Northern Health

EMERGENCY DEPARTMENT ORIENTATION MANUAL

JMO Orientation, Version 11, July 2023

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Introduction

Please ensure you read this manual prior to starting your first shift.

This is a pre-COVID manual. There are significant operational and process changes within the ED as we respond to the pandemic and you will be updated via email as these occur.

Northern Health Emergency Department

The Emergency Department is divided into different clinical areas:

Area	**Beds**	**Senior Supervision AM/PM**	**Senior Supervision Night**
Admissions	5 resuscitation beds 18 monitored beds	Admissions consultant	Senior registrar Consultant on call
Assessment cubicles	9 monitored beds 5 AV offload beds	Assessment consultant	
Assessment waiting room	6 assessment areas	Assessment waiting room consultant (Assessment consultant if there is not a 4th consultant)	
Fast Track	8 beds	Senior registrar	
Short Stay Unit (SSU) and Clinical Decisions Unit (CDU)	SSU beds 1 – 14 SSU beds 15 – 19 and 21 - 23 Recliner chair spaces 24 and 25	SSU consultant	
Emergency Observation Unit (EOU)	Ward 6	EOU consultant AM SSU consultant PM	
Paediatrics	8 beds	PEM consultant	PEM consultant OR Consultant on call

Additional spaces within the ED

- Procedure room
- Plaster room
- Eye room

These additional spaces are shared rooms. Keeping these shared rooms clean and tidy is the responsibility of all users, and it is expected that following a procedure staff will ensure sharps are safely disposed, equipment is restocked if required and the room is cleaned and ready for the next user. Please note, cleaning these rooms is not to be left to nursing staff to do.

Shifts and Allocations

Shifts

Day shift	0800 – 1730
Evening shift	1400 – 2330
Night shift	2300 – 0830

Start of shift

- Day shift – meet in office area upstairs for morning meeting and allocations
- Evening shift – meet in office area upstairs for afternoon meeting and allocations
- Night shift – meet at the allocations board in the assessment area and introduce yourself to the evening consultant and senior night registrar.

End of shift

- Ensure all patients have appropriate documentation completed.
- Handover all patients to consultant/senior registrar, including those who have been admitted. They may direct you to handover to another junior doctor, but they need to be aware of all your patients.
- Make sure the patients have been handed over on EDIS. (Click on 'All Areas' and check for your 4-letter code to see if still against any ED patient)
- Document the handover on CPF.
- Check with ED consultant prior to leaving.

Leadership Huddles

- During the day, there are several huddles, which involve the ED Team meeting with managers from the rest of the hospital to discuss access and safety issues.
- At 1100, there is a leadership huddle in the Assessment Area which the Assessment Consultant will attend. Junior doctors do not need to attend this.
- At 2300, there is a leadership huddle in Assessment, which the evening ED consultants and all night junior doctors should attend.

Night shift

Supervision on night shift:

- A senior registrar will be allocated to every night shift
- Consultant on call, available for telephone advice
- PEM consultant on call (currently 3 days per week), available for telephone advice

HMOs should discuss all their patients with a registrar, in particular those deemed suitable for discharge, and prior to referring to an off-site specialty registrar or consultant.

Criteria for calling the EP on call overnight

	EP advice optional	**EP to be informed**	**EP to attend**
Clinical	• Any clinical concern	• Code Blue in ED • Patient required intubation • Unwell patient PLUS unclear diagnosis OR not responding to treatment OR unclear disposition • Delay to ICU transfer > 1 hour • Presence of another consultant attending ED • Code STEMI patient requiring airway/haemodynamic support • Unexplained/unexpected deaths in adult patients • Any paediatric death • Disagreement between medical/nursing/EMH regarding the use of mechanical restraints for EMH patients	• Paediatric Code Blue
Flow and disposition	• Concern about advice given by other specialities	• Patient requires ARV/PIPER transfer • Dispute between units regarding disposition of a patient • Excess clinical risk due to volume or acuity of patients	• Time critical transfer with delay to transfer by ARV/PIPER
Operational	• Code Yellow	• External Code Blue requiring prolonged attendance by ED staff • Code Black • Code Purple • Code Orange • Involvement of outside government agency (e.g. DHS) • Nurse in charge request	• Code Brown • Senior registrar becomes incapacitated

Paediatric Issues

For issues related to paediatric patients, please call the PEM on call, when available.

If there is no PEM on call, please contact the Adult consultant on call as above

If Adult consultant needs further advice, consultant or registrar to escalate as follows:

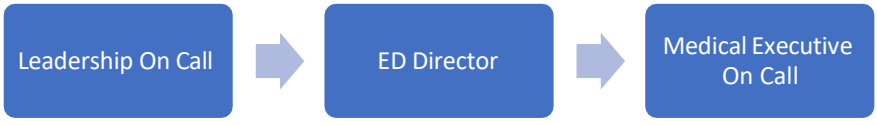
- Specialist paediatric clinical advice – contact Paediatric ED Director or Leadership On-Call Consultant
- Logistic issues/advice – contact ED leadership on call

Monday to Thursday, if Paediatric ED Director or Leadership On-Call Consultant are required to attend ED, the Adult consultant must also attend.

Escalation

If there is disagreement about the need for attendance of the emergency physician on call, escalate to leadership on call.

If unable to contact the emergency physician on call, escalate as follows:



If unable to contact the PEM consultant on call, escalate as follows:

IT systems

Program	Password	Function
EDIS	Each doctor will be given a 4 letter code – ensure you have this prior to your first shift.	Patient tracking within the ED, assign doctor to patient
CPF	User-name and log in	Clinical notes, other documentation, pathology results and radiology reports
Synapse	User-name and log in	Radiology images and reports
Inteleviewer	Username: nhemergency Password: Hospital1	Radiology reports – unverified dictated reports

Seeing Patients and See Sort Send

Priority of seeing patients

- Cat 1 and Cat 2 patients should be seen first
- Cat 3, 4 and 5 patients should be seen in time priority (you can do this by clicking on LOS or Length of Stay on EDIS screen) – see those who have been waiting the longest
- If in doubt, check with the consultant in charge of the area

See Sort Send – the process of seeing patients, and adding cognitive debiasing

See

- Assign yourself to a patient
- Take a history and examine the patient
- Order basic investigations (if not already done)

Sort

- Early discussion with senior doctor – working diagnosis, management plan and disposition
- The senior doctor will ask you 'have you considered the worst-case scenario?'
- Write the plan under the clinical comments section of EDIS
- Aim for bed request within 90 minutes of patient arrival
- Complete your clinical notes on CPF

Send

- Discharge
    - Discharge letter to GP
    - Give patient clear instructions on when to return
    - Complete all fields on EDIS
    - See 'Discharge' section below
- Admission to SSU/CDU/EOU
    - Make referral - discussion with consultant in charge
    - Phone nurse in charge of ward
    - Choose appropriate plan on CPF Emergency tab (Click 'Yes' on 'Is this patient going to SSU/CDU/EOU?' which will bring up the plans

    - Make bed request on EDIS
    - Complete medication and fluid chart
- Admission to the ward
    - Complete bed request as soon as decision has been made by ED consultant
    - Make referral to inpatient registrar or consultant
    - Complete medication and fluid charts
    - Complete the transfer of care form

Handover and SSU/CDU referrals

- The receiving team will also ask the question, 'have you considered the worst-case scenario?'
- At handover, any extra management tasks generated by this discussion will be carried out by the receiving team.

