Worcestershire Acute Hospitals NHS Trust

Emergency Medicine Standard Operating Procedure

WRH Emergency Department – Role of the Emergency Physician In Charge (EPIC)

Written by	
Approved by	
Date of Approval	
Date of next review This is the most current document and is to be used until a revised version is available	

Aim and scope of Standard Operating Procedure

Target Staff Categories

Who

Consultant

EPIC will identify her/himself to the Nurse in Charge (NiC) at the start of their shift and wear arm band.

When

When there is only one consultant on duty then clearly that person is 'EPIC', however it is accepted that she/he will not be able to fulfill the all multiple roles as outlined below, all of the time. Flexibility and adapting to circumstances as they arise will be a priority.

When there are two ED consultants on shift then the role, as outlined below, is to be undertaken and hence the need for the 'EPIC' consultant to be clearly identified.

EPIC Role - when two or more consultants present

- Setting the tone for the shift – on time, concise, supportive.
- Organising handover (08:00hrs, 13:00hrs)
- Staff allocation (accounting for ENPs and any GPs) incl. RAT if appropriate
- Good communication with other consultants on shift; to ensure problems are tackled early and any issues fed back at quick catch-ups.
- Ensuring junior doctors take their breaks (2 for 10hr shift; 1 otherwise)
- Ensuring junior doctors know that you are the 'go to' consultant for advice
- Senior doctor for all admissions to be discussed with.
- Monitoring patient flow – ensuring all patients have a plan, 4hr EAS target, monitoring specialty delays.
- Cannot see the 'next one in the pile' but maybe able to expedite cases / investigations.
- Regular 'quick catch-ups' with NiC (minimum 2hrly, hourly if possible)

<u>Quick Catch-Ups</u>

Purpose:

To ensure EPIC and NiC have a shared vision of and for the shift and safety. Suggested format might be:

S summarise current department situation incl. rapid run down of patient plans

T things that have gone well

O opportunities to improve, feedback for daily brief

P priorities for next shift

Potential Strategies for use by the EPIC

Table 1 Problem solving approaches used by emergency physicians in charge

Heuristic	Definition	Example
Deflecting	Triaging a patient to alternative care	Sending a self-presenting patient to an urgent care centre or a general practitioner
Front loading	Organising investigations for patients early on in their ED stay	Ensuring X-rays are organised early for patients with suspected fractures or CTs for patients with head injuries or suspected renal colic
Placing	Moving patients to a different area, either to improve the appropriateness if care or to free up specific resources	Identifying which patients who have arrived by ambulance can sit in the waiting room, or identifying which patients can go to the observation ward
Plucking	Picking out patients that need a specific intervention to speed up their progress	Early referral to liaison mental health services for appropriate patients
Flooding	Putting a large number of staff in an area to empty an area in advance of a surge	Allocating extra staff to the paediatric area to cope with an expected surge of children after school hours
Targeting	Putting specific resource into an area to help flow	Placing a senior doctor into an area of low acuity to efficiently see lots of patients
Chasing	Chasing investigations and consultations and decisions from inpatient teams. Managing dissent	Clarifying which inpatient team will take over further care
Guiding	Advising staff	Advising junior clinical staff which patients can be sent home safely and which need to be admitted
Juggling	Moving resource around to alleviate bottlenecks	Reallocating a single staff to a resuscitation room case and arranging another staff member to take on their other work

Board Rounds

08:00hrs, 13:00hrs and as necessary; depending on likely impact on departmental productivity. EPIC to determine whether huddles with senior nurse and doctor more appropriate depending on departmental workload, NiC availability etc.

- Handover of any patients if doctors going off duty and to include those referred and not seen by specialties yet.
- Awareness of any sick patients in the department.
- Ensure all patients have plans.
- There is no need for those patients seen by specialty teams to be discussed unless specific concerns.
- Effective handover.
- Allocation of doctors to particular areas / tasks.
- Breaks
- Remind doctors it is their responsibility to keep Patient First up to date and to use the Staff Message system.

Acknowledgements: