

Wilson Memorial General Hospital (WMGH) Locum Orientation

Marathon Locum Orientation/Locum Roles

Orientation for Locum Physicians at Wilson Memorial General Hospital (WMGH)

BACKGROUND HOSPITAL INFORMATION:

Communities served: Marathon, First Nations communities of Pic River and Pic Mobert and occasionally patients from White River.

Beds: 8 acute care beds plus an obstetrics LDRP room
1 observation room
12 chronic care beds.

Nursing staff: 2 RN's and 1-2 RPN's on each 12 hour shift (7 to 7). Typically the RPN's provide service on the chronic care patient ward. The RN's work in acute care with one RN per shift assigned to the ward, and one to the ER. The RN's do move between the two acute care areas of the hospital to assist one another with their respective workloads.

Physiotherapy services: 7:30am and 3:30pm Monday to Friday.

Lab: 7:30 am to 5:00 pm Monday to Friday with lab staff available on call outside of those hours. Lab outpatient hours are from 8:30am to 4:00pm.

Diagnostic Imaging: 8 am to 4 pm with staff available for on call outside of those hours. Only one of the technicians has been trained to do ultrasound so that service is not consistently available on-call. Dr. Barb Zelek can do some limited obstetrical ultrasound assessments if the ultrasound technician is not available. Portable U/S available for physicians to use in ER. Dr. Zelek has also been certified in Emergency Department Targeted Ultrasound.

Call ins:

At our facility the lab and diagnostic imaging staff are on call after their regular hours are complete (as above). Each call-in costs the hospital 4 hours of regular time service. Where it is determined that waiting to obtain lab or x-ray services until the regular hours of operation is unlikely to impact care, our tendency as physicians is to wait. For example, one might choose to splint a probable Boxer's fracture for a number of hours rather than seek an immediate x-ray in a case where it is possible to do so.

ON CALL SERVICES:

Physician weekday on call shifts:

full shift (24 hours): 8:00am to 08:00am the following day

split shift (12 hour blocks): 8:00-20:00 and 20:00-08:00

On call physicians are:

- on call for the hospital during the entire call shift. The non-on-call MRPs cover their own stable inpatients to 5 pm, including chronic care patients.
- expected to cover requests from clinic docs for assessment for admission, and urgent ER procedures and investigations.

- expected to remain within a 10 minute response time from the facility
- expected to be within easy reach of a telephone

Pagers and cell phones are supplied by the clinic. The nurses have been instructed to page the physician for all urgent or stat calls, in case the cell phone is out of range. There may also occasionally be after hours calls from THAS (telephone health advisory system) to discuss patients enrolled with the Marathon Family Health Team.

Elective booked procedures: (e.g. Toenail resections, joint injections, cast removals etc.) are typically done in the morning in ER. You may book your own procedures generated from clinic on your call day; if it should not wait, (eg I+D), send to doc on call.

If possible avoid doing elective procedures during the hours of 17:15 -19:30 (RN's dinner and shift handover).

Triage: The people in the community are encouraged to use the emergency department for urgent and emergent care problems. When the RN relays a history it is reasonable for the physician to manage the patient by providing the RN with instructions for the patient regarding care and follow-up e.g. an 8 year old presenting with ear pain and no fever may be instructed to try Tylenol and/or Advil for 24-48 hours and follow up at the clinic if symptoms persist.

It is not necessary that the physician on call see all of the patients presenting to the ER. However, we do try to provide as supportive an environment for our staff as is reasonable, so if the RN asks specifically that the physician see the patient, the physician is strongly encouraged to do so.

At the start of an ER shift, there is a standing folder by the doctor's computer with ER charts deferred by the RN as CTAS 5 from the night before. These require a quick review, and signoff by the ER doc coming on shift.

Handover:

- **Patients deferred out of one's own call day** (eg. Someone presenting at 2am with ankle pain asked to return at 9 am the next day) may be seen by the deferring physician OR handed over to the next call day physician with clear verbal handover. We usually have a handover phone call, if necessary, at the end of each call shift to relay information on acute inpatients and outpatients and anyone in the process of being worked up.
- **Patients admitted by the on call physician** are transferred to their usual family doctor the next morning (8 am). Log into the clinic EMR via remote desktop in the doctor's lounge and check the patient's demographics section to find the patient's usual doctor (if it is blank, they have no family doctor.) **If they do not have a doctor or their doctor is away, the admitting doctor continues to follow these patients to discharge.**

On Monday morning, the outgoing Sunday on call doc should do the 8 am handover for any patients admitted over the weekend. Locums may also get an 8 am phone call when not on call, to pick up a new inpatient who is the patient of the doc for whom the locum is covering paperwork in clinic.

If the inpatient is not discharged at the end of the locum period, hand over inpatients to:

- another doctor who knows the case, OR
- the doc on call for the day of the locum's departure.

If, during the locum, one locum gets more than 3 inpatients assigned to them at a time, this can be redistributed via corridor conversations to keep the workload manageable.

Backup: A specific local physician will be assigned as the back up on days that a locum is on call. Please call this person first for any questions you may have. Our local practice is to offer one another assistance when requested. The same is expected of the locum when not on call: that they would come urgently if possible, if called to assist in the ER. If backup assistance is needed when on call use the systems below:

- In **critical situations** ask the ward clerk or ER nurse to check the sign out board at the nurse's station to determine who might be available to come and assist.
- In **non-critical situations** review the posted schedule and determine which local doctor is least busy at that time, and therefore most able to help.
- There is always one physician on call for obstetrics when the program is open. The "Obs doc" will be available as last resort for any Emergency backup requirements, unless that doctor makes specific arrangements to have his/her responsibilities covered by another physician. Memos will be posted if the obs program is closed for any reason.

