

IMPORTANT: All CT and Ultrasound examinations must have an appointment. Please telephone 5320 4270 for a scheduled time. Hours of operation 8.00am to 6.00pm.

Examination/s Requested

Emergency Department

Clinical History/findings

Transport
Walking ☐
Chair ☐
Trolley ☐
Bedside ☐
Ambulance ☐

Classification
Private ☐
Pension ☐
R.T.A. ☐
W/Comp ☐
Vet Affairs ☐
H.C.C. ☐

Radiologist/MIT
Date/Time

Copy to:

Signature Date
M.O. Name Pager No.
PLEASE NOTE: RADIOLOGY REQUESTS MUST BE SIGNED AND DATED BY REFERRING PRACTITIONER. THIS IS A LEGAL REQUIREMENT

10. Minor Trauma – Case 2: X-Rays and fracture management

Observe the management of 3 patients who have limb fractures. These patients may be children or adults.

1. Describe the fracture

Describe the management

Describe the follow-up arrangements and advice to patient

2. Describe the fracture

Describe the management

Describe the follow-up arrangements and advice to patient

3. Describe the fracture

Describe the management

Describe the follow-up arrangements and advice to patient

11. O&G – Case 1: PV Bleeding

A 24 year old woman presents with abdominal pain and some PV bleeding, a small amount of dark blood. Her last normal menstrual period was 5 weeks ago, and she is on the oral contraceptive pill

List the differential diagnosis

Outline your initial investigations

Describe a strategy using pathology and radiological testing including interpretation of the results

How will management differ at 8pm on a Wednesday evening compared to 8am in the morning?

What follow-up will you arrange?

11. O&G - Case 2 - Hyperemesis Gravidarum pathway

A 30 year old woman presents with ongoing vomiting in early pregnancy, She is G3P2 and 7 weeks pregnant, with a normal intrauterine pregnancy confirmed on ultrasound a few days ago. She is unable to keep fluids down and feels dizzy on standing

List the likely diagnosis and any other differential diagnoses

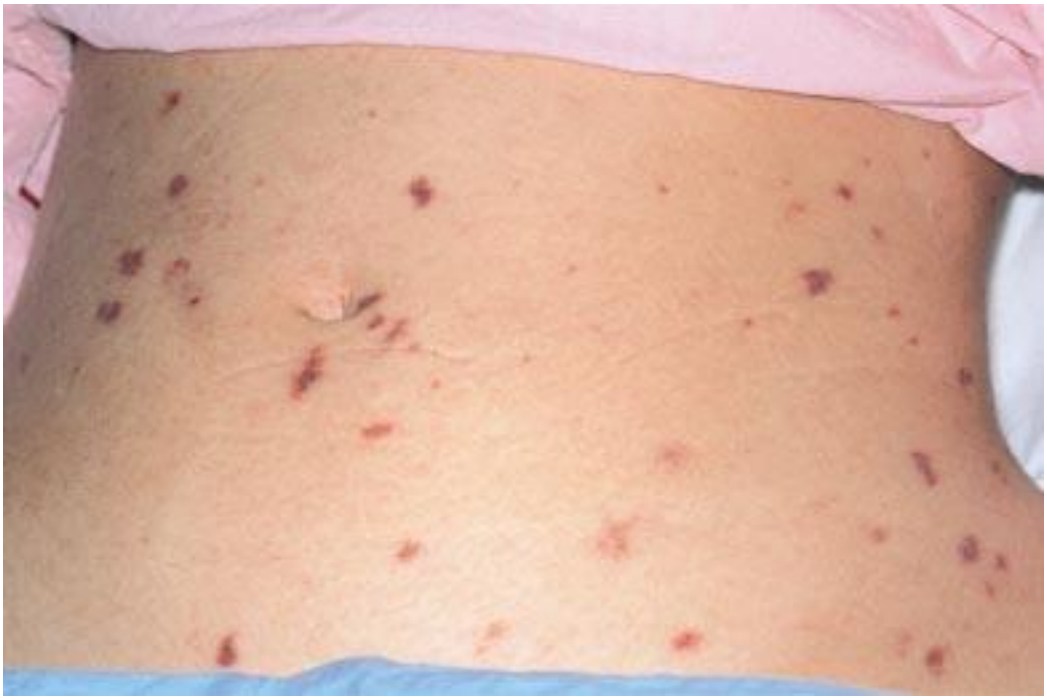
Outline the most important features in your initial assessment of her

Outline your initial management

Complete a SSU pathway for her

12. Sepsis – Case 1: Patient with fever

A 19 years old woman presents with fever, sore throat, leg pain and a rash



List your differential diagnoses, including common problems and those that must not be missed

Outline your initial management

12. Sepsis – Case 2: Elderly patient

An 84 year old lady has been brought to the Emergency Department by ambulance, after being found confused at home by her daughter. Her Oxygen saturation is 88% on air and respiratory rate 28/min. Her BP is 85/50, her heart rate 110, and her GCS 13. Her temperature is 34.2C. The ambulance officers state that her breathing is rapid, and she smells of offensive urine.

