

Medicine induction checklist

* Mandatory training both trust and lead employer
* IT training-paperlite
* Dictation software access - EPRO
* Name badge and bleep
* Car parking (if needed)
* Rota
* Departmental and acute take (booklet) induction
* BLS

**This is a detailed document to support your induction but please if you only remember one thing remember if in doubt please ask we as consultants and the whole wider team are here to support you in looking after our patients! So no question is ever a silly question.**

MEDICINE INDUCTION - AINTREE

Updated Feb 2022

*The aim of this document is to give new staff and locums an overview of how the Medical On calls work at Aintree in the hope you will feel more comfortable when commencing your role.*

*You will not be working alone, and colleagues on your shift will be able to explain systems and working practices in more detail.*

**If there are any clinical concerns, the Lead Consultant (POD) is available 9am-10pm Mon-Fri and 9am-9pm Sat and Sun on Bleep 5548**

*Specialty Consultants are also available 24/7, as well as the Medical Lead Admin Consultant (for management or staffing issues) - contactable via switchboard*

**This document is regularly changing to try and keep up to date with changes in processes etc. Therefore there might be some errors or old information. Please if you spot anything or think anything is missing let me know as I am happy for edits to be suggested after all this is put together to help yourselves and future trainees rotating into the hospital.**

**Daniel.komrower@liverpoolft.nhs.uk**

**WELCOME**

Welcome to Aintree Hospital part of Liverpool University Hospitals NHS Foundation Trust. We sincerely hope that you enjoy your time with us. Our busy department sees a wide variety of acute medical presentations offering many educational opportunities during your training here.

This welcome pack is aimed at improving your understanding of the on calls you will be scheduled for and contains the following information

* Introduction to the acute medical dept for when on call
* Specific Job Roles when on call
* An overview of the medical on call system
* The Acute take and how it runs
* Referrals, outpatient clinic and follow up options
* Procedures
* List of clinical guidelines available
* Ward cover outline inc METs
* Where we cover-geographically and wards inc Aintree to home and escalation plans
* Leave policy – sickness, annual and study
* Signing up for locums
* Additional information

## Introduction to the department

The department is responsible for the areas known as the Acute Medicine Unit (AMU) which includes Medical assessment bays (MAB/FAB) and the Ambulatory Emergency Care (AEC).

**AMU** – Acute Medicine Unit -

The unit has 4 bays and 3 side rooms and includes a 4 bedded High Care Area Bay.

**High Care Area (HCA) - also known as Enhanced Care Area (ECA)**

This comprises 4 beds. These are “Medical Resus” beds for patients who need a higher level of care or monitoring than a standard bed. There is a detailed SOP that outlines how this area works.

Medical StR’s and Consultants have admitting rights to the HCA, but StR’s should discuss the patient with the Consultant looking after HCA (9am-10pm). The Consultant rota is displayed on AMU.

Medical patients in the resuscitation/HDU bay in AED might be suitable for a prompt transfer to HCA, with the patient then being promptly assessed on arrival to ECA.

**MABFAB** – Male and Female Assessment Bays

**Exclusion Criteria for MABFAB**

* Patients requiring Resus/High care/Haemodynamically unstable patients
* Patients requiring cardiac monitoring
* Patients requiring isolation for infection control
* Patients being considered for acute NIV
* Patients requiring one to one care (unless adequate staffing is allocated)
* Patients that have had senior review with decision to admit (unless discussed with the POD)

**AEC -** Ambulatory Emergency Care unit

* Is a mixed sex seated clinical area with capacity to deal with ambulatory patients, new GP referrals and patients requiring same day treatment or investigations. It is run like an unselected medical outpatient clinic dealing predominantly with the same day urgent investigation of ambulatory and stable patients. The AEC can operate out of See and Treat AED rooms – 9-13 as well as assessment space within the AMU area.

**AMU** –

It consists of 4 bays – 22 patients

Admission Criteria/ patient suitability:

* Low risk COVID patients (though this might change depending on current COVID pathways)
* Have had a Senior Medicine review (Consultant or STR) in ED or AMU/AEC/MABFAB
* It is anticipated that Acute Medicine will be able to turn them around and discharge them within 48 hours.
* ‘HAT’ (Home after Test) patients on MABFAB (e.g. post LP)
* ‘Gen Med’ patients where the Acute Medicine Consultant judges that they need a further 24 hours of work up/investigation under the care of Acute Medicine prior to going to the ward.

|  |  |  |  |
| --- | --- | --- | --- |
| **Consultant** |  | **Roles, responsibility and interests** | **Key messages** |
| Paul Albert | C:\Users\INTHKOMD\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\Q0FEHBGX\IMG_6638.JPG | Clinical Director for Acute Medicine  Respiratory Medicine: COPD and Community Respiratory Services | Tell us if you have ideas about how we could do things differently |
| Catherine Woodward |  | Consultant in Acute Medicine  Medical examiner  Medical student co lead |  |
| Stephen Smith | C:\Users\INTHKOMD\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\HSM2DDX8\a5ede0f7-4af9-4601-bc18-b82dd46fd3ae.JPG | Consultant Physician in Acute Internal Medicine with an interest in: Ambulatory Emergency Care/Same Day Emergency Care, Medical Education, Venous Thrombo-Embolism, Medical Law and Ethics. Co-lead for SSW and Audit | Don’t be afraid to ask questions |
| Katie Bennett | C:\Users\INTHKOMD\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\Q0FEHBGX\IMG_4995.JPG | Consultant in Acute Medicine and Diabetes  & Endocrinology  Diabetic foot disease  Ambulatory Care  Deteriorating patient group lead  Travelling & baking | Get started on your eportfolio as early as possible and take the lead on asking for WBAs.  We are here to help and support you – any problems or questions…tell us! |
| Gurinder Tack |  | Acute Medicine (Tuesdays)  Respiratory Medicine: Lung Cancer/Infection  Trust Champion for Flexible Working  IMT Training programme director | Lots of training possibilities so seek out educational opportunities on every shift – ask for SLEs/WBPAs |
| Anne Allan | C:\Users\INTHKOMD\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\2SV3GD70\aa induction.jpg | Consultant in acute medicine.  Governance, incidents/datix, education, medical students, ANPs and wellbeing | If you don’t know ask |
| Craig Gradden | Me July 2020 | Consultant Acute Physician and Nephrologist  Co-Governance Lead for Acute Medicine (including datix and incidents)  Co-Teaching Lead for Acute Medicine  Mortality Lead for Acute Medicine | Maximise attendance and opportunities of departmental teaching; present interesting/learning cases, audit work, etc., and get feedback for portfolio.  Beware of prescribing as high risk area for patient safety, and common theme of datix incidents. |
| Dan Komrower | C:\Users\INTHKOMD\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\2SV3GD70\IMG_6150.JPG | Lead for AMU juniors and PAs | Complete discharge summaries prior to patients leaving brief and to the point – you don’t need to write an essay!  Smile and thank people! |
| Angharad Ford | C:\Users\aford\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\0MY7L738\20200424_112233_resized.jpg | Medical devices Lead.  Trust Medical Examiner  Ultrasound (FAMUS trainer)  Dermatology  Basic Makaton sign language (pack of communication pictures on a lanyard in my office if required) | When performing procedures complete a safety checklist (a form on PENS)–this is audited.  Please ensure you have training and a competency statement for any devices you use. We have an AMU Spirometer, ABG analyser and ultrasound. |
| Umair Sharif |  | Consultant in Acute Medicine and Renal |  |
| Jack Wong |  | Consultant in Acute Medicine and ITU | Hope you enjoy your time here with us and don’t hesitate to ask for help whenever you need. |
| Lisa Davies | C:\Users\INTHKOMD\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\3SFPRCC6\LD photo 2015.JPG | Respiratory Consultant | There are lots of options to manage patients as outpatient or via ambulatory care so please don’t just admit patient as default option but ask senior about other options |
| Raj Malipatil |  | Locum |  |
| Houssam Atwa |  | Locum |  |
| Jennifer Christie |  | Rheumatology consultant  Acute medicine (Wed AEC) | Everyone is very approachable-ask if you don’t know! |
| Alex Bello | C:\Users\MEDSBELA\AppData\Local\Microsoft\Windows\INetCache\Content.Word\20200730_115408.jpg | Specialty Doctor, Staff Grade.  AMU Junior rota lead.  Ultrasound (FAMUS)  Clinical Hypnotherapy, Coaching and mind-body connection. Veganism. | Always happy to help, so if you have any problems with the rota or anything else, please feel free to approach me. |

## Roles when on call

The Acute take by its very nature is busy and at sometimes unpredictable. The flexibility we expect from our trainees is supported by a dynamic and experienced consultant workforce which is constantly present on the unit between 8am and 10pm.

