QEUH Department of Acute Medicine

Induction Handbook

February 2025

CONTENTS

SECTION 1 - INTRODUCTION

The QEUH is a large 1,677-bedded teaching hospital based in South Glasgow. The Acute Medicine team has input to a number of areas across the hospital. Most of these are on the ground floor and currently include:

- IAU (Initial Assessment Unit)
- SDUCC – Same Day Urgent Care Centre (previously called AECU - Ambulatory Emergency Care Unit)
- ARU5 (30 bedded Acute Receiving Unit)
- SSW (Short Stay Ward) – located in ARU3

Some of the team also have input to running the medical HDU which is a 9 bedded critical care unit based on the 1st floor.

Consultant Team

The following 21 consultants currently work with the Acute Medicine team within IAU/SDUCC/ARU5:

Dr Neil Ritchie (ID/Clinical Director - Acute)
Dr Neil McGuchan (Rheumatology/Clinical Director - Medicine)
Dr Linsay McCallum (Clinical Pharmacology/ Deputy Clinical Director - Acute)
Dr Allan Drummond (AIM)
Dr Durga Ghosh (AIM/Undergraduate ground floor lead)
Dr Chris Brown (AIM/Diabetes/IMS2 TPD)
Dr Colin Muir (AIM/MHDU/Stroke)
Dr Chris McNally (AIM/MHDU/IMS2 TPD)
Dr Gemma McGrory (AIM/IMS1 TPD/ADME)
Dr John McFeely (AIM/MHDU)
Dr David Bell (ID)
Dr Beth White (ID)
Dr Marie Freel (Endocrine/APGD Medicine West of Scotland)
Dr John Yates (ID)
Dr Craig Harrow (Clinical Pharmacology/Stroke)
Dr Scott Muir (Clinical Pharmacology/Stroke)
Dr Alisdair MacConnachie (ID)
Dr David Barr (ID/MHDU)
Dr Jamie McAllister (ID/MHDU)
Dr Si Han Tan (Rheumatology)
Dr Lindsay Henderson (GUM)

In addition, there is a large cohort of consultants who work within the specialty ARU pods who you will potentially also work alongside on the ground floor at various times.

We also have a GP with a Specialist Interest in Acute Medicine (Dr Veronica McDougall) who works within SDUCC.

We have a team of AIM registrars/IMT3's/Clinical Fellows directly attached to Acute Medicine at any one time as well as a large weekly rotation of junior doctors during their on-call shifts. You will be issued with a departmental rota prior to starting and allocated an educational and/or clinical supervisor who you should arrange to meet early to help develop your own specific training objectives for the attachment.

The medical rota team are responsible for the on-call rota that you will all receive and we will issue a monthly departmental rota. This departmental rota is co-ordinated by Dr McGrory – there may be the opportunity for trainee volunteers to assist with this role throughout the year. Please ensure all annual leave and study leave requests are completed at least 6 weeks in advance. A full rota guidance document will also be issued.

In addition to the core Acute Medicine staffing we also have a "SpR of the week" 9-5 weekday role which will be contributed to from all the medical specialties across the year by trainees in 1-2 week blocks. This includes trainees from cardiology, renal and neurology who normally contribute to specialty rotas rather than the General Medicine on-call rota. The Acute team will also contribute to the SpR of the Week rota. The SpR of the Week will gain experience working across the ground floor clinical areas allowing WBA's to be performed to help meet the trainees Internal Medicine requirements each year. They will also usually hold the medical referrals page and one of the cardiac arrest pages.

SECTION 2 – THE GROUND FLOOR (OVERVIEW) & IAU OPERATIONAL INFORMATION:

The ground floor at the QEUH consists of a 26-bayed IAU (the medical Initial Assessment Unit for GP referrals to medicine), a separate SDUCC (Same Day Urgent Care Centre), and five Acute Receiving Units (ARU's 1-5).

ARU 1 – Respiratory Medicine (16 beds)
ARU 2 - General Medicine (16 beds)
ARU 3 – SSW (12 beds)
ARU 4 – Geriatric Medicine (16 beds)
ARU 5 – Acute/General Medicine (30 beds)

Most medical patients admitted to the QEUH are admitted either after self-presenting to ED or after GP referral to IAU/SDUCC. All medical patients admitted via ED will move to an ARU to be clerked by a trainee and seen by a consultant. IAU patients may also move to an ARU bed but will often move directly to a downstream medical ward after consultant review in IAU.

SDUCC assesses any GP referrals to medicine who are thought to be ambulatory at the point of initial referral and are potential same day discharges. Patients can also move here if they are felt to be ambulatory on arrival at IAU. There is a separate entrance at the side of the hospital for SDUCC. There are 3 cubicles available for clinical assessments and patients will usually move to an ARU bed if they require admission. There is also a large waiting area within SDUCC for patients who are awaiting investigation results.

GP REFERRALS

IAU accepts GP referrals of medical patients who are not felt to be suitable for ambulatory care at the point of initial GP referral. We follow the 2023 GGC Speciality Triage document which lists which conditions are seen by which specialties. This document can be found in Appendix 1.

ARRANGED ADMISSIONS/TRANSFERS

Arranged admissions/transfers should not be sent via either ED or IAU but arranged via the Bed Manager (82376) and the patient not advised to attend hospital or have an ambulance booked until an ARU bed is identified.

If a bed is not available and the patient's condition is life threatening then they should be sent to ED resus to stabilise the patient whilst an appropriate bed is identified. In these cases it is anticipated that the critical care team would also be aware of and accepted the patient.

PATIENTS FROM O/P CLINICS

Patients requiring admission from clinics are admitted by phone call to the medical team who will accept the patient (if appropriate) and then the referrer will contact the bed

manager directly (82376). They will be admitted directly to an ARU bed for medical assessment rather than IAU. Some patients may also be admitted directly from clinics to a downstream specialty ward if they are felt to be stable and a bed is available in the correct ward.

Patients who become acutely unwell in a clinic are directed to the Emergency Department. These patients must be accompanied by notes and appropriate background information from the clinic. The referring clinician should speak directly to the ED senior doctor or consultant on duty (82828).

PATIENT FLOW THROUGH IAU

IAU comprises two triage bays and 24 assessment bays. On arrival, patients are triaged by the nursing team and an initial triage category given based on their observations and clinical presentation. If they are presenting with chest pain, an ECG will be done as soon as possible after arrival.

The patients will have their initial investigations performed (bloods and ECG) by the nursing staff as part of the triage process.

- **Triage 1** (acutely unwell and unstable), a senior doctor/nurse will decide if immediate transfer to Resus is required. Patients transferred to Resus are discussed with the ED consultant and subsequently looked after by the A&E team.
- **Triage 2** (higher risk patients) including chest pain requiring early review
- **Triage 3** all other medical admissions (patients triage category can be changed if change in clinical condition while waiting to be seen or any significant delays in review)

Following bloods and ECG, patients will move to a bay once available for medical assessment. They may also move directly to an ARU bed if a side room is required e.g. neutropenic patient or suspected infective diarrhoea.

ASSESSMENT & CLERKING

New GP referrals patients will arrive in IAU to be seen 24 hours a day, 7 days a week.

All doctors are able to clerk in patients in IAU. FY1 doctors can clerk new patients but must ensure a more senior doctor reviews the patient immediately afterwards and writes their own assessment in the notes. Early in the year, we would advise FY1 doctors to focus on completing ward round jobs rather than clerking but as the year progresses they should aim to become more involved in the clerking process. After 6pm, FY1's should concentrate on ensuring tasks are completed post consultant reviews rather than seeing new patients.

The role of the registrars during the day is to help review patients, perform procedures and support junior colleagues. The registrars may also be asked to assist with unwell patients in the ARUs if required. Senior AIM trainees should also partake in supervised PTWR's with the consultants.

The morning IAU consultant will perform a ward round of patients remaining in the unit overnight. Throughout the day they will lead the unit and perform consultant reviews of patients who have had a full clerking and have investigation results available. A second consultant supports IAU 2-8pm on weekdays.

The consultants finish at 8pm on weekdays (one consultant until 10pm on Mondays) and it is then the responsibility of the registrar to manage the unit - ensure they know who is waiting to be seen, organise the medical team across the ground floor and determine who needs to be seen most urgently.

THE IAU DAY

0800 - Consultant Ward Round. The night shift doctors who have clerked in IAU patients should attend the ward round from 8am to present their patients and get feedback / ACATs based on this.

0900 - Medical team handover meeting in IAU Doctor's room – attended by day and night medical staff. Check staffing for the day and discuss any issues which occurred during overnight shift.

0910 – lunchtime - IAU Consultant ward round continues with FY1 responsible for arranging investigations and ensuring EDLs completed. Any middle grade doctors should also join the ward rounds where possible for learning opportunities and to ensure good communication around any unwell or complex patients. Day 2 patients who have already seen a consultant but remain in IAU overnight will usually be reviewed by the middle grades/registrars but should be discussed/highlighted to the consultant if any concerns. New patients will also arrive during the morning period who will require clerk-in/medical assessment.