What is your differential diagnosis?

What tool-kit would you like to use to help with management?

Outline your steps in managing this patient. What investigations would you like to do? Which rapid tests will help you decide management?

If the patient does not respond to initial management, what other steps can be taken, and which staff would you like to get involved?

The daughter arrives soon after, wishing to see her mother. She states that her mother has been adamant that she does not want to be resuscitated? What steps need to be taken now?

Observe someone having a conservation regarding 'Goals of Care' with a patient or their family.

13. Paediatrics – Case 1: Febrile Neutropenia

A three year old child is brought to the Emergency Department by their parents. The child has a fever and is unwell. Mum tells the triage nurse that the child has cancer and has recently had chemo at the Royal Children's hospital. She requests that the triage nurse ring the Royal Children's immediately, but does not have the phone number with her.

What additional information would you like to know?

Outline the most important features to look for during clinical assessment

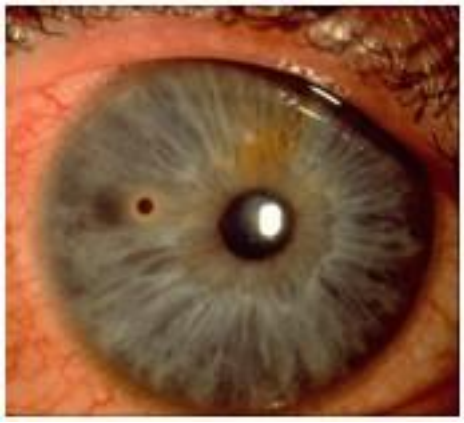
When should you involve the treating team?

How should the treating doctor involve the parents or carers' in the assessment and management?

How is the management altered by the child's age?

14. Eyes and Ears – Case 1: Eye pain

A 24 year old welder returned home from work and over the course of the evening he has increasing pain in his eye. He attends the ED at 11pm and is seen at midnight.



Describe the findings above

Outline the steps required in treatment

Outline the discharge plan including advice given

14. Eyes and Ears – Case 2: Painful Red Eye

A 57 year old woman with a red, painful eye, with nausea and vomiting. The symptoms commenced rapidly and there is no history of trauma. Her vision is blurry.

Describe the key findings as you would to a specialist over the phone

What is the diagnosis?

Outline the treatment of this condition

14. Eyes and Ears – Case 3: Throat

A 22 year old man presents to the triage nurse stating that he has tonsillitis. He saw his GP today, who prescribed an antibiotic, but unfortunately he cannot swallow tablets, due to pain. He had managed to get one down but he vomited shortly afterwards.

Outline your differential diagnosis

What investigations are required?

Outline your treatment of this man

Find a SSU pathway for tonsillitis and complete it

15. Aged care – Case 1: Unable to walk

A 91 year old lady is brought in by ambulance from a residential care facility. She has a letter containing some information about her, but not too much detail about today's problem, other than to say the GP did not see the patient but recommended that the patient be assessed in ED because she cannot walk

What common problems contribute to decline in mobility or function in elderly patients?

Are investigations appropriate? List some tests that are of most value in this situation

TASK: Observe a member of the ECCT (Emergency care co-ordination team) assess an elderly patient.

What specific questions are important in the aged care assessment?

What are the possible disposition options for this patient?

Who is involved in making decisions about the disposition of this patient?

What specialties are involved in aged care assessment? What services can the ECCT provide for patients?

BHS Emergency Department Skills and Procedures Checklist – HMO 1

Introduction

The skills and procedure check list have been developed to help you keep a record of your learning and will be used in your end of term appraisal. Where possible ask a senior doctor to observe you undertaking any of the following procedures or document yourself what you have achieved. Some of these procedures can be used for mini clinical exercise assessment (mini-CEX).

