
Australasian College
for Emergency Medicine

# Components of an emergency medicine consultation

**Policy P55**

**v3.0** December 2019
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## Document review

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| Timeframe for review: | every three years, or earlier if required. |
| Document authorisation: | Council of Advocacy, Practice and Partnerships |
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| Document maintenance: | Department of Policy and Strategic Partnerships |

## Revision history

| Version | Date | Pages revised / Brief Explanation of Revision |
|---|---|---|
| 1.0 | November 2008 | Approved by Council |
| 2.0 | July 2014 | Amendments to 3.2, 3.5, 3.8, 3.10, 3.15, 3.16, 3.18, 3.19, 3.21, 3.22.1 |
| 3.0 | November 2019 | Reconciliation with other ACEM standards. Addition of responsibility to notify of patients who present more than once with same condition |

# 1. Purpose and scope

The purpose of this Policy is to document the components of an emergency medicine consultation. An emergency medicine consultation is a complex, structured process of significantly variable length, depending on the complexity of the patient.

This Policy is applicable to all Australian and New Zealand Emergency Departments and providers of emergency care.

This Policy does not apply to requests for telephone consultations (see ACEM policies P44 and P181).[1,2]

# 2. Policy

The purpose of the emergency medicine consultation is to maximise patient benefit, whilst minimising delay and inefficiency in the patient journey.

The components listed below will apply to every emergency medicine consultation.

For each episode of care provided by an ED, the tasks below should be completed.

## 2.1 Pre-arrival notification

Relevant information from other care providers should be available to triage staff and senior medical staff within the ED upon arrival of the patient to the ED.

## 2.2 Triage

A treatment priority will be allocated to all patients who arrive for care based on the presenting complaint and/or vital signs recorded at presentation.

## 2.3 Initiation of care

Immediate care will be provided to patients who present with severe physiological and/or psychological disturbance.

Effective first aid will be provided to patients waiting for treatment.

Early symptomatic treatment should be provided as soon as possible to all patients.

## 2.4 Registration

Appropriate information will be obtained to enable correct identification of the patient and facilitate subsequent communication with the patient, their relatives and relevant healthcare providers.

The patient's previous medical record will be retrieved for ED staff review within an hour of the patient's presentation.

1. Australasian College for Emergency Medicine. *P44 Policy on the Provision of Emergency Department Telephone Medical Advice to the General Public*. ACEM, Melbourne.
2. Australasian College for Emergency Medicine. *P181 Policy on the Provision of Emergency Medical Telephone Support to other Health Professionals*. ACEM, Melbourne.

## 2.5 Introduction to patient and caregivers

Each patient will be correctly identified using the three unique identifiers as defined by the Australian Commission for Safety and Quality in Health Care and in line with ACEM guidelines.[3,4]

Each staff member will introduce themselves to the patient and caregivers, outlining their role in the provision of the patient's care.

## 2.6 History taking

A medical history will be obtained from the patient. The history may be focused on areas relevant to the provision of emergency care.

When required, additional historical information will be obtained from other relevant sources such as pre-hospital providers, caregivers, residential care facilities, bystanders and the patient's relatives or friends.

## 2.7 Physical examination

The patient will have a physical examination performed that is relevant to their presenting problem(s).

When appropriate, patients should receive a primary nursing assessment, including relevant vital signs.

## 2.8 Consultation with supervisor

All resuscitation cases will be discussed with the most senior medical officer. This should be an emergency physician, or if not available, the most senior emergency doctor.

The most senior medical officer will be notified of all patients identified as presenting more than once to the ED (or other healthcare provider) with the same condition.

Doctors engaged in junior roles – non-senior decision makers in accordance with ACEM policy[5] – will consult a senior decision maker in the ED on the diagnostic and management plan for all patients.

Non-medical staff will practice in accordance with delegated authority from the responsible emergency physician, in line with ACEM policy[6].

## 2.9 Diagnostic and management plan

A diagnostic and management plan will be generated in consultation with the patient, caregivers and the ED staff member (and supervisor in the case of junior doctors).

## 2.10 Investigation ordering

Investigations relevant to the patient's problem will be performed. Results of common ED investigations requested, including pathology and medical imaging should be available within an hour of the investigation being performed. Investigations should be performed in line with ACEM policy on pathology testing and resource stewardship.[7,8,9,10]

3. Australian Commission for Safety and Quality in Health Care. October 2012. Improvement Guide Standard 5: Patient Identification and Procedure Matching. ASQHC, Sydney, 2012.
4. Australasian College for Emergency Medicine. *G29 Guidelines for Ensuring Correct Patient, Correct Side and Correct Site Procedures in Emergency Departments*. ACEM, Melbourne.
5. Australasian College for Emergency Medicine. *G23 Guidelines on Constructing and Retaining a Senior Emergency Medicine (EM) Workforce*. ACEM, Melbourne.
6. Australasian College for Emergency Medicine. *P67 Policy on Extended Role Nursing and Allied Health Practitioners Working in Emergency Departments*. ACEM, Melbourne.
7. Australasian College for Emergency Medicine and Royal Australian College of Pathologists. *G125 Pathology Testing in the Emergency Department*. ACEM/RACP, Melbourne.
8. Australasian College for Emergency Medicine and Royal Australian and New Zealand College of Radiologists. *G126 Guidelines on Diagnostic Imaging*. ACEM/RANZCR, Melbourne.
9. Australasian College for Emergency Medicine. *P435 Policy on Resource Stewardship*. ACEM, Melbourne.
10. Australasian College for Emergency Medicine and Choosing Wisely Australia/NPS MedicineWise. *Five Things Clinicians and Consumers Should Question*. NPS MedicineWise, Sydney, 2015.

