**Emergency Department to Pediatrics Consults/SPR Role**

**CanMEDS: Manager, Scholar**

The SPR will take call first call from the Emergency Department and also any internal consults. Outlined are guidelines for the SPR:

1. The residents are informed that if they do receive calls from anywhere else i.e. outside hospitals, outside physicians, outside consultants, healthcare workers, or parents, that those calls should not be accepted and should be directed to the on-call pediatrician.

2. After receiving the call from the Emergency Department, it is the SPRs responsibility to go down to the ED in a timely manner as outlined in the attached flow chart. If the child is ill, the SPR should deal with the situation right away and should inform their attending that there is sick child in the ED and the steps being taken. The senior resident should also be aware that the pediatric emergency physicians can also be called upon to help in such a circumstance. Some tips when receiving calls from the ER:

    a) The SPR is to return the page to ER physician within 5 minutes. When discussing the consult, the SPR should gather at least the following information:

        a. Consult question/reason. (Reason could be "I think he needs admission.")

        b. Patient name, age, location, Short HPI, Stable or not, vitals, any significant PE or lab findings.

        c. If the SPR is not given all this information, they are to ask the ER MD for this information, prior to starting the consult.

3. If the child is stable then it is the SPRs responsibility to ensure that the child is seen in a timely manner as outlined in the attached flow sheet. Please call the JPR to come to the ER with you.

        i. If the child needs admission, disposition plan and bridging orders should be written for the patient within 30 minutes. Bridging orders should include all anticipated monitoring and treatment required for the consulted patient over the next two hours. The full assessment can then be completed. This can start in the emergency room but should not delay the transfer of the child to the ward. Assessments should then be completed on the ward.

ii. If the SPR feels the child does not need admission they should contact their staff right away, who will assist them in discharge planning and collaboration with the ER staff on this.

iii. In instances where urgent patient care prevents the SPR from being able to present to the ER in the timeline described above, the SPR should tell the ER MD that they will be able to come down within x minutes of time, but will be sending the JPR. If both the JPR and SPR are busy, inform the ER MD that one or both residents will be down as soon as possible. The attending physician should also be informed.

4. If at any time there is a backlog in the ED, in that many consultations are building up, or the SPR is busy in another area, there should be no hesitation in contacting the attending pediatrician to ensure that our patients are receiving prompt and quality care in the ED.

5. If the SPR feels that a referral made from the ED is inappropriate, they should contact their attending physician and discuss this with them.

**Eyeballing patients**

Upon arrival in the ER, the SPR should:

1) Assess if the patient is stable or not (reviewing the patient's vitals, brief history/examination).
2) Review the working differential diagnosis and treatment plan thus far.
3) Review bridging orders.
    a. Remember that the bridging orders are brief orders, not full admission orders.
    b. The SPR should also write "Admit-To" orders and any additional orders that are felt to be necessary. These should include an order that "SPR is to be paged when the patient arrives on the ward."

*If possible the above three steps should be done with the JPR.*

4) Determine the proper location for the patient (Step down vs. ward).
5) Check-in with bedside nurse and review orders.
6) The patient should not be moved from the ER during this process.

