Cork Emergency Medicine
NCHD Manual, Jan 2015
Welcome

Welcome to the Emergency Medicine (EM) service for Cork City and County. We look forward to seeing you when you start as a Senior House Officer in one of our departments.

You can find a copy of this entire manual on the Cork Emergency Medicine website http://www.EMed.ie. The website is our reference manual, widely used by EM colleagues around the world as a continuously updated tool to support a safe working environment for yourselves and most importantly, our patients.

Please read all the information carefully and email Dr. Jason van der Velde (jason.vandervelde@hse.ie), who is co-ordinating your Continuing Professional Development, to principally confirm that you have read this manual. In this email, please outline your teaching requirements for the next months, and highlight any problem areas you might or might not have.

Yours sincerely,

Dr. Gerard McCarthy	FRCSI FRCSEd(EM) FCEM
Prof. Stephen Cusack	MB BSc(Hons) FRCSI FCEM
Dr. Chris Luke	FRCSEd (EM) FRCPI FCEM
Dr. Gemma Kelleher	MB FRCSI MMedSc(Hons) DMI FFSEM FCEM
Dr. Íomhar O'Sullivan	FCEM FRCSEd (EM) MRCPI MMedSc (Hon)
Dr. Conor Deasy	MB, DIMC, Dip Tox, DCH, FCEM, FACEM, PhD
Dr. Nandini Kandamany	MB, BCh, BAO, MRCPI (Paedicatrics and Child Health).
Dr. Brian O'Riordan	MB, BCh, BAO, MRCPI, FACEM, FCEM

Consultants in Emergency Medicine
Cork University & Mercy University Hospitals

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Ten Commandments of Emergency Medicine

1. Your first duty is to minimise the danger of death or deterioration in your patient's health, to relieve their distress and to arrange for their appropriate disposal. Worry about distress and deterioration, not diagnosis.
2. Be meticulous, legible and logical in your clinical notes. This will help everyone else involved in the patient's care, initially and later. **ALWAYS clearly print your name on the chart**, including the **time** you first see the patient, and the time you discharge or refer the patient onwards.
3. Wash your hands before every patient contact. This is the simplest way of reducing disease transmission.
4. Only undertake investigations in the ED if they are going to alter the immediate management of your patient. You may need to justify your actions (e.g. ordering x-rays or blood tests) to the individual patient (and family), in a clinical governance setting and in a court of law.
5. Be evidence-based, logical and cost-effective in your prescribing. Don't prescribe adverse reactions and unnecessary expense.
6. Follow the WHO recommended "analgesic step ladder" in relieving pain, i.e. (i) Paracetamol, (ii) Ibuprofen, (iii) Codeine-Paracetamol combinations and (iv) Opioids. Only in unusual circumstances should alternative medication be provided e.g. **NEVER** use Pethidine unless discussed with your consultant (see http://www.EMed.ie).
7. Only undertake procedures whose benefit to the patient outweighs the hazard e.g. full cast should not be badly applied when a simple splint might do. And don't give medication intravenously when normal gastrointestinal function exists, unless there are special indications.
8. Get advice or a review whenever in doubt: this means asking senior medical and nursing colleagues and communicating your plan of care to the nurses and your registrar.
9. Arrange follow-up for every patient e.g. by their GP, if no other follow up arranged. The easiest way to reduce error is to ensure that all patients who come to the ED are reviewed medically at least once thereafter.
10. Treat the patient, not the test.

Continuing Professional Development (CPD)

We run a full and varied programme of Continuing Professional Development to enable all of you to achieve your individual College requirements and continued Irish Medical Council registration. What you put in is what you get out. The IMC has become far more particular in scrutinising and recording ongoing CPD. These records are increasingly the first thing that is looked at during any Fitness to Practice or Medical Negligence Enquiry.

1) SHO Induction 2 Weeks 08h15 – 09h45

Daily in first 2 Weeks (except on Induction Days)
Note it is essential to attend Spinal Manual Handling session on Friday the 16th
You are paid to and thus expected to attend ALL activities during the Induction 2 weeks.

2) SHO Induction Day 08h45 – 16h45

Attend on ***either*** Monday the 12th ***or*** Monday 19th Jan 2015, depending on your rota. This full day program is identical, and repeated to allow you to attend when you are not scheduled for duty. It may be necessary for you to attend ½ of one day and ½ of the other, depending on your allocated shifts in the department.

3) Departmental Teaching 08h15 to 09h45 Thursdays
& Clinical Risk Meeting 08h15 to 09h45 Last Thursday of the Month

Departmental teaching takes place in the ED Tutorial Room from 08h15 to 09h45. Failure to attend at least 60% of the scheduled teaching sessions may make it impossible to certify you as having satisfactorily completed your six months in Emergency Medicine. You may legitimately record teaching time as time working on your timesheets.
You are expected to attend a MINIMUM of 60% of Thursday Morning Teaching

4) **MCEM / FCEM OSCE Practice & Simulation** 08h15 – 09h00 on Monday Mornings

Multidisciplinary Applied Simulation runs most Monday mornings for staff on the floor, if spare Resuscitation Bay or procedure room available. All welcome to drop in. In the run up to MCEM/FCEM OSCES, further sessions will be arranged around individual candidates' shifts; all are welcome.

5) EIR / Journal Club

07h00 Thursdays in the Radiology Tutorial Room
Alternating Thursday morning is either Journal Club our EIR, our multidisciplinary research group meetings. These are usually very well attended and you'll be asked to review a paper at least once in 6 months.

6) Audit

Audit is part of the requirement for doctors on the General and Supervised registries. Please discuss ideas and research questions with your mentors early on in the 6 months in order to fulfil this requirement. There is ongoing research in the department. If you would like to tackle a bigger research project again, please discuss with your mentor.

CPD Attendance Certificate

CONTINUING PROFESSIONAL DEVELOPMENT

To be maintained by NCHD and brought to Teaching Coordinator for verification

Name _____
IMC # _____
Email _____
College _____
Hospital _____

Date	CPD Description	Venue	CPD credit	Organised by	Organisers Signature
	EM Induction Day	CUMH	8	Internal Teaching	

Total CPD Points

_____

Teaching Coordinator: Dr. Jason van der Velde
Clinical Lead MEDICO CORK
Emergency Department
Cork University Hospital
Jason.vandervelde@hse.ie

Reference

Cork Division of Emergency Medicine
Professional Reference

Name of applicant: _____

Candidate for: _____

	Highest order Top 5%	First rate Top 20%	Good	Satisfactory	Comments
Medical Knowledge					
Clinical performance					
Organisation Note-keeping, Investigations					
Communication with patients					
Relationships with colleagues					
Academic potential					
Attendance at Teaching					

General comments regarding career advice/prospects:
_____
_____

Signed: _____ Date: _____

Before Starting your 1st Day

1. Visit medical manpower to sign and complete all necessary paperwork. Both hospitals will require an identification badge, which acts as your swipe access to the Emergency Department. This is the single most important thing to have in your hand BEFORE you start your first day.
    a. NOTE IN CUH, to obtain an ID card, you need to take your signed staff form (the one you get from Medical Manpower) to the Security Office which is on the 1st floor, near the staff canteen. It is best to do this on the very 1st Monday morning straight after your meeting with Prof. Cusack. You can only get your photograph done and ID cards issued on Tuesdays and as such, will get individually telephoned to facilitate this.

Medical Manpower Contacts:

- CUH	Amy Quinlan	amy.quinlan@hse.ie	021 4921318
- MUH	Fiona Lynch	flynch@muh.ie	021 4935548

2. You must complete the attached confidential medical staffing record and return it to Kathleen Foley, Dr. McCarthy's secretary, if you are working in CUH or Bernice O'Regan, Dr. Luke's secretary, if you are working in MUH.

3. Visit your department and introduce yourself !

4. Do access the intranet page that leads to the handbook for the citywide division of emergency medicine. http://www.EMed.ie

5. Dress Code. We expect all NCHDs to wear scrubs and suitable footwear. Kathleen Foley will email CUH you about scrubs. In MUH, ask the porters for help obtaining scrubs.

