

**ER Rotation Orientation:**

1) Schedule
   - Available on the website through the On-call intranet heading; [http://www.brownbears.com/freecal/student](http://www.brownbears.com/freecal/student)
   - Comprised of 10 shifts (4 day, 4 second, 2 w/e) in 14 days. Rotation templates vary with the number of students on a rotation; PLEASE see this template [here](#).
   - The second shift student is on-call overnight at the discretion of the overnight doctor
     1. Should you be here all night and very tired, please communicate that; the schedule is flexible
   - When on the day schedule you are welcome to join ECC doctors during walk through rounds (7:30a & 5:30p) if your cases’ treatments & SOAPs completed.

2) Inpatient ECC Cases
   - **Patient Responsibility:**
     1. **During the week,** the daytime student is responsible for inpatients on the ECC Service
        a) **Mon-Fri am:** Cases that remain on ECC are responsibility of the daytime student. Check the transfer website ([http://uwveterinarycare.wisc.edu/transfers/](http://uwveterinarycare.wisc.edu/transfers/)) & communicate with each other by email/page about inpatients.
           o The 7:30a-5:30p student’s responsibilities include Tx orders & a charge sheet, SOAP, 8am treatments, any Rx’s / requests (eg- rads, labs); these are expected to be done by 8 am. Each inpatient will require 30-45 minutes.
           Plan accordingly (# transfers/suggested arrival time): 1 transfer/6:45 am, 2 transfers/6:15 am, 3 transfers/5:45 am
           New ER receiving begins at 7:30 am for the daytime student; plan accordingly.
        b) **Certain weekdays without a day student will require the student from the prior day to provide 8 am treatments.** See available template [here](#).
     2. **On Weekends:** the student involved with patient admission to the hospital is responsible for that patient through the weekend. Round w/ the doctor on the case before leaving for the day.
        i.e., - you admit a patient on Fri, you’re responsible for 8am treatment orders/SOAP/client update & visit remainder of the weekend
        a) Exceptions are surgical cases that are taken over by the operative team. Cases that are critically ill often stay with ECC after surgery; communicate w/ the doctors for specific case clarification.
        b) Check the transfer website for new cases. Newly admitted cases w/o a student the night prior are the responsibility of the day student.

3) ER Cases
   - Actively sign up / volunteer for new ER cases. You can write your name on the grease board outside ER & let the techs know (they may edit the paging list).
   - Our expectation is ER students see 3-5 ER cases / shift. You may also have 2-3 CCU inpatients as well.
   - Do your best, within reason, to see as many cases as you can.

4) Paper work
   - It is expected that every case has a fax sent to the client’s primary DVM w/in 24 hours or sooner. Options are
     1. Discharge report for out-patients,
     2. ER Transfer form for cases that stay (even if Dr Bach saw it & is keeping the case),
     3. Euthanasia form
   - If the client’s primary veterinarian is not know, ask & try to obtain the information.
• Please avoid the phrase “referring veterinarian” in these documents; instead use the doctors name ("Dr. Dowling") or the clinic’s name ("All things great & small Vet Hospital")

5) Check list
• Please work proactively on your check list items. Faculty will work with you on ~1/3, interns & residents on ~1/3, and technicians on ~1/3.

6) Supplemental Educational Material
• Reading material / articles are available in the black 3 ring binder labeled ER Rotation Student. You can make copies for yourself. Some of the articles are in pdf version on the W:\vmth\ER Rotation.

7) ER Email
• Please include our email (er@vetmed.wisc.edu) on all discharges.

8) Phones
• ER Calls – HELP ANSWER THE PHONE!
  1. Clients (Joe public ± referring vets) are able to call ring directly in the ER bypassing the front staff. What this means is we’ll need to answer the phone w/ something generic such as "Hi this is Jon with the emergency service; how can I help you."
     a) Existing clients: log the call in vetstar, share w/ appropriate service (eg- derm, Int med, etc)
     b) Non-client: record call in the log book
     c) Please ask for help /input as needed.
• Outgoing calls (clients, etc)
  1. Do not use the CCU main phone to call clients
  2. Use *67 before dialing out: 9, 1, ten digit number
  3. If a client does not accept blocked calls: use phones in reception area up front

9) Omnicell access
• Meet with Jim in pharmacy re getting CCU omnicell access for your rotation.