2pm - Short medical team meeting in doctors room. All medical team to attend. Review staffing, outstanding tasks, unwell patients and roles for remainder of day.

Remainder of day is for assessment and clerking/presentation of new patients.

HANDOVERS

The daily 9am handover occur individually in each receiving area e.g. IAU/ARU5. The night and day teams are expected to attend. At weekends, the handover occurs in Outpatient Waiting Area B located off the main hospital atrium. For registrars on-call in the evenings, handover occurs at 4.55pm in the doctors room in SDUCC. Nightshift handovers are arranged by H@N and location will depend on which area you are assigned to work that evening.

SECTION 3 - SDUCC (SAME DAY URGENT CARE CENTRE) & SSW (SHORT STAY WARD)

SDUCC

This unit was formerly called the Ambulatory Emergency Care Unit (AECU) and is based in a separate area on the ground floor with its own external entrance and adjacent to ARU5 for any patients requiring admission. Any patients thought to be ambulatory at point of GP telephone referral or patients triaged in IAU as low risk and thought to be possible same day discharges can be assessed here. A team of ANP's are based in SDUCC alongside medical staff. There is a GPwSI based here (two days/week) alongside a member of the AIM trainee team five days/week. There will also be a dedicated consultant covering the unit from 2-6pm. SDUCC is closed after 9pm on weekdays. It offers a reduced service at the weekend and often works out of IAU on these days.

For any patients unwell on arrival, room 90 in ARU5 is often utilised as a high-acuity bed to allow admission and rapid medical assessment/initiation of treatment. These patients will be handed over and become the responsibility of the ARU5 team. It can also be utilised for any patients in SDUCC who require admission after investigation results are available e.g. large volume PTE or confirmed ACS.

SDUCC offers an excellent opportunity for trainees to gain experiencing in assessing an ambulatory cohort of patients and develop leadership skills in the day-to-day management of the unit.

HOT CLINICS

Daily hot clinics run in the morning in SDUCC Monday-Friday and are run by the GPwSI & AIM team. These are available for rapid re-review of patients discharged from IAU or SDUCC – this can be to review clinical progress, repeat abnormal bloods or re-review patients with any outstanding investigation results available. There is a hot clinic referral form available in SDUCC. If you are unsure if a patient is suitable, please discuss with the GPwSI/consultant team. Further information about hot clinics is also available on the AIM App/website.

PROTOCOLS FOR AMBULATORY CARE PATHWAYS

A series of Ambulatory Care pathways are available via the Acute Medicine website/App – details of how to access this can be found in Appendix 2.

SHORT STAY WARD (SSW)

This ward opened in its current location in ARU3 in early 2024 and is run on weekdays by the Acute Medical consultants alongside a team of ANP's. If procedures are required for this ward, the SpR of the Week is the first point of contact for the team. SSW is also a good training opportunity for the AIM registrars during their QEUH attachment to assist with WBA's while working alongside the AIM consultant team.

SECTION 4 - STAFFING

IAU

Monday to Friday there is a consultant in the unit 8am-8pm (10pm on Mondays). On weekends and bank holidays, the consultant covers 8am-4pm.

On call / Out of hours cover for IAU patients is from consultants on call for the most appropriate medical specialty for the patient (e.g. Resp, Gastro, Gen Med, ID).

If there are concerns about patient safety overnight due to how busy it is in IAU, these should be raised initially with the nurse in charge & the hospital co-ordinator. The General Manager on call and the on-call "contingency" consultant can be contacted if further senior input is required.

On weekdays, IAU has a dedicated registrar 9-5pm and backshift middle grade doctors who start at lunchtime. There is also additional input after 5pm from the senior tier on-call rota. There are two FY1's in the unit – one works 8am-6pm while the other works 9am-9pm.

Overnight cover in IAU:
There is a H@N team consisting of a mixture of registrars and middle grade doctors who cover IAU and the ARU's overnight. As the workload can be variable across the different clinical areas, it is expected that they will work closely as a team to ensure they are flexible and adapt to the needs of any individual shift.

ARU5

There will be a team of FY1's, middle graders and a registrar working in ARU5 each day. There may also be ANP's working in this ward. There will be two consultants for the morning ward rounds and one consultant covering the ward in the afternoons. There is currently consultant cover until 9pm on Monday/Tuesday/Friday and 6pm on Wednesday/Thursday. Weekend consultant cover for the ward is provided by a combination of the General Medicine and Gastroenterology teams.