**Lead Consultant (POD)** 9:00 – 22:00 (21:00 at weekends) Bleep 5548

This is the Consultant who oversees the Medical Take. They are highlighted in **bold** on the weekly rota displayed on AMU. They are mainly based on MABFAB, AMU and AEC, but will also go to AED depending on clinical need. They support the StR in running and coordinating the Medical Take and they should liaise with each other regularly through the course of the take.

Through the day, there are other AMU Consultants who do the morning post take Ward Round and see the new take. On weekday evenings (until 9pm), there are usually three additional Consultants.

**AEC Consultant** 9:00-20:00 (weekdays only) Bleep 5126

This consultant oversees AEC. They take all referrals to AEC and coordinate AEC care including the morning huddle at 9am and board rounds as required during the day.

**StR 1 and 3 9:00 – 21:30**

* Based mainly in AED but may also flex to MAB/FAB and AEC when needed.
* Co-ordinates medical take with the Lead Consultant, and works alongside FTST LD1 (bleep 5120)
* Receives all Medical referrals from AED through bleep 5085 (any for AEC should be redirected to bleep 5126)
* Maintains a list of the Acute Take
* Senior review of patients seen by AED and Medicine juniors
* Discusses all patients seen with the Lead Consultant or another AMU Consultant
* Should not be required to undertake any other clinical duties (eg ward reviews) other than acute take work without discussion with Lead Consultant
* Ensure educational feedback and discussion occurs if appropriate during handover at 9pm

**STR 2 9.00-17.00**

* Holds the MET bleep during normal hours and attends MET calls. Unless there is a MET call will continue normal day job
* Should not need to review referrals as these should go direct to the relevant specialty but might occasionally be contacted if not clear which specialty to be contact

**StR 2 17:00 – 21:30**

* Ward cover and referrals from other specialties.
* Attends MET Calls
* Senior review of medical admissions
* Discusses all patients seen with the Lead Consultant or another AMU Consultant
* Ensure educational feedback and discussion occurs if appropriate during handover at 5pm and 9pm

**Twilight Registrar** (Start works at 16:00) x 2 **16:00 - midnight**

* Supports management of acute medical take working in MABFAB, AED and AEC or AMU if required.
* Carry referral bleep during handover as does not need to attend 9pm handover
* Take a lead in having oversight of the GP arriving take and MAB/FAB patients between 10pm and midnight. Hands over to StR 3

**StR N1 and N2 21:00 – 09:30**

* Manages acute take patients as present either to AMU or in AED. Attends AED to see resus patients [and assess suitability for High Care Area (HCA)] and other medical patients when there are flow problems
* Works alongside F2ST N5 (bleep 5120)
* Receives all Medical referrals from AED through bleep 5085
* Maintains a list of the Acute Take
* Senior review of patients on the acute take
* Attends 8am huddle on AMU (weekdays only)
* Ensures that the correct patients are on the correct post take leasing with the site team at around 7am for this. There are cardiology, Resp, DMOP, Renal/Endocrine, gastro and Acute (for all the patients on AMU)-**currently this is not happening Due to Covid.**

**StR N3 21:00 – 09:30**

* Senior review of patients on the acute take
* Ward cover and referrals from other specialties.
* Attends MET Calls
* Attends 8am huddle on AMU

**Role of LD1/ F2ST N5/6**

* These doctors usually work with StR on MAB/FAB, AMU and FAU and help with the acute medical take, flexing to AED when necessary.
* Should not be required to undertake any other clinical duties (eg ward reviews) other than acute take work without discussion with Lead Consultant

**Role of LD2/3**

* These doctors usually work on AEC seeing acute take and hot clinic patients.
* Should not be required to undertake any other clinical duties (eg ward reviews) other than acute take work without discussion with AEC Consultant
* **care bundles – AKI, Sepsis, COPD, Pneumonia and Liver disease**

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| **Everybody’s responsibilities**   * **VTE screens** * **Dementia Screen** * **Real Time Discharge Summaries on Dashboard** * **Acknowledge ICE/Dashbaord test results** * **Ask a senior if in any doubt about any aspect of your role** * **Complete care bundles – AKI, Sepsis, COPD, Pneumonia and Liver disease** |

Medical On-call System – Overview (Mon – Fri)

**The on-call doctors are responsible for all the Medical Admissions and for all the wards out of hours.**

**LONG DAY SHIFT**

***Morning MEDICAL HANDOVER = 09:00- 09.30 for on-call day team with all night team and AMU juniors (Lead Consultant in attendance)***

***(Medical Handover Room next to Bed Management office)***

StR 1 9:00 – 21:30 Based MAB/FAB and AED

manage medical referrals from AED and GP

Co-ordinates medical take with the Lead Consultant.

Manages Medical patients in Resus

StR 2 09:00 – 21:30 MET and ward referrals

Str3 \* 09:00 – 21:30 Work with StR1 to see acute admissions

F2ST2 LD 1 Acute 9:00 – 21:30 MAB/FAB and medical patients in AED

F2ST2 LD 2 Acute 9:00 – 21:30 AEC based – go straight to AEC at 9am

F2ST2 LD 3 Acute 9:00 – 21:30 AEC or MABFAB based – go straight to AEC at 9am

LD 4 - MET 9:00 – 17:00 Ward work with MET/Arrests

(if LD4 gap MET bleep will move to LD 5)

**\*If IMY3 works outside Aintree they will not be present and will come at 5pm to MABFAB and report to lead physician**

***Acute Take Scrum 12:45 and 17:00 in AMU :Lead Consultant, StR1/3, LD1, twilight reg***

**EVENING SHIFT**

***Ward Team ONLY - MEDICAL HANDOVER = 17:00- 17:20 StR 2 + LD4 /5 + FY 1/2/ 3 – Board room***

2 x StR Twilight 16:00 – 00:00 Report to lead physician – role is to usually support acute take

Acute Medicine 14.00 – 22.00 HCA, AMU jobs and reviews, Short Stay Ward

F2ST2 LD 4 17:00 – 21:30 WARDS 10, 11, 14, 15, 22, 23, 25 (and MET)

F2ST2 LD 5 17:00 – 21:30 WARDS 8, ACCU, 20, 21, 24, 17b/19, 30, 31, 32, 33, 34, VIC

F2ST2 LD6 17:00-21:30 MABFAB at 5pm – go straight to MABFAB at 5pm

(if LD 4 gap MET bleep will move to LD 5)

FY 1 (wards) 17:00 – 21:30 17b/19, 30, 31, 32, 33, 34, 25

FY 2 (wards) 17:00 – 21:30 10, 11, 14, 15, 20, 21

FY 3 (wards) 17:00 – 21:30 VIC, 8, ACCU,22, 23, 24 and MET/Arrests

Ward patients to be escalated to LD4 and LD 5 before SpR2

17:00 starting doctors all work normal day job between09:00 and 17:00

Medical On-call System – Overview (Sat – Sun + Bank Holidays)

**The on-call doctors are responsible for all the Medical Admissions and for all the wards out of hours.**

DAY SHIFT

***MEDICAL HANDOVER = 9:00 – 9.30 all doctors on call to attend - Board Room***

StR 1 9:00 – 21:30 Based MAB/FAB/AMU and AED

Manage medical referrals from AED and GP

Co-ordinates medical take with the Lead Consultant.

Manages Medical patients in Resus

StR 2 9:00 – 21:30 WARDS + MET

StR 3 09:00 – 21:30 Based MAB/FAB/AMU and AED

Manage medical referrals from AED and GP

2 x StR Twilight 16:00 –0:00 Report lead physician – role is usually to acute take

F2ST2 LD1 9:00 – 21:30 MAB/FAB and medical patients in Resus

F2ST2 LD 2 9:00 – 21:30 PTWR AMU with Lead Consultant then AMU jobs including

TTOs and clerking.

