Southport & Ormskirk Hospital NHS
NHS Trust

Providing safe, clean and friendly care

Departmental Handbook

Medicine

February 2021

4th Edition Dr H Gibson (updated)

1st edition compiled by Dr G P Butcher and Dr J P Fox
2nd edition compiled by Dr P Mansour and Dr P McDonald
3rd edition compiled by Dr H Gibson

WELCOME TO OUR TRUST

Dear Doctor,

4th Edition: Updated content including Covid-19 pandemic. February 2021

3rd Edition: Times have changed and doctors move on. This 3rd edition of the medical handbook has been updated significantly with the latest important details that we hope you will find useful in *performing* your job in a safe environment for you and your patients. As well as the usual information of where and how, we have included new sections including contacts numbers, what conditions should be referred to medicine by AED, how and where to refer, wellbeing, Fatigue and Facilities Charter, Guardian of Safe Working, Exception reporting and more on your training and education. Pathways for medical conditions have been removed but are all accessible on the intranet. This handbook tells you how.

Do take every opportunity to see your attachment here at Southport as educational and remember that nearly all aspects of patient care will be informative in some way, including handovers, post-take ward rounds, ward rounds, red-green rounds and board rounds.

We, as our forerunners, hope you have an enjoyable experience while at Southport and Ormskirk NHS Trust.

Dr H Gibson June 2019

Credits: Special thanks to Drs Masroor Diwan, Kahlil Wahdati and Ashar Ahmed for proofreading and suggesting some additional material.

CONTENTS

This handbook can also be found under the Clinical Section of the Trust intranet.

INTRODUCTION

The duties of a doctor registered with the General Medical Council.

Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and you must:

- Make the care of your patient your first concern
- Protect and promote the health of patients and the public
- Provide a good standard of practice and care
    - Keep your professional knowledge and skills up to date
    - Recognise and work within the limits of your competence
    - Work with colleagues in ways that best serve patients' interests
- Treat patients as individuals and respect their dignity
    - Treat patients politely and considerately
    - Respect patients' right to confidentiality
- Work in partnership with patients
    - Listen to patients and respond to their concerns and preferences
    - Give patients the information they want or need in a way they can understand
    - Respect patients' right to reach decisions with you about their treatment and care
    - Support patients in caring for themselves to improve and maintain their health
- Be honest and open and act with integrity
    - Act without delay if you have good reason to believe that you or a colleague may be putting patients at risk

- Never discriminate unfairly against patients or colleagues
- Never abuse your patients' trust in you or the public's trust in the profession

You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.

IMPORTANT CONTACT NUMBERS

DEPARTMENTS

ECG (ECHO)	4041
CCU (7A)	4207
X-ray reception	4107
CxR O/C	4109
Ultrasound	4106
MRI	4485
CT	4152
Tele Medicine Clinic (OOH radiology)	01189485281
Endoscopy	4448 (SDGH) and 6487 (ODGH)
Dietician (emergency)	3813
O&G ODGH	5418
Ophthalmology/ENT	5227
IT	6666
Bed Manager	3800
Anaesthetist 1st on-call	3917 RF pager 1027
Anaesthetist 2nd on-call (ITU referrals):	
	3965 RF pager 1028
Mental Health	5909
ITU	4218

HOSPITALS

PRESTON	#6236
WHISTON	#6256
RLUH	#6112
CCC	#6105

LHCH	#6320
WCNN	#6115
UHA	01515255980

LABS

Haematology	4175
Biochemistry	4172
Histopathology	4679
Transfusion	4176
Whiston microbiology	01514301652
Med Micro secretary	4717
Renal referral	01515292420
Stroke	3879
Endocopists	3925/3973
Clinical Biochemist (urgent ANCA)	0151 2904520

DOCTOR ON CALL ASCOM NUMBERS

Medicine Registrar	3977	RF pager 1026
Medical FY2+ (9am-9pm)	3974	RF pager 1071
Medical FY2+ (twilight)	3976	RF pager 1032
Medical FY1	3975	RF pager 1024
Surgical Registrar	1025	
Surg/Urol FY2+	3981	RF pager 1072
Surg/Urol FY1	3980	RF pager 1019
Surg RMO	3724	RF pager 1053
Urology Registrar	mobile	
Orthopaedics Registrar	mobile	
Orthopaedics FY2+	5373	RF pager 1022
O&GRegistrar	5418	RF pager 1057
O&G FY2+	5404	RF pager 1056
Paeds Registrar	3722	RF pager 1062
Neo paeds Reg	5423	RF pager 1065
Paeds FY2+	3723	RF pager 1060

Paeds FY2+	3721	RF pager 1061

SECRETARIES

Acute Oncology

	Michelle Roberts	5237

Acute Medicine

Dr Gibson (HG)	Eira Roach (Acute Med)	4947
Dr Glackin (MEG)	Eira Roach (Acute Med)	4947
Dr Wahdati (KW)	Eira Roach (Acute Med)	4947
Dr Diwan (MD)	Eira Roach (Acute Med)	4947
	Amanda McCabe (Rheum)	4205
Dr Ahmed (AEA)	Eira Roach (Acute Med)	4947
	Kate Smith (rheumatology)	4527
Dr Hasnain Raza	Eira Roach (Acute Med)	4947

Cardiology

Dr P Mennim (PGM)	Vicki Flavell	4156/5185
Dr A Shalan (ASH)	Suzanne Sourbutts	4578
Dr Neuman Ahmed (NZA)	Suzanne Sourbutts	4578

Cardiac Electrophysiology

Dr Richard Snowden	Michelle Roberts	4156

Care of the Elderly

Dr L Hussain (LA)	Lilian Lock/Adel Wright	4570
Dr P McDonald (PAM)	Lorraine Coates	5181
Dr E Sykes (ES)	Lilian Lock/Adel Wright	4570

Endocrinology

Dr S Khan (SK)	Louise McGuiness	5180
Dr M Khan (MK)	Louise McGuiness	5180

Gastroenterology

Dr M Roberts (RTM)	Lesley Haywood	4101
Dr N Apostolou (NA)	Lesley Haywood	4101
Dr N Shami (MNS)	Lesley Haywood	4101

Neurology

Dr S Alusi	Sarah Foot	5187
Dr U Weishmann	Sarah Foot	5187

Renal

Hasnain Raza	Jan Nicholson	4569

Respiratory

Dr Banerjee (ANB)	Denise Dixon/Janet Croft	4155
Dr McManus (CJM)	Christine Lee	5182
Dr Youzguin (AY)	Denise Dixon/Janet Croft	4155

Rheumatology

Dr Ahmed (AEA)	Kate Smith	4527

Corporate Management Contact Numbers

Kate Monaghan DM (emergency medicine)	5363
Louise Hicks DM (specialist medicine)	4933
Rachel Cassidy OSM (general medicine)	3832
Lisa Edwards DM (general medicine)	5304
Cordelia Lieb-Corkish (OSM general medicine)	5156

WARDS

EAU/10A (Emergency Admissions Unit - medicine)	4244
ACU (Ambulatory Care - medicine**)**	4806
Short Stay Unit SSU)/9A (Acute Medicine / Respiratory Medicine)	4241

7A Cardiology	4207
7B Stroke	5021
9A Short Stay Unit (SSU)	4241
Acute, endocrine & diabetes	
9B/FESSU	4248
Frail Elderly Short Stay Unit	
10B/SAU;SSSU	4502
Surgical Assessment; Short Stay Surgical Units	
11A Surgical	5105
11B Gastroenterology	4245
14A Orthopaedics	4889
14B Respiratory	4894
15A Care of Elderly	5267
15B Care of Elderly	4232
ITU	4218
HDU	4503
CCU	4207
MDU	4220
OBS	4652

SPECIALIST NURSES

HALT		5376
Gastroenterology:		
PEG nurse Vaughan Fletcher	bleep	3925
PEG nurse Roger Nicholson	bleep	3973
Upper GI nurse Louise Keenan		4696
Colorectal nurse Jo Sutton		4250
IBD nurse Anne Hurst	4093, bleep 5478	
IBD nurse Lucy Aitchison	4093, bleep 5478	
Upper GI MDT Lesley Hogan		4875
Colorectal MDT Adam Dewsbury		4085
Respiratory:		
ACTRITE		4915
Sefton Community Respiratory Team		07867187659
Sefton Oxygen		0151 529 8334
Respiratory chronic conditions & oxygen		

Gail Massey, Jo Houghton 5162, Ascom 3775
Respiratory (lung cancer)
Janet Thompson, Mel Baron 5161/4653
Other:

OPAT	0151 285 4696
Acute Oncology (Julie)	3846
Stroke	3879
Diabetes Specialist Nurse	3633
DVT service	3803
SALT	4361
Dietician	3813

Other:

Security	3810/ext4941
Bed Manager	3800/1020
Head Porter	3851(2)/1018
Accommodation Office (Ruth Johnston)	4593

Community Heart Failure Team:
West Lancs: Virgin Care, Community heart Failure Team, Bickerstaff House, Ormskirk Hospital, Wigan, Road, Ormskirk, L39 2AZ email: vcl.westlancsheartfailure.nhs.net Tel:0300 247 0011
Sefton: Litherland Town Hall, Halton Hill Road, Litherland, L21 9NJ email:communitycardiacteam@nhs.net Tel: 0151 475 4030

Emergency ambulance transfer	0345 140 0144
Primary PCI (24/7)	
– Activate LHCH PPCI policy	0151 600 1817

CLINICAL SECTION

WARD OBLIGATIONS

In the Medicine Division we want to practice high quality, efficient medicine. In order to do this we must be consistent in our approach to a number of different activities. We call these **ward obligations**:

- All prescriptions have **allergy status** and **prescriber details**
- All antibiotic prescriptions (ARK) carry **indications**, **IV/oral switch date** and **stop date**
- There is a handover of **sick patients** to the on-call team every evening
- There is an electronic handover of **sick patients** / **discharges** for the weekend
- The on-call team meets for handover for Hospital At Night every night
- All case note entries are fully documented with **date**, **time**, **author** and **GMC number,** plus your own **bleep number** (not generic on-call bleep)
- All patients have an updated **Management Plan** on the **Ward Boards**
- All patients have an expected date of discharge (EDD) documented
- To encourage consistent note keeping. There is a ward round proforma available on each ward which should be used on all consultant ward rounds

All patients must have a **discharge letter** issued at the time of discharge. As a **minimum**, it must include:

- Admission details
- Diagnosis and significant co-morbidities
- Medication (highlighting any changes made in hospital)
- Follow up arrangements

- The EMIS package should be used wherever possible (Medway for ACU)

In addition the Chief Executive has highlighted items which should be **mandatory** for those employed in the Trust:

- Timekeeping
- Hand hygiene
- Patient observations
- Expected date of discharge
- IV sighting and care plans
- Antimicrobial stop dates
- Good case note documentation
- Uniform and dress code
- Call bells and Nutrition
- Timeliness of discharge letters
- Appraisal and mandatory training

BLEEPS

There are two type of bleeps:

- Ascom (mobile phone like in appearance)
- Radio pagers

Bleep numbers starting with a ‘1’ are for radio pagers. To access a radio pager dial 4477 and follow the instructions given. Ascom pagers can be used in the same was as a telephone by dialling the number. Text messages can be sent using the phone keyboard or on a desktop clicking on the green ‘INTERNAL BLEEPS’ icon on useful links (if present).

Bleeps should be collected from switchboard at the start of an attachment and handed back to switchboard on completion of an attachment.

Bleeps are allocated according to consultant team. ***Do not keep your bleep on changing specialty, even if you stay on the same ward.***

MEDICINE SPECIALTY WARDS

The wards are divided into specialty according to the Consultants having patients on those wards. Where possible, newly-admitted patients will be sent to the most appropriate ward determined by their admission diagnosis.

Patients admitted for tests with an early discharge planned may stay on EAU. Patients with a planned hospital stay of less than 72 hours can be admitted to SSU, regardless of diagnosis. Some patients may be suitable for Ambulatory Care and may be referred to the ACU.

Ward Template

This may change from time to time, particularly while the covid-19 pandemic continues.

7A – Cardiology
7B – Stroke
9A – Short Stay Unit (SSU) / Endocrine, Diabetes & General Medicine
9B – Frail Elderly Short Stay Unit (FESSU)
10A – Emergency Assessment Unit
10B – Surgical Assessment Unit
11A – Surgery
11B – Gastroenterology / General Medicine
14A – Orthopaedics
14B – Respiratory & General Medicine
15A – Care of Elderly / General Medicine
15B – Care of Elderly / General Medicine

Outliers on non-medical wards and HDU/ITU

All patients transferred or admitted directly to a medical ward are immediately placed under the care of one of the ward consultant and his/her team. During normal working hours that team should **provide care for the patient as soon as they arrive** even if they haven't had a formal post take review.

Medical patients may be admitted to non-medical wards under an allocated medical consultant, providing care along with their teams. *Please check with your consultant which outlying ward you may need to cover.*

You should check daily as to any new admissions and make sure that any patients under their team are reviewed daily and included in any ward rounds.

Medical patients may also be bedded on the Clinical Decisions Unit (CDU) in AED and are the responsibility of the Post-Take consultant's team. Similarly, patients on HDU/ITU are under the responsibility of the Post-Take consultant's team.

Coronary Care Unit

A four-bedded CCU is located on the same template as 7A. The consultant cardiologists (and their respective teams) care for these patients on a rotational basis for a week at a time during normal working hours (Monday 9am start).

A daily ward round is done each morning with follow-up visits as required. However, there is no separate out of hours cardiology consultant cover and at such times the patients are the responsibility of the on-call team and physician of the day.

At weekends the unit should be visited by the registrar and by the on-call physician if required. On normal working days

patients admitted as emergencies must be attended to by the admitting team of the day until the following morning unless and until they are specifically taken over by the cardiologist on for the week during that day.

The CCU is not staffed neither medically nor nursing wise to function as a medical HDU. If it is used in that way any such patient will remain the responsibility of the admitting consultant and their team.

BOARD ROUNDS/RED-GREEN ROUNDS

Board rounds are conducted with the white board as an aid. Ideally it should be multidisciplinary and led by the most senior doctor present, including the whole medical team, a nursing lead who knows the current situation with the patient, therapies, pharmacy, social worker and the discharge coordinator.

Each patient should be discussed with investigation results where appropriate - checking on clinical progress, and any obstacles to discharge, so that changes can be made early to improve the patient's progress and any changes to management documented.

The Expected Date of Discharge (EDD) helps planning for timely discharge, all patients should have one noted on the white board and in the case notes.

Red/Green rounds should similarly be multidisciplinary and review activities and goals for that day of the patient's stay, identifying and acting on obstacles delaying a patient's progress or discharge e.g. investigations or social issues. A Red day indicates goals for that day have not been achieved. A Green day represents completed goals. Where red days occur action should be undertaken to escalate any issues for delays in patient care.

Board rounds and Red/Green rounds should occur daily.

ON-CALL ADMISSIONS & EMERGENCIES

All junior doctors participate in the medical division's on-call rota to provide continuous inpatient medical cover for new admissions and existing patients. The on-call rota is compliant as per 2016 junior doctor's contract and can be viewed on the intranet EOL-MOL.

A full shift system including periods of night duty is in operation. The rota is different for different grades of staff and juniors should familiarise themselves with the rota for their grade.

When on call doctors will be mainly based in the Emergency Admissions Unit (EAU) or in the A&E department except for the FY1. However there may be times where attendance on ward patients may also be required (see weekends).

On weekdays the FY1 is expected to remain on ACU following handover until 5pm, clerking patients referred to ACU and then continue other on-call duties until night handover.

Structure

All patients are triaged in AED, including GP admissions. Patients may then be transferred to the ACU if appropriate for clerking by the FY1, transferred to EAU for clerking if space allows or remain in AED.

AED admitted patients will be seen by the AED team and referred to the appropriate specialty electronically. Medical patients may be transferred to EAU for clerking or remain in AED if too poorly to move. GP patients may be seen by AED doctors if unstable and no medical doctors are immediately available.

A joint clerking pro forma is in use to avoid unnecessary duplication.

Patients with CVA are directed to ward 7B (if a bed is available) unless thrombolised in which case they go to HDU. Acute cardiac patients needing CCU care are admitted directly but remain under the emergency team until taken over by the cardiologists the next normal working day.

Seriously ill patients requiring ITU/HDU care may be admitted direct to those wards following evaluation by the intensivists, but will be under the care of the post-take medical team.

Duties

The on-call doctors are a team and must work flexibly for the good of all patients (and themselves!).

However the usual allocation of duties is as follows:

- FY1 sees GP admissions on ACU
- FY2/CMT/IMT sees AED admissions either in AED or in EAU
- SpR/SAS reviews GP admissions seen by FY1/ANP/PA/nurse consultants (including ACU patients), deals with referrals from other specialities/complex admissions and leads the team
- The team is augmented by nurse consultants, ANPs and PAs who are based on the ACU

During normal working hours the ward based duties should be covered by other members of the team **or by cross cover from other members of the template**.

Juniors are expected to let other team members and nursing staff know what arrangements are in place on a day to day basis.

SpR/SAS grades will have no clinic duties when on call but should make sure that clinics have been automatically cancelled by checking well in advance with the consultant's secretary. This is especially important in the case of any swaps to the published rota.

AED to Medicine Referral Guidance

Referrals are in electronic form.

This can be accessed on URL:

https://bireports.southportandormskirk.nhs.uk/HDMSQL_Reports/Pages/Report.aspx?ItemPath=%2fReports%2fInternal%2fMedical+Referral+And+Post+Take+Patients+With+Location

Patients referred to in-patient teams should not ordinarily be referred back to AED. After assessment patients may either be discharged or referred to another speciality.

If there are concerns over a referral the speciality doctor should politely request that the case is discussed with an AED senior.

Patients may be referred to the Ambulatory Care Unit (ACU) if meeting certain criteria for ambulatory care. Referrals must be made using the ACU referral form.

Abdominal Pain:

Patients presenting with acute abdominal pain to AED who following AED assessment are felt to need admission should be referred to the surgical team on call *except* the following:

- Positive pregnancy test and suspected ectopic
- AED feel likely gynaecological pathology and accepted by O&G registrar. This will mainly apply to patients with a past history of gynaecological problems and/or other features to suggest acute gynaecological problem.
- Clear medical diagnosis e.g. pneumonia/DKA and absence of features of acute abdomen.
- Patients under follow up with gastroenterology with inflammatory bowel disease who present with abdominal

pain as part of a flare up of their disease (may need joint care but must be placed under a specific specialty team)

If following surgical review it is felt that surgical admission is not required an electronic registrar to registrar referral should be made to the appropriate speciality.

The following conditions will be referred to the surgical team from AED:

- Urinary Retention (unless neurological cause) – if not suitable for ACU pathway.
- Breast Pathology
- Vascular pathology if not for transfer to RLUH – e.g. chronic limb ischaemia/AAA/venous or arterial ulcers/gangrene).

The following conditions will be referred to the orthopaedics team from AED:

- Septic arthritis
- Osteomyelitis
- Fractures in patients who are for surgical intervention
- Acute back pain

Note: Diabetic foot complications e.g. cellulitis/infected ulcers are admitted under general medicine.

Post-Operative complications

If admission is required it should be under the operative team who should request input from other specialities if necessary.

Acute confusion

Patients with acute confusion/delirium are admitted under the medical team

Pyelonephritis

Acute pyelonephritis is admitted under the urology team. Patients are referred to the on-call surgical FY2+.

Note: Sepsis due to UTI in elderly patients (>75 years of age) is admitted under general medicine.

Common Ambulatory Care Conditions:

- Headache (without neurology)
- Anaemia
- Chest pain (pain free, non-ischaemic ECG, no significant cardiac history)
- Pulmonary Embolism (if haemodynamically stable and not requiring oxygen)
- Electrolyte disturbance (Na≥ 120, K ≤ 7.0, hypocalcaemia/hypomagnesaemia – all must be asymptomatic and have no ECG changes)
- Asthma – PEFR >50%
- Community Acquired Pneumonia with CURB-65 ≤ 2
- Collapse with normal ECG
- Cellulitis without sepsis, ulcers or PVD
- AF/SVT if asymptomatic and HR ≤120
- Stable heart failure
- Hypoglycaemia
- Hyperglycaemia in absence of DKA
- Any condition that will not need an overnight stay, patient is self-caring and well with NEWS ≤ 3

After ACU closes, patients can still be referred to ACU and sent home (e.g. anaemia requiring transfusion) with a contact telephone number for ACU to with the patient a arrange date and time to return.

Obstetric Patients:

Most obstetric patients will be referred medically unless there is a requirement to monitor the baby. However, all obstetric patients should be discussed with the obstetrician on-call.

Consultant cover and post-take reviews/rounds

All new medical admissions are seen by a consultant within 12 hours of admission.

Morning Post-Take follows the morning handover. Patients on EAU and ACU are reviewed by the acute physicians. Other patients i.e. those on specialty wards, AED are seen by the Physician of the Day (POD). The post-take junior(s) accompanies the POD and provides excellent learning opportunities and allows doctors to complete SLEs for the ePortfolio.

In the afternoons the acute physicians either review all existing patients of theirs directly or by Board round. The physician of the day is available to see any seriously ill existing or new patients and will be present on the EAU during the afternoon from 1pm and will review new admissions (either GP or AED) as and when they are ready until 7pm. Again, this should be used as a learning opportunity by presenting and discussing cases seen.

In addition, a second consultant is available from 5pm until 9.30pm to review new patients, including those on ACU.

Overnight the physician of the day is available on call (via switchboard) for advice and will attend as required.

At weekends the physician of the day sees all new admissions on EAU, SSU and outlying wards. Juniors will attend as available.

A second consultant assists the on call consultant with patient reviews on Saturday and Sunday mornings. There is also a second registrar employed to review patients on wards (including patients on iv antibiotics), and to facilitate discharge. A discharge FY2+ additionally is required to review all weekend AKI blood results (list provided by CCOT at morning handover) and act on these as appropriate i.e. review patient if deteriorating, ensure

repeat U&Es following day, ensure fluids prescribed where appropriate.

The physician of the day will be present or available on EAU until 5pm to review new admissions or other patients as necessary. He/she is on-call thereafter from home until the next working day.

Handover

Morning handover starts at 9am **promptly** in the safety hub every day including weekends. All night team on-call doctors, day on-call doctors and EAU doctors must attend (except where covid restrictions are in place and only essential staff are present). A register is taken of all present. The handover is consultant led and all patients, particularly who are deteriorating or are scoring on the NEWS2 system are highlighted. In addition any AKI 3 patients or those with a GI bleed are also discussed. The RCP toolkit 1 SBAR pathway for handover is followed. The handover provides excellent learning opportunities and forum for discussion of the acutely unwell patient.

Hospital at Night

The workload of the hospital at night is delegated to ‘The Hospital at Night Team’ which is overseen by the Nurse Co-ordinator and SpR/SAS with a handover meeting each evening at 9pm in the ‘Safety Hub’.

Unless needed for urgent patient care, all resident doctors should attend the meeting to receive handover details of any patients who are, or may cause concern overnight

At the same time the night co-ordinator will allocate routine on-going ward work. Junior members of the team may be required to cross cover specialities if workloads require this. Again, the handover provides excellent learning opportunities.

The medical registrar is the medical lead for the whole team and should make every effort to attend. All members of the hospital at night team are required to sign in and must inform the night nurse co-ordinator on ASCOM 3800 if unable to attend.

CARDIAC ARREST 2222

The medical on call team are also the cardiac arrest team for the Southport site. They will carry additional bleeps during this period which must always be handed directly to the next person on duty at the end of the shift.

These bleeps are tested on a daily basis at 10am and switchboard contacted to confirm they are working. The team covers all buildings and immediate grounds on the Southport site and are usually supplemented by an anaesthetic doctor. After all arrests a DATIX should be completed by the team leader.

Cardiac resuscitation and DNACPR

Cardiopulmonary resuscitation is an advanced treatment that may be lifesaving in certain circumstances. However for some patients with terminal or advanced incurable conditions it is not in their best interests and may well be futile.

To avoid subjecting such patients to unnecessary distress, the Trust operates a “Do Not Attempt Cardiopulmonary Resuscitation” policy (DNACPR) in line with national guidelines. Full details of the policy are on the Trust website.

Current guidance, reflecting a recent high court ruling, states that a decision to implement a DNACPR notice must be discussed with the patient unless this is not possible either due to the patient’s condition or if in the clinicians considered opinion the necessary discussion would cause major harm to the patient. The presumption is that this discussion will take place and if not the reasons why not fully documented in the case notes. Seek senior advice if in doubt. Similarly the decision must be

communicated to family members as soon as possible with full documentation of the discussions taken place.

Many patients will already have a community DNACPR which will be brought in with the patient on admission (Lilac form). It is also necessary to check if a DNACPR order has been previously made in the hospital and can be found under 'ALERTS' on Medway or Evolve. A duplicate form may need to be issued for the current admission and placed in the case notes.

If the patient is unable to agree to DNACPR a mental capacity assessment must be documented if cognitively impaired and a discussion with the family documented. Forms are available for this and are also included in the COVID clerking proforma.

***Escalation and ceiling of care must also be documented*.** Document this in the notes and at the bottom of the Lilac form.

Nursing staff should be made aware of the patient's status.

If a DNACPR order is requested by a consultant on the Post-Take ward round (PTWR) this must be completed at the earliest opportunity by the PTWR junior doctor.

A patient and family information leaflet is available and copies can be found under the "Patients leaflets "section on the trust intranet site. DNACPR orders should be countersigned by a senior doctor if not initially completed by them.

CLERKING PROFORMA

A joint medical/emergency department proforma is used for all medical patients admitted to the hospital except on ACU. A separate COVID clerking proforma is used for those patients suspected of covid and is available in AED.

ALL sections of the proforma must be completed. If some parts are omitted by the AED clerking doctor, go back and complete the relevant section and initial. In particular, please ensure that social history/circumstances, medications and allergy status are completed.

Investigation results must be documented in the relevant areas including bloods, ECG, CxR/imaging and when relevant, urine dip. **IF ANY BLOODS ARE HAEMOLYSED, THEY MUST BE REPEATED IMMEDIATELY**. It is your responsibility to ensure these are reviewed in a timely manner.

If a medication list is not available use your smart card to access the EMISweb primary care 'Summary Care Record' for a list of the current prescribed medications.

The 'Additional information' page is for the brief review of the patient if initially seen by an AED doctor, with additional information. Do not re-clerk the patient (unless necessary to do so).

The PTWR is completed by the reviewing consultant. You may be asked to 'scribe' for the consultant. If this is the case please ensure all sections of the PTWR form are completed, **including AKI/sepsis/VTE assessments, Escalation, DNAR, smoking cessation, dispersal of patient and confirm an explanation of what is to be done has been given to the patient**.

All entries must be signed and include a printed name, grade and GMC number where indicated to do so.

Venous Thrombo-Embolism (VTE)

All newly assessed patients should be scored for their risk of VTE. This must be recorded on the drug chart for those admitted or the orange VTE assessment sheet if no drug chart is written. Appropriate treatment should prescribed as needed (to be given within 4 hours of admission – do **not** delay until next morning). If chemical prophylaxis is prescribed this must be done on the printed prescription on the **front** of the drug chart.

At 24 hours after admission the patient must be re-assessed and treatment either continued or ceased as appropriate and this reassessment must be documented on the drug chart.

EAU – 10 COMMANDMENTS

1. Hand wash/gel as you go in/out of bays and each cubicle. MAKE IT OBVIOUS: YOU ARE BEING WATCHED!
2. Complete drug cardex properly: Patient details; date of admission; ALLERGIES; SIGN front BEFORE prescribing with name, grade, GMC number & signature
3. Complete ALL SECTIONS of VTE assessment. You must sign, date and time entry.
4. ALWAYS include INDICATION, REVIEW/STOP DATE or DURATION of antibiotic therapy and steroids (BOTH iv AND PO); PRESCRIBE oxygen always when used
5. COMPLETE ALL SECTIONS of clerking proforma, including parts not completed by AED. This includes date/time of admission/clerking; FH, SH, RESULTS (including CxR, ECG and urine analysis); Sepsis/AKI assessment; checklist. This is audited!
6. IF A PATIENT IS DISCHARGED, THEY MUST HAVE A DISCHARGE LETTER PROVIDED BEFORE they leave the unit.
7. YOU ARE RESPONSIBLE FOR ENSURING ALL OP INVESTIGATIONS ARE REQUESTED WHEN COMPLETING THE DISCHARGE LETTER
8. COMPLETE SCORES eg CURB65 for pneumonia, CRUSADE/GRACE scores, ABCD2 etc
9. If any blood result is haemolysed, REPEAT it immediately
10. On examination IF YOU DON’T PUT YOUR FINGER IN IT, YOU WILL PUT YOUR FOOT IN IT!

COVID

During the covid pandemic it is essential you follow Trust guidelines to maintain safety for you and your patients. PPE is provided as per Government guidance. The Trust operates a one-way system for corridors and stairwells. Please make use of masks and hand gel provided at strategic points.

There are RED and AMBER areas designated in AED and where patients are deemed to have or are suspected to have covid a covid clerking proforma is to be used.

All doctors should be fit tested and you can make arrangements with the medical operational service managers (OSM) if you have not been fit tested:

Medical Staffing: Telephone 0170470 4767/5156

Email: **rachel.cassidy2@nhs.net**

Email: **c.lieb-corkish@nhs.net**

Due to illness you may find that you are asked to cover a different ward rather than the ward you usually work on. This will only be temporary and as needs require. Similarly, wards may change in specialty to accommodate patients diagnosed with covid.

You should be ‘risk assessed’ which should either be done by your lead employer or on specialty induction. If you have not been risk assessed please contact the OSMs on the numbers above.

National Early Warning Score (NEWS2)

NEWS is a system of recording several physiological patient variables on a regular basis. A deteriorating NEWS is a useful

adjunct to clinical assessment in the early detection of a patient whose condition is worsening.

By triggering a consistent, structured and progressive response it facilitates early recognition of such patients by non-medical staff and prompts and monitors the results of medical intervention in such patients.

All patients are scored on admission and thereafter at least twice daily. Scores are recorded on the standard nursing observations chart or VITALPac.

