The Emergency Department

Middle Tier Induction pack

Date	Version
June 2024	V9

Purpose

Information to all new middle tier doctors starting in the Emergency Department. This includes permanent grades and trainees.

Links to other policies and procedures

Version History

V1-5	July 2013 - 2017	Author: N Bothma
V6	July 2020	Author: Induction Team
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Appendices

Forms (Personal details; Scrubs order; leave requests; absence reporting)	https://sites.google.com/view/derriforded-education/derriforded-induction
Induction checklist	Handout at induction
Safeguarding children	Covered at induction
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Introduction

Welcome to the Emergency Department (ED). We hope that you will enjoy working as part of our team. This introductory letter is not exhaustive, but will hopefully give you a synopsis of the key points to working in the ED at Derriford.

What is our aim?

We aim to provide patients with the same care we would like for our families or ourselves. We aim to be the best ED in the South West.

About our ED

Derriford ED is the busiest ED in the South West.

Our current department has

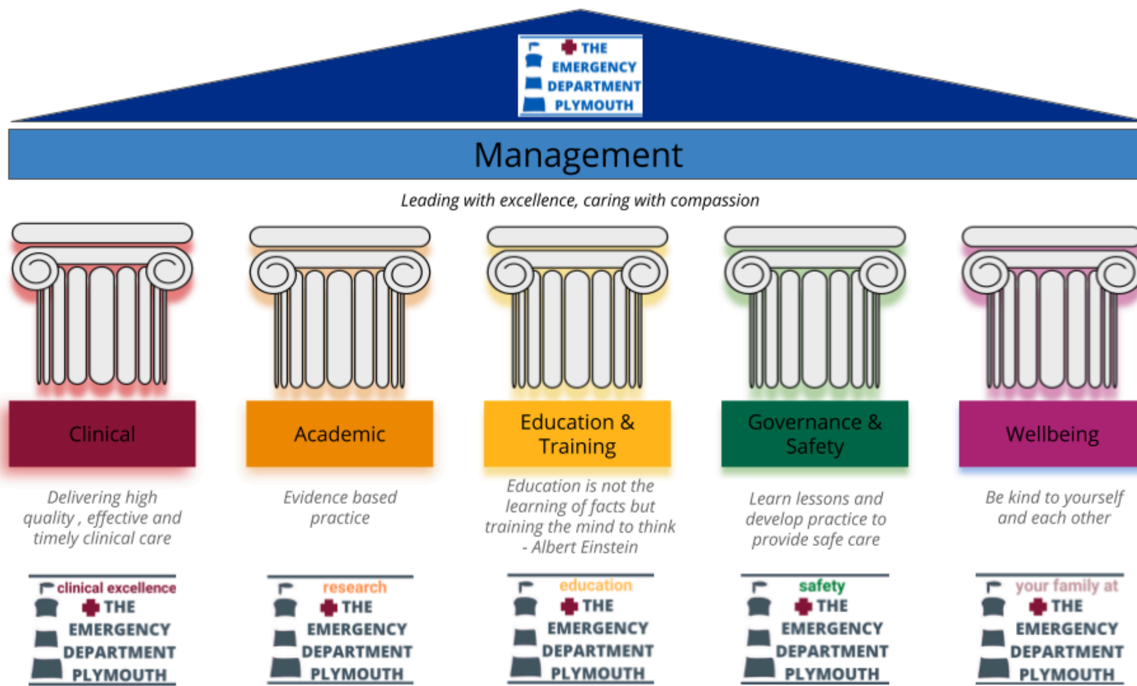
- Reception and waiting areas
- 7 resus bays
- 19 majors cubicles; 7 ambulatory majors cubicles
- Minor injuries area
- Children & Young people area

A £160m rebuild of the ED has commenced in 2025, as part of the Future Hospitals Programme. This will provide a state-of-the-art ED suitable for our growing population.

In addition to providing emergency, inpatient and follow up care for patients attending the ED we also provide support for local Minor Injuries Units (Cumberland). We have close links with the British Antarctic Medical Survey (BASMU) and the military.