Element	Procedure/skill	Dates
Airway	Airway care with simple adjuncts such as pharyngeal airway	
	Insertion of LMA	
	Simple airway manoeuvers	
Breathing	Bag mask ventilation*	
	Perform & interpret peak flow - adult	
	Apply oxygen mask	
	Apply nasal prongs	
	Administer nebuliser	
	Administer medication via a spacer	
	Teach use of spacer	
Circulation	IV access – adult*	
	IV access – large bore	
	Venipuncture	
	Perform & interpret an ECG	
	IV infusion including the prescription of fluids	
	IV infusion of blood & blood products including gaining consent	
Seizure or altered level of consciousness	Perform BLS	
	Urethral catheterisation in adult females& males	
	NG & feeding tube insertion	
Pain Relief	Preparation and administration of IV medication, injections & fluids	
	Injection of local anaesthetic to skin	
	Subcutaneous injection	
	Intramuscular injection	
	Plaster cast/splint limb immobilisation*	
Trauma	Application of a semi-rigid collar*	
	Interpret trauma series X-rays	

	Reduction of minor joint dislocation*	
Element	**Procedure/skill**	**Dates**
Trauma	Application of appropriate analgesia	
	Clean wound with minor contamination	
	Surgical knots & simple suture insertion*	
	Close wound with tissue adhesive	
Febrile Patient	Examine ear, nose, throat	
	IV access	
	Blood cultures	
Breathing difficulty	Interpret chest x-ray	
Vomiting Patient	Assess hydration	
	NG & feeding tube insertion	
	IV access	
	IV infusion including the calculation of fluids requirements	
Skin and soft tissue injury	Apply appropriate burn first aid and dressing	
Early pregnancy bleeding/pain	Venous cannulation	
	Gynaecological speculum and pelvic examination*	
Toxicological Emergencies	Appropriate dose, calculation and administration of NAC	
Ophthalmological Emergencies	Corneal & other superficial foreign body removal*	

- * These procedures can be used for the Mini-CEX

BHS Emergency Department Skills and Procedures Checklist – HMO 2+

Introduction

The skills and procedure check list have been developed to help you keep a record of your learning and will be used in your end of term appraisal. Where possible ask a senior doctor to observe you undertaking any of the following procedures or document yourself what you have achieved. Some of these procedures can be used for mini clinical exercise assessment (mini-CEX).

Element	Procedure/skill	Dates
Airway	Airway care with simple adjuncts such as pharyngeal airway	
	Insertion of LMA	
	Simple airway manoeuvers	
	Application of a cervical collar	
Breathing	Bag mask ventilation*	
	Perform & interpret peak flow – adult	
	Apply oxygen mask	
	Apply nasal prongs	
	Administer nebuliser	
	Administer medication via a spacer	
	Teach use of spacer	
Circulation	IV access – adult*	
	IV access – large bore	
	Arterial puncture in an adult	
	Venipuncture	
	Intraosseous access	
	Perform & interpret and ECG	
	Safe defibrillation*	
	IV infusion including the prescription of fluids	
	IV infusion of blood & blood products	
Seizure or altered level of consciousness	Perform BLS	
	Urethral catheterisation in adult females& males	
	NG & feeding tube insertion	
	Lumbar Puncture - adult	
Pain Relief	Preparation and administration of IV medication, injections & fluids	

	Injection of local anaesthetic to skin	
	Digital nerve block	
	Subcutaneous injection	
Element	**Procedure/skill**	**Dates**
Pain relief	Intramuscular injection	
	Plaster cast/splint limb immobilisation*	
Trauma	Spine immobilization	
	Application of a semi-rigid collar*	
	In-line c-spine immobilization	
	Splinting of long bone fractures	
	Needle decompression/aspiration of tension or simple pneumothorax	
	Splinting of pelvic fracture	
	Interpret trauma series X-rays	
	Reduction of minor joint dislocation	
	Apply plaster of Paris backslab to lower limb*	
	Infiltration of local anaesthetic	
	Clean wound with minor contamination	
	Surgical knots & simple suture insertion*	
	Close wound with tissue adhesive	
Paediatrics - Febrile child	Examine ear, nose, throat	
	Obtain a clean catch urine	
	IV access	
	Blood cultures	
Paediatrics – breathing difficulty	Perform & interpret peak flow – child	
	Interpret chest x-ray	
Paediatrics - trauma	Appropriate simple airway techniques	
	Cervical spine immobilization	
	IV access and fluid resuscitation	
	Plaster cast/splint limb immobilisation	
	Application of appropriate analgesia	
Paediatrics - vomiting	Assess hydration	
	NG & feeding tube insertion	
	IV access	
	IV infusion including the calculation of fluids requirements	
Skin and soft tissue injury	Apply appropriate burn first aid and dressing	
Early pregnancy bleeding/pain	Venous cannulation	
	Gynaecological speculum and pelvic examination*	
	Foetal Doppler	
Toxicological Emergencies	Appropriate dose, calculation and administration of NAC	
Ophthalmological Emergencies	Corneal & other superficial foreign body removal* Measures Intra-ocular pressure	

- * These procedures can be used for the Mini-CEX

BHS Emergency Department Mini-CEX Assessment

Introduction

A mini-CEX exercise assessment (mini-CEX) is a 15-20 minute snapshot of doctor-patient interaction observed and assessed by a senior departmental doctor.