Please note, all patient representations should be reviewed by a senior doctor.

See Sort Send
Adding Cognitive Debiasing to our work

@ <30 minutes

See

History
Examination
Investigations

@ <5 minutes

Sort

Discuss
Debias
Decide

Have you considered the worst case scenario?

@ <90 minutes

Send

Discharge SSU/CDU/EOU ward

Communicate plan and timeframe to the patient

Handover

Departing team:
ISBAR format handover

Receiving team:
Have you considered the worst case scenario

➡ Any changes to management plan should be actioned by the Receiving Team

SSU/CDU Referrals

Referring team:
ISBAR format handover

SSU/CDU team:
Have you considered the worst case scenario?

Pathology

To request a blood sample, complete the pathology ordering form.

To request a group and hold or blood products, complete the blood bank form. Please note, all group and hold sample labels must be handwritten, with a date, time and signature that match those details on the request form.

Pathology samples are sent to the laboratory using the pneumatic tube system (various locations around the ED). In the event the system is not working, please notify the nurse in charge.

There is a blood gas machine located in Admissions. Please give the sample, along with a patient identification sticker, to one of the nursing staff, and they will run the test for you.

RAT/LIAT testing – Nasopharyngeal swabs can be found in the department, and you can perform these swabs on the patients who need COVID exclusion. These tubes can then be brought to the processing area in bed 20 in the SCOVID Waiting Room (SCWR).

Radiology

Radiology services are provided by Healthcare Imaging.

To request radiology services, please complete the radiology form, providing as much detail as possible. Ultrasound, CT and MRI requests will require a consultant signature.

Where to take the completed form:

- X-rays
    - In hours – ED X-ray room
    - Out of hours – radiology main department
- Ultrasounds
    - In hours – radiology main department sonographers office
    - Out of hours – radiology main department, and call sonographer on call to come in
- CTs/MRIs
    - In hours – CT room
    - Out of hours – CT room or radiology main department, will need to call MRI technician to come in
- Outpatient requests
    - Radiology main department, wall opposite the photocopier – leave in the appropriate box

Reporting

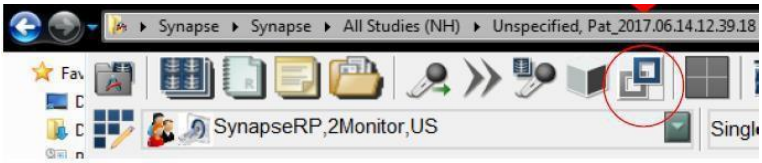
In hours, imaging is reported by radiologists on site. Out of hours, images are reported by Everlight (an external reporting company).

Transferring radiology images to another health service

Hub and Spoke is the system to transfer radiology images between health services. For example- to send neuroimaging to St Vincent's radiology session

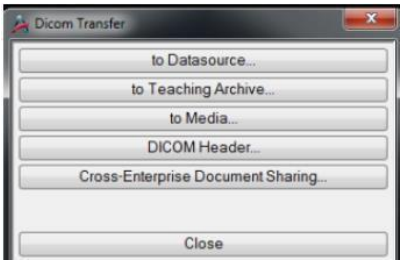
1. Download and Complete the Hub and Spoke Transfer form (found under the 'FORMS' button on intranet homepage)
   This **MUST** be faxed to receiving hospital to enable upload on their radiology viewer. You must also attach fax notification to the Northern Hospital Medical Record as a record.

2. Open Synapse, find patient etc as above. Double click on the record that matches what you wish to transmit



3. Click the 'DICOM Transfer' Box

4. Select "To Datasource…"



5. Click the circle next to "Other" as "Destination Data Source"

6. In the text box “Destination AE Title”:
   Enter the intended destination for image transfer, by using the Urgent (MXU) codes:

DESTINATION AE TITLES		
Hospital	**Routine**	**Urgent**
Alfred Health	MX_ALH_V	MXU_ALH_V
Ambulance Victoria	MX_AMB_V	MXU_AMB_V
Austin Health	MX_AUH_V	MXU_AUH_V
Ballarat Health Service	MX_BALHS_V	MXU_BALHS_V
Barwon Health	MX_BAH_V	MXU_BAH_V
Bendigo Health Care Group	MX_BHCG_V	MXU_BHCG_V
Breastscreen Victoria	MX_BSV_V	MXU_BSV_V
Cabrini Hospital	MX_CABH_V	MXU_CABH_V
Eastern Health	MX_EASH_V	MXU_EASH_V
Lake Imaging	MX_LAKEIMG_V	MXU_LAKEIMG_V
Monash Health	MX_MONASH_V	MXU_MONASH_V
Northern Health	MX_NORTH_V	MXU_NORTH_V
Royal Darwin Hospital	MX_NTGH_NT	MX_NTGH_NT
Peninsula Health Care Network	MX_PHCN_V	MXU_PHCN_V
Peter MacCallum Cancer Institute	MX_PMCC_V	MXU_PMCC_V
Royal Children's Hospital	MX_RCH_V	MXU_RCH_V
Royal Melbourne	MX_RMH_V	MXU_RMH_V
Royal Women's Hospital	MX_RWH_V	MXU_RWH_V
St Vincent's	MX_STV_V	MXU_STV_V
Tasmania Health Royal Hobart & Launceston General Hospitals	MX_TASHS_T	MXU_TASHS_T
Western Health	MX_WH_V	MXU_WH_V
Western Private	MX_WESTP_V	MXU_WESTP_V

7. Then click “Start”

8. The Status Box will read “completed” in blue when transmission has been successful. This may take a few minutes for CT and MRI studies where many images are generated for transmission.

9. Remember to complete the **Hub and Spoke Transfer form** from Radiology if not yet done.

Documentation

All patient encounters are documented electronically in CPF under Emergency "Emerg Summary".

Please do not directly copy and paste information from other encounters without verifying the information with the patient/carer first.

GP letters can be generated for discharged patients using the CPF summary. All discharged patients require a discharge letter.

Any additional phone consultations, referrals and handover should be clearly documented.

Discussion with specialty teams should be clearly documented in your notes with the name of the doctor, time and date of discussion.

Any operation/conflict issues should be documented in a neutral factual manner under 'Consultations'.

If patients are being admitted to SSU/CDU/EOU remember to click 'Yes' on the 'Is this patient going to SSU/CDU/EOU?' button and choose the most appropriate plan.