Our ED is a teaching department for many different professional groups, and has strong links with the University of Plymouth and the Peninsula School of Medicine and Dentistry. We are increasingly involved in research. We already care for patients with acute illness and injury presenting to hospital and community services. In the future we would also like to develop our pre-hospital service.

Pillars



Our Staff

To help run our service we have about 170 permanent staff plus rotating resident doctors

- Consultants: 22 whole time equivalents (WTE) ; 27 members – currently expanding
- Middle Tier Doctors: 33 (including 13 HST trainees, 5 CT3s, plus clinical fellows, associate specialists and specialty doctors)
- Nurse Practitioners (ENPs)
- Junior Doctors usually about 12 WTE SHOs plus 4 F1s
- ACPs
- Sisters
- Band 5 Nurses
- HCAs
- Porters
- Receptionists and clerical staff
- Support staff - e.g. housekeepers

In addition we share a small management team from the ED Service Line, including a Service Line Clinical Director (Dr Richard Bullough), Service Line Matron (Vicky Carter) and Service Line Manager (Gemma Cochrane).

How many patients attend the ED?

We currently see >100 000 new patients a year, around 280/day. Of these patients 78% are adults and 22% are children.

What are the key performance measures?

Here are key measures at the time of writing:

Every patient should have received first aid and **pain relief** within half an hour of arrival. The pain score should be documented so that when we audit we get an accurate picture of how we are doing.

Every patient should have their bloods taken, their X-rays done, and be seen by a practitioner or doctor within an hour of arrival (See 1-2-3-4 system).

Patients needing admission should be referred within 2 hours of arrival (where possible).

Time critical conditions:

- Patients should be referred to PPCI Team who presents with STEMI
    - Take note of the (patient) call to balloon time 90 minutes
- Patients should have their primary X-rays CT within 30 minutes of arrival in major trauma
- Patients should be in CT within 60 minutes of arrival for stroke
- Patients with severe sepsis should be identified, be risk stratified and if appropriate receive the 'Sepsis 6' treatment bundle within an hour
- Patients with dislocated joints should have them relocated within an hour of arrival

Patients being admitted to the wards should have all urgent and emergency treatments completed before they leave the ED. They should all have an SBAR handover completed.

We should pass infection control inspections.

We have to meet current standards for clinical care, and Trust clinical governance requirements. We also operate using keeping clinical quality indicators in mind, which are used to measure our performance by the Department of Health.

Roles and responsibilities

We want to be the best ED in the UK. We have high expectations of the clinicians working in our department and make no apologies for this.

Basic clinical responsibilities are clear. This involves acting as a senior doctor on the shop floor.

The role includes:

- Leading on standards of behaviour and dress.
- Leading on standards of clinical behaviour (e.g. communication, documentation, completing information on Nervecentre, work ethic).
- Supporting your colleagues and ensuring civility at all times.
- Ensuring timely attendance at formal handover at 0800 and 2200.
- Ensuring that all medical staff are clearly allocated their duties while on shift, and that breaks are taken.
- Ensuring clinical safety of the ED.
- Ensuring a consultant is aware of any major problems (e.g. clinical, staffing, equipment). Otherwise potential complaints, potential SUIs, anything likely to generate publicity.
- Ensuring clinical and performance targets are met.
- Ensuring that 1-2-3-4 system is being followed and that plans are being documented contemporaneously on Nervecentre.
- Leading resuscitation and trauma teams.
- Supporting training and education in the ED.

There is always a consultant available, either on the shop floor or at home, to support this role.

The shop floor

Tight supervision of the ED remains a key factor in maintaining clinical standards and safety, enabling us to fulfil our role, and preventing our role becoming eroded. It is also important in maintaining / building our reputation. This means:

- The senior doctor or Emergency Physician In Charge (EPIC) should aim to have an overall picture of the overall state of the department regarding flow, input in both staff and patients.
- All sick patients should be reviewed by a senior doctor.
- All patients seen by supernumerary/ tier 1 clinicians (e.g. year 1 foundation doctors and tACPs) should have a physical review.

If there is doubt about whether patients need admission, the first port of call should always be the EPIC. Consideration of other routes of care, such as the acute frailty service and same day emergency care (SDEC) should be encouraged where appropriate.