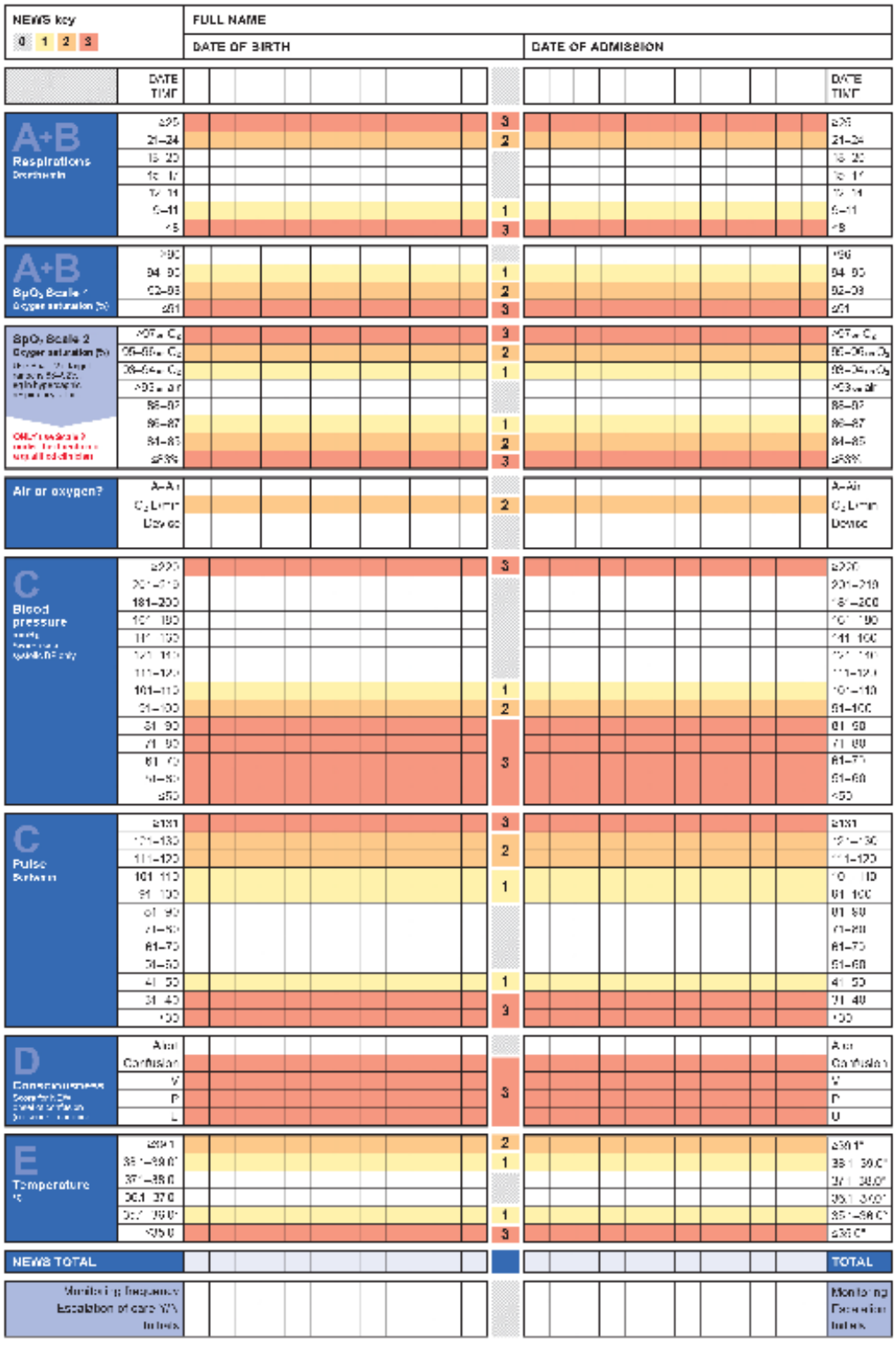
Patients reaching the baseline “trigger” score will have their frequency of observations increased. Once a patient triggers medical staff will be informed and must attend the patient. A deteriorating score will trigger an increasing level of senior medical input with assessment for and where appropriate transfer to a higher level of care (HDU/ITU).

A copy of the scoring sheet and the trigger process is shown on the next page.

Certain patients may have a maximum level of care stipulated by their consultant team in advance of any deterioration (e.g. non-invasive but not invasive ventilation) and all teams should document this clearly. Some patients may have been positively excluded from the scheme by their team (e.g. patients on End of Life care) by nature of their condition where an escalation of care would not be in the best interests of the patient.

It must be stressed that NEWS will not detect all possible ways in which a patient may show signs of severe illness and deterioration and should always be used alongside full clinical assessment and judgement as an aid to management and that some patients with a low NEWS may still need interventions and escalation of care.

Observation chart for the National Early Warning Score (NEWS2)



Royal College of Physicians

<table>
<tr><th>NEWS</th><th>Minimum</th><th colspan="3">Clinical Response</th></tr>
<tr><td>Total = 0</td><td>12 Hourly</td><td colspan="3">• Monitor full set of NEWS observations at least every 12 hours.</td></tr>
<tr><td>Total = 1 to 4</td><td>4 to 6 hourly</td><td colspan="3">• Registered Nurse to decide whether to increase observation frequency above minimum.
• Consider:
○ Oxygen
○ Fluid bolus
○ Nebulizer
○ Analgesia</td></tr>
<tr><td>Total = 5 or 6 or 3 in any one parameter

(New score or if not improving with treatment)</td><td>1 hourly

Commence fluid balance chart</td><td colspan="3">• Review by medical team within 60 minutes
• Screen for sepsis if infection possible
• Contact Critical Care Outreach on bleep 3914 / 3935
• Review and document escalation ceilings with ST3+:

End of Life, Ward or Critical Care</td></tr>
<tr><td rowspan="3">Total = 7 or more

(New score or not improving with treatment)</td><td rowspan="3">1 hourly

Continuous monitoring where available

Commence fluid balance chart

Measure hourly input and output</td><td colspan="3">Escalation Decision (if none documented default is Critical Care)</td></tr>
<tr><td>End of Life</td><td>Ward Care</td><td>Critical Care</td></tr>
<tr><td>Follow IPC

If no IPC ST3+ doctor and shift leader to consider IPC</td><td>Medical review within 30 minutes

Discussion with ST3+ within 60 minutes</td><td>ST3+ review or telephone discussion within 30 mins

Critical Care Outreach review within 60 minutes (3914 / 3935)</td></tr>
</table>

Changes in the response to the scores above must be made by a **Consultant** and documented in the medical notes. Reductions in observation frequency outside of the above protocol must be made by the **Shift Leader** and the reason documented in the medical notes.

WEEKENDS AND OUT OF HOURS

Weekend and out of hours working

Out of normal working hours **all** medical patients in the hospital are covered by the on call team and at night the medical SpR/SAS leads the hospital at night team.

Ward Rounds

There are three consultant led ward rounds: EAU PTWR, ‘Safari’ PTWR and Discharge WR.

There are two on-call registrars at weekends: SpR/SAS(1) 9am-9.30pm and SpR/SAS(2) 9am – 5pm

Two FY2/CMT/IMT doctors - (1) 9am-9.30pm and (2) 12midday-12midnight) and two FY1s 9am-9.30pm

Junior doctors are to accompany as below:

	Saturday	**Sunday**
EAU	FY1	FY1
Safari	FY2/CMT/IMT(9-9)	FY2/CMT/IMT(9-9)
Discharge	Discharge FY2/CMT/IMT	FY1
Other Roles	SpR/SAS (1) Clerking/A&E	SpR/SAS(1) Clerking/A&E
	SpR/SAS(2) CCU, ward reviews	SpR/SAS(2) CCU, ward reviews
	FY2/CMT/IMT (12-12) Clerking/attend ward	FY2/CMT/IMT(12-12) Clerking/attend ward
	FY1(2) Ward patients/jobs	

ESCALATION:

If indicated, discuss any cases that need escalation with a senior. The consultant of the day is available via telephone if off site.

SENIOR REVIEW:

At weekends a resident consultant is available for post-take ward rounds (see above) and reviewing on-take from 9am until 5pm and non-resident until 9am the following morning. In addition there is a further PTWR consultant and a discharge consultant on-site at weekends from 9am until 5pm and 5pm to 9pm.

HANDOVER:

SDGH operates an electronic handover system over the weekend and bank holidays for all unwell patients to on-call SpR/SAS, FY2+ and FY1 doctors as appropriate. This can be accessed on the intranet:

URL: **http://intranet1/wardhandover**

To use the handover form simply select site (SDGH/ODGH), select ward and a list of patients and review details will appear. To add patients, select the green ‘add patient’ button.

After the morning handover meeting all doctors should access the electronic handover for jobs/reviews allocated to them.

AKI:

A list of all patients with an AKI alert (and stage) will be provided by the Critical Care Outreach Team (CCOT) Nurse at handover for the weekend medical team to review AKI patients. The ‘discharge’ FY2/CMT/IMT doctor will be responsible for reviewing

investigation results (U&E's) for all patients via Medway and address any concerns of worsening AKI and review patients when indicated. The SpR will need to review any AKI stage 3 patients.

RADIOLOGY:

X-rays: Book on Medway and ring 4109 or Ascom 3993

CT: request on Medway. If NICE guideline compliant eg CVA, anticoagulation head injuries, speak to the radiographer based in AED (3993/4109). If not NICE compliant the SpR on-call will need to speak to out-of-hours radiologist via switchboard or Tele Medicine Clinic (TMC):

Tel: 01189485281

TMC have a list of doctors that they will receive calls from. If a locum doctor is on-call it may be necessary for them to speak to another doctor who is on the list to get a scan done.

MRI: Only MSCC spine will be done at weekends as this is an emergency. Discussion needs to be consultant to consultant.

MICROBIOLOGY:

For out-of-hours microbiology advice, until 11pm the microbiology consultant will accept calls from all cadres of medical staff. After 11 pm, they ask that only senior nursing staff, bed managers, registrars (ST3+) and Consultants are put through.

REFERRALS

Different specialties require different means/types of referral. Please ensure you know what is required before requesting a referral. Sufficient clinical information must be provided and the reason for referral (the question being asked) must be stated clearly. "Please kindly review" will not do! It is preferable that the

referral is made to a specialty rather than a named consultant as the latter may lead to a delay in review if not available e.g. on annual leave.

Southport is a relatively small Trust and in many cases it may be preferable to ***speak to a relevant specialty consultant*** before making a written referral.

In-patient:

In-patient referrals are written on specific referral forms consisting of two layers – a white sheet and copy pink sheet. Please ensure all relevant information is completed. The white copy should be hand-delivered to the relevant specialty secretary. Do not put them under doors or on consultant office desks/under doors. Place the pink copy in the case notes.

Remember it may be preferable to speak to a consultant rather than send a referral in most cases.

Special cases:

Renal:

Referrals can be made to the Trust's renal physician, Dr Hasnain Raza via the renal secretary. Out of hours and if Dr Raza is not available contact the renal physician on-call at Aintree. The renal secretary is based on the ground floor medical records corridor.

Neurology:

This is a paid service. Neurology provides reviews on a Tuesday and Friday afternoon only (if available). Any emergency advice can be obtained from the Walton Centre for Neurology and Neurosurgery (WCNN). The neurology secretary is based on the ward 15s corridor.

Please ensure that the referral is for an acute issue. Do NOT refer for:

- Acute headache if investigations are negative eg migraine (send home & refer to OPD), SAH (neurosurgical referral)
- Seizures (first) – refer to WCNN first fit clinic OPD
- Seizures in known epilepsy unless ongoing during admission and unable to control
- Alcohol withdrawal
- Syncope (exclude cardiac causes)
- Falls in elderly – eg movement disorders which can be reviewed and managed by local Care of Elderly team
- Elderly with established dementia
- Metabolic encephalopathy where underlying cause already identified

Endoscopy/gastroenterology:

Gastroenterology provides a drop in advice service on a 2 week rostered basis held in the gastroenterology office on the ward 15s corridor daily. If the consultant is not available it is possible to speak to the registrar or contact the gastroenterology secretary (Lesley Haywood) on 4101. Information on who the responsible gastroenterologist is can be found on the gastroenterology consultant office door and outside endoscopy.

Urgent in hours endoscopies should be discussed with the responsible gastroenterology consultant above.

Written referrals should be discussed with the responsible consultant first as many referrals can be dealt with by advice.

Chest OPD and Rapid Access Lung Clinic:

Referrals must be ***written or typed on headed paper*** giving sufficient background information. Patients are seen within two weeks in the rapid access lung clinic on a Friday.

Chest Drains:

Emergency chest drains such as pneumothorax can be done by those competent to do so in AED or the wards with or without USS guidance. Pleural drains must be done under USS guidance. The respiratory team will undertake chest drain insertion on ward 14B and patients should be referred to the chest team if required.

Acute Oncology:

Acute oncology referrals are made in the usual way with referrals being faxed on the number below or emailed to:

soh-tr.acute-oncology@nhs.net

An oncology nurse service is available, who will see patients referred to oncology and who checks with each ward for patients on a daily basis.

Office/Ansa machine **5237** Ascom **3846** Fax **5247**

Pathways for neutropenic sepsis and MSCC are on the intranet via Clinical Guidelines. These must be followed appropriately and are audited by the AOT as part of a national directive.

Please note: if patients are admitted on oral chemotherapy it should be stopped until otherwise directed by oncologist/haematologist.

On rare occasions during holidays/study leave there may not be anyone available within the trust. Urgent clinical advice can be reached via Clatterbridge Hospital on 0151 335 1155

Stroke:

Stroke nurses are available to review patients from 7am until midnight (7 say service) and all stroke patients should be referred to them on Ascom 3879. An out-of-hours Tele-stroke service is provided with thrombolysis in AED.

Patients that need to be referred for TIA clinic should be referred to the stroke nurses who will make the necessary arrangements.

Outreach/ITU/HDU:

Outreach provide a 24 hour service and can be contacted on 3914. The outreach team can also contact HDU/ITU

HDU/ITU can be contacted via switch: ask for 1st anaesthetist on-call.

How to refer to LHCH (cardiology):

1. Go to LHCH urgent referral website: https://urgent referrals.lhcs.nhs.uk/
2. Enter your NHS email.
3. Open your NHS email account and click on the link to confirm your NHS email (you will have to do this the first time only).
4. Now select the appropriate type of referral:
    a. Cardiac surgical referral for Pacemaker.
    b. ACS referral for Angiogram after an ACS event eg NSTEMI
    c. Rhythm referral for ICD
5. You will need to scan the ECG of the patient. Any copier can be used. If it is your first time you will have to register. Select option ‘send to my email’ and follow the instructions on the screen.
6. Now download the ECGs from the email to your desktop.
7. Upload them on the referral.
8. Fill in the whole referral and send submit.
9. You will get a confirmation email on your NHS email with a reference number. Note it down in the case notes.

Done!

Primary PCI for STEMI - LHCH:

Activate LHCH PPCI policy immediately a STEMI has been diagnosed by telephone on dedicated number 0151 600 1817. A Primary PCI transfer checklist should be completed (available from A&E) and an emergency ambulance transfer to LHCH requested on 0345 1400 144, requesting “EMERGENCY TRANSFER FOR PRIMARY PCI”. The checklist form must be handed to the Transferring Ambulance Crew.