SDUCC

There will be a GPwSI (Dr McDougall) based in the unit 10-6 two days per week and a registrar 9-5 each day from the AIM rota. There will also be a dedicated consultant for SDUCC from 2-6pm.

SICKNESS ABSENCE

Please report any sickness absence as early as possible to the medical rota team, the AIM rota leads and colleagues in the clinical area where you were due to work that day.

ADVANCED NURSE PRACTITIONERS (ANPs)

We have a large team of ANPs who work within the ground floor. The largest cohort work within SDUCC where they run the VTE service and also manage a wide range of medical patients supported by the medics in SDUCC. There is also a team of ANP's who work within the medical short-stay ward (SSW), a team working within ARU5 and a team of cardiology ANP's who help support the whole ground floor with assessment of cardiology patients.

ADMINISTRATION STAFF

The IAU/ground floor secretaries are based adjacent to the unit, near the IAU patient reception area. They maintain the Clinical Portal worklists of all patients discharged from IAU/SDUCC/ARU5 (see below). They will also co-ordinate the usage of dictaphones and troubleshoot any issues. Any general enquiries to the secretarial team can be made via the generic email address: ggc.qeuhiausecretaries@ggc.scot.nhs.uk

There are also ward clerkesses based in the unit who ensure all patients have EDL's complete prior to casenotes being scanned to clinical portal and are able to assist with locating any required proformas etc.

SECTION 5 – EDUCATION & TRAINING

LEARNING OPPORTUNITIES

There are numerous good learning opportunities within Acute Medicine at the QEUH. Some of these include:

- Present as many patients as you can to the consultant on the unit that day as this provides immediate and regular feedback. Workplace Based Assessments (WBA's) including ACAT's, mini-CEX's and CBD's should be performed regularly throughout the year and all consultants will support this.

- Consultant PTWR's – these occur daily and are a good opportunity to see and discuss patients with a wide variety of different medical presentations. Senior AIM trainees should aim to perform supervised PTWR's.

- Procedures – there are a number of procedures likely to be required each day across the ground floor. All doctors rotating through Acute Medicine should become independent at performing lumbar puncture and there may also be opportunities to perform ascitic procedures, central lines, joint aspirations and pleural procedures (under direct supervision by pleural ultrasound trained personnel). For those already competent in these procedures there should be the opportunity to teach these procedures to more junior medical colleagues.

- Specialist Skills – all AIM trainees are required to have a specialist skill and we are able to support a large number of different skills – please speak to your supervisor to discuss how we can accommodate any specific skill or if you wish to discuss starting a particular skill. A full list of potential skills can be found on the JRCPTB website.

- Leadership – we expect our senior trainees to show excellent leadership skills in running a busy acute medical take and help to support the rotating junior medical staff. The hospital also has a Chief Resident role each year which some of our trainees may be interested in applying to undertake.

- Clinical governance meetings are held every 4 months. These are currently led by Dr McNally and trainees are welcome to attend – trainees can also present cases/data (e.g. M&M) at these meetings.

TEACHING

Dedicated teaching sessions will be arranged throughout the year and full details of these sessions will be circulated to the team once finalised. There will also be Ultrasound teaching sessions arranged for Acute Medicine trainees to help meet their curriculum requirements.

UNDERGRADUATE TEACHING

We have a large cohort of medical students attached to the department each rotation and please feel free to get involved with any teaching both formally and informally. Dr Ghosh organises the medical student attachments – please contact her if you wish to be involved in formal teaching or becoming a buddy/supervisor for the medical students.

QI/RESEARCH

The Unit has a keen interest in QI/research and encourage trainee involvement in projects throughout the year. Please speak to your supervisor to discuss any potential projects to ensure no overlap with colleagues or duplication of recent work by other trainees.

SECTION 6 - IT ISSUES

TRAKCARE IN IAU

IAU is set up as an Emergency department on Trak care and not as a ward. This allows us to manage patient flow through the department electronically.

There are two important differences to the wards:

• "Clinician Assign". All medical staff must do this as soon as they start clerking a patient. This means your name is visible on Trak assigned to that patient and the team know which patients have been seen and by whom.

• Patients discharged from IAU or SDUCC require Emergency Discharge Letters (EDLs), not IDLs

TRAKCARE – "CLINICIAN ASSIGN"

Select a patient on the IAU Trakcare screen by clicking on them.

Then select the "Clinician Popup" tab from the top of the screen.

If you are logged onto Trakcare, your name will come up as default. Otherwise search for your name. Click update and your name will appear on the screen.