There will always be at least two senior doctors on the shopfloor at all times. If there are

- TWO seniors, one should remain in majors/resus and one in ambulatory majors.
- THREE seniors, one senior should be primarily in resus.
- FOUR seniors, one senior should go to paeds.
- This arrangement will of course need to be flexible dependent on the patient acuity and burden, as well as skill mix and number/experience of juniors.

We strive to deliver a senior-led service. Senior medical staff need to be aware of all patients in majors / resus, as well as most patients in ambulatory. Due to patient numbers, an in-depth knowledge of all patients is not possible, but there should be awareness of all sick and high risk patients.

A senior on the day shift needs to take handover from the night team. Usually this will be the consultant in charge, who will check staffing for the day and allocate medical staff to the areas of the ED.
If you are off sick, please ensure that you inform the EPIC consultant (01752 437005)
of short term shift absence (< 48 - 72 hr). Email plh-tr.edjuniordoctors@nhs.net, Gemma Cochrane, Chelsea Harris, Emma McMaster and Emma Edwards.

We also expect our Middle Tier doctors to support the smooth running and improvement of our ED. We hope you will also actively participate in service development. This particularly involves leading, managing and supporting change.

Audit and research are key activities of this department. All Middle Tier doctors will be expected to actively participate in audit. There is always research activity going on, and we can support you if you have your own ideas.
QIP lead: Dr Suzy Connor
Audit lead: Dr Simon Horne
Academic lead: Dr Jason Smith

Appraisal and ARCP

All Middle Tier doctors are expected to participate in annual appraisal / ARCP. We would like this to include a 360 degree appraisal/MSF every 3 years. We would expect your appraiser to be a senior Emergency Physician, who is trained in appraisal, but appraisers from other specialties are also acceptable. Registrars in training are obviously expected to participate in the established Deanery / School processes. You will be allocated a clinical supervisor for the duration of your placement.

CPD

We expect you to keep up with current developments in emergency care. There are a number of mechanisms available to support you in this, and you are given time as part of your generic SPA/EDT to achieve this. We do expect our Middle Tier doctors to undertake CPD, if possible through the Royal College of Emergency Medicine mechanisms. If you aren't registered with RCEM for CPD you will need to produce, for your appraisal, evidence that you are hitting 50 CPD points annually using their scoring system.

Qualifications

We expect **all** senior doctors to be current in *ALS, ATLS / ETC, and APLS*. Ideally you should all have done either a MIMMS or an HMIMMS course, although this is not a requirement. You will also need *Research Governance* training to participate in research activities (Academic pillar).
There is a Middle Tier sign off sheet which acts as a reference for non-trainee doctors to ensure that our 'red top' seniors (capable of being the solo senior overnight) are meeting the standard we would expect for a doctor in an ST4+ level of training. It can be found here.

There are also **mandatory Trust training** requirements.

- All new doctors must undergo ***Trust Induction***.
- All senior doctors should undergo ***Level 3 Child Protection*** training every 3 years.
- All senior doctors should have a ***BLS update*** (either in isolation, as part of ILS, or as part of ALS) every year.
- All doctors need to complete the ***Medical Staffing Update*** online every year.
- All medical staff need to have ***manual handling*** training every 2 years. This is not part of the Medical Staffing Update.

If you wish to undertake **ultrasound** in the ED you need to have done the relevant courses and be enrolled as part of the RCEM Ultrasound Accreditation Programme.
Ultrasound Lead: Dr Tom Odbert

If you wish to undertake **(ketamine) sedation of children** in the ED you need to be accredited to do this. This involves having current APLS/EPALS certification, spending time with the Paediatric Anaesthetists in the hospital (as well as having your Initial Anaesthetic Competency (IAC) completed), having relevant experience under your belt, and being signed off by an EM consultant.

What you should be getting from the ED

- Support from the consultants, senior nurses, and other middle tier doctors.
- A nominated clinical supervisor.
- Fair working patterns and scheduling, including flexibility when "stuff happens".
- The opportunity to receive feedback on clinical and other aspects of your work.

- Opportunity for personal and professional development.
- Support to meet the CPD requirements outlined above.
- Opportunity to teach medical students and others.
- Opportunity to undertake audit and become involved in QIP.
- Opportunity to be involved in research.
- Access to teaching (e.g. Super Wednesdays, M&M meetings, trauma meetings).