6. Arrange for necessary computer access codes. See specific section in this manual.

7. Empower yourselves with the "Ground Rules" for emergency admissions and referrals. If in doubt, always ask. This is probably the most demanding part of your job. Learn quickly to be an effective communicator. The Communication tool "ISBAR" is attached as a potentially helpful guide. It has formally been introduced into clinical care as part of the National Early Warning Score Project. Please see http://www.hse.ie/go/nationalearlywarningscore

8. Familiarise yourself with the Clinic Proforma that must be filled out for all referrals to the fracture clinic, plaster room, physiotherapists and soft tissue services. Again, everything is downloadable from http://www.EMed.ie

Confidential Medical Staffing Record

These details are required of all doctors working in the Emergency Department to facilitate medico-legal record keeping and management. Please print the details and hand to Kathleen Foley in CUH or Bernice O'Regan in MUH.

Name: _____

Photograph Extremely Important

Current Cork address: _____
_____

Date of Birth:

Date	Month	Year

Capacity in which employed: _____

Overseas or forwarding address: _____
_____

Tel. No.: Current/home_____ Forwarding_____ Mobile_____ E-mail: _____

Irish Medical Council Registration details:

Number_____ Type_____ Period valid_____

Medical Indemnity details: MDU ☐ MPS ☐ Other (specify) ☐

Number_____ Type_____ Period valid_____

Dates worked in Emergency Department:

From: _____ To: _____

Dates worked in Emergency Department:

From: _____ To: _____

Specimen signature:_____

Please provide a copy of CV

ROTA

Everybody is entitled to three weeks annual leave. Annual leave should be taken in a logical manner and in acknowledgement of the fact that a service must be provided. Therefore, working in a twenty-four hour per day 365-day per year job in the Emergency Department, not everyone can take leave at the same time. Study leave is ultimately at the discretion of the Consultant/employer and must be taken for approved exams, courses, etc.

Sick leave must be notified by phone to the Registrar or Consultant on duty directly. Certificates must be provided as outlined in your contract.

The rota is made up 6 months in advance. Significant changes, once this rota starts, are nearly impossible to implement, given that your change will affect a number of your colleagues. It is in your best interest to contact the person responsible for you rota NOW, and tell them about your plans for the next 6 months! All leave applications are a 3-step process, with no exceptions:

1) Rota coordinator ensures your request can be accommodated on the rota and signs an "Annual Leave Form." These are available from Medical Manpower.
2) You then take this request to Medical Manpower for verification against previous leave.
3) This form must THEN be taken to Dr. Chris Luke in the Mercy or Dr. Gemma Kelleher in CUH for final approval and RETURNED to Medical Manpower.

Radiology

- X-rays ordered must be done by the physician with their correct log-in. Paper requests to be used by locum doctors and any other doctor who is waiting for a password for the iCM electronic requesting system.

- Treat the patient, not the investigation: the diagnosis of many important conditions depends mainly on clinical findings (e.g. fractured base of skull, scaphoid fracture, Salter-Harris Type I injuries to the paediatric epiphysis).

Comment [RO1]: I've taken out pulled elbow because they shouldn't be x-rayed at all.

- **Never look at an x-ray without seeing the patient first**. A clear understanding of the mechanism of injury may prompt the discovery of a second injury (typical "paired injuries" include a cervical spinal injury in the significantly head injured patient, fracture of the radial head with Colles' fracture, a fracture of the styloid process of the 5th metatarsal and an ankle fracture, a fractured calcaneus and fractured thoraco-lumbar junction).

- Only request a radiograph when necessary (e.g. x-rays are rarely required in cases of a fractured coccyx, fractured nose, head injury undergoing CT scanning or isolated rib fracture). Clinical justification of radiation exposure is a legal requirement (SI478).