Acute take as required

F2ST2 LD 3 9:00 – 21:30 PTWR AMU with 2nd AMU Consultant, AMU jobs

. and clerking as required

F2ST2LD 4 9:00 – 21:30 Wards 10, 11, 14, 15, 22, 23, 24, 25, MET

(ward 10,11 after 17:00)

F2ST2LD 5 9:00 – 21:30 PTWR ACCU and cardiology (MET spare)

Wards - 8, ACCU, 20, 21, 17/19, 30, 31, 32, 33, 34

(Ward 17,19 after 17:00)

F2ST2 LD 6 9:00 – 17:00 PTWR GASTRO

Wards 10,11,17,19 until 17:00

FY 1 9:00 – 21:30 PTWR DME

wards 30, 31, 32, 33, 34

FY 2 9:00 – 21:30 PTWR Diabetes

wards 17, 20, 21, 24, 25

FY 3 9:00 – 21:30 PTWR Thoracic

Wards VIC, 8, ACCU, 22, 23

FY 49:00 – 21:30 PTWR Renal

wards 10, 11, 14, 15

Medical On-call System – Overview (Nights)

**NIGHT SHIFT (WEEKDAYS AND WEEKENDS)**

***Night MEDICAL HANDOVER = 21:00 – 21.30 all doctors on call to attend***

***(Board room next to restuarant)***

StR N1 21:00 – 9:30 AMU and Medical patients in AED Resus.

Responsible for take

StR N2 21:00 – 9:30 AMU and ED

STR N3 21:00 – 9:30 Wards + MET

F2ST2 N5 21:00 – 9:30 AMU,MABFAB and Medical patients in AED.

F2ST2 N6 (on take) 21:00 – 9:30 Clerking on AMU/AEC/MABFAB, essential jobs on AMU.

F2ST2 N7 (wards) 21:00 – 9:30 All WARDS +MET,

FY N (wards) 21:00 – 9:30 All issues dealt with by F2-ST2

Nurse Clinicians (filter all calls to F1 Doctors ) – Bleep 2075

Monday – Friday 16:30 – 21:15 (Bleep 5141) Monday – Friday 21:15 – 07:15 (Bleep 2075)

**Handover and Scrums**

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| Time and location | Function and action | Who |
| 8am  AMU MDT ROOM | **Scrum**  Handover from night team in AMU MDT room | Night team  8am Amu team |
| 9am  HANDOVER ROOM | **Medical Handover**  Handover any information from night team to day team  MET team to be handed over and introduced | Night team  On call day team (Spr1 LD1 IMY3)  MET team (spr2 and LD4)  Lead Physician |
| 9am  AEC | **AEC Huddle**  Review staffing and number of HOT clinic patients | AEC team  Inc LD2 and LD3 |
| 12:45 and 5pm  AMU MDT ROOM | **Acute take scrum**  Handover in AMU room to allow 5pm finishes to handover to 2-10pm shift and also new starters at 5pm to attend | 2-10pm AMU doctor  Lead consultant  SPR1/3, Twilight reg, LD1 and LD6 when they start at 5pm |
| 5pm  BOARD ROOM | **HOSPITAL HANDOVER**  Handover for ward based staff | Evening ward based on call team STr2, LD4, LD5, FYs |
| 9pm  BOARDROOM | **Medical Handover**  Handover – Board room near main restaurant | All night team and all leaving day team |

**At weekends**

**Everybody**

|  |  |  |
| --- | --- | --- |
| 9am  BOARDROOM | **Medical Handover**  Handover any information from night team to day team  MET team to be handed over and introduced | Night team  All day team  MET team  Lead Physician |
| 12:45 and 5pm  AMU MDT ROOM | **Acute take scrum**  **Handover in AMU room to allow 5pm finishes to handover to 2-10pm shift and also new starters at 5pm to attend** | 2-10pm AMU doctor  Lead consultant  SPR1/3, Twilight reg, LD1 and LD6 when they start at 5pm |
| 9pm  BOARDROOM | **Medical Handover**  Handover – Board room near main restaurant | All night team and all leaving day team |

## The acute take

**Pathways to be accepted on to the acute medical take;**

1. **GP referrals**

During weekdays GP refer direct to community service that informs us electronically of the referral. This information is available via the Adastra list which is managed by the clerical team in AEc and AED only.

Only patients on this list are medically accepted all others will require AED review/striage/pitstop and referral to medical team.

Accepted patients are directed to AEC or MABFAB (if no space in MABFAB then will go to AED) (blue light patients go to AED and are treated as non medically accepted)

**Patients arriving in AED with a GP letter who have not come through the referral system should be discussed with Str to check that they are appropriate for Acute Medicine (patients suitable for AEC can be discussed directly with AEC ext 8280)**

1. **AED referrals**

These must be accepted by the StR prior to transfer. The referring AED doctor should prescribe the patient’s medications on EPMA. These patients should then go directly to MABFAB or AEC (AMU out of hours) within 15 minutes, if space. These patients do not need re-clerking on MABFAB, AMU/AEC.

The StR or Consultant may see these patients directly. Otherwise, the ANP/junior doctors should read through the notes, document the bloods/relevant investigations, and seek a Consultant, then review the patient together.

AED can senior pitstop\* (brief review and initiation of investigations and emergency management) patients and refer directly to medical registrar. These patients will need a full junior medical review and will be allocated a junior blue number.

\*A ‘pitstop’ model has been introduced on the MABFAB and AEC, where all patients receive a senior (Consultant or StR) review within one hour of arrival. This might be a full senior review (if the patient has already been clerked by AED) or a brief ‘eyeballing’ for patients who need to be clerked- this will help to guide investigations and management plan from the outset. The Consultant pitstop does NOT replace the Senior Review that is still required within 4 hours of arrival, by which time a decision whether to admit or discharge, and a full management plan should be in place.

**All referrals accept for AEC patients must be referred via Dashboard and placed on the medical take list / MEDICAL REFERRAL list.**

1. **Clinic or specialty referrals**

The general principle is that if a patient needs to be admitted from clinic then the appropriate specialty bed should be sought via the admitting Dr from clinic.

**Is the patient suitable for ambulatory care?**

* Patient unlikely to require admission
* No infection control issues that would prevent patient from waiting in waiting room
* Patient able to self care or accompanied by carer to support patient to wait for assessment in a seated waiting area

If yes to the above then please contact AEC8280 or via bleep 5126 and handover patient to clinical staff and then make arrangements for patients to get to AEC ASAP.

**Note: AEC HOT clinic cannot be used for patients discharged from ward. Please do not refer any patients to hot clinic from any ward other than AMU and ED as this is not appropriate.**

**Patient requiring admission (eg overnight bed stay) or not suitable for AEC.**

1. Contact site team on bleep 3456 to try and arrange admission to own speciality ward based beds.
2. If no beds on own wards available
   1. Contact MABFAB via ext 5036 and handover to clinical staff if no response can bleep Lead Physician on 5548
   2. Contact Site team on bleep 2180 and they will inform you where space for patient to go is available.

The Acute Medicine Consultant – Lead Physician is available on bleep 5548 but please do not contact prior to trying above pathways to prevent unnecessary disturbances of consultant.

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| **Hot Clinic** | **GP Accepted** | **AED – non ambulatory**  **bleep STR 5085** | **AED - Ambulatory**  **Phone 8280 (b5126)**  **(overnight STR bleep 5085)** |
| All patients on arrival should have EWS carried out within 30minutes by the team in charge of the area they attend | | | |
| Referral on ICE/Dashboard after discussion with medical team. Please state if patient is a COVID risk as will need to be seen in side room \*. | **Patient only medically accepted**  If patient is on Adastra list, then clerks print Adastra sheet for case notes and ensure patient is added to the medical take list.  COVID patients to be seen in side room ED or AMU | **Post AED clerking**  Referrals made to medical STR on bleep 5085  Transfer immediately to MABFAB if agreed | **Post AED Clerking**  Referrals to AEC consultant bleep 5126 or 8pm-9am to StR on bleep 5085.  Transfer immediately to AEC |
| Please ensureEPMA/VTE/iv fluids have been prescribed and added to medical take list | |
| If potential COVID will need to be seen in sideroom or virtually | After 9pm inform StR 5085 | **Pitstopping**  Referrals must be made to medical StR on bleep 5085 | **Pitstopping or striage**  **Patients** with a clear medical presentation prior to clerking, refer to AEC phone 8280 (bleep 5126) and if accepted clerical team to transfer to AEC system |
| Any patient with high NEWS or a medical condition requiring a resus bed should go to resus and the medical StR on bleep 5085 should be informed. If the patient is considered suitable for HCA in AMU discuss with med consultant | | | |
| **Striage and ED pitstop to Medicine should not take place overnight 8pm-9am due to reduced medical staffing:**  **After 8pm if a patient arrives with GP letter they can be referred to Medical StR after a comprehensive pitstop**  Weekends and bank holidays: Capacity may be limited to and must be discussed with appropriate consultant as directed above. | | | |

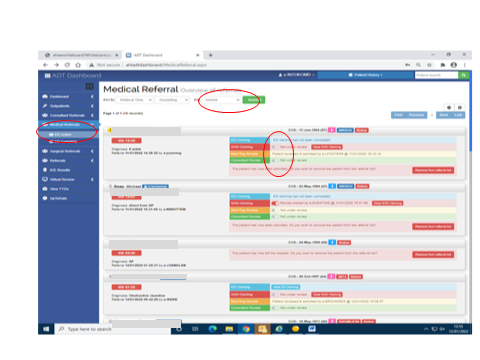
**mentia Screen**

## The electronic take lists and white boards

We have recently installed a new computer system into Aintree (paperlite). You should receive training on this as part of hospital induction below lays out the management and oversight process for patients within Acute Medicine.