Discharging Patients

Determine safety of discharge

Patients should be clinically and functionally safe for discharge. The level of supervision required from a senior decision maker regarding the safety of discharge is outlined below according to designation.

Senior Decision Maker is defined as a consultant or senior registrar.

Intern	Discuss all patients after initial assessment and at discharge.
HMO	Discuss all patients at some point in the patient journey. Discuss at point of discharge if the patient meets red flags.
Registrar	May discharge a patient without discussion with a SDM unless the patient meets red flags.
NP/AMP	May discharge patients who fall within their scope of practice. Discuss at point of discharge if the patient meets red flags.

Red flags for discharge:

- Complex presentation
- Abnormal observations
- NESB without adequate communication regarding discharge instructions

Risk assessment

Appropriate risk assessment should be undertaken at the discretion of the clinician. In addition to clinical risk, social circumstances which may impact on a patient's readiness for discharge from the ED should be considered.

Nursing staff may utilise the pre-discharge screen on the Emergency Observation Chart to identify patients who may be high risk.

If a patient is identified as high risk, this should be escalated to the ANUM in charge of the area and the supervising senior decision maker. The patient should also be referred to the Discharge Planning and Support Services during working hours. Discharge should be delayed until the level of support has been confirmed. Some patients may require admission to facilitate this.

Discharge communication and instructions

Ensure that the decision to discharge has been communicated with the patient (use an interpreter to communicate when required).

The patient should be given the following verbal advice:

- Discharge plan
- Safety net advice and reasons to return for medical review (confirm the ability of the patient to return)
- Inform patient about community options

The patient should be provided with the following written information:

- Discharge summary, which includes:
    - Plan for patient
    - Safety net advice/when to return to ED
    - Instructions on GP follow up

Medical certificates should be given to the patient prior to discharge and comply with current legislation.

Nursing staff should complete the discharge checklist on the Emergency Observation Chart, prior to discharging the patient. This requirement is nullified if the patient has been discharged by medical staff.

Referrals

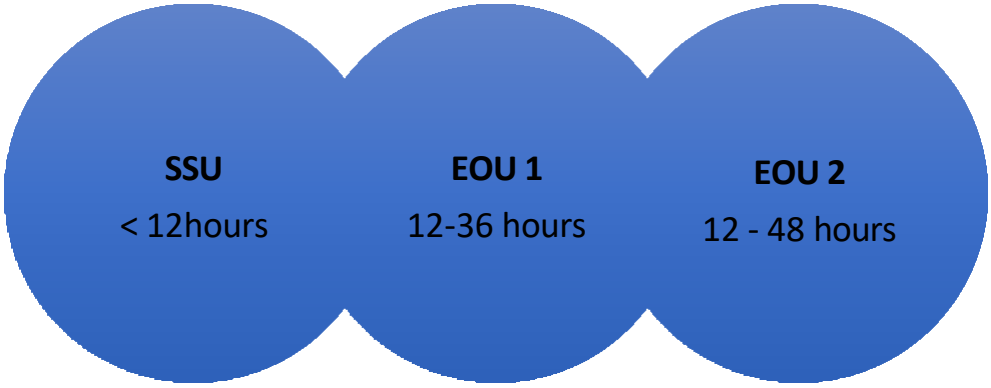
All relevant referrals should be made prior to discharging the patient. Details of referrals should be included in the written discharge summary.

References

https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2014_025.pdf

SSU, CDU and EOU

SSU/CDU and EOU1 are managed by the Emergency Consultants. These wards are suitable to manage a range of simple conditions, with a predicted length of stay less than 36 hours. They are not suitable for complicated patients with multiple issues.



SSU/CDU

Location	Emergency Department
Medical Staff	SSU consultant HMO Intern
How to refer	Refer to SSU consultant on 52562/58740 (Overnight: ED senior registrar to take referrals)

Inclusion Criteria

- The expected length of stay of less than 12 hours for SSU.
- Patient has a diagnosis that is suitable to SSU (there are SSU plans that are diagnosis based) and expected departure status will be **home**, **BHS**, **HITH** or a **pre- arranged transfer to another hospital or residential care facility (ie. nursing home or supported accommodation)**.
- Patient **must be ambulant** unless admission is for 'awaiting transfer" to another institution and this transfer has been arranged.
- Cubicles 11 – 14 in SSU are able to accommodate patients under droplet precautions (eg. Influenza and COVID-19).

Exclusion Criteria

- Behaviourally disturbed patients, aggressive patient or patients who are at risk of absconding. You can check EDIS by clicking on the Alerts button to see if there have been any behavioural alerts on a particular patient. Any involuntary patient under an Assessment Order of the Mental Health Act is excluded from the SSU.
- Patients who require full nursing care (assistance with mobility, incontinent etc.), unless awaiting transport back to institution of origin.
- Paediatric cases (< 18 years of age).
- Pregnant patients > 20 weeks
- Unstable patients
- Patients requiring contact isolation (apart from EOU which have single beds)

Direct Admissions

Some patients may be referred by the triage nurse, or 'pulled' by the SSU consultant, without an initial assessment in ED. These patients will need to have a full history and examination by the SSU HMO/intern, documented in Emerg Summary on CPF, as well as printing and completing the relevant SSU/CDU Plan.

Agreed patients suitable for direct admission:

- Chest pain age < 35 years old
- Hyperemesis gravidarum
- Stable 1st trimester PV bleeding
- Migraine
- Renal colic
- Suspected or confirmed DVT
- Vaccination reaction
- Virtual ED patient approved by the SSU consultant
- Other - as determined by the SSU consultant

Role of the SSU/CDU Intern/HMO – see separate orientation manual.

EOU

Location	Unit G
Medical Staff	Divided into two teams: EOU1 – ED consultant and HMO EOU 2 – Medical consultant, registrar and HMO
How to refer	Refer to EOU1 consultant on 58740 Consultant will decide if the patient will be allocated to EOU1 or EOU2 (Overnight: ED senior registrar to take referrals) Refer to NIC on 52080
	Handover to either EOU 1 HMO or EOU2 registrar
Overnight	ED senior registrar to take referrals

Inclusion Criteria

- The expected length of stay is less than 24 – 48 hours
- Patients with defined diagnoses that will benefit from a brief intervention and/or a period of observation,
- Stable undifferentiated patients requiring limited further assessments, investigations +/- treatment and observation.
- Patients who will benefit from a brief course of treatment that will either result in resolution of the condition, or stabilise the condition so that treatment can continue in the community i.e. HITH
- Patients who have been accepted for transfer to Broadmeadows Hospital (BH) and appear on the Bed Management Portal. They may be waiting for a bed to become available or for an investigation to be completed i.e. CT scan.
- All patients admitted to OU must have a management plan and a full set of observation documented on arrival.
- Patient is ambulant (or expected to be ambulant within 24hrs) unless transfer to another institution has been arranged

Exclusion Criteria

- Complex premorbid conditions requiring high level of nursing care
- Patients who are undifferentiated and who have complex comorbidities.
- Acute behavioural disturbance
- Undifferentiated abdominal pain for investigation in pts > 50 years old
- Nursing home / Hostel / Elderly patients unless the patient has been accepted for transfer to BHS.
- Paediatric cases (< 18 years of age).
- Pregnancy > 20 weeks
- Unstable patients
- Patients with complex social issues i.e. not coping at home
- Representations within 72 hours of discharge Role

of the EOU HMO – see separate orientation manual. **Clinical**

Plans

The Clinical Plans on PROMPT Forms (search 'Adult SSU') will give you an idea of the conditions that are suitable to be managed in SSU/CDU/EOU and also a suggested management plan.