When a registrar/consultant performs a senior review on a patient who has been initially clerked in by a junior, they should then "clinician assign" themselves as well to keep the floorplan updated with respect to the most senior clinician who has seen the patient.

TRAKCARE – EMERGENCY DISCHARGE LETTERS (EDLs)

All patients require an EDL irrespective of whether they are discharged, self-discharge or die in the department. This should be performed (wherever possible) prior to the patient leaving the department and should be done by the doctor who reviewed and discharged the patient.

These are different to IDLs. They should be short, briefly explain why the patient attended and the diagnosis/management plan which was made. You do not need to give detailed lists of medication unless there have been significant changes. There are TTO - 'To Take Out' packs of commonly prescribed meds for discharge (e.g. antibiotics, steroids, analgesia) which can be hand prescribed at the back of the admission proforma, so most patients discharged from IAU do not need the EDL to go via pharmacy. It should take less than 5 minutes per EDL. If a patient has a dosette box requiring changes or a patient requires a discharge medicine that is not stored on the ward, the prescription will need to go to pharmacy via a paper script as well as completing an EDL.

All doctors and ANPs who clerk patients and discharge patients themselves, should complete the EDL at the time of discharge. This is important from a clinical governance perspective and is the most efficient way of ensuring GP's receive early and accurate details around each patient attendance.

In general, do not routinely arrange outpatient investigations for patients being discharged from IAU or SDUCC. It may be better for primary care to co-ordinate certain investigations (e.g. only primary care has access to refer to the rapid access chest pain clinic) or it may be more appropriate to refer on to a speciality clinic for follow-up. **Please discuss any outpatient tests with a consultant before booking.**

Note in the EDL any outstanding investigation results so that the person performing the FDL will know to chase them.

Do not ask GPs to review any outstanding results at the time of discharge or chase outpatient test results. If we organised the test, then we should review the results and we will communicate these to both the patient and the GP. It is acceptable to ask a GP to arrange simple follow-up tests (e.g. repeat U&E's after a change in diuretic medication etc).

FDLs

The IAU secretary team co-ordinate the FDL review worklists on clinical portal for consultants and registrars.

IAU, ARU5 & SSW discharges are reviewed by the consultant team.

SDUCC discharges (for patients not seen by consultants) are shared between the SDUCC GPwSI and the registrar team.

The aim of the FDL review is to check the formal radiology reports from the attendance, check the EDL accuracy including ensuring all abnormal blood results have been seen, and to check the results of any outstanding investigations at the time of discharge. An entry can be put on clinical portal in the notes section to record that the attendance has been reviewed and no formal FDL is required. An FDL or clinical letter to the GP (and/or a clinical letter to the patient) can be dictated if further information requires to be communicated. Patients can be left on the portal worklist with a suitable follow-up date for review if they are awaiting further investigation results.

SECTION 7 - MEDICAL HDU

This is a 9 bedded unit based on the 1st floor within the large critical care complex. It is currently run by the following consultants:

- Dr C McNally (AIM)
- Dr J McFeely (AIM)
- Dr C Muir (AIM)
- Dr C Wright (Critical Care)
- Dr B Docking (Critical Care)
- Dr R McCartney (Respiratory)
- Dr K Gillis (Renal)
- Dr G Jayasekara (Respiratory)
- Dr J McAllister (ID)
- Dr D Barr (ID)
- Dr M McGettrick (Respiratory)
- Dr R Livingstone (Endocrine)

There is a consultant based in the unit 8am-6pm Monday-Friday 52 weeks a year. At weekends and overnight the consultant cover for patients is provided by the on-call consultants predominantly from the respiratory, general medicine and gastroenterology teams.

There is a senior tier doctor allocated to MHDU every weekday from the AIM rota 9-5. In addition there will be at least one middle grade doctor (usually an IMT2 to fulfil their curriculum requirements) based in the unit daytime. In the evenings the unit is covered by the on-call team. At weekends there is a designated trainee responsible for MHDU with support from the consultants as above.

MHDU is an excellent learning environment where a wide variety of cases are admitted from different medical specialties. These include severe DKA, septic shock, multi-organ failure and complex respiratory failure. There should be the opportunity to become competent at central venous access (ultrasound guided) and arterial line insertion for those doctors with longer attachments to MHDU.

Full induction information about MHDU can be found on the GIM App under the Specialty Induction section.