**Below tries to lay out a very brief overview of how we manage our patients the key bit of information is please ask about this when you start and also please use the below systems so we all know where our patients are along their pathway.**

**Dashboard – Acute Medical Take List**

****All patients referred by AED or GP arrivals (excluding patients that are within AEC) are added to the medical take list. This can be done via the AED clerking document or via an order either on Dashboard or ICE – AED Medical Referral. When working on the acute take you should work way through the list in clinical priority order if people have been escalated or time order. **It is important to look though as some GP patients will arrive and not have had a review at all prior to being added to the list therefore please check for these first and priorities them for review.**

Change to Aintree site

Select Medical referrals – ED active

Change to Aintree site

Select Medical referrals – ED active

When seeing patient toggle button to seeing patient so other people don’t start reviewing when you are seeing and when done complete proforma

**When you go and review a patient please use toggle button to state that you are going to see patient and when completed review please complete review so clear patient has finished being seen and then can move out of department.**

**White Board – AED**

The AED white board shows medical patient by having an M letter within their little box. This changes colour as they have been seen Red – requires medical senior or junior review, Amber had senior review, Green had consultant review

**White Board – AMU**

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Clinical Status Button

There is a free text option to add text below the patients’ name. This can be edited by double clicking on the name when logged into the whiteboard or by the patient screen on dashboard. When double clicking it will display patient details here you can add in free text but also up date whether they have had a junior and senior review and if they are to be admitted, discharged or HAT (Home after Test). Bed requests can also be made



Senior, Junior review

Admit, Discharge, HAT

Free text area

This white board also has a clinical status button which if clicks shows the whole ward updates and is useful in seeing if patients need further reviews.



**White Board – AEC**

The AEC patients are split between acute take patients (new today patients) and hot clinic patients (returning patients). As you see and action patients the patienst can be moved between the areas of the board to show what stage of their journey they are at.



**Referrals, Outpatient clinics and follow up options**

We have an SOP for who accepts which presentations in Aintree while there may be exceptions but this has been Approved by all departments.

**Guidance for Referral for Specialty Assessment from the Emergency Department**

**This document is currently under review so information might have changed as part of merger process and realignment of services but it is included as guidance**

**CHEST INJURY**

1. Fractured ribs Surgery/Major Trauma

(unless complicating chronic lung disease) (Medicine)

1. Traumatic pneumothorax Surgery/Major Trauma
2. Sternal fracture – as for rib fractures Surgery/Major Trauma

**CHEST PAIN / DYSPNOEA**

1. ACS Medicine
2. Thoracic aortic dissection RLUBHT vascular team
3. Pericarditis Medicine
4. Arrhythmia MEDICINE
5. LVF MEDICINE
6. PE MEDICINE
7. Spontaneous pneumothorax MEDICINE
8. Pneumonia including chest sepsis MEDICINE
9. Exacerbation COPD\* MEDICINE
10. Exacerbation asthma\* MEDICINE
11. Pulmonary fibrosis MEDICINE
12. Epiglottitis ENT/SAU
13. GORD MEDICINE
14. ? cause MEDICINE

Alternative options for assessment that do not require admission are

* Rapid access chest pain clinic via Sigma referral – AED/Amu chest pain clinic
* Ambulatory heart failure clinic – can be discussed with team 9-5pm on bleep 5071 or sigma referral
* Ambulatory AF – sigma referral – Atrial fib
* \*Respiratory nurse review – mon-fri 9-5pm – bleep 5303
* COPD exacerbation consider ACTRITE referral for care at home
* Urgent nurse led asthma clinic follow up can be arranged via sigma referral respiratory nurse.

**COLLAPSE**

1. Arrythmia MEDICINE
2. Postural hypotension\* MEDICINE
3. Seizure MEDICINE
4. Vertigo / labyrinthitis MEDICINE
5. ?cause MEDICINE

\*Consider frailty team referral

Alternative options to admission

* First fit clinic – referral information via document management system on intranet search seizure.
* Syncopy clinic- for patients who are intermediate risk or low risk with recurring episodes. Referral made on Sigma

**VISUAL LOSS**

1. Amaurosis fugax MEDICINE/AEC
2. Retinal vascular occlusion Ophthalmology
3. Vitreous haemorrhage Ophthalmology
4. Retinal detachment Ophthalmology Ophthalmology
5. Macular degeneration Ophthalmology

\*TIA clinic referral criteria can be found in document management system search TIA

**PAINFUL EYE**

1. Acute closed angle glaucoma Ophthalmology

2. Uveitis, iritis, scleritis Ophthalmology

**DOUBLE VISION**

1. Acute 6th nerve palsy MEDICINE/AEC +/- ophthalmology
2. Acute 3rd nerve palsy MEDICINE/AEC+/- ophthalmology

**FACIAL WEAKNESS**

1. Bell’s palsy MEDICINE/AEC +/- ENT
2. CVA MEDICINE

**SOFT TISSUE INFECTION -** disposal is based on region affected

1. Hand and upper limb MEDICINE/AEC
2. Lower limb MEDICINE/AEC
3. Facial Cellulitis. MEDICINE/AEC
4. Peri-orbital cellulitis MEDICINE/AEC +/- ophthalmology
5. Orbital cellulitis Ophthalmology
6. Dacrocystitis Ophthalmology
7. Pressure sores MEDICINE/AEC
8. Cellultis with absent pulses RLHBUT vascular
9. Stevens-Johnson syndrome / Toxic epidermal necrolysis MEDICINE
10. Staphylococcal scalded skin syndrome MEDICINE

Alternative to admission include

* Home cellulitis pathway available by document management system

**ABSCESSES**

Limb Orthopaedic

Trunk SAU

**HAND INJURIES**

Closed fractures carpus / metacarpals Orthopaedic

Ulnar collateral ligament rupture Orthopaedic

Complex intra-articular fractures of PIP joint Orthopaedic

Open hand fractures without tissue loss Orthopaedic

Open hand fractures with tissue loss Orthopaedic

Human bites Orthopaedic

Penetrating animal bites Orthopaedic

Hand injuries with suspected neurovascular damage / Orthopaedic

Suspected tendon injuries on volar surface / Closed tendon rupture

**MUSCULOSKELETAL**

1. Suspected septic arthritis
   1. Native Joint (excluding hand) MEDICINE/AEC
   2. Prosthetic Joint Orthopaedic
   3. Joints distal to wrist (ie. hand) MEDICINE/AEC
2. Suspected crystal arthropathy MEDICINE/AEC
3. Suspected inflammatory arthropathy MEDICINE/AEC
4. Monoarthritis ? cause MEDICINE/AEC
5. Hip pain following fall ? fractured neck of femur Orthopaedic
6. Fractured pubic ramus MEDICINE/FAU
7. Fractured acetabulum Orthopaedic
8. Bony injury following mechanical fall ED / Orthopaedic
9. Bony injury following syncope/collapse with LOC MEDICINE/FAU
10. Back pain due to vertebral collapse ( non-malignant) MEDICINE/FAU
11. Muscular/OA back pain ED / Orthopaedic
12. Malignant vertebral body collapse MEDICINE/Oncology
13. Cauda equina syndrome ED / WCNN
14. Disc prolapse ED / WCNN
15. Malignant spinal cord compression MEDICINE

**ABDOMINAL**

1. Abdominal pain – non-specific - SAU

(unless known current patient of gastroenterology in relation to the same problem)