- Look at every x-ray, the whole x-ray and the x-ray as a whole: remember the ABC's of x-ray interpretation (A = Adequacy and Alignment; B = Bone; C = Cartilage and joints; S = Soft tissues).

- Re-examine the patient when there is an incongruity between the x-ray and the expected findings. If an x-ray does not look quite right, ask and listen: there probably is something wrong.

- Apply the Rule of Twos: i.e. get two views (at right angle to each other), include two joints (above and below the injury site), x-ray two sides (when necessary, e.g. with subtle epiphyseal injuries in children), on two occasions, (e.g. for stress or scaphoid fractures), and where possible get two x-rays (reference and abnormal).

- Take x-rays before and after procedures e.g. removal of foreign bodies or reduction of dislocations and fractures.

- The evacuated vacuum mattresses have to be inflated for plain film (ie. Air let in) – if a patient is not in a collar and needs one, this must be applied in advance of going to xray for cervical spine imaging. Patients who are requiring C Spine X ray should go to Xray with a collar on – if you have cleared the C Spine using Nexus or Canadian C Spine rules, you do not need an xray C SPINE.

- Appropriate patients destined for AMAU from ED to have x-rays first before journeying to AMAU. The latter said, DO NOT EVER ORDER AN INVESTIGATION THAT YOU DO NOT REQUIRE FOR YOUR DECISION MAKING OR ARE NOT GOING TO PERSONALLY FOLLOW UP! You are NOT being unhelpful to your colleagues! It is a Medical Council Regulation that if you order a test, YOU PERSONALLY are responsible for following up

its results. Plain and simple, it is inappropriate for a specialty to "not accept a patient if test x is not done first." **Don't order USS for GP follow-up !**

CUH

ICM

This is your platform for ordering all your patient investigations and getting results. Sharing of login details is strictly prohibited, as each investigation request is date stamped with your IMC number.

Go to any of the computer terminals in the department and navigate to the CUH Staff Directory, which is a link off the desktop, or else type http://100.24.9.212 into the web browser.

1) Go to CUH Forms and Click "Application Forms"
2) In the Application Forms for CUH page click "ICM User Account Request"
3) Click the link on the bottom of the next page called "Create A Profile"
4) Fill this form in and click "Create Profile" button when finished
5) You will be directed to another form, ensure this is properly filled in and that you tick the boxes for access to Citrix 4.5 and Clinical Manager are both ticked. Then agree to policy statement.

PACS

This is the radiology-viewing platform.
Go to main Radiology Department front desk on the ground floor. Fill out Application form and put into box beside it. The PACS Office will phone you with your login details. For further support contact them on **20284**.

MUH

Laboratory requests are paper based. Please ask the nursing staff to show you how to access results.

PACS

Please contact PACS at extension 5451 to set up a 20 minute appointment. They will give you your login and teach you how to use the system. It would be helpful to arrange this visit with one or more of your new colleagues, to cut down on workload for the PACS radiographer.

IV Cannulation

Please remember the following with peripheral venous cannulation (PVC):

- Up to 80% of inpatients are cannulated
- Cannulation has complications, particularly sepsis, phlebitis and septicaemia
- In the past, a significant proportion of cannulae inserted in the ED were never used
- Please THINK before inserting a potentially harmful cannula
- Blood sampling is not an appropriate indication for the insertion of a PVC
- Avoid insertion sites over joints (particularly the antecubital area)
- Start distally
- Use the smallest gauge practical needle unless clinically indicated
- Always use an extension set to prevent mechanical phlebitis
- Document details of cannulation

on front of ED patient notes

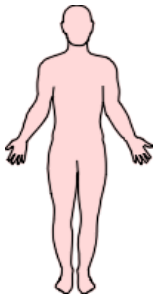
- Full aseptic, no touch technique

The rules are:

- Don't put them in
- Get them out
- Look after them properly
- SCRUB THE HUB EVERY TIME

1 Peripheral Cannula Insertion Record

Please indicate insertion site:



Right Left

Date:
Ward:
Size:
Reason for insertion:

Inserted by (print):

Daily Inspection (Sig.):
24 hours:

48 Hours:

72 Hours:

Peripheral Cannula Removal Record
Date removed:
Reason for removal:
Removed by (Sig.):

It is imperative that the hub of the MicroCLAVE needle free connector on peripheral and central lines is swabbed with 70% alcohol prior to each use.
In order to prevent contamination, evidence supports scrubbing the hub using time and friction (15 seconds) with a 70% alcohol swab each time a line is accessed (Kaler et al 2007).