Appendix 1 – Specialty Triage Document

NHS GGC South Sector Specialty Triage Poster

South Sector Clinical Director Group

NHS Greater Glasgow and Clyde

Best practice Guidelines

REFERRALS

- On occasion a GP or specialist may not have been able to contact the on-call specialty. The referral should still be accepted, and patient transferred to specialty assessment area.
- ED staff will endeavour to identify an "incorrect referral" and inform "correct" specialty as per Specialty Triage Document. These should be accepted, and patient transferred to specialty assessment area.

ASSESSMENT

- For critically unwell/resus patients ED will endeavour to undertake any relevant investigation (e.g. bloods and ECG) upon patient arrival.
- Please advise of any impediment to attendance at time of discussion.
- If initial referral was to the incorrect specialty, then specialty to specialty referral is required: not simply declined back to ED.

ADMISSION

- Accept admission as soon as it possible. Do not delay admission for unnecessary re-review in ED.
- Communicate plan to nurse floor controller and consultant in charge.
- Patients should not await formal imaging reports or investigation unless this will dramatically change management e.g. taken directly to theatre.

Cardiology

- arrhythmias
- endocarditis
- heart failure
- haemodynamically unstable PE
- suspected Acute Coronary Syndromes, NB Acute Aortic Syndrome may present as chest pain but is managed by Vascular or GJNH

Gynaecology

- significant vaginal bleed/pelvic pain/ pelvic inflammatory disease
- vulval abscess/1 herpetic infection
- Symptomatic gynae malignancy
- Prolapsed uterus requiring packing

ENT

- Following patients can be accepted by the treatment room M-F, 9-5 from triage:
  - foreign body in ear
  - pinna haematoma
  - fish bone
  - recurrent epistaxis (not actively bleeding and haemodynamically stable)
  - Traumatic TM perforation

General Surgery

- patients with abdominal pain (including severe dyspepsia)
- vomiting or diarrhoea other than infective diarrhoea (determined by sig abdo pain).
- dysphagia
- patients with disseminated surgical cancers who have been previously looked after by surgery such as colon, upper GI and breast (unless chemo related problem)
- rectal bleeding other than melaena
- constipation
- perforation of bowel
- ischaemic bowel
- cholecystitis, obstructive jaundice
- pancreatitis
- lateralising loin pain without fever
- peri-anal / pilonidal abscess
- to 'thigh and buttock stabbings above mid thigh, shoulder, axilla & upper arm stabbings
- chest wall injury (including simple traumatic pneumothorax)
- flail segment
- suspected renal colic (no proven calculi or >1 yr since Ix)
- cellulitis 2y to IV Drug use (usually Plastics)
- groin abscesses

Orthopaedics

- fractures needing operative intervention
- musculoskeletal back pain and suspected vertebral fractures for Ix or treatment
- hip pain with suspected fracture but negative x-ray.
- septic arthritis of prosthetic joint
- forearm / hand cellulitis (refer to ortho/ hand team as appropriate)
- thigh and buttock stabbings below mid-thigh (ED to determine)
- ?cauda equina - NB metastatic spinal cord compression to be admitted under parent specialty of the primary tumour
- spinal fractures including Cervical spine
- patients with fractures not requiring operative intervention but fracture precludes them from going home

Urology

- frank haematuria
- renal colic with known calculus
- lateralising loin pain/pyelonephritis in presence of known significant urinary tract abnormality
- advanced prostate CA with a current urological presentation
- Retention (if not suitable for ambulatory management)
- blocked/infected nephrostomies

Miscellaneous

- Post-operative complications return to the parent specialty (simultaneous ED resuscitation if required)
- Patients with a GP referral letter (even without telephone contact will be referred to the specialty)
- Patients being admitted from outpatient clinics are admitted by contacting the bed manager and do not come to the ED. If the patient is acutely unwell requiring resuscitation then they can come to the ED with appropriate background information and contact being made with the CiC.

Medicine

- asthma, chest infections
- deep vein thrombosis and /or stable pulmonary embolism
- pleural effusion
- primary lung tumours
- respiratory failure
- spontaneous pneumothorax
- hepatitis, alcoholic liver disease
- inflammatory bowel disease (unless suspected perforation)
- infective diarrhoea & vomiting
- painless (non obstructive) jaundice
- haematemesis & melaena
- dizziness & blackouts
- falls (without fractures or suspected fractures)
- arthritis, joint pains
- septic arthritis
- diabetic metabolic decompensation, hypoglycaemia
- renal failure
- hypercalcaemia, other metabolic emergencies
- cellulitis, other infections (if forearm, hand refer to ortho/hand team)
- septicaemia
- lower urinary tract infection
- self-poisoning, alcohol withdrawal
- suspected neutropaenic sepsis, or chemo/oncology (d/w Beatson) otherwise all previously treated cancers should be referred to relevant surgical team
- uncomplicated pyelonephritis - fever & loin pain (loin pain without fever is unlikely to be pyelonephritis)
- diabetic foot
- delirium, coma
- acutely reduced functional ability
- DME services take patients according to the HIS Frailty Criteria – see Trak for details