1. Intra abdominal sepsis SAU
2. Abdominal pain in women of reproductive age without SAU
   1. frank PV bleeding
   2. disordered menstruation
   3. dyspareunia
3. Ectopic pregnancy LWH
4. Ovarian cyst LWH
5. Acute Pancreatitis SAU
6. Chronic Pancreatitis (ie. Typical pain with normal amylase) SAU
   1. Patient known to Prof team at RLUBHT
   2. Not currently under RLUBHT
7. Perforated viscus SAU
8. Appendicitis SAU
9. Constipation SAU
10. Small / large bowel obstruction SAU
11. Mesenteric infarction SAU
12. Psoas abscess SAU
13. Renal calculus Urology/SAU
14. Renal colic, Suspected pyelonephritis and urological problems including urinary sepsis associated with an obstructed urinary tract or with inflammation of the male GU tract

Urology/SAU

1. Urosepsis presenting as acute delirium MEDICINE
2. Obstructive Uropathy / urine retention Urology/SAU
3. Testicular torsion Urology/SAU
4. Orchitis Urology/SAU
5. Hepatitis MEDICINE/AEC
6. Obstructive jaundice MEDICINE/AEC
7. Colitis MEDICINE/AEC
8. Upper GI bleed including melaena MEDICINE
9. Gastritis/PUD ( previously diagnosed on OGD) MEDICINE/AEC
10. Cholecystitis/cholangitis/biliary sepsis SAU
11. Diverticulitis SAU
12. Fresh blood PR SAU
13. Vascular
    1. ruptured AAA for surgical intervention RLUBHT vascular team
    2. ruptured AAA for non-intervention (terminal care) RLUBHT via LIVES
    3. acutely ischaemic lower limb or non-critical ischaemia but unable to be seen in Out-patients RLUBHT via LIVES
    4. actutely ischaemic upper limb
       1. Distal to Elbow Plastics/vascular
       2. Proximal to Elbow RLUBHT vascular

**CONFUSION**

1. Intracerebral Haemorrhage MEDICINE/ASU
2. Head injury ED
3. Meningitis / encephalitis MEDICINE
4. Sepsis ? source MEDICINE
5. ?cause MEDICINE

**METABOLIC**

1. Dehydration MEDICINE
2. Diabeteic ketoacidosis MEDICINE
3. HHS MEDICINE
4. Addisons disease MEDICINE
5. AKI MEDICINE

**LIMB PAIN**

1. Limb ischaemia RLUBHT vascular
2. Venous arterial ulcers +/- cellulitis MEDICINE +/- vascular
3. Previous arterial reconstruction surgery RLUBHT vascular
4. ? DVT MEDICINE/AEC

Alternative to admission

* DVT pathway available for out of hour care – will need referral to AEC hot clinic

**ENT**

Tonsillar Haemorrhage (including post-operative) ENT

Epistaxis

Initial Packing ED/ENT

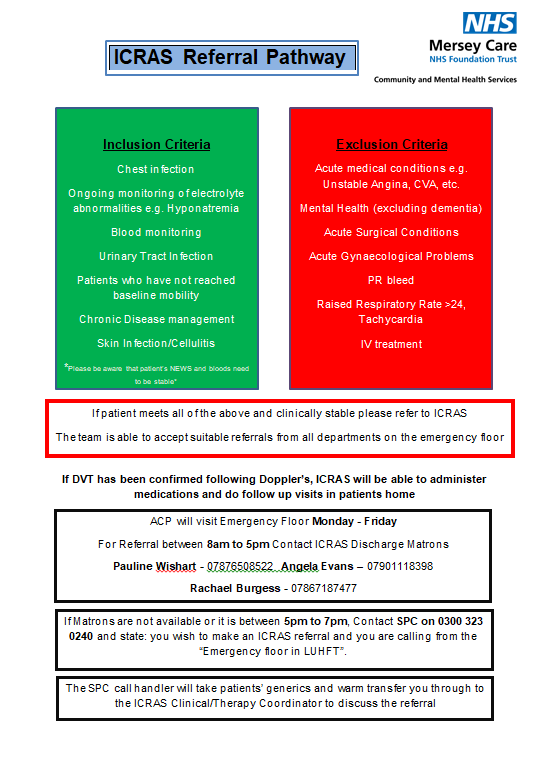
If bleeding post packing ENT

If secondary to bleeding disorder/over anticoagulation MEDICINE + ENT

**Criteria to admit and alternative options and follow up options**

**To try and support you in avoiding unnecessary hospital admission for our patients the below options for ongoing care without admission are set out in below table this is not going to be all options so if you consider the patient well enough to go home discuss with senior as options for ambulatory care might be available.**