Cardiology radiological investigations:

CT/MRI at LHCH – Fill in Radiology Request form (LHCH form available on wards or secretaries office) including eGFR and date of eGFR, scan and email to:

Radiology.appointments@lhch.nhs.uk

Myocardial Perfusion scan (MIBI) – Fill in Royal Preston Hospital NUCLEAR MEDICINE IMAGING REFERRAL FORM, scan and email to:

PrestonNuclearMed@LTHTR.nhs.uk

In ‘subject’ line enter:

[secure] patient name and NHS number

Ambulatory Care

Referrals for ‘hot clinic’ review must be handwritten on a referral proforma specifically for ACU. ACU will accept referrals from A&E and other acute areas only. If a patient from a specialty ward needs review or repeat bloods after discharge this must be done as a ward attender for that ward.

ECG, PHYSIOLOGICAL MEASUREMENT AND CONSENT

The following tests are available from the cardiorespiratory department. Before booking please ensure that the test is appropriate to your patient's needs and that the request form is fully filled in.

Standard 12 lead ECG. Daily service to all wards on normal working days. Leave completed forms in designated collection point on ward. Outpatients should take request form to the department. For urgent or repeat traces in hours contact technician on Ascom 3936 or department on 4041. Out of hours machines are available for use on all wards.

Echocardiograms. Before requesting an echo please consider whether it can be performed on an outpatient basis first. If an echo has been performed within the last 12 months a repeat may not be necessary. Check on Medway (under 'all proformas') and Evolve (under 'investigations'). An echo is not necessarily required for all patients transferred to Liverpool Heart & Chest Hospital (LHCH).

Daily departmental service on normal working days. Leave completed forms in ward designated collection point or take to the ECG department in outpatients. Patients should be fit enough for transfer to department by chair. (If not or if needing supplemental oxygen contact dept to discuss transfer arrangements.)

For urgent service contact department on 4041. (Inpatients with fast AF echos for "LV function" are best delayed until rate control achieved.)

On CCU/HDU/ITU bedside echos are the norm. Leave forms with nursing staff on unit. Other requests for bedside echos should be made by senior medical staff directly to department. Outpatients should take request from to department.

Requests for transoesophageal echocardiograms (TOE) should be made by consultants/SpRs to Dr Shalan directly.

24-hour ambulatory ECGs. Available as outpatient only. Send completed request form to department stating date patient will be discharged. This test is **not** routinely done on inpatients – use telemetry (wards EAU, SSU and 7A). Send outpatients to department with request form. For longer periods of monitoring and self-activating devices contact department to discuss best option.

Exercise tests. Available as outpatient only (unless consultant specified as inpatient, in which case appropriate medical supervision must be provided). Patient MUST be able to walk without aid or mobility restrictions. May only be requested by F2 or senior. Ensure full details on request form are completed (if in doubt seek senior advice). Send forms to department.

Tilt table testing. Available as outpatient only. Should only be requested by senior staff. **Note:** these patients require consenting for this test by the requesting doctor (specific consent forms available in department). Request should also specify if coronary sinus massage (CSM) required prior to test.

Pulmonary function testing. Spirometry (with reversibility if required). Send request form to department. “Full studies” available as in/outpatient (senior request).

CONSENT

Informed consent is a cornerstone of the relationship between patient and treating doctor.

For minor procedures such as taking of temp, BP or giving blood the patient's willingness to accept the intervention by letting you access the relevant part is taken as implicit evidence of consent.

For more major procedures written consent is usually obtained (although not strictly necessary in law) as evidence that the risks and benefits of the proposed treatment have been discussed. (Written consent alone without adequate explanation is not valid.)

For most procedures in the Trust, the practitioner doing the procedure obtains the consent however in medicine two procedures have been agreed for which delegated consent can be used. These are **upper and distal lower GI endoscopy (OGD and flexible sigmoidoscopy).**

Some other procedures previously did not require written consent but now do. These are listed below under LocSSIPS.

Before undertaking this role you must have completed your training in taking consent.

Adults unable to consent

If an adult is unable to give informed consent by nature of their acute illness or other capacity reasons then **no one** else is able to give consent on their behalf.

In these cases a medical practitioner must act in what he/she perceives to be in the best interests of the patient. In emergency situations then proceed but for all other interventions seek senior help.

LocSSIPS

- local safety standard for invasive procedure
- written locally by Southport and Ormskirk NHS Trust.

- It is not intended that LocSSIPs address procedures that involve the simple penetration of the skin or entry of a body cavity, e.g. the insertion of a peripheral intravenous cannula; a urinary catheter or ionising radiation such as taking a plain X-ray.

- LocSSIP checklists should be completed each time an invasive procedure is performed at the Trust but outside the operating theatre.

- LocSSIPs are available for the following:
  - Lumbar puncture
  - Ascitic tap
  - Pleural aspiration
  - Intercostal chest drain insertion
  - Joint aspiration and injection

These can be accessed from the clinical section:

http://intranet1/policies/handbooks.asp?dir=e:\wwwroot\handbook\Clinical%20Section\handbooks\LoCSSIPs

These will be added to in the future as more LocSSIPs are developed.

ENDOSCOPY

The endoscopy services are organised on two sites: the Treatment Centre at Ormskirk where all diagnostic gastroscopy, flexible sigmoidoscopy and colonoscopy take place.

Colonoscopy, therapeutics upper GI endoscopy and ERCP are performed at Southport.

For upper GI bleeds please resuscitate and grade using the Blatchford score – see GI bleed pathway on intranet.

Urgent out of hours endoscopy:

Patients needing urgent endoscopies should be discussed with gastroenterologist on-call at University Hospital Aintree (via switchboard) after discussion with the medical on-call consultant. Patients must be haemodynamically stabilised prior to transfer. Medical escort will be required.

Preparation for an OGD

- **Nil by mouth** for 6 hours prior to procedure.
- May be longer if delayed emptying of stomach is suspected, a naso-gastric tube may be inserted to enable the stomach to be emptied fully and an intravenous infusion commenced (‘drip and suck’) in these cases. Patient’s own medical team should decide if this is necessary.
- **Consent** must be done on the ward by the patient’s own medical team. If this is not done the patient cannot be brought to endoscopy and the procedure may be cancelled. Delegated consent can be applied.
- **INR** done on day of procedure if patient on wafarin. For guidelines on stopping wafarin prior to gastroscopy contact pathology lab. Also see gastroenterology on Clinical Section of intranet.
- **Venflon or cannula** in right hand if possible
- Gown
- **Endoscopy checklist** a full theatre checklist is not required
- **Drug chart** please send with patient

Contact the endoscopy unit SDGH for any further advice on ext 4448 Monday to Friday 8am to 5.30pm.

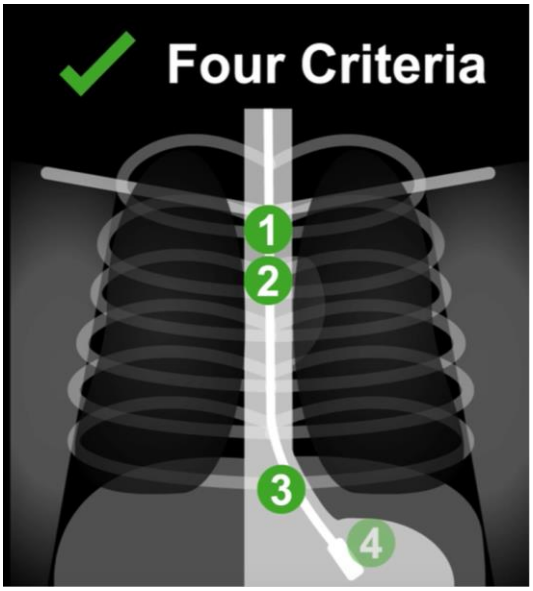
CLINICS

Attendance at specialty clinics is expected for CMT/IMT with a minimum of 20 per year. Clinics are an excellent learning opportunity. It should be noted that in some instances it is not possible to see patients independently due to shortage of clinic room space, although there may be ample opportunity to see patients in the Ormskirk out-patient site.

CMT/IMT doctors will be allocated to clinics and a timetable drawn up for these. However there may be other clinics you may wish to attend e.g. GUM, neurology, renal, ophthalmology etc. Do be prepared to ask.

NG TUBE INSERTION

You may be asked to insert or confirm safe NG tube placement either during your day work or while on-call. You must consider and document the following in the case notes:



- Does the tube follow the oesophagus?
- Does the tube bisect the carina or bronchi?
- Does the tube cross the diaphragm in the midline?
- Is the tip clearly visible below left hemi-diaphram?

Document the following:

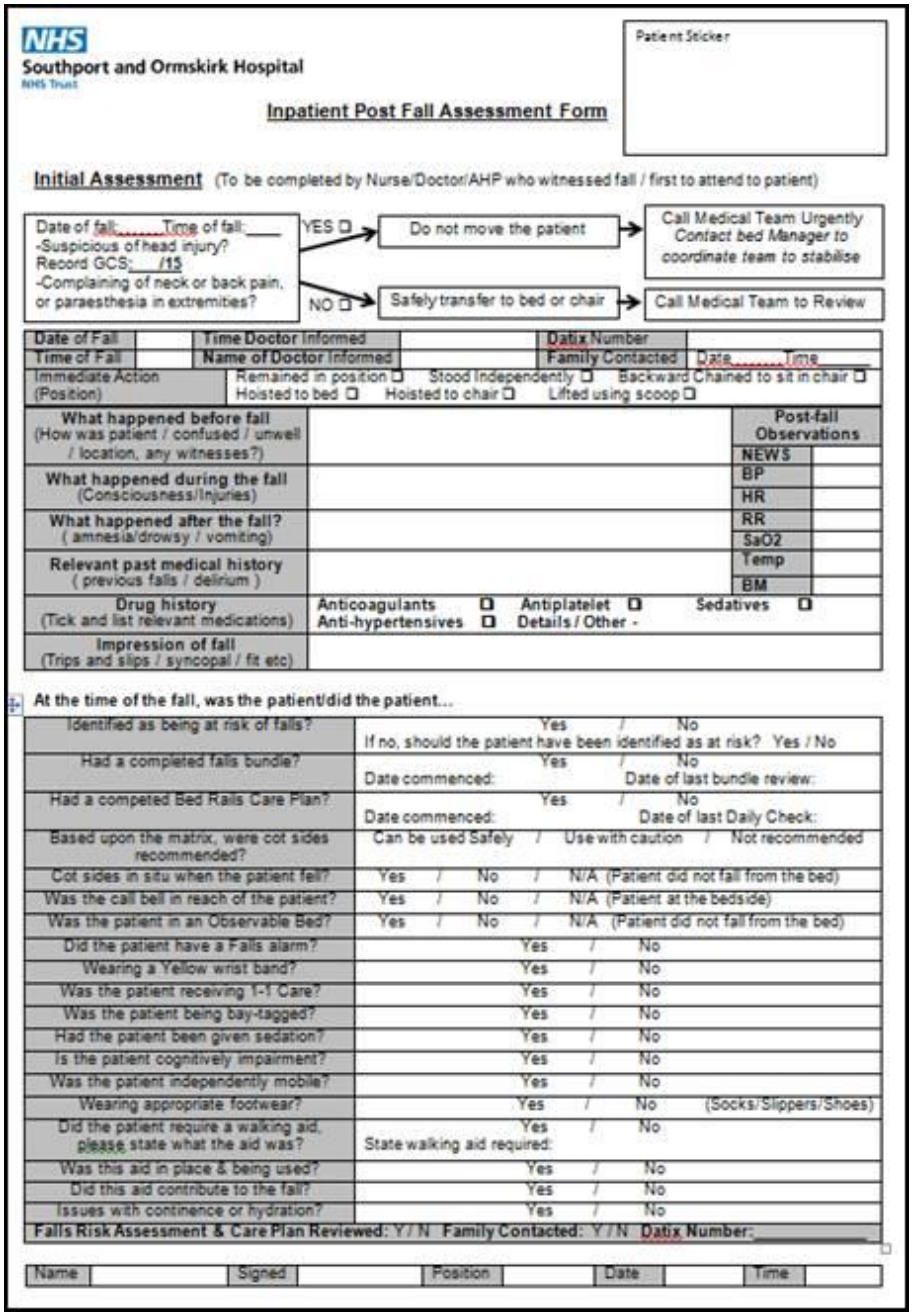
- Who confirmed the position of the nasogastric tube
- Confirmation that any x-ray viewed was the most current x-ray for the correct patient
- How the position of the NG tube was interpreted using the ‘four criteria’ e.g.

-NG tube follows path of oesophagus,
-bisecting bronchi,
-remains midline to level of diaphragm and deviates to left
-Tip is seen about7cm below diaphragm

- Clear instructions

FALLS

All patients who have had a fall while in the hospital ***must*** have an **inpatient falls assessment form** completed. You will be asked to do this by the ward nurses, particularly when on-call. http://intranet1/handbook/Clinical%20Section/Pathways%20and%20Careplans/Nursing%20Core%20Care%20Plans/053%20Post%20Falls%20Assessment.pdf



NHS
Southport and Ormskirk Hospital
NHS Trust

Patient Sticker

Inpatient Post Fall Assessment Form

Initial Assessment (To be completed by Nurse/Doctor/AHP who witnessed fall / first to attend to patient)

Date of fall:_____Time of fall:____
-Suspicious of head injury?
Record GCS:___/15
-Complaining of neck or back pain, or paraesthesia in extremities?