Ground Rules

Daily Routine

08h00 Morning Board Round

Entire Emergency Department team assembles in front of Nursing Station to handover and discuss all patients in the department from the night, discuss any issues arising from the night before, assign roles for the day and impart any important departmental information.

16h00 Board Round

Entire team assembles to discuss any issues currently in the department and appraise On-Call Consultant and NCHD staff coming on shift of patients in the department.

22h00 Board Round

Entire Emergency Department team assembles in front of Nursing Station to handover and discuss all patients in the department from the day, discuss any issues arising from the day before, assign roles for the night and impart any important departmental information.

Seeing Patients

The nursing staff will triage patients according to acuity. It is your responsibility to see the next patient to be seen in your assigned area. When you pick up a card to see a patient, your first responsibility is to **write your name on the card, the time you are seeing the patient and click "seen by {your name}" on the computer system.** This is vitally important to keep electronically on top of waiting times and departmental flow.

Referring or Discharging of Patients
CUH Emergency Department operates a strict Registrar to Registrar or alternatively Consultant to Consultant referral policy. All SHOs must discuss any patient for admission with the Registrar assigned to them during the board round. By the same token, SHOs are asked to discuss all discharges with a Registrar or Consultant first.

Registrars, on either discharging or referring a patient, please write the time you are discharging or referring the patient. Then, very clearly record your follow-up or referral plan eg. "Discharge home @ 12h00 for follow up GP PRN" or "Referred to medicine @ 12h00"

CUH Emergency Admissions

Interdisciplinary / Departmental Referral Policy

All emergency medical/paediatric/surgical referrals should be admitted to the appropriate ward of the relevant medical/paediatric/surgical service, either directly or via the Emergency Department, as rapidly and efficiently as possible.

If a patient presents to the Emergency Department and is deemed to warrant admission to the medical/paediatric/surgical on-call service then contact with and referral to the appropriate on-call team should occur without delay.

If there is a difference of opinion between the EM Registrar and the on-call or AMU Medical Registrar as to whether a patient being referred for general medical admission is 'medical' or not, ***the On-Call Medical Registrar Must STILL See That Patient*** in the Emergency Department before determining that the patient should be admitted under the care of a medical specialty or suitable for discharge. [Note: It is current policy as per the Division of Internal Medicine's SOP (Standard Operating Procedure) that all medical patients presenting to ED MUST be seen by the duty Medical Registrar].

Medical patients admitted from the Emergency Department shall be directed by the AMU or On-Call Team to the appropriate Specialty service, as per existing protocols. Transfer of care from an AUMT service must include contact and agreement with the other medical specialty at consultant level confirming the transfer of care.

Any child requiring admission needs to be discussed with the Paediatric Registrar on-call. Equally, it is inappropriate for children to be discharged from the ED by an SHO, therefore all cases should be discussed with the Registrar in EM before discharge. ***All paediatric patients received with a GP letter addressed to "Paediatrics on-call" should be discussed with Paediatrics prior to discharge.*** Patients admitted from the ED to the Paediatric Unit shall be admitted under the care of the consultant paediatrician on-call, with the exception of certain children e.g. minor head injury, who are admitted under the EM service. Transfer of care of that admission to another consultant will only take place when there is contact and agreement at consultant level that confirms such a transfer of care.

If there is a difference of opinion between the EM Registrar and the on-call Surgical Registar as to whether a patient being referred for surgical admission is 'surgical' or not, ***the on-call Surgical Registrar MUST STILL see that patient*** in the Emergency Department before determining that the patient is 'surgical' or otherwise. Patients admitted from the Emergency Department to the on-call general surgical team shall be admitted under the care of the general surgical consultant on-call. Transfer of care of that admission to another consultant will only take place when there is contact and agreement at consultant level that confirms such a transfer of care.