|  |  |  |
| --- | --- | --- |
| **Alternative pathways to safely avoid admission** | | |
| Social Support | | |
| * Contact next of kin and/or any other available family member to identify whether they can offer support, explicitly explaining the risk to the patient of being admitted and providing them with details for further support in the community. * Patient or family can contact Careline 24/7 who can arrange an assessment. In an emergency they aim to start the assessment and provide help within 24 hours. For all other cases they aim to complete assessments within 28 days. They can go online to <https://liverpool.gov.uk/adult-social-care/getting-help/needs-assessment/> or call 0151 233 3800. * Weigh up (with the patient’s involvement if applicable and if not with the next of kin) whether the benefits of admission for support outweigh the risks of nosocomial infection, including the significant risk of death with nosocomial Covid-19 which is a higher risk in the elderly. * Aintree – Urgently contact discharge managers or ERT via switch board if unable to discharge with above. | | |
| Ambulatory Care | | |
| * In hours cases can be discussed with AEC consultant bleep 5126 * Out of hours with the medical registrar bleep 5085 or phone 8280 * Complete a ICE / Dashboard hot clinic referral after above discussions * Appropriate investigations to be requested as virtual ward priority | | |
| **Specialty specific Pathways** | | |
| Cardiology | | |
| Rapid access chest pain clinic | As per chest pain pathway | ICE/Dashboard referral – orders search type AED/AMU Chest pain |
| AF clinic | Ambulatory AF patient for rhythm or rate control | ICE/Dashboard referral – orders search type Atrial fib  **ECG must be placed in tray in AEC and AED reception area** |
| Ambulatory heart failure | Patients who require IV diuretics/close monitoring but could have in ambulatory setting Mon-Fri | ICE/Dashboard referral – order search heart failure. Can also discuss heart failure team bleep 5071/2690 |
| Syncope clinic | Intermediate risk patients or low risk patients with recurrent episodes. | Referral via ICE/Dashboard  **ECG must be placed in tray in AEC and AED reception area** |
| Dermatology | | |
| Ambulatory Dermatology clinic  *Currently not functioning trying to reboot* | Decision made with Medical consultant or registrar that patient needs urgent dermatological review and safe for ambulatory management | Book into slot via folder in AEC  ICE/dashboard order  IP Dermatology order stating – state can they be seen in clinic |
| Suspected skin cancer | Urgent 2 week wait referral from Broadgreen | Letter to skin cancer clinic faxed 0151 530 2678 |
| Non urgent chronic conditions/incidental findings | Referrals not accepted | Refer back to GP to consider referral to outpatient dermatology clinic |
|  | Gastroenterology |  |
| Rapid access slots | For admission avoidance or early discharge | Via clerks in AMU or AEC\* |
| Specialist services | Can discuss with team to facilitate discharge | IP UGIB : bleep 5008  IBD nurse: x4801 (9-12)  bleep 5009 (12-4)  PEG nurse : bleep 5028  HPB ANP: bleep 5637 |
| **Diabetes – Additional flow chart available for new diagnosis of high sugar – document management system search hyperglycaemia** | | |
| T1DM | DKA or suspected-urgent AED assessment and contact on call cons.  T1DM either new presentation or hyperglycaemia (not DKA) refer to Aintree Diabetes Centre.  Out of hours contact on call consultant to discuss next day options. | Diabetes centre 0151 529 4876  Diabetes nurse bleep 2197    Known poorly controlled diabetics can contact the centre out of hours themselves to arrange appointment for next working day |
| T2DM | New presentation type 2 diabetes; GP can refer to “Diabetes and You” (community diabetes team).  Hyperglycaemia not unwell; refer to community diabetes team via diabetes specialist nurse or via referral form | Diabetes specialist nurse: 0151 529 0283  Referral form; [Liverpool.Diabetes@NHS.NET](mailto:Liverpool.Diabetes@NHS.NET)  Diabetes and You numbers:  Liverpool 0151 529 0283  Sefton 0151 475 4085 Knowsley 0151 676 5103 |
| Haematology | | |
| LMWH | Patient discharged on >6 weeks LMWH  (Soon to need additional document as part of shared care agreement with GP – please check with pharmacy) | ICE/Dashboard referral – order search type LMWH |
| Warfarin | New starting warfarin | ICE/Dashboard order – type warfarin. To get appointment date phone 4421 |
| General Haematology | IP review via ICE/Dashboard order.  OP request via ICE/Dashboard order (clearly state for OPD) or letter, fax to 4626. | All referrals to be triaged by haem consultant. |
| **Rheumatology** | | |
| consultant of the week/registrar advice | If wanting to discuss a patient during working hours | Rheumatology office: x2448 / 3342 |
| Early Arthritis Clinic | New possible inflammatory arthritis  Aim to see within 2 weeks  Avoid systemic steroids without discussing with rheumatologist | ICE/DASHBOARD referral to Rheumatology specifying EAC or fax letter to Dr Estrach (fax 2944) |
| Nurse-led rapid access clinics | Inflammatory arthritis known to the department | Helpline: x3034 option 3 |
| General clinics | New possible rheumatological diagnosis | ICE/DASHBOARD referral to Rheumatology or fax 2944 to be triage to adequate pathway |
| Specialist clinics | Scleroderma: Dr Anderson  Behçets: Prof Moot  Myositis: Dr Cotton | Dr Anderson secretary: x 8497  Behçets’ helpline: x8123  Rheum secretary: x8497 |
| Hot clinic | Dr Christie: Wednesdays on AEC | Rheumatology urgent clinic folder located on AEC (do not overbook, bleep rheum registrar if clinic is full) |
|  | COVID |  |
| Oximetry at home | Patients presenting to AED or AMU who do not require admission at the point of assessment but require monitoring in case they deteriorate – allowing pick up of silent hypoxia | Aintree – AED matron office oximeters available and referral form (on AEC) to be handed to AEC/AMU ward clerks  Royal – AED clerical team to provide referral information and nurse coordinator to provide oximeter |
| Covid Virtual ward | Patients slightly sicker than above – able to go home with daily clinical community input and close monitor can be discharged on oxygen, steroids | Via ICE/Dashboard referral IP Respiratory Specialist Nurse |
| **Respiratory** | | |
| Acute Medicine Respiratory Clinic | For admission avoidance or early discharge   * PE follow up * Not for lung cancer /nodule patients these need referral via IP ICE/Dashboard referral system * See COPD referral | ICE/Dashboard referral order - Acute Medicine Respiratory Clinic |
| Post pneumonia clinic | No longer exists arranged by individual departments | Acute take patients referred via Acute Medicine Respiratory Clinic |
| Possible new lung malignancy | Refer new possible lung cancer via IP ICE/Dashboard referral system | IP ICE/DASHBOARD referral- seen as OP in a Joint Lung clinic (AUH IP Thoracic) |
| Asthma Nurse clinic | Nurse led asthma clinic for patient admitted with exacerbation of asthma | Via ICE/Dashboard referral to IP Respiratory Specialist Nurses |
| Pleural Clinic | If ambulatory can be referred to pleural clinic for assessment | Via ICE/Dashboard IP Thoracic state for consideration for pleural clinic |
| COPD  actrite contacts: - Liverpool: x2514, 07774432650  - Sefton: 01514754260, 07867187659  - Knowsley (LHCH): 01516001076 | This is complicated due to different community teams.  1) all patient sent home with supported discharge team (actrite) follow up is automatically arranged for their COPD so they are unlikely to need additional follow up unless non COPD respiratory issue.  2) Knowsley patients (usually L32 and L33) have a comprehensive COPD community service if they need follow up write to Dr Wat at LHCH. | |
| **Neurology** | | |
| General neurology review | Outpatient referral for general neurology issues | Letter faxed to 5769 or email [wcnnreferrals@nhs.net](mailto:wcnnreferrals@nhs.net) |
| Rapid Access Neurology Ambulatory Clinic | Patients that need “inpatient” time scale review but do not need admission  Needs neurology input but can manage at home eg ? MS  All possible cases should be discussed with neurology | * 9-5pm – phone 07977022703 * Out of hours – on call neurology registrar via switch |
| Headache clinic | Outpatient referral for chronic headache | Letter faxed to 5769 or email [wcnnreferrals@nhs.net](mailto:wcnnreferrals@nhs.net) marked for headache clinic |
| First Fit clinic | First seizure and can go home for urgent neurology review as OP | Via Walton Seizure Pathway - Available in AMU or online search document management system “Seizure” |
| Renal | | |
| Nephrology Hot Clinic  (PCU / RRU) | Appropriate patients are:   * AKI 2 and 3 with no clear cause * Suspected Nephrotic syndrome (urine ACR >300) with Albumin >25 * Early follow-up of patients already known to Renal * Suspected GN and clinically well – discuss with Nephrology team before discharge   All cases discussed with Nephrology team / AMU consultant | Referrals sent via ICE/Dashboard to AUH Renal RRU Referral  Following patients are not appropriate:   * Suspected vasculitis with involvement of kidneys +other organs * Suspected myeloma * Suspected or confirmed obstructive uropathy * Rapidly worsening kidney functions – creatinine increase ≥3 X reference in 48 hrs Or ≥354 μmol/L |
|  | Stroke |  |
| Rapid Access TIA Clinic | Ambulatory TIA patients as per pathway | Via TIA Clinic Pathway  Available in AMU or online search document management system “TIA Clinic” fax to 8707 / 3787 |



**Clinical Information –** guidelines are available via the Document management system (DMS) on the intranet

1. **DVT / PE Service:** This service is now integrated within AEC please see guidelines

**2. ACTRITE:** Acute Chest Triage Rapid Intervention Team also known as CRT (Community Respiratory Team): available for previously diagnosed COPD patients who are suitable for home management of their acute exacerbation of COPD.

The service provides early supported discharge from hospital for patients with an exacerbation of COPD and Hospital at Home in the community (Hospital Prevention referrals from GP Via UCD with a 2 hour response). An ACTRITE proforma is completed prior to patient discharge. This also contains patient inclusion/exclusion criteria.

The hours of service are 8am to 8pm 7 days a week.

###### **Office Number: Ext 2514 Mobile Number: 07880794162 Team Coordinator**

**Patients with a Knowlsey GP have a separate service**

**3. GASTROENTEROLOGY:** Bleep 5008 to liaise with the nurse specialist for urgent OGD’s these should also be requested on sigma including OOH and complete a GI bleed assessment form at the time of referral.

**4. DIABETES LIAISON TEAM**: Bleep number 2197. We also have a Diabetes ‘in reach’ team which visits AMU daily to review patients with diabetes.

**5. ALCOHOL NURSES**: Bleep number 5246.

**6. STROKE NURSES**: Bleep 5024. Please also ensure that stroke proformas are completed for stroke patients. All patients with suspected Stroke/TIA should be referred urgently to the Stroke Nurse.

**7. ACUTE ONCOLOGY**

The Acute Oncology advisory team at Aintree provide support and advice -

* For cancer patients with new symptoms
* For cancer patients who are on chemotherapy
* For cancer patients who are having radiotherapy
* Patients with a new cancer

·      Patients with a new cancer of unknown primary

Contact them on 529 8378 or bleep 5398; referral can also be made directly using Sigma

Please note out-patient appointments should be booked directly with

Clatterbridge Cancer Centre, contact via switch

Acute Oncology CNS Ext 8349 Bleep 5398

1. **Palliative Care**

There is a palliative care team available via switch and also filing cabinet on Amu with all palliative care pathways please use individual care plans for end of life patients.

1. **Spinal Cord Compression**

Detailed guidelines available please follow this is a clinical emergency and proforma available to guide process

1. **Guillain-Barre Syndrome** – guideline and proforma available to support management
2. **Neurosurgical referrals**  - done via ORION - <https://orioncloud.org>.

**Procedures**

1. **Lumbar puncture-** There is a lumbar puncture pack which can be collected from the lab opposite the entrance to ED. This contains all of the sample bottles you will need to send and instruction. Spinal needles, drapes and the other equipment can be obtained from AMU.
2. **Chest drains and Aspiration kit-** US and equipment can be found in ED andin the AMU treatment room.
3. **Central lines-**Equipment can be found in ED and ITU. Additional equipment can be found on ward 15. There is an US scanner in the ED that can be used.
4. **Knee aspiration-**There are hot joint packs in the path lab opposite ED the rest of the equipment can be found on the wards. Once sample taken for urgent microbiology overnight the on call microbiologist needs to be contacted so that they know to process the sample.
5. **Ascitic drains-** kits can be found on both the gastro wards and on AMU
6. **NIV-** There is an NIV protocol on the intranet and this can be started in resus.