YES ☐ → Do not move the patient → Call Medical Team Urgently *Contact bed Manager to coordinate team to stabilise*

NO ☐ → Safely transfer to bed or chair → Call Medical Team to Review

Date of Fall		Time Doctor Informed		Datix Number	
Time of Fall		Name of Doctor Informed		Family Contacted	Date_____Time_____
Immediate Action (Position)	Remained in position ☐ Stood Independently ☐ Backward Chained to sit in chair ☐ Hoisted to bed ☐ Hoisted to chair ☐ Lifted using scoop ☐				

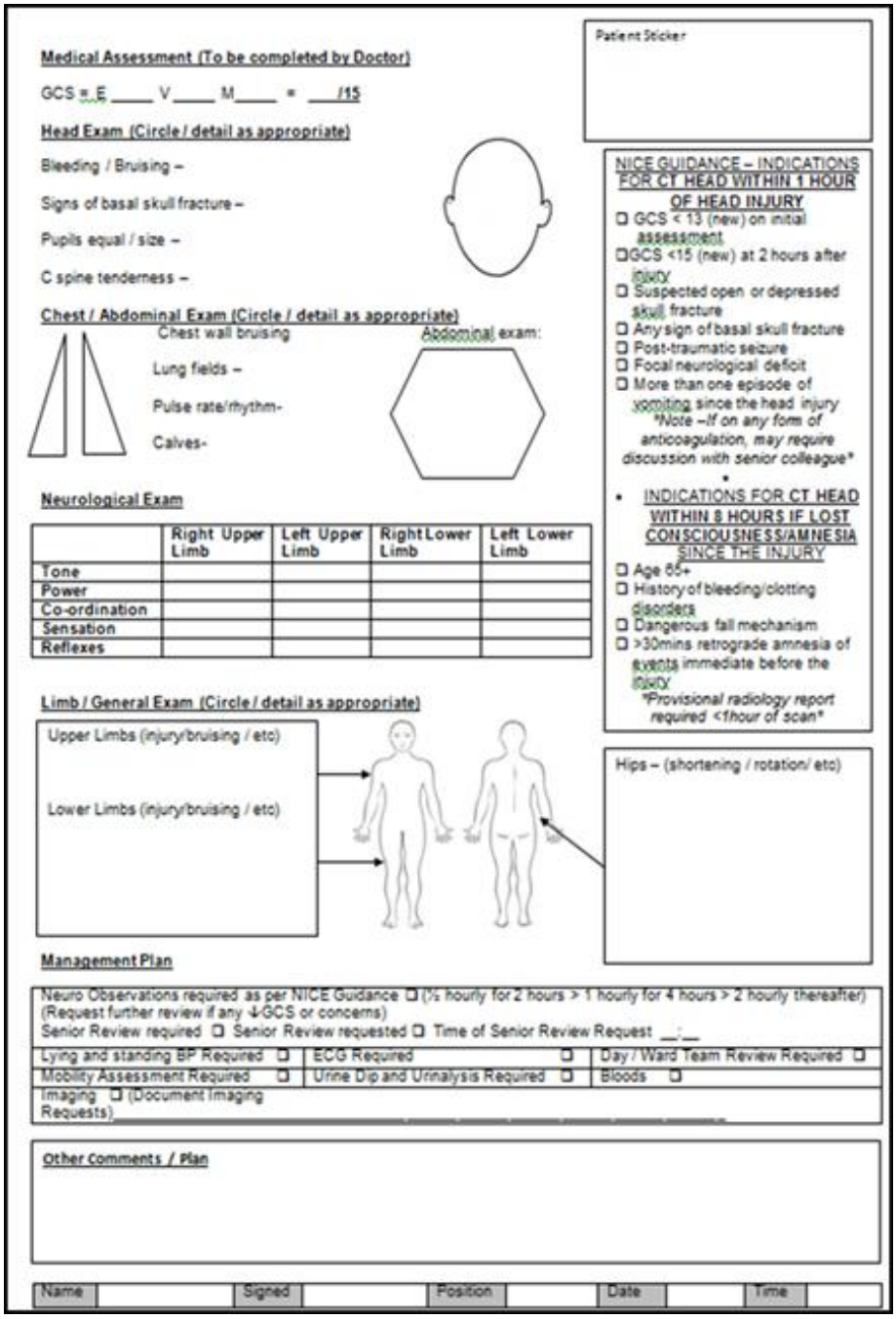
What happened before fall (How was patient / confused / unwell / location, any witnesses?)		Post-fall Observations	
What happened during the fall (Consciousness/Injuries)		NEWS	
What happened after the fall? (amnesia/drowsy / vomiting)		BP	
Relevant past medical history (previous falls / delirium)		HR	
Drug history (Tick and list relevant medications)	Anticoagulants ☐ Antiplatelet ☐ Sedatives ☐ Anti-hypertensives ☐ Details / Other -	RR	
Impression of fall (Trips and slips / syncopal / fit etc)		SaO2	
		Temp	
		BM	

At the time of the fall, was the patient/did the patient...

Identified as being at risk of falls?	Yes / No If no, should the patient have been identified as at risk? Yes / No
Had a completed falls bundle?	Yes / No Date commenced: Date of last bundle review:
Had a competed Bed Rails Care Plan?	Yes / No Date commenced: Date of last Daily Check:
Based upon the matrix, were cot sides recommended?	Can be used Safely / Use with caution / Not recommended
Cot sides in situ when the patient fell?	Yes / No / N/A (Patient did not fall from the bed)
Was the call bell in reach of the patient?	Yes / No / N/A (Patient at the bedside)
Was the patient in an Observable Bed?	Yes / No / N/A (Patient did not fall from the bed)
Did the patient have a Falls alarm?	Yes / No
Wearing a Yellow wrist band?	Yes / No
Was the patient receiving 1-1 Care?	Yes / No
Was the patient being bay-tagged?	Yes / No
Had the patient been given sedation?	Yes / No
Is the patient cognitively impairment?	Yes / No
Was the patient independently mobile?	Yes / No
Wearing appropriate footwear?	Yes / No (Socks/Slippers/Shoes)
Did the patient require a walking aid, please state what the aid was?	Yes / No State walking aid required:
Was this aid in place & being used?	Yes / No
Did this aid contribute to the fall?	Yes / No
Issues with continence or hydration?	Yes / No

Falls Risk Assessment & Care Plan Reviewed: Y / N **Family Contacted:** Y / N **Datix Number:**_____

Name		Signed		Position		Date		Time	



Medical Assessment (To be completed by Doctor)

GCS = E ____ V____ M____ = ___/15

Patient Sticker

Head Exam (Circle / detail as appropriate)

Bleeding / Bruising –

Signs of basal skull fracture –

Pupils equal / size –

C spine tenderness –

NICE GUIDANCE – INDICATIONS FOR CT HEAD WITHIN 1 HOUR OF HEAD INJURY

- ☐ GCS < 13 (new) on initial assessment
- ☐ GCS <15 (new) at 2 hours after injury
- ☐ Suspected open or depressed skull fracture
- ☐ Any sign of basal skull fracture
- ☐ Post-traumatic seizure
- ☐ Focal neurological deficit
- ☐ More than one episode of vomiting since the head injury

Note –If on any form of anticoagulation, may require discussion with senior colleague

- INDICATIONS FOR CT HEAD WITHIN 8 HOURS IF LOST CONSCIOUSNESS/AMNESIA SINCE THE INJURY
- ☐ Age 65+
- ☐ History of bleeding/clotting disorders
- ☐ Dangerous fall mechanism
- ☐ >30mins retrograde amnesia of events immediate before the injury

Provisional radiology report required <1hour of scan

Chest / Abdominal Exam (Circle / detail as appropriate)

Chest wall bruising

Lung fields –

Pulse rate/rhythm-

Calves-

Abdominal exam:

Neurological Exam

	Right Upper Limb	Left Upper Limb	Right Lower Limb	Left Lower Limb
Tone				
Power				
Co-ordination				
Sensation				
Reflexes				

Limb / General Exam (Circle / detail as appropriate)

Upper Limbs (injury/bruising / etc)

Lower Limbs (injury/bruising / etc)

Hips – (shortening / rotation/ etc)

Management Plan

Neuro Observations required as per NICE Guidance ☐ (½ hourly for 2 hours > 1 hourly for 4 hours > 2 hourly thereafter)
(Request further review if any ↓GCS or concerns)
Senior Review required ☐ Senior Review requested ☐ Time of Senior Review Request __:__

Lying and standing BP Required ☐	ECG Required ☐	Day / Ward Team Review Required ☐
Mobility Assessment Required ☐	Urine Dip and Urinalysis Required ☐	Bloods ☐
Imaging ☐ (Document Imaging Requests)		

Other Comments / Plan

Name		Signed		Position		Date		Time	

Inpatient Falls Assessment Form

CLINICAL CODING & DIAGNOSES

Accurate coding is important as death certification, standardised mortality rates, audit, performance and tariffs (pay to the hospital) are all based on data collected from notes.

Please include ***all*** co-morbidities and the diagnosis pertaining to the current admission. It is useful to note that certain diagnoses carry a zero pay rate such as admission for alcohol detox or any mental health issues with no acute medical problem eg worsening of dementia.

CAN CODE	CAN'T CODE
Diagnosis	Differential diagnosis
Treat as	Possible
Probably	Likely
Presumed	Maybe
Symptoms where no definitive diagnosis is made	Suspected
	?
	Impression

Death Certification:

1. Confirmation of Death

•Identity confirmed by wrist band
•General inspection
•No signs of respiratory effort
•No response to verbal stimuli
•No response to painful stimuli
•No pupillary response to light
•No central pulse
•No heart sounds after 1 minute of auscultation
•No respiratory sounds after 1 minute

Document above, time of death, who was present at time of death and discussions with family etc.

2. Death certificates

Death certificates should be completed as soon as possible after death as delays can lead to distress of grieving relatives. You must have been involved in the care of the patient in some way. You will probably be contacted by the mortuary/bereavement office to complete the death certificate if you were involved in the patient's care.
If the death occurred within 24 hours of admission or is the result of trauma in the hospital eg cerebral bleed following a fall, it must be reported to the coroner. Other causes for referral may include suicide, violence, neglect (by self or others) or industrial disease and deaths for which the cause is not known.

- It should be completed to the best of your knowledge and belief, be accurate and is a permanent legal record of cause of death.
- Avoid manner/mode of death eg 'heart failure' unless qualifying with a specific cause.

- Think carefully what you write as cause of death. No one should die from a urinary tract infection (UTI) but a patient may die from *sepsis* in part 1a due to a *urinary tract infection* in part 1b. Similarly, *Acute Kidney Injury* (AKI) should not be a cause of death unless unavoidable etc.
- Avoid abbreviations eg COPD. Avoid 'old age' alone if possible.
- Include your GMC number when signing and printing your name.
-

If unsure, ask!

You will be asked to complete a mortality review at the same time as completing the death certificate.

3. Cremation Forms

In addition to completing the death certificate, you may be asked to complete a cremation form part A. This is private practice and therefore incurs a fee which must be declared in your Tax return.
It is necessary for you to view the body and to check the body for any pacemaker devices.

Kardex: Antibiotics, insulin, drugs and Oxygen Prescribing:

- Ensure all patient details are present (use addressograph) and date
- Check allergy status and state reaction. You must sign once done.

- Before prescribing any medications you must fill in your details on the front including name, grade, GMC number and signature.
- Antibiotics are prescribed using the ARK principle for which you must do your training. Initial antibiotics are prescribed as 'possible' or 'probable' (circle). Up to 3 days will be given by the nurses but the prescription **MUST** be reviewed to continue. An indication must **ALWAYS** be given. Once infection is confirmed go on to the finalised prescription. A stop date **MUST** be given. iv antibiotics should only be given for up to 48 hours unless there is a reason to continue. **IF THE PATIENT IS TO CONTINUE ANTIOBOTICS OVER A WEEKEND THEY *MUST* BE PRESCRIBED BEFORE THE WEEKEND.**
- **Oxygen MUST ALWAYS be prescribed**. It is a drug!
- Print drug names clearly in capital letters using generic names only. Any changes eg dose, require the drug to be crossed off and a new entry made.
- **Insulin, gentamicin and anticoagulants have dedicated pages.**
- **Long acting insulins MUST be continued in diabetic emergencies eg DKA**
- Fluids must be prescribed on the fluid prescription pages.
- Do not forget PRN medications.
- Initial VTE prophylaxis (clexane) must be prescribed on the first page and VTE assessment completed, including risk for bleeding and type of prophylaxis (chemical/mechanical) and ***signed, dated and timed.***

ARK (Antibiotic Review Toolkit) TRAINING:

Online training for antibiotic prescribing can be found on URL:

https://tinyurl.com/y8wcycgu

On completion a certificate can be downloaded for your ePortfolio.

WRITING DISCHARGE LETTERS

Discharge letters must be completed for all patients including transfers and deaths.

There are two systems in use presently for medicine:

- EMIS (medical wards)
- Medway (Ambulatory Care Unit)

You should receive training to use these on induction.

If a patient is discharged from AED by medicine, a discharge letter still must be written.

Important points to note:

- Please ensure that relevant information is provided – the discharge letter is a formal legal document of handover to other health care professionals such as GPs.
- To ensure prompt discharge of patients please complete discharges in an anticipatory fashion. Discharge letters should be completed as the first job of the day.
- Do not leave discharge letters/TTOs to on-call doctors out of hours or at weekends.
- Discharge letters must be completed before patients can be transferred to the Discharge Lounge and patients cannot go home by ambulance if the TTOs are not available by 4pm.
- Delays in writing discharge letters is likely to result in a delay in discharge and prevent flow from AED.

Other points:

- Write a brief and relevant summary of admission and journey in hospital.

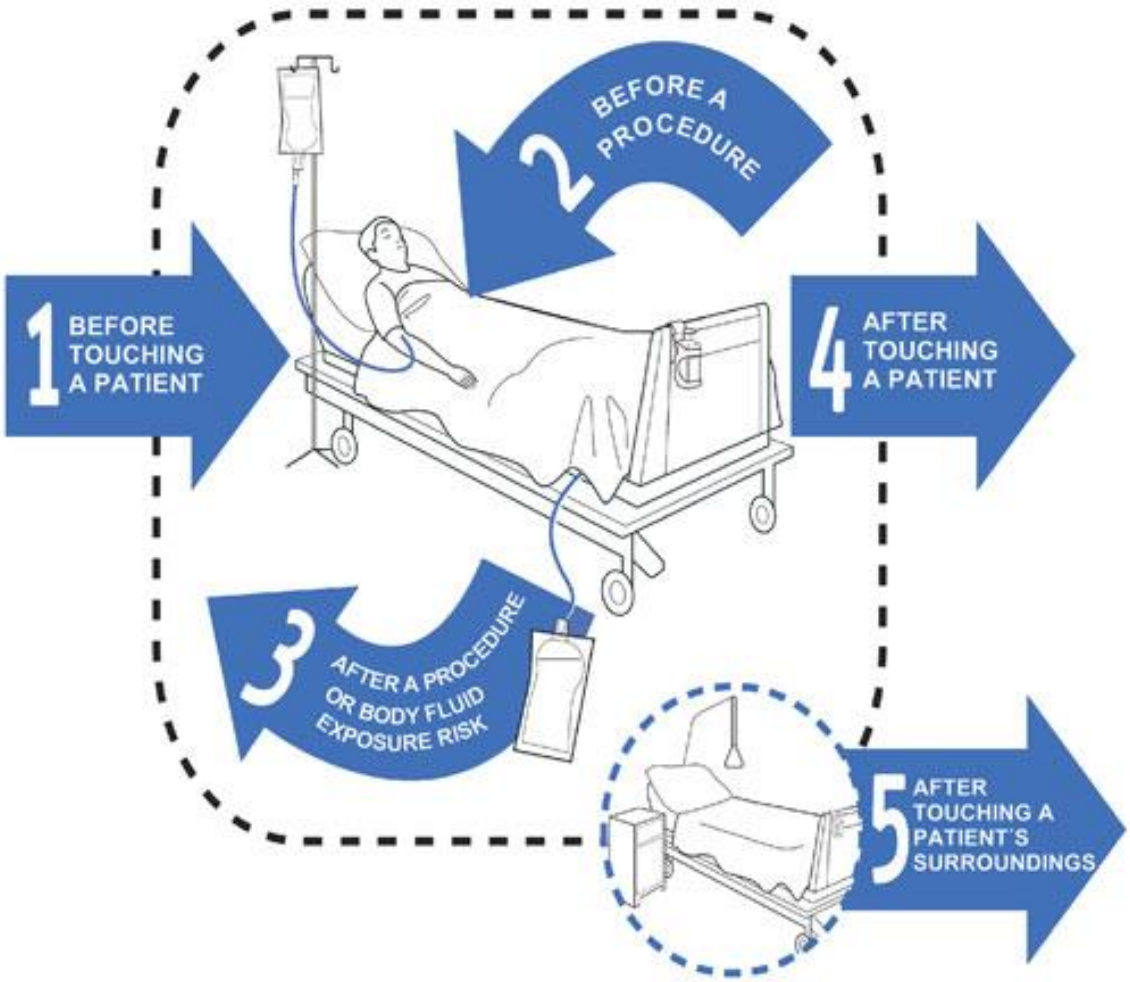
- Include complications such as AKI (with stage), HAP, anaemia requiring transfusion etc
- Include treatment given, changes to medications and follow-up details.
- **DO NOT DELEGATE TASKS** to the GP unless not related to the acute care episode or continued monitoring after two weeks. ie Do not ask the GP to chase up investigations such as ECHO, cultures, CxR reports etc.
- Primary Care will not do investigations such as bloods within TWO WEEKS of discharge. If a patient requires investigations before this they must be brought back to the ward as a ‘Ward Attender’.