Referrals

Use the ISBAR format to present referrals:

Identification	Introduce yourself and reason for contact Patient name, age, location
Situation	Main issue or problem Summarise history of presenting complaint
Background	Past medical history Other relevant history
Assessment	Vital signs Stable or unstable Relevant examination findings Investigations Management to date
Recommendation	Differential diagnosis Ongoing management plan Disposition

- Contact the relevant doctor using the phone/paging system (see phone directory)
- If there is no response in a reasonable time frame, escalate to the consultant
- You should not have to make multiple referrals – if the team refuses the referral, escalate to the ED consultant
- If a team suggests SSU/CDU/EOU referral instead of inpatient referral, they should be referring to the SSU/CDU/EOU consultant themselves. Inpatient teams do not have admission rights to SSU/CDU/EOU
- The exception to this is when referring to speciality teams who suggest general medical admission is more appropriate

Transfer of Care forms

Once a patient has been referred to an inpatient team, a Transfer of Care form should be completed. This form allows for the patient to be safely transferred to the ward, even in the event that a bed is ready before the inpatient team has reviewed the patient in ED.

The section 'senior sign off' must only be completed just prior to the patient leaving ED, by one of the consultants (senior registrar overnight only).

Broadmeadows Hospital Referrals

Broadmeadows Hospital is part of Northern Health. It has two main wards, the acute medicine ward and the aged care ward.

Suitable patients are those who require general medical admission, but do not meet the below exclusion criteria.

Broadmeadows Hospital (BH) Acute Medicine/ACU

Exclusion Criteria

- The patient requires or is **likely to require ICU or HDU level care**
- Needs **sub-specialty unit management** that is not available at BH
- Needs **urgent investigation** that is not available at BH (MRI, Biopsy, Echocardiograph, Fluoroscopy, Angiogram)
- Requires **telemetry**
- **Undifferentiated abdominal pain**
- Needs **emergency surgical procedure** (there is only low-risk elective surgery at BH)
- Has a **pleural effusion** which may require drainage (refer to Pleural service at TNH)
- Patients with **trauma** (including from falls) who have not been appropriately cleared of major injury. This includes patients with potential spinal injury. Patients who have had significant trauma should be admitted under the trauma surgical team at TNH.
    - If a patient has a spinal fracture for conservative management, a **Spinal Management Plan** must be completed prior to transfer to BH. Spinal braces need to be fitted at TNH prior to transfer due to limited orthotics presence at BH.
    - Caution about patients with **rib fractures** and significant pain (high risk of deterioration). Discuss with ward consultant before accepting.
- **Severe behavioral disturbance/absconding risk**
    - BPSD- may need KAW behavioral bed (secure GEM/ dementia care ward at BECC); should be transferred to locked part of unit B at TNH under medical unit initially

      Note - Lower acuity BPSD/delirium and 'wandering' is generally suitable for ACU on unit 3 at BH, which is a locked ward, but this is best discussed with the aged care reg/consultant, unit 3 NUM or hospital coordinator before accepting.
    - Psychiatry- needs Psych at TNH
    - Other (ABI/ ID/ other)- needs careful triaging at TNH for appropriate location of care
- Needs **Drug and alcohol services review.** This should be completed prior to transfer as D+A is not available at BH

If there is any uncertainty about whether a patient is appropriate for Broadmeadows Hospital, please contact the Broadmeadows acute medicine & ACU consultant on call (Note – the BH hospital coordinator can assist with this process on ph 8345 5231)

How to refer:

- 8 am to 8 pm – phone the acute medicine or aged care registrar
- 8 pm – 8 am – call the AMT registrar

It is especially important to document the date and time of the referral, and who you have spoken to.

Once the patient is accepted, inform the Nurse In Charge and they will place the patient on the BHS portal.

Depending on the time of BHS bed availability, patients can either stay in ED or be transferred to SSU/CDU to await transport when booked.

Patients who have been accepted to BHS pending the results of further investigations (CT, MRI or USS) should be referred to EOU.

External referrals

For consultation/advice/referral to services not available at Northern Hospital, please contact the following health services:

ENT	Austin Hospital
Eyes	Eye and Ear Hospital
Maxillofacial	Austin Hospital
Neurosurgery (isolated)	St Vincent's Hospital
Trauma (multiple injuries) patients > 16 yrs old	Royal Melbourne Hospital
Paediatric patients Trauma patients < 16 yrs old	Royal Children's Hospital

Critically unwell patients requiring transfer:

Adult – contact ARV
1300 368 661

Paediatric – contact PIPER
1300 137 650

Outpatient referrals

Since August 2020, TNH ED has used an electronic referral system known as Referral Manager (eTriage). This replaces the previously used purple referral forms.

All referrals made to Specialist Clinics, Community Access and Allied Health will now be made electronically via CPF. You can do so by clicking on the Summary tab on CPF and then look for the underlined 'Submit Internal Referral' link to click on.

If the request is urgent or required the same day, this need to be indicated on the referral as a Category 1 and included in the reason for referral. Specialist Clinics Administration staff will be monitoring these referrals from 0730 hours to allocate same day / urgent appointments. Please advise these patients that they will be contacted in the morning (if seen out of business hours).

Virtual Triage

Virtual triage was introduced in late 2020. Patients are able to be assessed (and sometimes discharged) entirely by phone or over video call. Emergency Consultants, ED registrars and GPs facilitate this service. If a patient requires investigations, virtual triage will arrange these. Some virtual triage patients will be advised to present to ED in person, or alternatively, they may be advised to present as a direct admission to SSU.

When you take over care of a virtual triage patient, please read the CPF entry made by the virtual triage consultant and follow the documented plan.

TALS

A high number of patients presenting to ED do not speak English as their first language. TALS is the translation service provided. There are 38 in house interpreters available.

How to contact:

- In hours contact interpreter's office on 58188
- After hours - phone interpreter available on 88072300

Codes at Northern Hospital

To call a Code, pick up the phone and call 2222 and request the Code, and specify the area in ED ie 'Code Stroke, Emergency Department, Assessment 27'.