If the ED is not meeting your needs you must let us know, so that solutions can be put in place.

Job Planning

For Speciality doctors and Associate Specialists (SAS), your time is now allocated between DCC (direct clinical care) and SPA (Supporting Professional Activities). DCC encompasses work on the shop floor, along with results work, and other administration related directly to patient care. SPA encompasses the rest. You will get generic SPAs which enable you to keep up to date with your emails, CPD, and undertake basic departmental activity and mandatory training. This includes audit activity within the department.
It is important to note that you will be expected to demonstrate that your SPA time is used productively as part of both the job planning and appraisal process.

Trainees are expected to undertake management activity, supported by consultants, as part of their professional development. This is required by RCEM and also enhances CVs and prepares you for future consultant roles.

As far as Speciality Doctors and Associate Specialists are concerned, we are very keen to encourage active participation in departmental management and service development. There are a wide range of potential activities, and the opportunity to be allocated specific SPA to enable you to undertake these tasks. You will obviously be expected to deliver, if specific time is allocated. This can form part of the job planning process.

Rota

Middle tier doctors take part in a **full shift rota**.

Dr Emma McMaster coordinates the rota at present with Emma Edwards.

Information about the rota and how to request leave can be found here.

SPA/EDT

The Trust expects doctors to be **on-site** for these scheduled activities, as well as being flexible and available for clinical duties if the need arises. If you do arrange to attend meetings or activities that are held off-site, please indicate this ahead of time. If you intend to attend CPD activities and travel, you should use *study leave* for this purpose.

A list of examples (not exhaustive) of generic activities that should be done in this allocated time:

- Non-clinical administration
- Continuing professional development (CPD) time
- Clinical teaching and mentoring time
- Training for self and others on new equipment or techniques (incl. induction)
- Mandatory Trust training
- Department meetings for audit, patient safety, revisions to procedures, hospital policy discussions, clinical governance etc.
- Job Planning and appraisal (to be considered as preparation for revalidation)
- Conducting or managing clinical audits/quality improvement projects.

Information about how EDT time should be spent is here.

Sustainable working

The demand on the ED is constantly changing and increasing, and we have only a finite number of staff. Therefore, it may be necessary for us to change our shifts and shift patterns to enable us to deliver our service safely. We need to be mindful that our job has a high intensity, and the risk of burn-out is a real one.

To help prevent over exhaustion and long-term unsustainable working patterns, we have tried to define what we think is reasonable boundaries within which we can deliver our service safely.

Leave

Annual leave

Trainees/fellows

Annual leave entitlement is 27 or 32 days, depending on length of service in the NHS and contract type. (More than 5 years service will get 32 days). Plus Bank holidays

LTFT doctors will have a pro-rata reduction in their leave entitlements.

Your leave entitlement is taken into account in your annualised rostering as are BH.

Study Leave

Full time trainees get 30 days of study leave per year. The regional training days and leadership days will come from this pot. The HST days will be added to rota automatically and need not be requested.
Please request the leave in advance of the rota deadlines where possible.
As per rota guidelines you must request leave on Allocate/Healthroster and send an email to Emma Edwards and Emma McMaster.

SL forms – see the Postgraduate Medical Centre Plymouth website.
SAS – send completed form to Emma Edwards.
Trainees and fellows send form to both your ES and Emma Edwards for completion prior to sending on to PGMC.

Sick leave and any other unplanned absence from work

Please ensure that you inform the EPIC consultant (01752 437005) of short term shift absence (< 48 - 72 hr)

1. Email plh-tr.edjuniordoctors@nhs.net
2. Please also copy in your individual rota lead plus Gemma Cochrane and Chelsea Harris
    - e.edwards9@nhs.net and emmamcmaster@nhs.net

PERMANENT STAFF

ALL leave requests are done via the Healthroster online system.
Permanent staff partakes in self rostering and annualisation of the work.

Please note that at present when applying for **STUDY LEAVE** you need to book the time off on Healthroster, but you still need to send paperwork to the MG Rota coordinator and then PGMC for educational approval.