It is your responsibility to ensure all outpatient investigations have been requested and follow-up has been requested.

If you are uncertain of diagnosis or what to write please do ask someone for help.

HAND HYGIENE

The Five Moments for Hand Hygiene have been identified as the critical times when hand hygiene should be performed:



NON-CLINICAL SECTION

IT TOOLS

Available programs provided are listed below.

Clinical:

- **Medway –** System C Electronic Patient Record (EPR). For all information regarding admissions, outpatient bookings, investigation ordering (ordercomms) and viewing of investigation results. Discharge letters for ACU.
- **Evolve –** Scanned electronic patients notes. All old notes and current notes are scanned to Evolve for viewing on the Trust intranet.
- **Medisec –** Electronic dictation system
- **EMIS –** Discharge letters and TTOs
- **PACS –** Radiology viewing system
- **CRIS –** Radiology management system
- **VitalPAC –** Patient observations (NEWS2) and current alerts

Patients for Weekend Handover are entered via URL:

http://intranet1/wardhandover

Corporate:

- **EOL-MOL –** Medics on Line. For viewing rostas, booking leave
- HealthMedics – Exception reporting
- **DATIX –** incident reporting system
- **ESR –** electronic staff record

You should have received training and passwords on the use of all these systems in your corporate induction.

If you are unable to remember your Windows username and Password please contact the IT helpdesk on 6666.

Other IT contact numbers:

- Medway: 6666
- PACS: Charlotte Sesnan 6562
- EOL-MOL: Katherine Ashcroft/Louise Evans 4799/4790
- DATIX: Risk dept – Jess Hassan 4738
- EMIS (secondary care): 6666
- Medisec: SDGH Jo Chetham 4637; ODGH Lynn Thornton 6712
- VitalPAC: 6666

WELLBEING

ANNUAL LEAVE, STUDY LEAVE & PROFESSIONAL LEAVE

Juniors are entitled to annual leave appropriate to their grade (HR will advise if unsure). F2 and above are also entitled to study leave.

Application for such should be made on the trust leave form which should be fully completed stating the type of leave to be taken. Study leave requests require a second form giving details of the course/ exam and likely expenses. Study leave and expenses are **never** granted retrospectively.

These should be submitted to medical staffing for approval. Leave will be approved or refused electronically and you should **not** make any travel arrangements until the full period of leave

requested is confirmed. The taking of leave that is not applied for or that is not approved will result in disciplinary action.

All swaps to the published rota must also be approved in a similar manner to ensure that overall levels of cover throughout the division are adequate.

Applications should be made at least 6 weeks in advance especially if outpatient clinics, etc, are to be cancelled. It is your responsibility to tell your consultant's secretary of any clinics/ investigative sessions that will be cancelled so that they can check this occurs.

All leave is granted subject to provision of a safe service to patients, particularly if the period of notice is short.

You are strongly advised to plan intended study leave at the start of the year as it is often **not** possible to have multiple members of staff away on courses at exam-times.

SICKNESS

Illness that necessitates your absence from work ***must*** be notified to medical staffing as soon as possible, particularly if this involves on call work. The consultant's secretary should also be informed separately if possible.

The self-certification scheme applies for episodes of less than I week thereafter a medical note must be obtained and sent to medical staffing.

You may be required to undergo a return to work interview and for longer periods of leave occupational health assessment.

You should also let the school of medicine/ general practice know of any significant periods of sick leave that might affect your training.

Medical Staffing: Telephone 0170470 4767/5156

Email: rachel.cassidy2@nhs.net

Email: c.lieb-corkish@nhs.net

FATIGUE AND FACILITIES CHARTER

The Trust has signed up to the BMA's Fatigue and Facilities Charter.

This is to ensure that you have provision for rest, particularly when on-call or after an on-call especially at night, and to provide facilities for your safe return to home such as a room to sleep in if you feel too tired to drive or a taxi to the nearest station/home. *On average, one doctor or nurse dies in a car accident driving home after a night shift per six months in the UK.*

It is essential that you take your breaks in a timely fashion to prevent fatigue or exhaustion and that you remain safe for you and your patients during the working shift.

The Trust has recently refurbished the doctor's mess and the registrars room at Southport and facilities are provided to heat food, prepare drinks, access computers and rest.

Rooms for rest following a night shift or 24 hour on-call are available at Southport (Y Block) and there are 3 rooms at Ormskirk.

To request a room in advance for post on-call contact:

Ruth Johnston on 4593

or email:

soh-tr.accommodation@nhs.net

ruth.johnston2@nhs.net

(Please note that room availability is limited).

The rooms are on a first-come-first-served basis, therefore when possible rooms should be requested in advance of the shift. Please try to give as much notice as possible.

In the event of there being no rooms available, the Trust will pay for a taxi or public transport journey to home and return to site.

Process for requesting accommodation on unplanned/ad-hoc basis

The Trust understands that there will be unplanned occasions when accommodation is required and reserving a room in advance is not possible.

In this event, contact the Accommodation Office within working hours, the relevant Porters site office, Switchboard or bed manager (3800) when out of normal working hours. Before releasing keys to individuals, the Porters or Switchboard will cross check the member of staffs name and job title with the Switchboard team who have access to the rostering system to confirm employment status and rota pattern. Members of staff should present valid photo ID such as Trust or Locum (if agency locum) badge or photo drivers licence.

Porters contact details are:

Southport: Phone extension 4084 or ASCOM 3851. Office based behind the front desk at the hospital main reception.

Ormskirk: Phone extension 6153 or ASCOM 3751. Office based behind the front desk at the hospital main reception.

Switchboard can be contacted by dialling 0, then 0.

GUARDIAN OF SAFE WORKING (GOSW)

The GOSW is Dr. Sharryn Gardner (Paediatric AED Consultant)

e-Exception reports are generated through the ‘Allocate eRosta system’.

You should all be provided with passwords when you start your rotation at Southport and Ormskirk NHS Trust.

e-Exception reports form part of the Junior Doctor’s 2016 contract. We encourage exception reporting as it helps us help you to ensure that you get your education and training for your future career in your chosen specialty.

You should not be discouraged to complete these and if so you must report this to the GOSW.

e-Exception reports should be completed for:

- When you were unable to avail yourself to teaching as you were unable to leave your clinical area eg compromising patient safety

- When you have stayed beyond your rostered shift as it was not possible to leave your clinical area on time eg outstanding jobs needed to be completed that could not be handed over (within a reasonable time)

- ‘Other’ can include when the intensity of the shift was felt to be unsafe in your opinion

e-Exception reports should not be completed:

- for voluntarily staying beyond your shift for educational reasons

- for periods of time that are deemed too short.

LESS THAN FULL TIME WORKING

LTFT working must be agreed by the HEE and medical HR informed. If there are any irregularities in your terms of employment eg on-call rota issues, please contact the OSMs immediately to remedy these.

The Champion for LTFT working is Dr Beth Glackin (Acute Medicine) based in the ACU/AMU.

INCIDENT REPORTING - DATIX

Datix incident forms should be used to highlight incidents, near misses or good practice.

These are collated, lessons identified and feedback given to relevant departments to improve clinical practice and patient safety.

All clinicians have a duty to ‘speak up’ to promote a culture of patient safety. No one should be discouraged from completing DATIX forms through fear of being treated differently as a result of generating a concern. However, nor should it be used tit-for-tat.

DATIX incident reporting can be done via the computer desktop by selecting the DATIX icon.

FREEDOM TO ‘SPEAK UP’ GUARDIAN

When things go wrong in the delivery of care, the quality of the care we provide can be affected and patients can suffer as a result. That is why everyone who works in the Trust should feel free to speak up, even when they are not sure whether there is a serious issue at stake or not. Examples can include bullying behaviour, unsafe practice etc.

We all have a responsibility to consider any situation that may affect patient care or have implications for the welfare of staff or Trust resources.

If you want to raise a concern in confidence: You can discuss any concern that you have with your Educational Supervisor. They will advise you of the action that they will take to address the issue. In most cases this will ensure that the issue is resolved.

If you feel that it is not possible for you to discuss the matter with your supervisor, you can raise your concerns with the Freedom to Speak Up Guardian, Trust chaplain the Rev Martin Abrams. If you wish to raise a concern in confidence with him, you can either email or call him on 01704 70 4639 or 07467 374 824.

JUNIOR DOCTOR’S FORUM (JDF) and LOCAL NEGOTIATING COMMITTEE (LNC)

Junior doctors have a right to have a say in service conditions to undertake their job in a safe manner. The JDF is a forum that meets every month, attended by the executive members of the Trust and where junior doctor issues can be raised. It is supported by the BMA who have a representative present at meetings. Please use this forum to express any concerns or

praise that you may have. It is chaired by the GOSW, Dr Sharryn Gardner.

The LNC represents all medical staff and is involved in negotiating terms and conditions with the management of the Trust. It is answerable to the Medical Staff Committee. It has representatives of doctors at all grades who are elected by peers. It meets once every two months and jointly meets with the executive committee and, similarly to JDF, is supported by the BMA with representation at meetings. Three junior doctors form part of the LNC who are expected to be members of the BMA. This is a very active committee and decisions made by them influence your working conditions ensuring national terms and conditions are followed. We encourage you to become involved. The LNC is chaired by Dr Henry Gibson.

SOCIAL MEDIA

The GMC has guidance on the use of social media. It is important to remember that this is a public domain and it is necessary to appreciate that you can cross professional and personal boundaries that can lead to disciplinary action taken against you by the GMC.

You should follow the Trust's guidelines on social media.

Do not post any information that identifies the Trust including photographs of the hospital or uniform that identifies you as an employee of the Trust unless permission has been given first.

If you wish to express any views regarding health care bring this to the attention of relevant individuals in the Trust, not on social media. Remember, any comments by you as a doctor is seen by the public as reflecting views by the profession. You must not use publicly accessible social media to discuss individual patients or their care with those patients or anyone else.

If you identify yourself as a doctor you must include your name. Any information uploaded anonymously can be traced back to the originator.

WhatsApp is being used more commonly between doctors to communicate – again check if it is safe to do so and check your privacy settings. Do not use this app to discuss or name patients.

CLINICAL EDUCATION

Southport and Ormskirk NHS Trust provides formal training for all trainees and medical students. There are Education Centres on both sites, affiliated with UCAS with Library facilities and a clinical skills laboratory.

You should take advantage of the learning environment. Please remember that while not obvious, a lot of learning takes place subliminally, particularly on ward rounds while doing what appears to be purely service!

All formal medicine teaching is at Southport.

Access to the library: Register with Library staff for 24 hour access.

Clinical skills laboratory: for details of what is available and for access contact Andy Burke on 5246.

Education Contacts:

Director for Medical Education: Dr Ann Holden.

College Tutor for Medicine: Dr Ankur Banajee

Post Graduate Tutor for the Trust: Miss Helen Mackay

Foundation Programme Director: Dr Katie Scott

Head of Medical Education: Ms Dawn Aspinall

Foundation Coordinator: Mr Tony Brown

Post Graduate Coordinators: Laurie Baldwin & Zoe Whiteside

SAS Educational lead: Dr Jo Robson 4124

Clinical Sub-Dean: Mr Krish Gokhul

Educator Development Lead: Dr Suchi Singh

SOUTHPORT		
Post Grad team	ext 5246	soh-tr.PostGrad-News@nhs.net
Receptionist/study leave/room bookings CEC)	ext 4377	soh-tr.studyleave@nhs.net
LIBRARY		
Glenda Morris	ext 4202	glenda.morris@nhs.net
Saffron Webb	ext 4202/6403	saffron.webb@nhs.net

ORMSKIRK. As above but use ext 6214 for all staff.

SUPERVISION AND APPRAISAL FOR TRAINEES

All Foundation Core and Specialty trainees should have three appraisal interviews during their appointment.

Foundation, Core Trainees and Specialty Trainees will be allocated their Clinical Supervisor (CS) when you join the department and Educational Supervisor (ES) as appropriate. If you are not allocated to a CS or ES please contact the relevant tutor. The CS role is to ensure you receive appropriate clinical training during your stay in your relevant department. Your ES will ensure that all your educational and training needs are met.

You should make every effort to arrange to meet your CS on a weekly basis and your ES as required including review of your progress and training needs during your stay at Southport.

For some trainees (Specialty Trainees) your ES may not be based at Southport, depending on allocation by your Training Programme Director.

SKILLS, COMPETENCIES AND EPORTFOLIOS

Full engagement with the ePortfolio (HORUS/NHS-ePortfolio) is expected. SLEs should be undertaken in a timely manner and be relevant to your curriculum. Please ensure that you ask your CS or whomever is doing your SLE before the event ie ward round/ward review/red-green round/handover etc.

Post-take ward rounds can be a useful time to obtain ACATs/CBDs particularly after a night shift on-call in EAU when the PTWR starts at 8am and provides excellent learning opportunities.

The Skills laboratory can be made available for where skills are needed according to your curriculum. Reflections are an important part of training and you should aim to undertake reflective practice at least once a week.

SLEs form an interactive part of your training and feedback should be constructive.

You should meet with your CS and ES on a regular basis to review your ePortfolio. It is up to you to arrange your meetings – do not expect your supervisor to do this for you.

Your CS will be expected to complete reports on your progress after each attachment and your ES will be expected to provide reports at the end of the training year.

If you have any concerns please contact the relevant supervisor or tutor/programme director for your specialty.

QIP/AUDIT

As part of your training you are expected to undertake an audit or quality improvement project (QIP). Please speak to your clinical supervisor regarding appropriate audit/QIP for your attachment.

All audits must be registered in the Audit Department (**Contact: Janette Mills - 5270**) and presented in the Medical Audit meeting that takes place every two months. Audits should have the loop closed. Therefore time your audit accordingly.

TEACHING PROGRAMMES 2020/2021

All teaching will take place at Southport Clinical Education Centre unless stated. You are all entitled and expected to attend four hours protected teaching time per week. Please note that during the Covid pandemic this is subject to change.