Code Red	Fire/smoke
Code Yellow	Internal emergency
Code Orange	Evacuation
Code Grey	Unarmed violence
Code Black	Armed violence
Code Purple	Bomb threat
Code Brown	External emergency
Code Blue	Medical emergency

Additional clinical codes:

Code Pink	Patient in imminent labour
Code Green	Patient requiring urgent caesarean section
Code Trauma	Patient presenting with trauma meeting the Code Trauma criteria
Code STEMI	Patient presenting with ACS meeting STEMI criteria requiring urgent PCI
Code Stroke	Patient presenting with stroke symptoms who may be eligible for thrombolysis or clot retrieval
Code AAA	Patient presenting with signs of a ruptured AAA requiring urgent surgery

The above Codes should be discussed with the consultant prior to activation.
See specific polices on Prompt for further information on individual codes.

Clinically Deteriorating Patients in ED

Patients will present to ED unwell, or become more unwell during their time in ED, and those meeting pre-MET or MET call criteria require medical review.

Medical teams with primary responsibility for medical review of patient:

- Non-admitted – ED team
- Admitted – inpatient team

The ED team should still be aware of MET calls for admitted patients, and they should commence review of those unwell patients, until the team arrives.

	Non-admitted	Admitted
Pre-MET	Nursing staff will advise consultant/treating doctor ED doctor to review	Pre-MET via switchboard Inpatient team to review
MET	ED overhead announcement 'MET call bed **' ED doctor to review	MET call via switchboard Inpatient team to review

Code Blue in ED

Patients in resus often meet Code Blue criteria. A Code Blue may be activated at the discretion of the medical/nursing team, if further help is required (see section below).
For paediatric patients meeting Code Blue criteria, a Code Blue should always be activated.

Critically Unwell Patients

Critically unwell patients require a team response. The staff for Resus Teams 1 and 2 are on the daily allocations sheet. Please attend resus if you hear 'Resus Team to resus' announced on the overhead paging system.

See the Deteriorating Patient / Escalation of Clinical Care for more details on default resus roles for the ED team and other critical care teams.

Trauma patients

- AGSU registrar will attend Trauma Standby/Code Trauma calls – they should perform the role of Assessment Doctor
- See Code Trauma - Adult Trauma Management and Code Trauma - Paediatric Trauma Management for further details on the Trauma Team and reception of these patients

Overnight

- Initially, all ED registrars should attend a critically unwell resus patient overnight, until Anaesthetics/ICU are able to provide assistance
- Anaesthetics/ICU may have competing priorities and be unable to attend
- Discuss all critically unwell patients with ED consultant on call – they may be required to attend if the patient requires ongoing resuscitation

External Code Blue

Areas covered

- ED
- SSU
- Cath lab
- Radiology
- All ground floor areas excluding wards
- Outpatient clinics
- NCHER

Code Blue Team response outside of ED

Medical	Assessment Consultant
	Assessment Registrar
Nursing	Resus Nurse allocated to External Code Blue
	Assessment Nurse allocated to External Code Blue - must take the red bag and resus trolley (depending on location).

Emergency buzzer Team Response within ED

Medical	1 consultant from the area
	1 registrar from the area
	Treating doctor (if allocated)
	Assessment Waiting Room EP (Assessment Cubicles EP if not available) to check if consultant for the area does not have competing priorities
Nursing	ANUM for the area
	Bedside nurse
	Resus nurse allocated to Code Blue
	Assessment Nurse allocated to Code Blue – must take resus trolley (depending on location)

MENTAL HEALTH PATIENTS

Common psychiatric presentations to ED include:

- Self-harm/suicidal ideation
- Aggression and violence
- Psychosis
- Mania
- Depression
- Drug affected behaviour
- Eating disorders
- Drug overdoses
- Delirium

Mental State Assessment at TNH

First, check under the mental health tab of CPF to see if there is an open episode (this is the pink tab). Look for one saying NAMHS or NWAMHS. This is often the fastest way of determining what the community team want done (they generally have had a better opportunity to get a longitudinal view).

Second check the patient alerts to see if there is a relevant frequent presenter plan

Thirdly, contact EMH on ext 52055 to do a CMI check if there is no relevant information from MH tab or plan. This will give information about past contacts with psychiatric services statewide.

Mental state assessment should ideally be performed in a cubicle with attention paid to

1) Privacy/ confidentiality
2) Personal safety
    a. Be aware of ability to exit cubicle
    b. Ensure items which can be used as weapons are not in cubicle – ends of beds, IV poles, tray tables are the most important

Patients who arrive with police

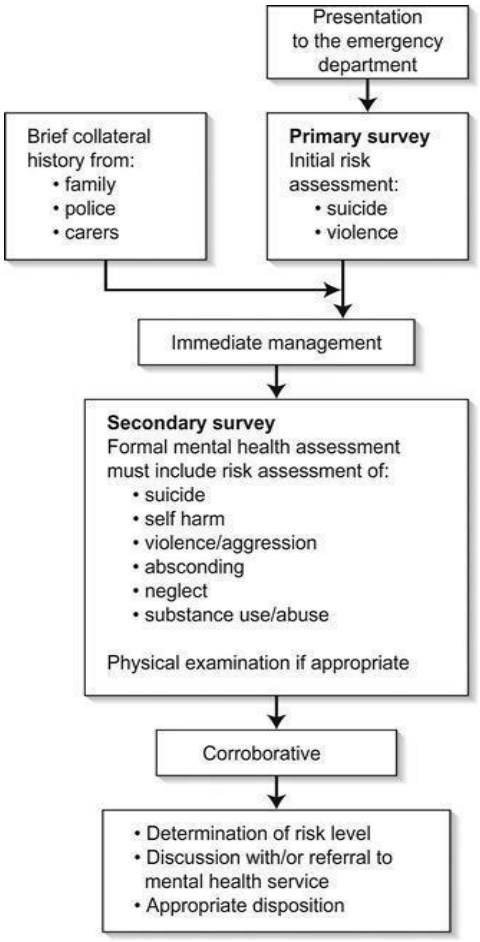
Prior to releasing the police check with the consultant/senior registrar (this is because there are sometimes other psychiatric assessment services which can be involved between hours of 3 pm and 11 pm for patients of Northern Area Mental Health catchment).

Outside of these times, talk to the police about the circumstances and clarify forensic plan (uncommonly the police will want to remain as they wish to arrest patient if psychiatrically stable). If there has been a domestic dispute police will also be able to tell you if the patient is able to return to their usual address. This is important for discharge planning.

Geography matters

Patients suburb determines which mental health team they are seen by. http://www.health.vic.gov.au/mentalhealthservices/ allows a search by suburb/ postcode for the right mental health service. Generally services are most available in hours if you are looking to speak to case managers for patients outside of NAMHS/ NWAMHS.