It is the responsibility of in-patient teams to look after their referred patients in the emergency department. It is not your responsibility to order further investigations, chart fluids/drugs etc. The latter is vitally important from a medic-legal perspective. If a patient

requires urgent resuscitation or emergency care due to acute deterioration, we will of course oblige our colleagues and their patient in tending to the patient's immediate needs.

ISBAR

Identify

Hello my name is ……
I am the Emergency Medicine SHO
Who am I speaking to?
(It is important to record the persons name and position in the notes)

I am calling you about ……
(Give patients full name, DOB and location in the department.)

Situation

Cleary and VERY simply state what is going on with the patient in one clear sentence i.e. "Sell" the patient.
If you can't think of one sentence, you are unlikely to "sell" your patient!

Background

State clearly and simply the relevant Clinical Background/History/Mechanism of Injury/Context.

Assessment

State what YOU believe the problem is. Communicate RELEVANT clinical findings and RELEVANT investigation results.

Recommendation

Think what your expectations are and communicate them clearly e.g. "I would like you to assess the patient and give your opinion please, he may need to be admitted" or "I believe this patient needs to be admitted"

Assist your colleague by giving a time frame e.g. "I believe this patient requires urgent …." or "This patient is quite stable and comfortable and can wait until you are finished your clinic."

Out Patient Referral forms

The below referral form must be completed or patients will be bounced back to the referring ED. To print it, please see the http://www.emed.ie clinics or administration pages or search for referral.

CORK UNIVERSITY HOSPITAL

Emergency Department

Referral Request to: /Fracture Clinic / Review Clinic / Dressing Clinic / Soft Tissue Clinic

Patient Label

Date of Referral: / /

Date of Injury: / / Date of (Suspected) Diagnosis: / /

Details of Incident:

X-ray / Imaging Results:

(Suspected) Diagnosis:

Treatment to Date:

Additional Information:

Referring Doctor (BLOCK CAPITALS)

Patient's General Practitioner:
Address of GP:

FOR OFFICE USE ONLY:

Date and Time of Appointment:

Signed:
N.B. PATIENT WILL NOT BE REVIEWED WITHOUT THE RELEVANT DOCUMENTATION AND X-RAYS.

Facial & Soft Tissue Clinic

The Facial & Soft Tissue Clinic is a clinic run each morning by the plastic surgical service at CUH. They will see facial trauma and complex lacerations that are deemed to require exploration or other plastic surgical input. They also see patients with facial fractures, other than mandibular fractures. Access to the clinic is by contacting the SHO in Plastic Surgery on call in CUH.

It is often appropriate in children with significant lacerations that a general anaesthetic be administered, to facilitate closure in a less stressful manner for the child. Some such cases may be suitable for management in the ED under procedural sedation. Such cases should be discussed with the Consultant in Emergency Medicine or Plastic Surgical Registrar on call.

Maxilla-Facial services are available through the DENTAL HOSPITAL, which is located on the grounds of CUH.

Review Clinics

Review clinics are run by the Consultants in Emergency Medicine. Any member of the medical staff in the Emergency Department may refer patients to this clinic. However, please discuss this with the registrar or consultant first.

Please note that the review clinics are ***most definitely not*** a substitute for a GP surgery, another hospital outpatient clinic or a proper diagnosis at first presentation. Referral onwards to this clinic will not result in a patient "jumping the waiting list" for referral to another specialty unless there is a genuine urgent development in their condition.

Review Clinics ARE NOT for second opinions. These should be sought on the day of initial presentation i.e. ask your Registrar or Consultant!

GP Letters

Poor communication is repeatedly cited as a significant cause of adverse incidents in patient care. In an ideal environment, all patient attendances would result in a letter going to the GP. Whilst it is acknowledged that this may not always happen, there are certain categories of patients who must have a GP letter upon discharge.