TRAINEES

Full time trainees get 30 days of study leave per year. The regional training days and leadership days will come from this pot. The HST days will be added to rota automatically and need not be requested.
Please request the leave in advance of the rota deadlines where possible - by email and via Healthroster (Allocate). If the rota has been written and the SL request clashes with a premium clinical shift (late/night/weekend) then that shift will need to be swapped. This is your responsibility - much easier to plan your study in advance.

- To get paid for SL the dates must also be requested via the Allocate App (you gain a login through Medical Staffing):
  - https://phnteol.allocate-cloud.com/EmployeeOnlineHealth/PHNTLIVE/Logi

- NB Study leave is not "pre-allocated" for the hours calculations in the same way as annual leave. Therefore if you request SL this will reduce your hours to work pot. It is in your interest to use your entitlement!

Study leave claim/expenses

Study leave forms should be sent to the postgrad centre 6 weeks BEFORE the SL and need to be signed by your ES and Emma Edwards as rota coordinator. Expenses should be claimed no later than 3 months after the course. They are strict with the time limits and you risk not getting your courses/expenses paid if they aren't adhered to.

Please see:
https://www.pgmeplymouth.com/study-leave

Special requests other than leave

PLEASE NOTE:

1. *SPA cannot be requested for activities where you need to travel or be off-site (there are some exceptions, e.g. mandatory training or teaching).*
2. *DAY OFF can be requested, but please remember this will mean more working days in another week. If you really need the day off, please consider a leave request.*

If your leave has not been approved, the most likely reason will be that there are too many people away on those dates.

Information Technology

In order to function in the Trust, you will need to communicate with and receive communication from the Trust. If you do not already have an **NHS.net email address** when you arrive, then you will need to set up an account through the IT department or your service line secretary who will help to organise one for you. If you already have an NHS.net account, this will be used but IT will need to be contacted to inform them of the details.

You will also need to be able to access a number of IT systems in the Trust

- PHNT user logon (DMC) — ICT Plymouth
- Nervecentre — Damian Pudner
- Insignia Webpacs — Imaging
- iCM — Lab results and imaging requests
- Blood Gas machine — POCT

Parking Permit from plh-tr.uhpparking@nhs.net or visit the parking desk at the front entrance. Parking permits have a long waiting list, but ED doctors get priority and are granted permits during their rotation here. Please send your registration details to Gemma Cochrane once you have applied for your permit so she can ensure it gets actioned.

Education opportunities

Educational opportunities within the ED are listed on the education website.

Hand-Off SBAR

(Situation, Background, Assessment, Recommendation)

To be used at shift change and during in-house patient transfers between departments.

SITUATION:
Patient (sticker)

Today's date: ________________
Diagnosis: ___________________
Admit date: _________________
Provider pager: _______________

BACKGROUND:
Medical history:
Allergies:
Code status:
Current treatments/ interventions:

Fall precautions:
Restraint precautions:

ASSESSMENTS:

Neuro:

Respiratory:

Cardiac:

GI/GU:

Musculoskeletal:

Skin:
Dressing Δ due:

Psychosocial:

Last vital signs: BP______ HR_____
RR_____ Temp______
Pain scale_________

Accu checks:

Abnormal lab:

X ray results:

Lines/ fluids:

IV dressing Δ due:

RECOMMENDATIONS:

Goals:

Consults:

Tests/ treatments:

Discharge needs:

1-2-3-4: Information sheet

1-2-3-4 is a simple internal standard we are using to try and help get patients moving smoothly through the processes in the ED. It is carefully designed to help us deliver high quality care for patients, and to provide us with information we need to improve processes and secure the resources/backing we need to deliver that care.

Your job as a doctor / practitioner in the ED is to

1) Help us deliver the standard
2) Help us measure how we are doing by completing the computer tracking contemporaneously

- **1 hour**: See all patients
- **2 hours**: Simple minors / majors seen, treated and discharged. Everyone else has a plan (provisional and discussed with senior, or definitive)
- **3 hours**: Everyone has a definitive plan
- **4 hours**: Everyone discharged or admitted, provided it is clinically safe to do so

Plan = treatment and an idea of where the patient is likely to go