### 2.11 Communication with other emergency department care providers

Communication of the patient's diagnostic and management plan will occur with other relevant ED care providers (for example, allied health, social work, and drug and alcohol services).

Initial treatment orders will be available to other ED care providers.

### 2.12 Documentation of initial findings

Initial findings from history, examination and the management plan will be recorded in the patient's medical record as soon as possible following the initial consultation.

### 2.13 Performance of procedures

Relevant diagnostic and/or therapeutic procedures will be performed in compliance with relevant infection control standards.

Consent for procedures will be obtained according to standard policies.

### 2.14 Review of investigation results

Investigation results will be reviewed and recorded in the patient's medical record. An explanation for all abnormal results will also be recorded.

Alteration of the diagnostic and management plan will occur and be documented on the basis of unexpected results, as outlined in ACEM policy.[11]

### 2.15 Review of Patient's Condition

The patient's clinical condition will be reviewed at least hourly by ED staff.

Responsibility for ongoing care will be determined according to ACEM policy.[12]

Patients with features of deterioration will be reviewed more frequently by the responsible clinician.

Patients who continue to deteriorate despite intervention will be reviewed by the most senior available clinician.

Patients whose vital signs fall outside predetermined parameters will trigger a clinical review. Should a decision be made to amend reportable vital signs, this will be documented by medical staff.

### 2.16 Referral to Inpatient Unit

Patients requiring consultation from another hospital service will be referred as soon as possible.

The reason for referral will be communicated to the external unit, including whether admission to hospital is requested, and notification of this referral will be documented in the medical record, including the time of referral and to whom the referral was made.

If consultation with another service is to occur in the ED, it will be completed no later than one hour from the time of initial referral.

### 2.17 Completion of Medical Record

The patient's medical record will be completed in a timely manner. It will include a provisional diagnosis, referrals made, and details of the patient's disposition destination.

11. Australasian College for Emergency Medicine. *P54 Policy on Follow-up of Results on Investigations Ordered from Emergency Departments*. ACEM, Melbourne.
12. Australasian College for Emergency Medicine. *S18 Statement on Responsibility for Care in Emergency Departments*. ACEM, Melbourne.

### 2.18 Explanation of the Patient's Condition

An explanation of the patient's assessment and management will be provided to the patient, and as relevant, to the patient's caregivers. This will occur in a way that is appropriate to the patient's cultural, language and educational background.

### 2.19 Reporting

All statutory reporting obligations will be performed.

All relevant medical reports will be provided.

Patient consent shall be obtained where appropriate.

Incidents that caused or could have caused patient or staff harm will be reported, according to the principles of open disclosure. In addition, any incident must be reported in the local incident reporting system, with consideration given to anonymous, parallel reporting in the ACEM Emergency Medicine Event Register (EMER).

### 2.20 Quality, research and education

Patients may be asked to provide consent and participate in quality and research projects, when appropriate.

Patients may be asked to provide consent and participate in educational sessions, when appropriate.

### 2.21 Patients requiring ddmission

The patient will leave the ED within one hour of the decision to admit.

The patient will leave the ED with all appropriate urgent investigation results obtained and initial treatment orders, made in conjunction with the inpatient unit and enabling timely and safe transfer to the ward.

Transfer of the responsibility of care will occur between the ED and inpatient care providers.

### 2.22 Patients discharged from the emergency department

***Pre-discharge screening***

There will be a screening process to assess the patient's suitability and safety for discharge.

A mandatory component of this screening process will be consultation and authorisation of this discharge by an emergency physician or a delegate.

A set of vital signs should be recorded within the last hour of the patient's stay in the ED, either prior to discharge from the ED or admission as an inpatient.

***Discharge medications***

An explanation of the discharge medications and their possible adverse effects will be provided.

***Discharge instructions***

Instructions will be provided to the patient (and/or caregiver) of measures to be taken to assist in the patient's treatment, including the timing and service involved in scheduled review of their condition. Instructions will be also provided as to when to seek unscheduled review.

Where relevant, written discharge instructions should be given.

Documentation in the patient's medical record should reflect the content of discharge instructions.

***Discharge communication***

Communication of the patient's diagnostic and management plan will occur with other relevant health care providers.

### 2.23 Certification Completion

Completion of all relevant certificates will occur prior to the patient's discharge from the ED.

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