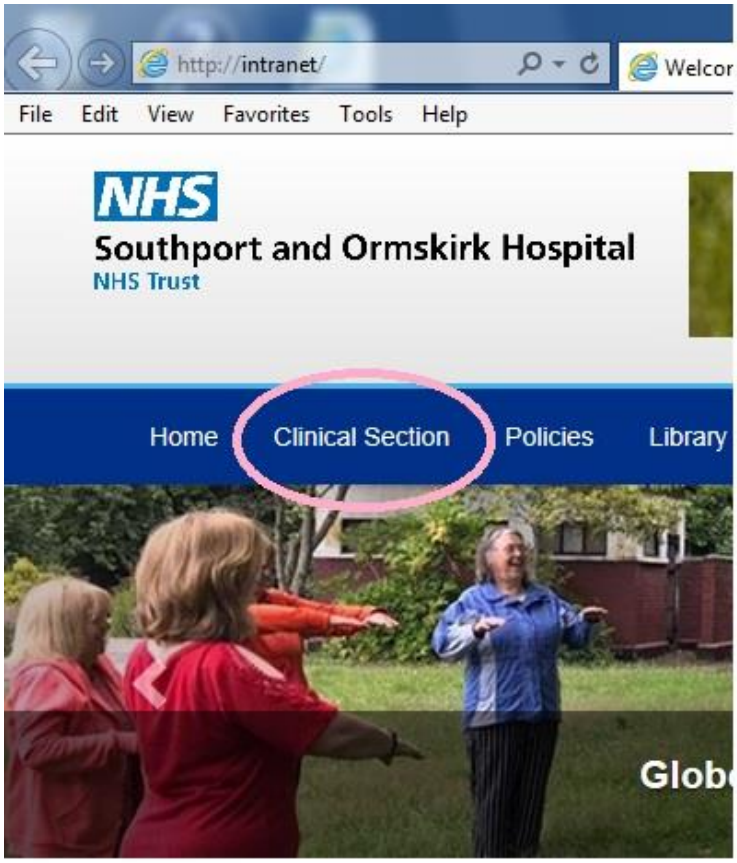
Medicine teaching	Monday	1-2pm (all grades)
Medicine teaching	Monday	2-3pm IMT/CT/GPST
Foundation Year 2	Wednesday	2-4pm
Foundation Year 1	Every other Thursday	9.30am-4.30pm
Paediatrics teaching	Mon/Tues/Wed (Ormskirk site)	Mon/Tues:12.30-1.30pm Wed: 3-4.30pm
A&E teaching	Thursday	2-4pm (all grades)
Grand Round	Friday (both sites)	1-2pm (all specialities and grades) Video conference option)

Surgery teaching	Friday	2-4pm (all grades)
Anaesthetics teaching	Wednesday	8.30-10.30am (all grades)
Obs and Gynae teaching	Wednesday (Ormskirk site)	1-5pm (all grades)
Ortho	Friday	12.30-1.30pm

GUIDELINES / PATHWAYS

Clinical Guidelines may be accessed from the intranet:

Open **Internet Explorer or Medway**, select **'Clinical Section'** Tab



You will be presented with the following pages where you can select various Trust guidelines, pathways, consent forms, handbooks etc. Please familiarise and use the **Sepsis, AKI and Pneumonia pathways** shown at the end of this section. Copies can be found on the 'Deteriorating Patient Trolley' on the wards.


NHS
Southport and Ormskirk Hospital
NHS Trust
Intranet A to Z
Clinical Section
Emergenc
Clinical Section
There are links to clinical policies, clinical guidelines, pathwa
consent forms.
Antibiotic Guidelines
Clinical Guidelines
Pathways and Careplans
Consent Forms
Clinical Policies
Referral Protocols
Handbooks
Resuscitation checklist
Deteriorating patient checklist
PICC lines
LoCSSIPs
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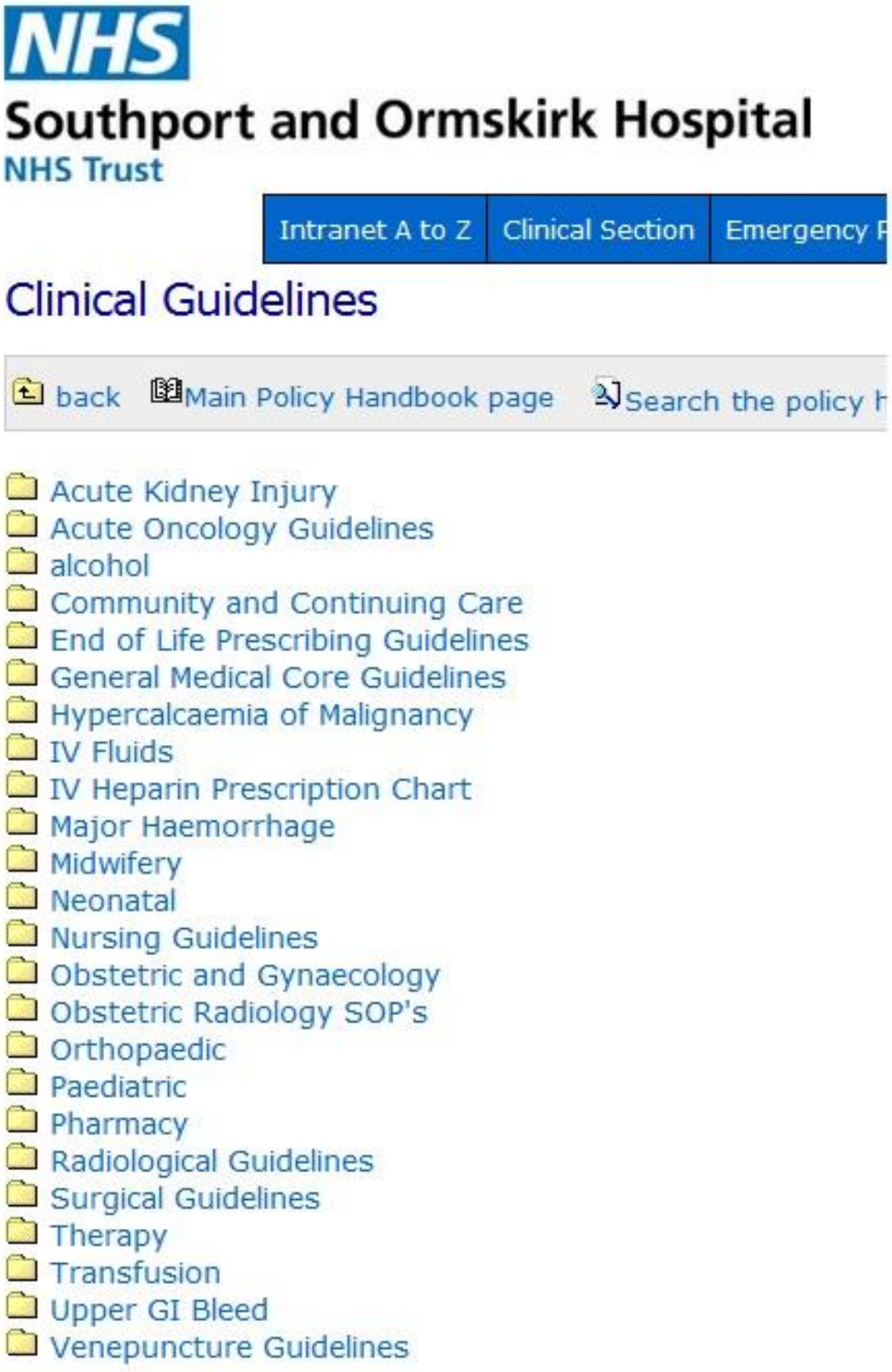
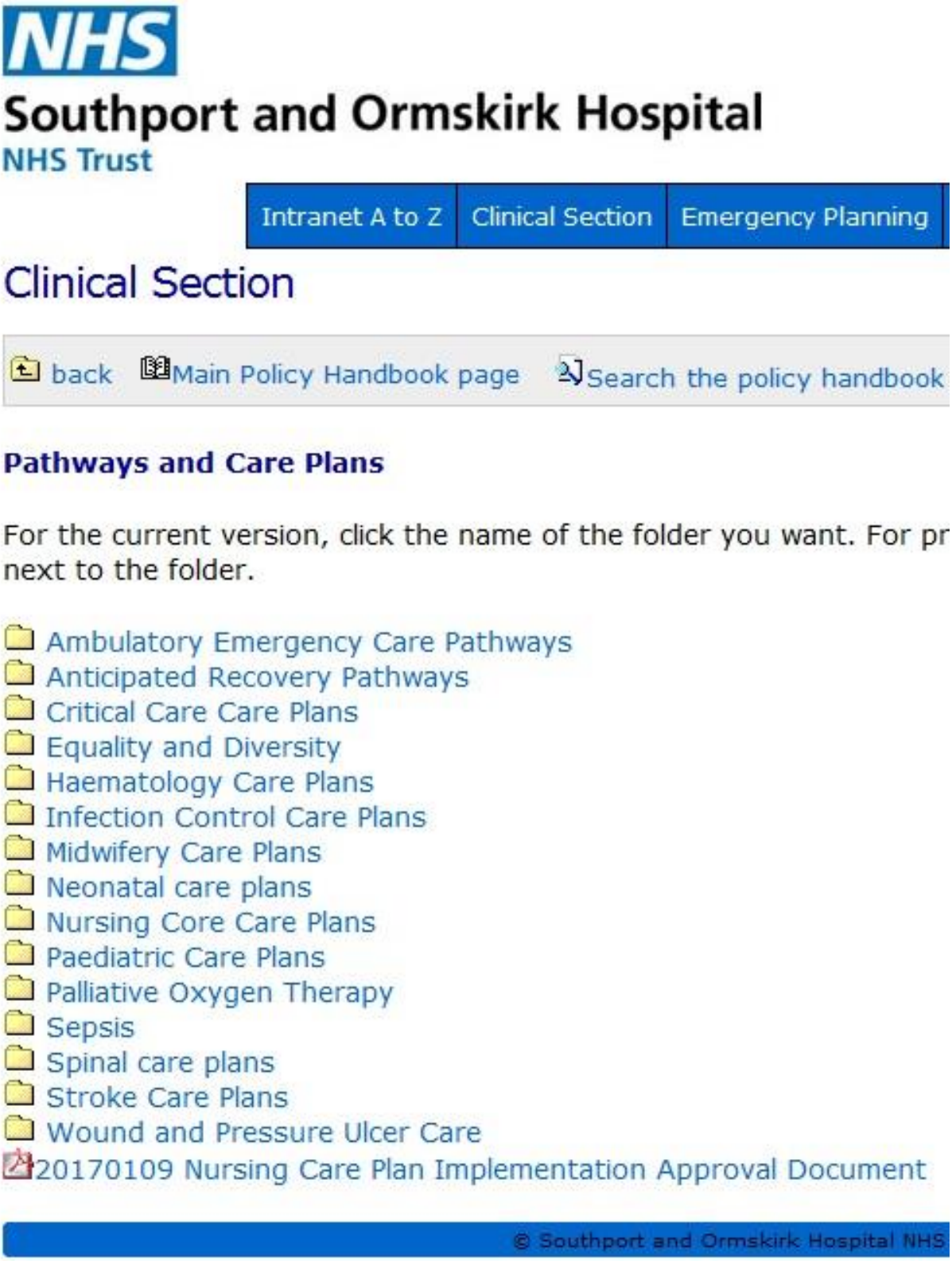

NHS
Southport and Ormskirk Hospital
NHS Trust
Intranet A to Z
Clinical Section
Emergency
Clinical Guidelines
back
Main Policy Handbook page
Search the policy
Acute Kidney Injury
Acute Oncology Guidelines
alcohol
Community and Continuing Care
End of Life Prescribing Guidelines
General Medical Core Guidelines
Hypercalcaemia of Malignancy
IV Fluids
IV Heparin Prescription Chart
Major Haemorrhage
Midwifery
Neonatal
Nursing Guidelines
Obstetric and Gynaecology
Obstetric Radiology SOP's
Orthopaedic
Paediatric
Pharmacy
Radiological Guidelines
Surgical Guidelines
Therapy
Transfusion
Upper GI Bleed
Venepuncture Guidelines


NHS
Southport and Ormskirk Hospital
NHS Trust
Intranet A to Z
Clinical Section
Emergency Planning
Clinical Section
back
Main Policy Handbook page
Search the policy handbook
Pathways and Care Plans
For the current version, click the name of the folder you want. For pr
next to the folder.
Ambulatory Emergency Care Pathways
Anticipated Recovery Pathways
Critical Care Care Plans
Equality and Diversity
Haematology Care Plans
Infection Control Care Plans
Midwifery Care Plans
Neonatal care plans
Nursing Core Care Plans
Paediatric Care Plans
Palliative Oxygen Therapy
Sepsis
Spinal care plans
Stroke Care Plans
Wound and Pressure Ulcer Care
20170109 Nursing Care Plan Implementation Approval Document
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NHS
Southport and Ormskirk Hospital
NHS Trust

Intranet A to Z | Clinical Section | Emergen

Clinical Section

back | Main Policy Handbook page | Search the policy

Consent Forms

There may be a patient information leaflet associated with
Find out more about contributing to the database and ho
20".

- Blank Consent Forms
- Cardiology Consent Forms
- Colorectal Consent Forms
- Dermatology Consent Forms
- Ear Nose and Throat Consent Forms
- Endoscopy Consent Forms
- General Surgey Consent Forms
- Gynaecology and Maternity Consent Forms
- Opthalmology Consent Forms
- Pain Consent Forms
- Radiology Consent Forms
- Respiratory and Lung Cconsent forms
- Spinal Consent Forms
- Urology Consent Forms
- Vascular Consent Forms
- Word versions of Consent

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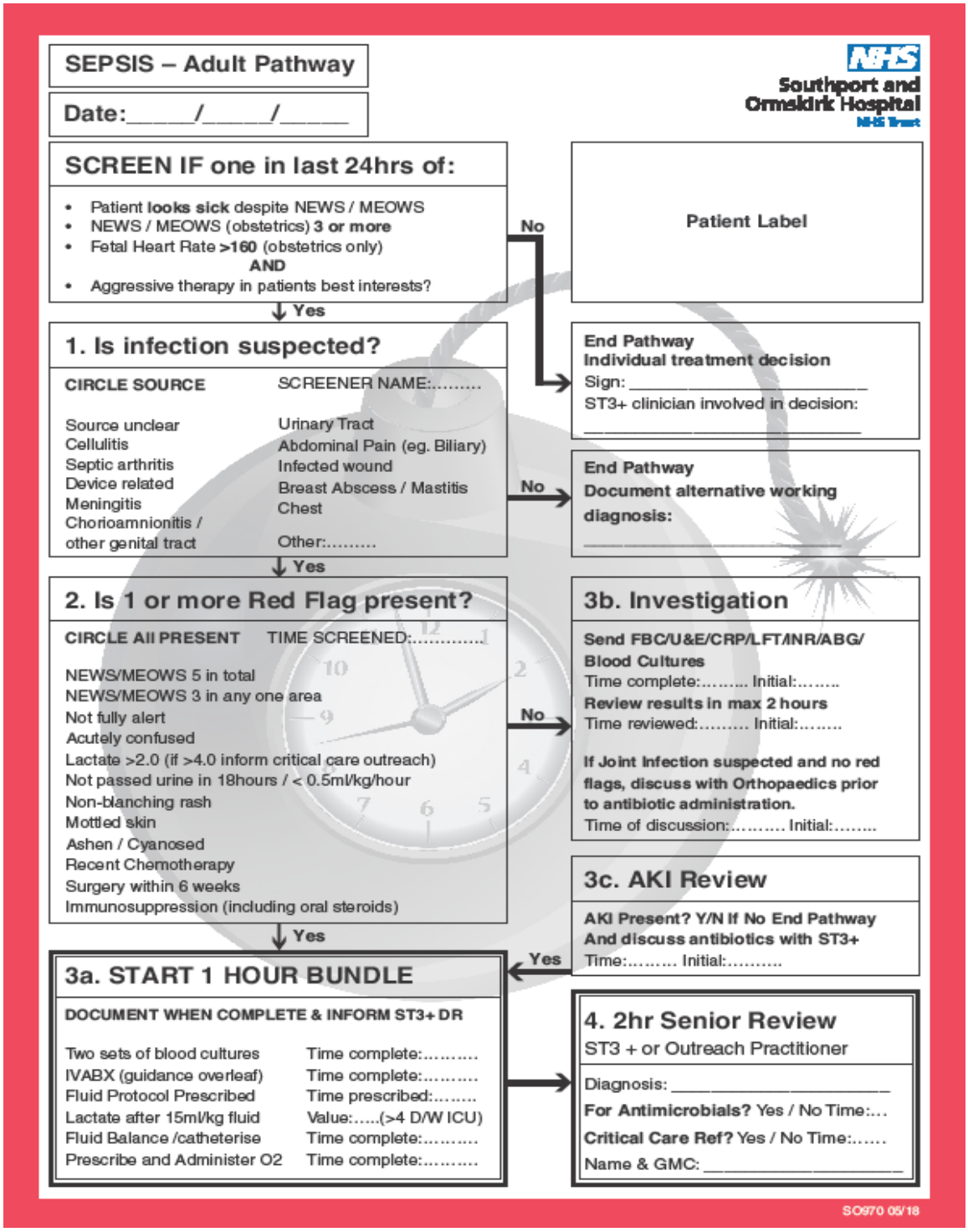
Guidelines are being updated continually. Please ensure you familiarise yourself how to access these.