10) Neatness
• The ER space is cozy, please help to keep things picked up / put away.
• Store charts above the computers, or in the black wire rack
• Use you lockers for book bags & lunch bags
• Pick up books / messes as you go

11) Triage: Expect to do both phone triage and ER arrival patient triage. The ER techs (Mandy, Emma, Emily, Sarah, Lindsey & others) do a majority of the triage. There may be shifts w/o a Triage tech; should that occur you’ll be expected to do more triage.
• Cases sometimes are triaged directly back to CCU & Dx/Tx started. Try to obtain consent for basic initial treatment and a CPR directive from the client. At the minimum do a cursory physical exam (complete if possible) prior to going to get history from client.

ER in the Lobby
Triaging a pet in the lobby should begin within 30 seconds of their arrival, and should take less than 2 minutes.
  1. Introduce yourself & you are there to Triage their pet
  2. Ask why they brought their pet in? Try to collect simple basic information.
  3. Quickly assess the pet; all of the following are indications for the pet to be Triaged back
     a. Pulse rate
        i. Cat: >220, <140 bpm
        ii. Large dog: >160, <60 bpm
        iii. Small dog: >180, <80 bpm
b. Respiratory rate
   i. >50 bpm or distressed
   ii. Significant upper airway noise (e.g. bulldog w/ brachycephalic syndrome or Retriever w/ laryngeal paralysis)
c. Mucous membranes: pale, grey, or muddy
d. Capillary refill time: >2 seconds
e. Seizures (even if pet currently appears BAR)
f. Collapse, or significant lethargy
g. Hemorrhage, trauma, open wounds
h. Eye injuries
i. History of excessive vomiting
j. Toxin exposure
k. Significant dehydration
l. Potential contagious infectious disease (e.g. parvo virus, feline upper respiratory infection, canine kennel cough): triage to room 1151 or an exam room to limit lobby contamination
m. Miscellaneous unsightly problems (e.g. epistaxis, oral foreign bodies (fish hook), etc)
n. If in doubt, triage the pet back; better safe than sorry

4. Inform the client of your assessment:
   a. “Buffy appears stable and can remain in the lobby; someone will be with you in a few minutes to obtain a full history and examine Buffy.”
   b. Or “I think Buffy should be taken back to CCU; we will start some basic treatments & tests and update you in 10-20 min.”
      i. Ask the client to remain in the lobby.

5. Record any triaged patient on the ER board outside CCU, and page/find the Dr.

Phone Triage
Phone Triage can be challenging as you are reliant upon a stranger with potentially no medical training to help you assess their pet. Start by answering the phone “UW ER, this is _____; how can I help you?” You need to simplify the questioning for clients; remember they likely have no medical training. Many of the reasons to triage a pet back to CCU listed above are indications for a client to bring their pet into the ER:
   a. Trouble breathing
   b. Mucous membranes: pale or grey
   c. Seizures
d. Collapse, or significant lethargy
e. Hemorrhage, trauma, open wounds
f. Eye injuries
g. History of excessive vomiting or diarrhea
h. Toxin exposure (ask them to bring any packaging with to the ER)
i. When in doubt, it is always safer for the pet to be seen
j. When in doubt, consult an available doctor or tech

1. Inform the client the ER fee is $117. A doctor will examine their pet and discuss potential treatment costs.
2. Obtain client & patient names and phone numbers and record pertinent information in the log book.
3. Provide good directions.
4. Ask when we should expect them to arrive, and share this information with the staff, technicians and doctors.
5. Be cognizant of drive time: we would not recommend respiratory distress (or other critical cases) have long car rides.