Emergency Medicine

- Head injury for assessment from primary care
- Admit isolated head injuries for observation

mi • 351360 v1.0

Appendix 2 - Departmental Guidelines

Acute Medicine

To access the departmental website containing up-to-date local guidelines/pathways please visit:

https://rightdecisions.scot.nhs.uk/qeuh-acute-medical/

The password is 2015.

The website can also be viewed in App form – please search for "Right Decisions" on either Apple/Android devices. The password is also 2015. The same App can also be used to access the QEUH General Medicine site. The password for the GIM App is 2020.

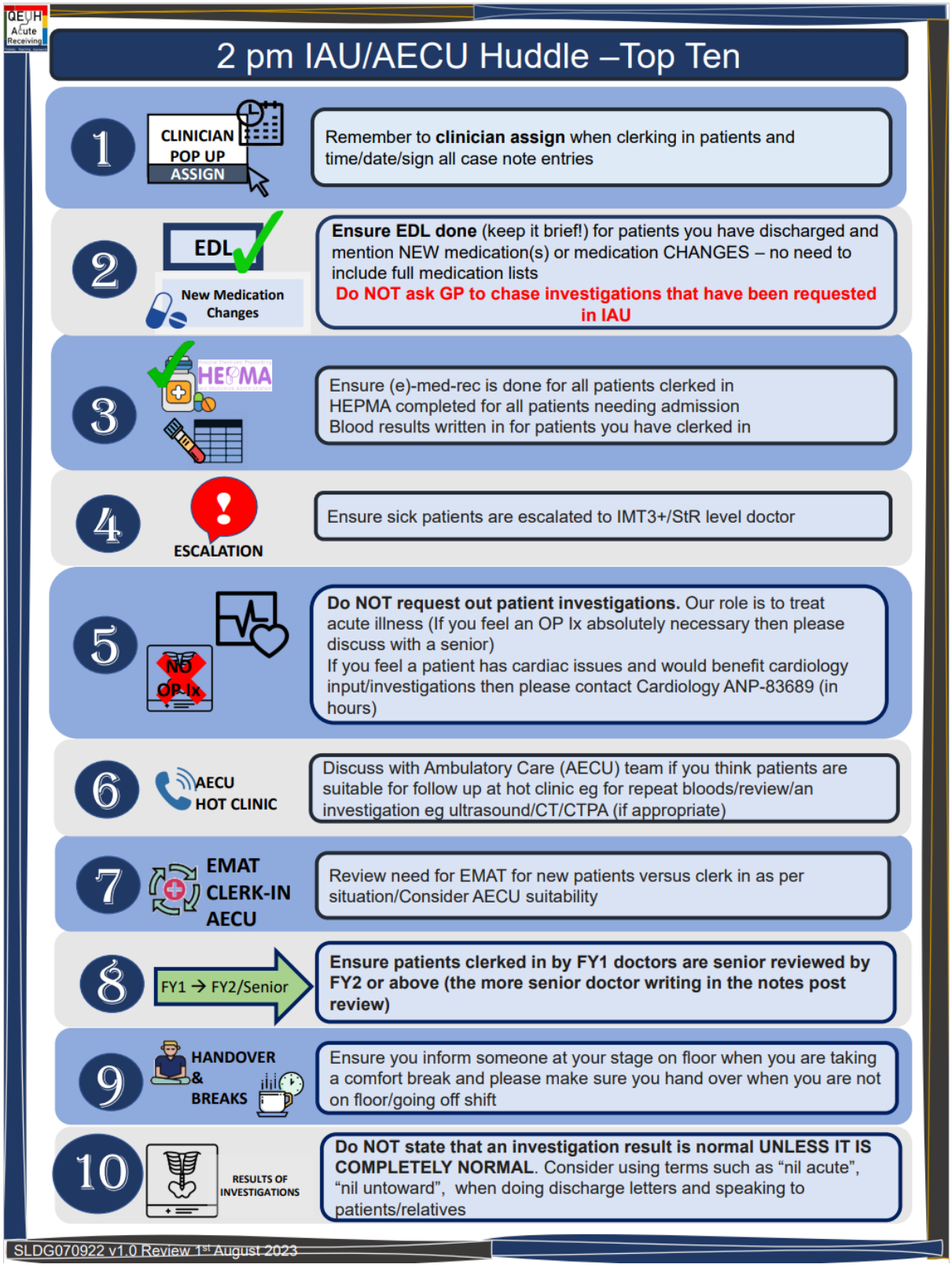
Gastroenterology

There are also a number of protocols from other departments which should be utilised. The GI protocols can be found at the following links and provide lots of useful information including GI bleeding and acute severe colitis bundles:

Via Sharepoint:

https://scottish.sharepoint.com/sites/GGCQEUHGastroenterologyunit

Appendix 3


QEUH Acute Receiving
2 pm IAU/AECU Huddle –Top Ten
1
CLINICIAN POP UP ASSIGN
Remember to clinician assign when clerking in patients and time/date/sign all case note entries
2
EDL
New Medication Changes
Ensure EDL done (keep it brief!) for patients you have discharged and mention NEW medication(s) or medication CHANGES – no need to include full medication lists
Do NOT ask GP to chase investigations that have been requested in IAU
3
HEPMA
Ensure (e)-med-rec is done for all patients clerked in
HEPMA completed for all patients needing admission
Blood results written in for patients you have clerked in
4
ESCALATION
Ensure sick patients are escalated to IMT3+/StR level doctor
5
NO OP Ix
Do NOT request out patient investigations. Our role is to treat acute illness (If you feel an OP Ix absolutely necessary then please discuss with a senior)
If you feel a patient has cardiac issues and would benefit cardiology input/investigations then please contact Cardiology ANP-83689 (in hours)
6
AECU HOT CLINIC
Discuss with Ambulatory Care (AECU) team if you think patients are suitable for follow up at hot clinic eg for repeat bloods/review/an investigation eg ultrasound/CT/CTPA (if appropriate)
7
EMAT CLERK-IN AECU
Review need for EMAT for new patients versus clerk in as per situation/Consider AECU suitability
8
FY1 → FY2/Senior
Ensure patients clerked in by FY1 doctors are senior reviewed by FY2 or above (the more senior doctor writing in the notes post review)
9
HANDOVER & BREAKS
Ensure you inform someone at your stage on floor when you are taking a comfort break and please make sure you hand over when you are not on floor/going off shift
10
RESULTS OF INVESTIGATIONS
Do NOT state that an investigation result is normal UNLESS IT IS COMPLETELY NORMAL. Consider using terms such as "nil acute", "nil untoward", when doing discharge letters and speaking to patients/relatives
SLDG070922 v1.0 Review 1st August 2023

Appendix 4 **25/07/22**

Policy for patients taken over for transfer to medical wards v3 - Patients within stack wards at QEUH.

1) If a patient is reviewed by specialty StR or medical registrar and is accepted for transfer to medicine, the following must be recorded in patient case note

- The name of the doctor who reviewed the patient
- The name of the Consultant they will be under when transferred
- The ward to which they should be transferred

2) The nursing staff on the ward should inform the bed manager of this information and the patient should be transferred as a priority.

3) The bed managers will keep a list of patients needing transfer between stack wards including the information above and patients should be transferred as soon as a bed becomes available. This patient list should be circulated each day at the same time as the boarders list

4) If a patient is not transferred by the following morning they will remain under the care of the consultant team on the original ward until they are transferred. If a patient is not transferred by the following morning they should be reviewed by the ward team, who liaise directly with the medical specialty for input prior to transfer

Patients being transferred back to medicine from NHS regional services (i.e. neurosurgery, PDRU, spinal injuries, renal) can be accepted for transfer back to medicine by the on call medical team after discussion with a consultant but do not need to be clinically reviewed. They should remain under the care of the regional service until they are transferred into an appropriate medical bed.

Patients on ground floor or in ED

1) Patients should be reviewed by the medical registrar following a request for a patient to be taken over under general medicine.

2) If a patient is accepted under general medicine, contact the bed manager for receiving who will facilitate the transfer of the patient to the correct ARU pod. In the event that the reviewing doctor is uncertain they should discuss this with Consultant in ARU2 to decide the most appropriate team to take over the patient

3) When a patient is accepted for transfer to medicine the following must be recorded in patient case notes

- The name of the doctor who reviewed the patient
- The name of the Consultant they will be under when transferred
- The ward to which they should be transferred

4) If a patient is not transferred by the following morning they will appear on the patients to be transferred list held by the bed managers but will remain under the care of the original team until after they are transferred. If a patient is not transferred by the following morning they should be reviewed by the ward team, who liaise directly with the medical specialty for input prior to transfer