**PLEASE COMPLETE LOCSIP CHECKLIST FOR ALL PATIENTS UNDERGOING INVASIVE PROCEDURES**

**Urgent OP Radiology Pathway-for patients coming back to AEC**

There is a pathway for urgent OP CT and MRI requests for patients that we are discharging from The Acute Take (see appendix). This should cut the number of journeys for patients, and eliminate the problem of patients returning to HOT clinic for scans that haven’t been done or reported.

If we are planning an outpatient CT or MRI with AEC/Hot Clinic Review afterwards, then we should follow this pathway.

Key points are:

* Select “VIRTUAL WARD PRIORITY” when selecting the priority on the Order (see below)
* Include the patient’s contact/mobile tel no in the clinical details
* Refer patient to the AEC team via orders on dashboard or ICE
* If a contrast CT is planned, the AEC/AMU nurse will provide Gastrograffin and the attached Patient info Sheet
* Radiology will arrange the CT/MRI
* Radiology will HOT REPORT the scan and will send the patient round to AEC from Radiology so that they can receive the results the same day

NOTE: CT requests may take up to 48 hours (MRI may take longer). Therefore, for CTPAs that can’t be done same day (eg stable patients seen on take late evening), the patient’s notes must be left with the AEC team to arrange scan the next day and contact patient.

**List of current guidelines available in the trust –** These might have changed as part of integration of services post-merger but have been included as guidance

There are currently a plethora of useful guidelines accessible via the trust Document management system (DMS) but they have to be searched for. When on the home page on tryst computers click on the middle tab titled documents (DMS) and this will bring up a separate page where you have to login. The search criteria and names of guidelines are sometimes counter intuitive which we are working on improving but below is a list of accessible guidelines and their names so if needed you can find them. There is in addition to this a Covid hub for the latest Covid updates and this is accessed via the intranet.

|  |  |
| --- | --- |
| Speciality | guideline |
| Acute medicine | AEC of patients needing IV Abx for cellulitis |
|  | Ambulatory Emergency Care (AEC) guideline for patients with Hypertensive Urgency |
|  | Guidelines for management and investigations of patients with confirmed or suspected Pulmonary Embolism. |
|  | Acute Asthma |
|  | The recognition and management of allergic reactions in adults inc anaphylaxis |
|  | Naloxone IV administration guidelines |
|  | Rapid tranquilisation protocol |
|  | The Treatment of Severe Metabolic Emergencies inc phosphate, sodium, potassium, calcium and magnesium. |
|  | Acute headache pathway |
|  | paracetamol OD care pathway |
|  | Acute hot joint guideline |
| Respiratory | Actrite referrals |
|  | Antimicrobial therapy for the management of bronchiectasis |
|  | Acute Asthma |
|  | COPD guidelines inc NIV |
|  | Clinical Guidelines for the preparation and ongoing care of patients with a tra-cheostomy transferred to wards from the Critical Care Unit |
|  | insertion of intercostal chest drain guidance |
|  | CAP guidelines |
|  | Thrombolysis for PE |
|  | Aminophilline |
| Gastroenterology | Acute alcohol withdrawal inc GMWAS |
|  | Acute alcohol withdrawal and seizures |
|  | Acute alcohol withdrawal and wernekes |
|  | Acute alcohol withdrawal and DT/psycosis |
|  | Alcohol related brain injury |
|  | Inpatient management of Ulcerative colitis |
|  | Inpatient management of Ulcerative colitis-ciclosporine |
|  | Inpatient management of Ulcerative colitis-infliximab |
|  | Guidelines for the Management of Refeeding Syndrome |
|  | Gallstone Disease – Inpatient Management Pathway |
|  | New onset Jaundice management pathway |
|  | Upper GI bleed proforma |
|  | Diagnosis and clinical management of C.diff |
| Endocrine | Antimicrobials for diabetic foot infections |
|  | GKI infusion guideline |
|  | Inpatient diabetes guidelines inc emergencies |
|  | Management of DKA |
|  | Management of hypoglycaemia in diabetic patients |
|  | HHS proforma and guidance |
|  | Steroid treatment and hyperglycaemia |
|  | Management of cranial diabtetes insipidus |
|  | endocrine investigations and protocols |
|  | Assesment and management of hyponatraemia-2010 ?out of date |
|  | hypernatraemia guidelines |
| Renal | AKI |
|  | Reduction of Risk from Contrast Enhanced Studies |
|  | The Treatment of Severe Metabolic Emergencies |
|  | Management of pulmonary oedema in patients with Renal failure |
|  | Antibiotics for PD and related infections |
|  | Management of dialysis patients with stage 5 chronic kidney disease (CKD) after parathyroidectomy |
|  | Clinical Guidelines on treatment options for Intravenous Iron |
|  | Thrombolysis guidelines for blocked tunnelled catheters |
|  | Treatment of hyperkalaemia including renal patients |
|  | vascular access bleeding fistula |
|  | vascular access thrombosed fistula |
| Cardiology | Chest pain pathway |
|  | NSTEMI ACS guidelines |
|  | Primary PCI protocol (mersey) |
|  | Amiodarone |
|  | Heart failure guidelines |
|  | Decision to withdraw ICD in adult patients |
|  | Ambulatory AF service: Ambulatory management of new onset Atrial Fibrillation by Arrhythmia Nurse Specialist |
| Rheumatology | Acute hot joint guideline |
|  | Giant cell/temporal arteritis guideline |
| Neurology | Cauda equina |
|  | Metastatic spinal cord compression |
|  | The Management of Bell’s Palsy |
|  | Guideline and monitoring for the management of Guillain-Barre Syndrome |
|  | Management of stroke and TIA |
|  | Meningitis guideline |
|  | Acute headache pathway |
|  | Thunderclap headache |
|  | Epilepsy and seizures management pathway |
|  | Management of parkinsons for inpatients |
| Oncology | Acute oncology referal guidelines |
|  | Immunotherapy-management of complications |
|  | cancer related emergencies inc complications of chemo/radiotherapy |
|  | Metastatic spinal cord compression |
|  | CUP-brain mets |
| haematology | Antiemetic Guidelines for Patients receiving chemotherapy for Haematological Disease |
|  | Neutropenic sepsis guidelines |
|  | Antimicrobials for neutropenic haematology patients |
|  | Use of Irradiated Blood Components |
|  | Tumour lysis syndrome prevention and management |
|  | Diagnosis and Management Guidelines for Patients with Heparin Induced Thrombocytopenia (HIT) |
|  | The use of Direct Oral AntiCoagulants (DOACs). |
|  | IVC Filter Insertion and Retrieval |
|  | Guidelines for management and investigations of patients with confirmed or suspected Pulmonary Embolism. |
|  | Major haemorrhage guidelines |
|  | management of transfusion reactions |
|  | warfarin reversal |
|  | Sickle cell crisis guidelines |
| Micro and ID | Diagnosis and management of Clostridium difficile Infection |
|  | varal gastroenteritis |
|  | Meningitis guideline |
|  | Neutropenic sepsis guidelines |
| DMOP and Stroke | Management of stroke and TIA |
|  | management of acute ischaemic stroke patient reciving thromblysis treatment |
|  | use of alteplase in acute ischaemic stroke |
|  | Management of parkinsons for inpatients |
|  | Dementia care in Aintree guidance |

**COVID 19 Information**

This is a rapidly changing process so please review the COVID hub – link will be on any desktop screen. Proforma for admission, ward distributions and policy such as dexamethasone usage all listed on the hub

<https://www.liverpoolft.nhs.uk/covid-19-hub/>

**Ward Cover**

During 9-5pm Monday to Friday the wards are covered by their regular teams in addition to MET teams for emergencies. Your days holding the MET bleep will be allocated by your department and will not appear on the master GIM rota that you are issued. You collect the bleep at 9am handover in the medical handover room and attend MET calls during the period you hold the bleep. Crucially we cover the whole Aintree site including the grounds and not just the building. Site map included below as the grounds are large it is worth familiarizing yourself with the site including the outbuildings towards the top of the map:



The Met team will include an SPR, SHO and FY1 at all times in addition to the nurse clinicians and an ODP. For anesthetic support you need to request assistance. ITU will attend “high risk” areas as standard and these include the NIV unit (VIC), AMU, MAB/FAB, ward 29, ward 28 (both surgical wards inc ENT and Max Fax) and major trauma.