Suggested basic approach when seeing patient



Distinguishing organic from psychiatric illness

Assessment of patient should include:

- Medical history
- Review of symptoms
- Vital signs
- Physical examination – including physical description of patient (in case of absconding)

High yield indicators of organic illness:

- First presentation
- Delirium
- Drug or alcohol use
- Recent or new onset medical problems

- Neurological signs or symptoms
- Abnormal vital signs

If you suspect organic illness as the cause of the patient's presentation, they will need further investigations:

- Baseline bloods – including TFTs and calcium profile
- Discuss further investigations and disposition with consultant

Even if organic illness is unlikely to be the cause, bloods may be required – the more common examples would be:

- Alcohol level if Hx of alcohol use
- FBE if on clozapine
- FBE/ U&E/ Ca/ PO4/ Mg/ LFT if patient appears to have significant physical self-neglect

How to do risk assessment (basic)

For suicidality – use Columbia screening tool to determine need to consult with EMH.
For psychosis – if thought disordered, delusional with thoughts of self-harm/ harm others consult with EMH (Psychosis is rare cf suicidality at TNH)
For manic disorder – excessive spending, poor/ no sleep, irritable – refer to EMH

How to do risk assessment (advanced)

Suicidality/ self-harm

- Take patient at face value unless documentation to contrary in past behaviour
- Determine impulsive vs planned. Impulsive with statement of no further plan/ regret and low lethality means (cutting, minor overdose) can often be discharged with provision of 1300 TRIAGE (1300 874 243) number for them to use if they feel at risk
- Commonly patients will use self-harm to relieve distress (what was previously known as borderline personality disorder but can also be called complex trauma disorder).
- Ongoing suicidality: ask if this feeling is frequent/ common or more than usual (many patients have chronic suicidal ideation). If there is a documented frequent presenter or enhanced mental health plan confirming this, or community team notes confirming this, then a patient will not be required to remain in ED to see EMH if they are at baseline
- Be aware that suicide risk is dynamic; all you as the ED clinician can be expected to do is assess the patient's risk at the time you see them

For psychosis

- determine how strongly patient holds beliefs, whether they have command hallucinations to harm others or themselves, whether they have a specific plan or previous attempts at executing the plan
- If a patient doesn't make sense (thought disordered) this is generally high risk (the exception would be if the community mental health team describe this as normal for patient)

For eating disorder – see separate procedure on Prompt.

Patients who have taken an intentional overdose

Risk assessment of toxicity should include the following questions:

- Agents ingested
- Amount
- Time since ingestion
- Co-ingestions
- Symptoms and clinical course
- Patient factors – weight, comorbidities (liver and renal disease)

The management and disposition of these patients depends on the specific agents taken and the risk assessment (both physical and psychiatric). Information sources include:

SPECTRE (see ED Intranet Page for more information on how to refer)

- POISONS Information (particularly in polypharmacy where agents will interact)
- Some agents do not affect a patient's alertness/ ability to be assessed mentally (as a classic example – pure paracetamol overdose). These patients may be referred to EMH before they are medically cleared
- Patients with ongoing sedation and/or need for monitoring may be referred to CDU, EOU or general medicine depending on their predicted length of stay and their requirement for a SIMON
- Obtunded patients or those requiring high levels of care should be referred to ICU

Referring to mental health (ext 52055)

Present the case including what in your mind is placing them at higher risk psychiatrically precluding discharge from the ED. If bloods have been taken or are pending, specifically mention this.

Sometimes referral can occur prior to seeing the patient (eg when the community team documents they are concerned for a patient they have been managing, and brought them in on an AO). Usually EMH are aware of these patients coming but sometimes the handover has been lost. In these cases, ED assessment can be limited to rapid physical assessment and provision of medication (+/- bloods as requested by EMH/ physical needs).

Chart usual medications (MH episode will sometimes be useful but can be difficult to navigate if patient unable to tell you).

Medically cleared and waiting for mental health?

Due to bed pressures and workload, often mental health are not able to see patients for several hours. Some patients are suitable to go to SSU to await mental health review– this has the advantage of providing a less stimulating environment (calmer patient) but the downside is that if the patient decides to leave, SSU will not prevent them leaving.

This limits use of SSU to

- Low risk patients (deemed by ED consultant/ senior registrar)

- Help seeking patients
- Voluntary admissions awaiting transfer to another hospital where a bed is confirmed, and ambulance has been booked

Management of acute behavioural disturbance and aggression

Always maintain your safety first – do not block/ prevent patient from leaving. Even if they are on a mental health assessment order/ treatment order. It is not ED clinical staff role to potentially put yourself in harm's way – that is what police and to some extent security is for.

Prior to moving a psychiatric patient into a cubicle area, the area must be made safe with removal of furniture and repositioning of other medical equipment. (eg IV trolleys)

Verbal de-escalation (see table below)

- Should be done by staff member who has established best rapport with patient
- Use a calm, low voice. If patient gets louder, talk softer – this often causes patients to change approach as they aren't getting the yelling/angry response they were expecting.
- Call security – Code Grey on ext 2222 via switchboard

Table 2. Ten domains of de-escalation.[27]

1. Respect personal space
2. Do not be provocative
3. Establish verbal contact
4. Be concise
5. Identify wants and feelings
6. Listen closely to what the patient is saying
7. Agree or agree to disagree
8. Lay down the law and set clear limits
9. Offer choices and optimism
10. Debrief the patient and staff

From Verbal De-escalation of the Agitated Patient, Richmond et al. Western Journal of Emergency Medicine 2011

Chemical restraint

- See Medication - Acute Behavioural Disturbance / Chemical Restraint

Physical restraint

- Should be a last resort
- Bed restraints applied by security

- Patients require one on one nursing and regular monitoring. This includes 4 hourly medical review if under the Mental Health Act.
- Released at earliest opportunity by security during a planned Code Grey
- Physically restrained patients should generally receive chemical restraint in order to facilitate release of restraint – there are some situational exceptions which the ED consultant will be aware of (the most common being patient is about to go to psych ward so we would avoid medicating parenterally with midazolam).

Mental health assessment orders

These are the orders which any medical practitioner can use to hold a patient legally in the emergency department/ hospital to be reviewed by a psychiatrist. It means that the patient needs to be seen by a consultant psychiatrist within 24 hours.

Often these are placed on patients before they arrive in the ED – which means that no person in the ED has the power to remove them (and if they arrive after 5 pm, it is unlikely that a psychiatrist will see the patient until the next morning). Even if the patient settles ED will be unable to discharge, and also unable to move to other locations (eg SSU).

Legal requirements around mental health

The main legal impacts are structured around the correct completion of the paperwork.
These forms are
MHA 101 – Assessment order
MHA 110 – Temporary treatment order
MHA 111 – Variation of treatment order
MHA 140 – Authority to use restrictive interventions
MHA 142 – Restrictive interventions observation chart

As a clinician the most important requirement comes when

- A patient is under the mental health act as an involuntary patient (any of an MHA 101, 110 or 111); AND
- They have been physically restrained
- The MH 142 **mandates** (ie no options or excuses, not even if the patient next door is arresting) 15 minutely nursing documentation and every 4 hours medical staff documentation of the patient's physical health
- The documentation does not need to be extensive, a simple "patient reviewed, no issues" will suffice
- Ideally avoid physically restraining for 4 hours or longer through the use of adequate sedation. Unfortunately, the ED is often forced to house patients with unacceptable risks of violence to other patients and staff (based on their own recent history) and release of restraint can be difficult or even impossible.