Instruction

While you are on your ED rotation, try to complete 2 mini-CEX assessments from the skills and procedure check list. It is likely that presenting a case to the Admitting Officer will be a practical way to perform this task. It may well help the AO give feedback and supervise you.

Date:		
Clinical Problem:		
Assessment Criteria	Descriptors	Results
1. History taking	• Elicits a history that is relevant, concise and accurate to patient's context and preferences • Effectively uses appropriate questions • Responds appropriately to verbal and non-verbal cues	□ Competent □ Not yet competent
2. Physical examination skills	• Performs a focused physical examination that is relevant and accurate • Explains to patient • Sensitive to patient's comfort and modesty	□ Competent □ Not yet competent
3. Communication skills	• Develops rapport, trust and understanding with patient/family • Accurately conveys relevant information and explanations to patients/family and other health professionals • Develops a shared plan of care with patients/families and other health professionals • Effectively manages challenges such as obtaining informed consent, delivering bad news, addressing anger and misunderstanding	□ Competent □ Not yet competent
4. Clinical judgment	• Demonstrates effective clinical problem solving and judgement to address patient problems • Interprets available data and integrates information to generate differential diagnoses and management plans	□ Competent □ Not yet competent
5. Professionalism/ Consideration for patient	• Exhibits honesty, integrity, compassion and respect • Participates effectively and appropriately in an interprofessional healthcare team • Appropriately manages conflicts of interest • Aware of own limitations	□ Competent □ Not yet competent
6. Organisation/ efficiency	• Sets priorities and manages time efficiently • Manages competing demands and stress • Appropriately manages supervision, resources and staff, ED access and flow	□ Competent □ Not yet competent
Overall	□ Competent	

performance	□ Not yet competent
Assessor comments on candidate's strengths and areas for improvement.	

Date:		
Clinical Problem:		
Assessment Criteria	Descriptors	Results
1. History taking	• Elicits a history that is relevant, concise and accurate to patient's context and preferences • Effectively uses appropriate questions • Responds appropriately to verbal and non-verbal cues	□ Competent □ Not yet competent
2. Physical examination skills	• Performs a focused physical examination that is relevant and accurate • Explains to patient • Sensitive to patient's comfort and modesty	□ Competent □ Not yet competent
3. Communication skills	• Develops rapport, trust and understanding with patient/family • Accurately conveys relevant information and explanations to patients/family and other health professionals • Develops a shared plan of care with patients/families and other health professionals • Effectively manages challenges such as obtaining informed consent, delivering bad news, addressing anger and misunderstanding	□ Competent □ Not yet competent
4. Clinical judgment	• Demonstrates effective clinical problem solving and judgement to address patient problems • Interprets available data and integrates information to generate differential diagnoses and management plans	□ Competent □ Not yet competent
5. Professionalism/ Consideration for patient	• Exhibits honesty, integrity, compassion and respect • Participates effectively and appropriately in an interprofessional healthcare team • Appropriately manages conflicts of interest • Aware of own limitations	□ Competent □ Not yet competent
6. Organisation/ efficiency	• Sets priorities and manages time efficiently • Manages competing demands and stress • Appropriately manages supervision, resources and staff, ED access and flow	□ Competent □ Not yet competent
Overall performance	□ Competent □ Not yet competent	
Assessor comments on candidate's strengths and areas for improvement.		

BHS Emergency Department Case Journals

Introduction
During your rotation in the ED you are asked to record 2 cases. The purpose of this assessment is to assist you to reflect on your clinical practice and develop insight into recognizing limitations. During your end of term rotation assessment you can get feedback on these journals. (NO PATIENT ID PLEASE)

Case/presentation	
Description – what happened	
Feelings – what were you thinking and feeling	
Evaluation – what was good and bad about the experience?	
Analysis - What sense can you make of the situation?	
Conclusion - What else could you have done?	

Action plan - If this case arose again would you do anything differently?	

Case/presentation	
Description – what happened	
Feelings – what were you thinking and feeling	
Evaluation – what was good and bad about the experience?	
Analysis - What sense can you make of the situation?	
Conclusion - What else could you have done?	
Action plan - If this case arose again would you do anything differently?	

BHS ED Self-directed learning workbook

Author Jaycen Cruickshank updated 2021 Heather Crook