We don’t have separate MET and cardiac arrests at Aintree.

When covering the wards you are covering for emergencies but will be continuing your routine specialty work. You should not be expected to review patients in Aintree to home as there is an SOP for consultant cover for them to ask for help not the on call Spr.

## Signing up for locums

To join the staff bank at present we are using an app called allocate to both book and arrange payment for shifts. To do this please contact medical roster team

You will then need to register for an account and go through pre-employment clearence.

For mor information please contact medical rostering team - Medical.Roster@liverpoolft.nhs.uk

**Sickness Procedure**

If you are unwell and are unable to attend work you must notify the following people:

1. Own department by usual process

2. Medical Staffing On-call if you have on call duties on Medical Roster Contact Details: Internal Ext: 6345 Mobile Number: 07814290349

3. Only if Colleen/Kelly or Medical Staffing On-call are unable to speak to you at the point you call, is it permissible to contact the ward and leave notification of your absence there with a senior member of staff.

You should personally inform one of the above in a *timely manner* providing the reason for your absence, likely duration, any affected work commitments, and the arrangements for keeping in touch.

What this means…

You must always report your absence *personally*. Only in exceptional circumstances (ie. where there is a specific reason such as incapacity or disability which means you are unable to use a telephone) should someone else should make contact on your behalf. However, in such circumstances, the responsibility to communicate your absence remains your own.

**Timely manner**

• You should ring as soon as you fall sick and you know you will be unable to attend for work; you must always inform them before the commencement of your normal starting time, but in any event, without unreasonable delay, on your first day of absence. For day staff this would normally be expected to be within one hour of their normal starting time. In the case of late, evening and night staff, notification of sickness should be made before the end of the normal daytime office hours on the same day, or as soon as practical thereafter.

**Reason for your absence**

• You must always provide appropriate details regarding the reason for the absence; it is not enough simply to say you are ‘ill’ or ‘unwell’.

**Likely duration**

• You must always advise the likely duration, and when you expect to return to duty.

**Any affected work commitments**

• You must always give details of any work issues that may need attention during your absence, or confirm that there are none if this is the case, and where appropriate provide the necessary information to enable these to be addressed.

**Arrangements for keeping in touch**

* You must keep in touch at regular intervals; as a minimum;
* On the first day
* On the 4th Day
* On the 8th Day
* On a weekly basis thereafter

If you do not initiate and maintain this contact, Coleen Mackenzie/Kelly Chadwick will contact you. They may also wish to contact you by telephone, by letter, or make a personal visit to your home should this be deemed necessary.

On return to duty, a ‘Return to Work’ interview will be held with your clinical supervisor. The aim of the return to work interview is to clarify the details of your sickness absence, ensure you are fit to resume to duty and see if any further assistance would be helpful to you for your return back to work. A full copy of the Notification and Certification of Sickness Procedure is available on the Intranet.

**Infection Control /Microbiology**

* We all have a vital role in Infection Prevention and Control in the Trust
* Hand hygiene is a key part of infection control. Please refer to **Hand hygiene guidelines** on the trust intranet.
* There is a ‘Bare below the elbow’ policy within the Trust
* **Antimicrobial prescribing guidance** can be selected from the Trust intranet homepage with guidelines by organ system or sepsis guidelines.
* If you are prescribing outside of the antibiotic guidelines then this must be discussed with and agreed by a senior member of staff and/or the Microbiology team, and the reason for not adhering to the antibiotic policy must be recorded within the medical notes.
* When prescribing antibiotics the reason for using the antibiotic ie. diagnosis and a stop or review date must be included
* If you are unsure whether an antibiotic is indicated then you should discuss this with a senior member of the Medical team or the Microbiology team
* Please read the **Infection Prevention and control- what you need to know** leaflet on the Trust intranet
* There are guidelines on Viral gastroenteritis and the Diagnosis and management of Clostridium difficile infection on the Trust intranet
* Please ASK patients on admission about **diarrhoea** and isolate as quickly as possible, use gloves and aprons for all contact with patients and their environment and clean your stethoscope if used with wipes. Wash hands with soap and water (not alcohol gel) after seeing a patient with diarrhoea. Ensure stool is tested and a stool chart is commenced. Review any antibiotics or PPI’s the patient is prescribed.
* If you have any questions or concerns about Infection Control, please contact the IPC team on **ext 4930 or bleep 4499**
* **CSF Samples:** If you need to send a CSF sample you must notify the microbiology department by telephone before you send the sample so that samples are processed in a timely fashion.
* **COVID information is available via** [**https://www.liverpoolft.nhs.uk/covid-19-hub/**](https://www.liverpoolft.nhs.uk/covid-19-hub/)

**Take Home Medication (TTOs)**

* Doctors/ANPs/PAs to document plan for discharge in the notes.
* Prescribe TTO on JAC before discharge with a brief accurate summary for GP to be written on dashboard discharge. If relevant: ‘NO INT’ can be typed on the TTO in JAC for ‘NO INTENDED CHANGES’
* Details of long term changes and course length of treatment should be included eg for antibiotics or anticoagulation

*During Lloyds pharmacy opening hours (9am-6pm Mon-Fri):* a handwritten paper outpatient prescription is issued.

*Hospital Pharmacy weekend hours (Sat 9am-3pm and Sun 2-3pm):* a handwritten Lloyd’s outpatient prescription is accepted.

Please ensure that a brief accurate JAC discharge summary or AEC HOT clinic letter is completed at the time of discharge (including any medications newly prescribed, discontinued or any dose changes).

*Out of pharmacy opening hours (or if patient is unable to collect TTOs from Lloyds Pharmacy):*

Check if TTO medications can be issued from pre-packed ward stock *(see poster in ward areas).*

Prescribe TTO on JAC before discharge.

If issued from pre-packed stock, print TTO and give to staff nurse to dispense medications.

If patient or relative is returning to collect TTO:

Type ‘TTO TO BE COLLECTED NEXT DAY’ as a dummy drug into the TTO section on JAC.

**Please discharge patient from JAC in order for pharmacy to process the TTO for next day.**

Doctor/ANP to check when next scheduled dose is and document plans to cover this.

*If prescribing treatment dose LMWH, please ensure patient weight is recorded on the discharge summary for pharmacy to verify LMWH dose. The patient may need to return to HOT clinic at 9am for a morning dose.*

Please supply patient with AMU/SSW telephone number and advise patient or relative to phone after 10am the next day (3pm if Sunday) to check TTO is available before attending to collect them.

**Discharge Letters – for acute take patients**

All letters must be completed as the patient is discharged from the AMU/AEC areas. We aim to complete ***real time*** discharge letters. Please do not discharge a patient without reviewing and acknowledging all their test results even if you didn’t order them. If you are worried about any results, please discuss with a senior doctor on duty and document it in the patient’s medical notes. Please ensure any outstanding/awaited outpatient investigations are mentioned in the discharge summary. Also kindly ensure that referrals for opinions and outpatient tests are made ***at the time*** of discharge and not left to someone else to do who may not know the patient. **THE DISCHARGING DOCTOR OWNS THE RESPONSIBILITY FOR ENSURING THE PATIENT IS DISCHARGED SAFELY** (and this includes making sure that follow up investigations/opinions/clinics/medication information particular regarding anticoagulation etc are arranged appropriately).

* ALL ACUTE ADMISSION/INPATIENTS DISCHARGES SHOULD BE DONE ON DASHBOARD WITH TTO MEDICATION PRESCRIBED VIA JAC
* *AMU* ***HOT CLINIC*** *DISCHARGES* SHOULD BE DONE ON DASHBOARD WITH TTO MEDICATION PRESCRIBED VIA JAC OR PAPER PRESCRIPTION OR STOCK MEDICATION – **BUT ANY NEW PRESCRIPTION GIVEN OR MEDICATION CHANGES (STARTED OR STOPPED) MUST BE DOCUMENTED WITHIN THE TEXT OF THE LETTER FOR GP TO BE AWARE**
* VERY RARELY EPRO SYSTEM MIGHT BE NEEDED TO BE USED FOR PATIENTS WHO HAVE NOT HAD AN ADMISSION EG VIRTUAL HOT CLINICS PLEASE ASK TEAM HOW TO DO THIS.

**PLEASE, MAKE SURE IF YOU ADMIT A PATIENT ON JAC TO DISCHARGE THEM AFTER YOU FINISH THE DISCHARGE SUMMARY.**