Occasionally a physician is required to travel with land or air ambulance to transfer a patient to Thunder Bay. Usually this is the role of the on call physician, and that physician has an obligation to arrange for on call coverage via the backup system prior to going on the transfer.

Ventilator: We have one vent that can provide excellent bipap/cpap intervention if needed. There is no RT and no nursing pool available for staffing the vent beyond several hours so it is used only:

- as an option for ER to support a patient while awaiting transfer or for a short trial of therapy
- for palliative care patients, to gain time before death while awaiting the arrival of a loved one.

Disaster: If there are a large or overwhelming number of casualties in the Emergency department, the physician on call may call a "Code Green", or disaster. If the locum physician is on call, he/she should immediately call one of the local colleagues and then follow the instructions as per "Code Green" policy in the Policy Binder (see below).

Obstetrics: Locums are not expected to provide obstetrical services. However, we have a policy that the on call physician may function as the "baby doc" at a delivery. Locums are expected to:

- have NRP certification
- familiarize themselves with the obstetrics room and neonatal resuscitation cart at the start of their time here.
- assess pre-term pregnant patients presenting to hospital (less than 37 weeks), for these will require transfer if delivery is a possibility.
- call in the obstetrical physician if it is felt that a pre-term delivery is imminent/possible.

Any patient presenting to the hospital who is 37 weeks gestational age or greater is usually considered the responsibility of the obstetrics physician on call that week. The RNs will usually call in that physician themselves.

Inpatients:

- **Admitted patients:** The MD on call will be responsible for all inpatients after 17:00. The on call physician can expect to receive a handover about any inpatients that they anticipate may develop problems through the night. If this has not happened for a particular patient and the on call physician is called, if they feel it would be helpful, they can consider having the hospital contact the attending physician
- **On weekends, the on-call physician is expected to round on all active inpatients. There should be a weekend transfer note on the chart to facilitate provision of care.** The note should be explicit regarding a care plan including anticipated problems or issues.
- **On weekdays,** the locum is expected to round on their own inpatients prior to the start of the clinic day, with the goal of discharging patients eligible for discharge by 11am.
- **ER hold:** An on-call physician may choose keep a patient in ER for observation for a period of time after initial assessment. As a general rule, this will be considered an ER hold if the duration of stay is less than 6 hours. If more than 6 hours, it then generally becomes an admission and an admitting Hx and PE, plus admitting orders must be completed. Exceptions for extending ER hold would be situations where a patient is waiting for test results but is not being actively managed (e.g. atypical chest pain awaiting the 6-hour troponin result to rule out ACS).

Transfers:

Thunder Bay Regional Health Sciences Centre (TBRHSC) is our regional referral center. To discuss a sick patient with a specialist call TBRHSC at **1-807-684-6001 or -6000 x0** and that service will connect with the specialist requested. For critically ill patients, plus pts who may not be critical but will certainly require transfer, (as well as in the case where you have contacted the specialist for advice, and transfer is recommended but there are no available beds in Thunder Bay), "Criticall" can be contacted and they will seek the nearest available bed and specialist appropriate to the case. The number for "Criticall" is posted on each of the telephones in ER and at the nurse's station.

Medical Records:

At the beginning of your stay you will be:

- provided with a key to the medical records department
- requested to provide an example of your signature and initials in medical records
- provided with a package of ER medical directives to sign, which allow the ER RN to initiate treatment before your arrival to the ER. Eg, chest pain, anaphylaxis.

It is expected that **prior to completion of their locum all physicians will:**

- sign off all of their lab work, x-ray reports and charts
- stop in at health records and ensure that any outstanding charting is completed

There is a 'locum' slot in the medical records department that you can check after hours, if needed.

The discharging physician will complete the discharge summary on any patients for whom they have cared. The exception to this would be a patient cared for by their family doctor during the week and

then discharged on a Saturday by the on call physician. The attending physician would then complete the discharge.

All medical record entries must note the date and time.

Policy Binders:

- *Hospital policies pertaining to nursing care:* located at the nursing station
- *Policies pertaining to medical care:* located in each of the ER rooms and in the physicians' office.

ER order sets/admissions:

There are several order sets/treatment protocols available via endpoint. You will have received login information. Please use these for all admissions.

Formulary:

There is a hospital formulary binder that outlines all of the medications that are kept in stock in the hospital. There are a number of non-formulary medications that may also be available, and you can check with the RN if you have questions about a particular medication. Non formulary medications can be ordered from the local pharmacy in town using a prescription *for hospital use*

Mask Fitting:

If you have never been fit in another facility for a mask for the prevention of FRI (Febrile Respiratory Illness), then please speak with the Director of Nursing regarding having a mask fitting scheduled. Your mask should stay in the facility for your use in the Emergency Department or on the ward.

Feedback:

If you have any feedback regarding your work at Wilson Memorial General Hospital, please feel free to contact the Chief of Staff, Dr. Sarah Newbery. If you have feedback regarding the conduct of staff at our facility, it would be appreciated if you could put that feedback in writing to Mrs. Janet Gobeil, Director of Nursing Services, and CC it to the Chief of Staff to follow up. (See email addresses below.) **Thank you** for being willing to provide service to our facility.

Useful Phone Numbers:

Hospital: 229-1740 Switchboard Ext:0; RN station Ext: 229 or 230; ER desk Ext: 317

MFHT Clinic doctor's line: 229-2068

Pharmacy doctor's line: 229-2209

Health Unit: 229-1820

Physician Recruiter (Brett): 229-1541 ext 232 or 228-0405 (cell)

Useful Email addresses:

Dr. Sarah Newbery snewbery@mfht.org

Janet Gobeil jgobeil@wmgh.net

Brett Redden bredde@mfht.org