DETERIORATING PATIENT PATHWAYS

SEPSIS PATHWAY:



SEPSIS – Adult Pathway

Date:_____/_____/_____

NHS Southport and Ormskirk Hospital NHS Trust

SCREEN IF one in last 24hrs of:

- Patient **looks sick** despite NEWS / MEOWS
- NEWS / MEOWS (obstetrics) **3 or more**
- Fetal Heart Rate **>160** (obstetrics only)

AND

- Aggressive therapy in patients best interests?

No → Patient Label

↓ Yes

1. Is infection suspected?

CIRCLE SOURCE SCREENER NAME:.....

Source unclear
Cellulitis
Septic arthritis
Device related
Meningitis
Chorioamnionitis / other genital tract
Urinary Tract
Abdominal Pain (eg. Biliary)
Infected wound
Breast Abscess / Mastitis
Chest
Other:.....

No → **End Pathway**
Individual treatment decision
Sign: _____
ST3+ clinician involved in decision: _____

↓ Yes

2. Is 1 or more Red Flag present?

CIRCLE All PRESENT TIME SCREENED:.....

NEWS/MEOWS 5 in total
NEWS/MEOWS 3 in any one area
Not fully alert
Acutely confused
Lactate >2.0 (if >4.0 inform critical care outreach)
Not passed urine in 18hours / < 0.5ml/kg/hour
Non-blanching rash
Mottled skin
Ashen / Cyanosed
Recent Chemotherapy
Surgery within 6 weeks
Immunosuppression (including oral steroids)

No → **End Pathway**
Document alternative working diagnosis:
_____

↓ Yes

3a. START 1 HOUR BUNDLE

DOCUMENT WHEN COMPLETE & INFORM ST3+ DR

Two sets of blood cultures	Time complete:.....
IVABX (guidance overleaf)	Time complete:.....
Fluid Protocol Prescribed	Time prescribed:.....
Lactate after 15ml/kg fluid	Value:.....(>4 D/W ICU)
Fluid Balance /catheterise	Time complete:.....
Prescribe and Administer O2	Time complete:.....

3b. Investigation

Send FBC/U&E/CRP/LFT/INR/ABG/ Blood Cultures
Time complete:..... Initial:.....
Review results in max 2 hours
Time reviewed:..... Initial:.....

If Joint Infection suspected and no red flags, discuss with Orthopaedics prior to antibiotic administration.
Time of discussion:..... Initial:.....

3c. AKI Review

AKI Present? Y/N If No End Pathway
And discuss antibiotics with ST3+
Time:..... Initial:.....

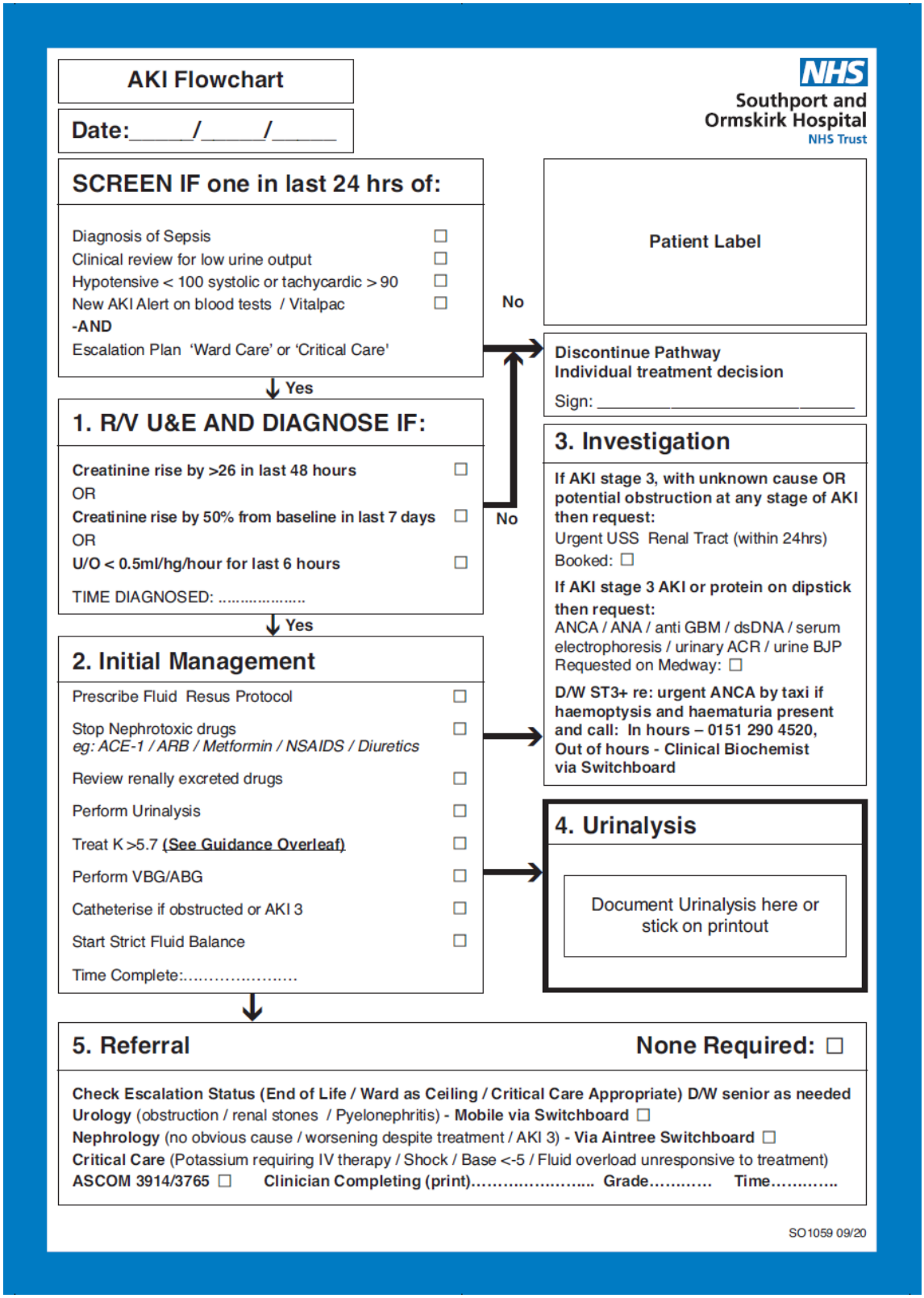
Yes ←

4. 2hr Senior Review
ST3 + or Outreach Practitioner

Diagnosis: _____
For Antimicrobials? Yes / No Time:...
Critical Care Ref? Yes / No Time:.....
Name & GMC: _____

SO970 05/18

AKI PATHWAY:



AKI Flowchart

Date:_____/_____/_____

NHS
Southport and Ormskirk Hospital
NHS Trust

SCREEN IF one in last 24 hrs of:

- Diagnosis of Sepsis ☐
- Clinical review for low urine output ☐
- Hypotensive < 100 systolic or tachycardic > 90 ☐
- New AKI Alert on blood tests / Vitalpac ☐

-AND

Escalation Plan 'Ward Care' or 'Critical Care'

No → **Patient Label**

No → **Discontinue Pathway**
Individual treatment decision
Sign: _____

↓ Yes

1. R/V U&E AND DIAGNOSE IF:

Creatinine rise by >26 in last 48 hours ☐
OR
Creatinine rise by 50% from baseline in last 7 days ☐
OR
U/O < 0.5ml/hg/hour for last 6 hours ☐

TIME DIAGNOSED: .....

No → **3. Investigation**

If AKI stage 3, with unknown cause OR potential obstruction at any stage of AKI then request:
Urgent USS Renal Tract (within 24hrs)
Booked: ☐

If AKI stage 3 AKI or protein on dipstick then request:
ANCA / ANA / anti GBM / dsDNA / serum electrophoresis / urinary ACR / urine BJP
Requested on Medway: ☐

D/W ST3+ re: urgent ANCA by taxi if haemoptysis and haematuria present and call: In hours – 0151 290 4520, Out of hours - Clinical Biochemist via Switchboard

↓ Yes

2. Initial Management

- Prescribe Fluid Resus Protocol ☐
- Stop Nephrotoxic drugs ☐
  eg: ACE-1 / ARB / Metformin / NSAIDS / Diuretics
- Review renally excreted drugs ☐
- Perform Urinalysis ☐
- Treat K >5.7 **(See Guidance Overleaf)** ☐
- Perform VBG/ABG ☐
- Catheterise if obstructed or AKI 3 ☐
- Start Strict Fluid Balance ☐

Time Complete:.....

→ **4. Urinalysis**

Document Urinalysis here or stick on printout

↓

5. Referral **None Required:** ☐

Check Escalation Status (End of Life / Ward as Ceiling / Critical Care Appropriate) D/W senior as needed
Urology (obstruction / renal stones / Pyelonephritis) - **Mobile via Switchboard** ☐
Nephrology (no obvious cause / worsening despite treatment / AKI 3) - **Via Aintree Switchboard** ☐
Critical Care (Potassium requiring IV therapy / Shock / Base <-5 / Fluid overload unresponsive to treatment)
ASCOM 3914/3765 ☐ **Clinician Completing (print).....** **Grade.....** **Time.....**

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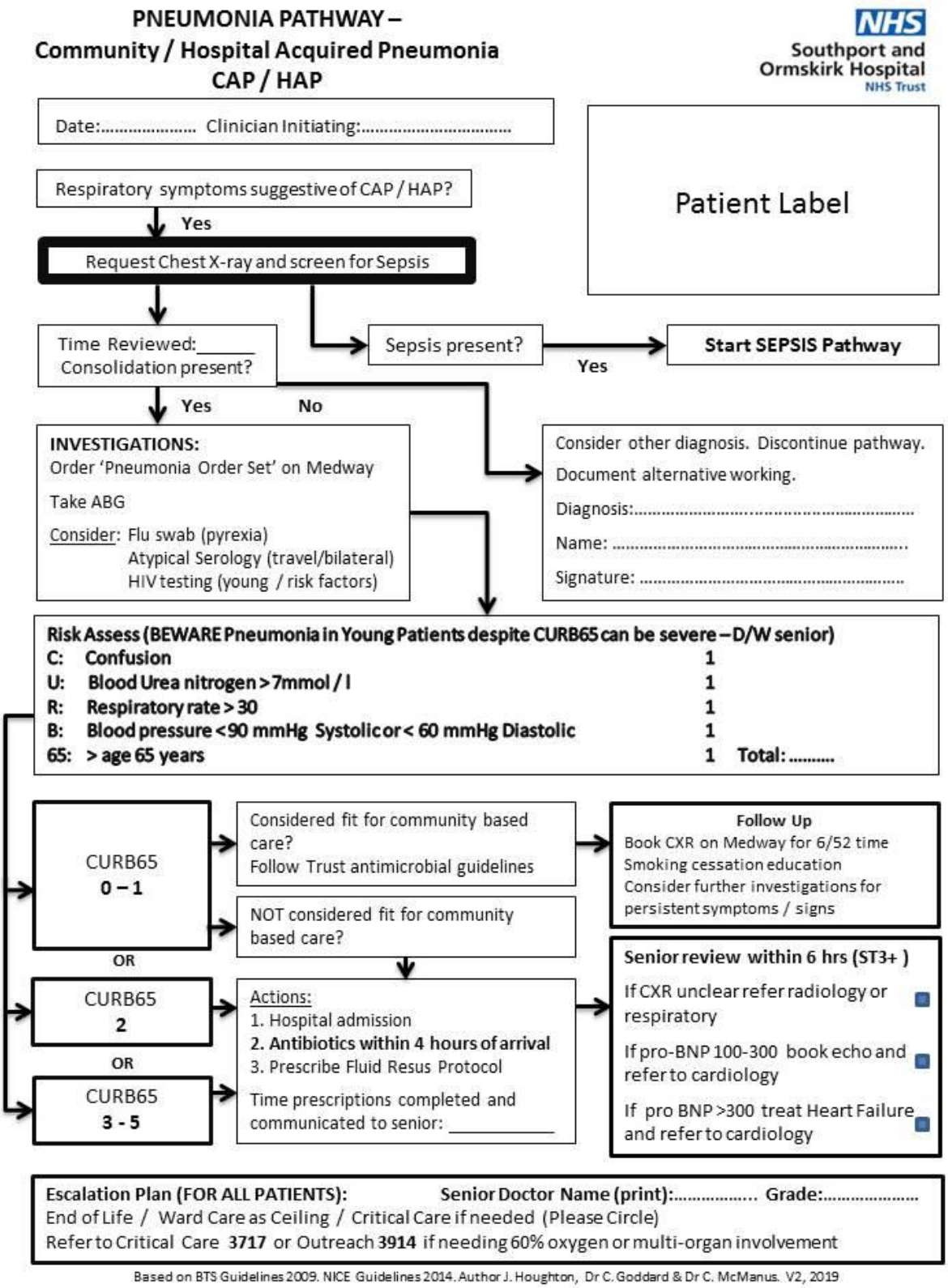
PNEUMONIA PATHWAY:



Other useful information:

Assessing Fitness to Drive - a guide for medical professionals (DVLA):

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/783444/assessing-fitness-to-drive-a-guide-for-medical-professionals.pdf

If there are any errors or omissions or would like to add additional information please email:

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