Tips for correct use of the other paperwork
MHA 101 – can be filled by any medical practitioner or mental health practitioner; it makes patient involuntary and needs psychiatrist review within 24 hours (for ED purposes).

Important to document the time, the grounds for making the order and tick the box indicating assessment cannot occur in the community.
MHA 110 – only filled by psychiatrists. Will indicate if patient is to stay in hospital or community while under involuntary status
MHA 111 – only filled by psychiatrists, moves patient from hospital to community or vice versa while involuntary
MHA 140 – complete if you need to restrain mechanically/ physically. Tick all boxes that apply (usually physical and or mechanical restraint, to prevent harm to person and to administer treatment). The psychiatrist on call needs to be notified – in practice calling EMH suffices, if you can't get hold of EMH call psychiatrist via switchboard. Can be completed by nursing staff.
MHA 142 – tick boxes for type of mechanical restraints, frequency of physical review (4 hours maximum)

Frequent Presenter Program

The Northern Hospital Frequent Presenters program is a program where patients who have multiple ED presentations due to complex medical, psychiatric and/or social needs can get more complex care delivered.

Aims

- To reduce ED presentations where care could be better delivered by alternative providers
- To streamline ED care so that repeated unnecessary re-investigation for an established condition does not occur
- To provide consistency of care and approach for complex patients

Responsibilities

The Committee receives referrals from ED staff or sometimes ambulance services of patients who are presenting to ED in a frequent manner. These patients are discussed by the committee and allocated to individual members who will then compile background information to present at the next committee meeting where the multidisciplinary team make suggestions and finalise the plan. The plan is then signed off by the Emergency Physician and submitted onto the electronic record (CPF).

Locating plans

Plans are stored electronically on CPF.

A patient with a plan will have an alert on EDIS. Unfortunately, if there are multiple alerts, EDIS defaults to a row of stars in the alert field, so the record will need to be highlighted on the EDIS “Tracking screen” and the “Alert” button at bottom right clicked.

If the patient has a plan one of the alert fields will be “ED Frequent Presenter” or “EDMGP”

To then find the plan, go to the Emergency tab on CPF, then “Filter” documents for “ED Frequent Presenter Management plan”

Review of plans

Plans are reviewed after 6 months of a plan; if the number of ED presentations have decreased there is generally no further scheduled plan review unless the clinical situation changes. However, the plan remains active until actively cancelled (with removal of the alert from iPM). If the number of presentations increases the plan will be reviewed to see if any

changes are required. Presentations are monitored monthly in an ongoing fashion to identify if issues/ needs have changed.

Referrals

Referrals are made via

1) email via hospital email to a committee member
2) placing a bradma in the frequent presenter book (A5 exercise book, blue colour, labelled at assessment waiting room pod) indicating patient is for frequent presenter plan

Background generally needed to assist with referral

- outline of recurrent presentation
- previous tests done
- psychosocial contributions (if known)
- safescript check (if concern about opiate dependence)
- current GP, current medication list
- what a plan is potentially looking for

For mental health patients known to a community team, using the mental health episode can provide a longitudinal view of the patient's progress.

Supervision and Assessments

Interns/HMOs

Each intern/HMO is allocated a supervisor from the consultant group. You are required to meet with them at least three times during your term in ED (start, middle and end of term). It is your responsibility to arrange these meetings.

Registrars

The DEMT team (Dr Phyllis Fu, Dr Peter Cheng and Dr Raj Kathirgamanathan) will provide feedback and arrange assessments as required by ACEM.

Mentoring

There is a mentoring program available for registrars who are interested. Dr Matthew Wilde is responsible, and those registrars who would like to be assigned a mentor should contact him.

Education Program

Junior doctor education takes place on various days of the week.

Interns/HMOs

- Interns and HMOs rostered to work on Friday mornings should all attend teaching 8 am to 9 am, with the exception of the SSU/EOU HMO
- There is also a virtual education session which runs fortnightly at variable times.

Registrars

- Registrar teaching time is Wednesday 9.30 am – 1.30 pm
- Registrars are all expected to attend, unless rostered for night shift
- The program is run by the education team

Work Based Assessments

- There is a consultant assigned to WBAs Monday to Friday – please contact them prior to arrange an assessment

Research, Quality and Simulation

Research

If you have an interest in research, please contact one of the ED Research Team:

- A Prof Joe Rotella – Adult Research Lead

- Mark Corden – Paediatric Research Lead

Quality Improvement

Please contact the ED Quality Lead if you would like to do an audit or other quality improvement project.

Simulation

Regular simulation plays an important role in embedding processes and practicing together as a team. The department holds a weekly in-situ simulation as well participating in inter-departmental simulation.

LEARNING OBJECTIVES

At the end of this rotation, under supervision, you should be able to:

1. Science and Scholarship

- Consolidate, expand and apply knowledge of the aetiology, pathology, clinical features, natural history and prognosis of common and important emergency presentations at all stages of life
- Access and use relevant treatment guidelines and protocols
- Seek and apply evidence to emergency patient care

2. Clinical Practice

- Assess patients with acute, undifferentiated illness at the point of first presentation.
- Demonstrate appropriate history taking and physical examination skills
- Develop management plans for patients presenting to the Emergency Department
- Order and interpret investigations in the initial management of patients presenting for acute care
- Participate in decisions to admit patients, making referrals and initiating treatment
- Develop skills in managing critically ill patients from the point of first presentation.

This includes:

a. Assessing critically ill patients
b. Actively participating in their initial investigation and treatment
c. Participating in resuscitation and trauma management

- Observe, learn and perform a range of procedural skills relevant to the emergency setting.

For example, interns and HMOs will be provided with opportunity to perform procedures such as: plaster cast application, suturing, IV insertion, venepuncture, IDC insertion, and lumbar puncture. Interns and HMOs may also be given opportunity to perform other resuscitation procedures, where possible, such as cardioversion, DCR, and arterial lines, under the supervision of Senior Medical Staff.