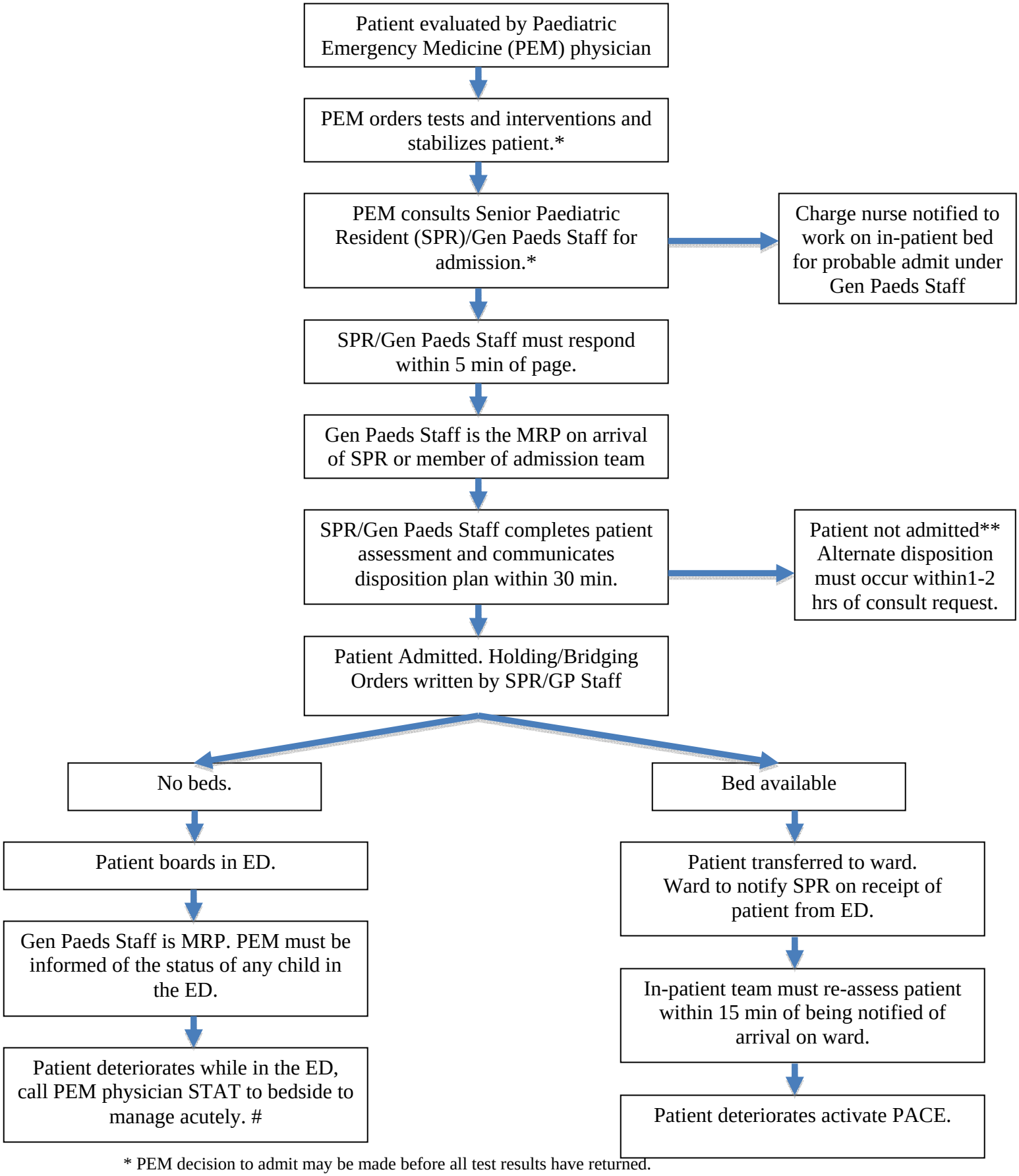
NOTE: Please remember that the time the SPR arrives on the ER is logged. Once the SPR arrives in the ER, the SPR must identify themselves to the bedside nurse and/or the PEM. The patient is taken off the ER MD tracker, and as such they are no longer following the patient.
NOTE: If there is concern regarding the patient's condition, please engage the ER MD. The patient is not to be moved from the ER while this discussion is going on. If necessary, please contact the appropriate consultant attending for assistance.

Reviewing Consults with the On Call Attending:

**CanMEDS: Communication, Collaboration, Professional and Medical Expert**

- The SPR and On Call attending should collaborate at the start of the on call period to review how the team will function through the night.
- The SPR will be first call and will do a brief assessment of the referred patient.
- If the SPR feels a patient does not need an admission they will contact the on-call attending, who will then come in to see the patient and collaborate with the ED physician if they do not feel an admission is warranted.
- If the patient needs admission, the SPR will write brief admitting orders. At which point if there is a bed the patient will go up to the ward where the full assessment and orders will be done.
- The on-call attending is expected to review all the patients seen from 1700-2300 hrs in person, either after each consult or clustered. Not more than 3 admissions will be cohorted at any time.
- All admissions after 2300 hrs will be discussed in detail with the SPR prior to morning handover. In order to facilitate that the SPR will call the attending following a maximum of 3 cohorted patients
- The SPR and attending physician will touch base either in person or by phone at 0600 hrs to review the night. The SPR should call the attending at 0600 hrs. to update the pediatrician on any patients admitted overnight.
- The SPR will be reminded that if at any time they have concerns they should not hesitate to call the on-call pediatrician.

# Paediatric Emergency Patient Flow (inclusive of Consultant Response)




* PEM decision to admit may be made before all test results have returned.
** Decision to not admit must be made and communicated by Gen Paeds Staff who has seen patient and/or discussed case with PEM.
# Request may be made by nursing staff or housestaff.