Policy for GP letters in the Emergency Department

A standard GP letter for patients discharged after assessment from the department is in a duplicate book in CUH. One copy is sent to the General Practitioner and the other is filed with the Emergency Department chart for departmental record.

In MUH ED, there is a computerised letter template. Print and sign 2 copies, one to the GP, one into the notes.

The following patients discharged from the Emergency Department must have General Practitioner letters forwarded to their current GPs:

- All patients discharged from the ED that have been referred for assessment by a GP.
- All prisoners that attend the Emergency Department escorted by prison officers must have a letter forwarded to the Medical Officer for that prison.
- All patients under the age of eighteen years and over the age of 65 years
- All homeless patients – This is a statutory requirement.

If a competent patient does not wish to inform their GP of their attendance no letter should be sent. However, the reason for this should be explored.

ED Physiotherapy

The Physiotherapy ED review clinic is held in the ED in the decontamination room for CUH and in the Physiotherapy Department in MUH. During clinic hours they carry a phone (ext 20221). In MUH they can be reached during clinic hours by telephone or out of hours.

Clinic Hours are Monday to Friday, 9am-12.30pm
During this time the Physiotherapist sees patients with scheduled physiotherapy appointments, and patients from the ED review clinic. Physiotherapists will endeavour to also see any patients presenting to the minor injury area in ED during clinic times. If they are unable to see them on the day, an appointment can be arranged by reception in both CUH and MUH within a few days.

Indications for referral to physiotherapy
Early soft tissue injuries e.g. knee and ankle sprain, neck sprain, acute low back pain, muscle injuries, day 2-5 post-injury for early movement and advice. Send the patient to reception with the blue physiotherapy referral form (please sign and date).

Advice leaflets
There are patient advice leaflets available for the more common soft tissue injuries: knee, ankle, wrist and hand, acute back pain, acute neck pain. These are kept in the minor injury area and some are on http://www.EMed.ie. There is also a separate advice leaflet in the application of ice and principles of RICE and MICE. This is a very useful leaflet for this patient group but a previous audit showed that it was rarely used.

The advice leaflets are designed to provide information to the patient on how they can best self manage their soft tissue injury for the first week after the injury. For soft tissue injury patients it is very useful for them to have this written advice on the importance of early movement, use of ice, etc. We need to increase the use of soft tissue injury advice leaflets.

Following grade 1-2 ankle sprain the patient should be advised to start partial weight bearing and heel to toe gait with crutches by day 1- 3 post injury. They should start wearing a shoe on the affected ankle (get a larger size shoe if necessary). Measuring for elbow crutches, the handle should reach the wrist crease. Always give 2 elbow crutches. Crutches are single patient use only.

Useful Resources

Your Consultants, Registrars and Nurses!

TOXBASE Poisons Information Database

Toxbase is an online clinical toxicology database, run by the UK National Poisons Information Service on behalf of the UK and Irish poisons information centres. It is an excellent up-to-date resource for information on acute poisoning. Toxbase is accessible to registered users at: http://www.toxbase.org or via http://www.EMed.ie

The Emergency Department at Cork University and Mercy University Hospitals are registered with this service. Each department has its own username and password for access to the database – these are available within each department.

Toxbase contains information on the toxicity, features and management for thousands of substances. A factsheet containing a summary for each product should be printed for inclusion in the individual patient's notes. Please **do not print** off information to keep for reference "later", as the site is regularly updated and printouts of information may soon become outdated.

Useful Web Sites

http://www.EMed.ie

This should be your first and last point of web reference as all contents is internally scrutinised. If you can't find the answer here, please ask and let Dr. Íomhar O'Sullivan know, so it may be included for future reference.

http://www.rch.org.au/clinicalguide and http://olchcnet.hse.ie
These paediatric guideline sites (from the Royal Children's Hospital, Melbourne and Our Lady's Children's Hospital, Crumlin respectively) are an excellent resource.

Q-Pulse

Most of the hospital policies are now available on this computer programme, accessed via any terminal.
Username: emd
Password: 1111