- Develop knowledge and skills in safe and effective prescribing of medications including fluids, blood and blood products
- Develop skills in synthesising acute management issues and presenting a concise patient assessment
- Develop skills in preparing appropriate medical documentation including

a. Records of clinical interactions
b. Discharge letters and summaries

- Develop effective communication skills needed for delivering care in an emergency setting through:

a. interactions with peers (particularly through clinical handover)
b. supervisors
c. patients and their families
d. other medical practitioners and health care workers involved in inpatient and ambulatory care

- Develop advanced skills in spoken, written and electronic communication
- Develop skills in obtaining informed consent, discussing poor outcomes and end of life care in conjunction with experienced clinicians

3. Health and Society

- Discuss allocating resources in providing emergency care
- Participate in quality assurance, improvement, risk management processes and/or incident reporting
- Screen patients for common diseases, provide care for chronic diseases and discuss healthcare behaviours with patients
- Develop knowledge about how patient care interacts with sub-acute, community and ambulatory care facilities, including appropriate discharge destinations and follow-up

4. Professionalism and leadership

- Develop skills in prioritising workload to maximise patient and health service outcomes
- Demonstrate an understanding of roles, responsibilities and interactions with various health professionals in managing each patient
- Participate actively in the multi-professional/disciplinary team
- Develop and reflect on skills and behaviours for safe professional and ethical practice consistent with the Medical Board of Australia's Good Medicine Practice: A Code of Conduct for Doctors in Australia

Junior Medical Workforce

Rosters

Northern Health rosters are available via "RosterOn". Staff can access "RosterOn" from any computer at Northern Health or via the web version externally.

Roster will be published in line with the EBA.

Leave Requests

Leave requests for the year should be submitted in writing to jmoedqueries@nh.org.au prior to the medical year commencing. The specific date is determined by the JMO Co-ordinator who emails ED staff requesting leave dates.
All requests will be plotted on a leave planner and allocated based on a first come first serve basis, with special consideration given for certain occasions.

During ACEM exams, leave will be limited to those sitting the exam (see the ACEM website for dates).

Please do not book any leave until your leave request has been approved.

Conference Leave
Conference leave form must first be approved and signed by the Head of Unit.

Only conferences relevant to ED will be approved.

- The conference leave form and details of the conference need to be submitted to the JMO Co-ordinator. This will be plotted on the leave planner to see if it can be granted.
- Conference leave can only be used for the days of the conference (i.e. travel days cannot be included).

Overtime

Northern Health allows overtime where there is demonstrable clinical need that cannot be handed over or managed by another doctor.

To claim overtime:

- Complete the overtime form.
- Write down the UR numbers of patients (to demonstrate the clinical need).
- The form must be signed by the consultant on the floor.
- The form must be submitted to Junior Medical Workforce within the following pay cycle either via email jmoedqueries@nh.org.au or dropped in to the Medical Workforce office.

Roster Swaps

Roster swaps are available at Northern Health. For a roster swap to be approved the following conditions must be adhered to:

1. It is the doctor's responsibility to arrange the swap with an appropriate colleague.
2. All swaps should be kept to within the pay period fortnight. In exceptional circumstances where this cannot be achieved further discussions must be held with the JMO Co-ordinator prior to approval being granted.
3. All shift swaps should be like hours for like hours. Where a swap results in a doctor working less than their contracted hours they will be placed on "Leave without pay" for the shortfall in hours
4. The appropriate JMO co-ordinator needs to be notified of the swap via email. Both parties participating in the swap must be copied into the email, as well as the Head of Unit.
5. All swaps need to be notified at least 48 hours prior to occurring.
6. There must be a 10-hour gap between shifts. In exceptional circumstances where this cannot be achieved further discussions must be held with the Head of Unit to see if a later start the following day can be granted.

Unplanned Leave

Please advise MWU and the EPIC / Senior Registrar.

Monday-Friday Between 0730-1700	Medical Workforce	MWU - 8405 2584 Mon-Fri or MWU Reception - 8405 8276
Monday-Friday Afterhours Between 1700-2200	Medical Workforce On-call	0438 201 362
Monday-Sunday Between 2200-0730	After-hours Hospital Coordinator	Via NH Switch
Weekends & Public Holidays Between 0700-2200	Medical Workforce On-call	0438 201 362
EPIC or Senior Registrar	Emergency Department Floor	8405 2610

Failure to make both phone calls will result in a delay to seeking a replacement for your shift.

You must call at least 2 hours prior to the start of your shift to ensure you receive sick pay as per the EBA. We do understand that this is not always possible for a day shift, but please call as soon as possible.

Documentation required

- For 3 single absences per year, the JMO will not be required to provide any supporting evidence to substantiate their claim for personal Leave. However, to be eligible for payment, the Doctor will be required to notify the Health Service two hours before the start of the shift, or as soon as practical.
- For other days absent due to personal illness or injury the JMO is required to provide evidence of illness.

Contacting Junior Medical Workforce

All enquiries and requests should be emailed to jmoedqueries@nh.org.au

Guidelines and Resources

Prompt
This is a database of guidelines published by Northern Health. This can be found by following the link from the homepage. Please see ED - Patient Management in the Emergency Department for information most relevant to ED.

ED Clinical Resource
This educational resource was created by Dr James Hayes, and it covers every core emergency medicine topic. It can be found on the desktop of most computers in the ED, under the folder name 'ED Clinical Resource'.

Austin Health Toxicology App
This app provides single page summaries on the risk assessment and management of many common poisonings and envenomations.

RCH Clinical Guidelines App
This app provides guidelines for the assessment and management of many common paediatric presentations

Emergency Department Intranet Page
The intranet page contains useful information on patient care, operations and education. It can be accessed from the main intranet page, or via the following link when connected to the NH Date Wifi network.
https://intranet.nh.org.au/departments-and-services/emergency-department/about-us/

Useful Contacts

Leadership Team		
Daniel Crompton	daniel.crompton@nh.org.au	Director of the Emergency Department
Heng Cheok	heng.cheok@nh.org.au	Deputy Director – Workforce and Education
Katie Smith	katie.smith3@nh.org.au	Deputy Director – Clinical Operations SSU Clinical Lead
Matthew Wilde	matthew.wilde@nh.org.au	Deputy Director – Quality
Keith Amarakone	keith.amarakone@nh.org.au	Director of Paediatric ED
A/Prof Joe Rotella	joe.a.rotella@nh.org.au	Director of SPECTRE (Substance Dependence,Psychiatry/ Mental Health, Envenomation, Clinical

		Toxicology, Recreational Substances)
Education Team		
Phyllis Fu	phyllis.fu@nh.org.au	Co-DEMT
Peter Cheng	peter.cheng@nh.org.au	Co-DEMT
Raj Kathirgamanathan	raj.kathirgamanathan@nh.org.au	Co-DEMT
Wei Chin Ng		Local WBA co-ordinator
Jenny Huang	jenny.huang@nh.org.au	Resident to Registrar Program Coordinator
Stefan Herodotou	stefan.herodotou@nh.org.au	Intern/HMO education
Rachael Coutts	rachael.coutts@nh.org.au	IMG Supervisor
Administration Team		
Stephanie Sarris	stephanie.sarris@nh.org.au	Administration Coordinator, Executive Assistant
Emma Tobin	emma.tobin@nh.org.au	Junior Medical Workforce Coordinator