NHS GGC North Sector Specialty Triage Poster (V5)

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.
- Attendance within 30 minutes of referral is required unless time critical intervention required elsewhere. 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 change.
- Patients should not await formal imaging reports or investigation unless this will dramatically change management e.g. taken directly to theatre.

CARDIOLOGY

Arrhythmias
Suspected ACS
Endocarditis
Heart failure
Suspected dissecting thoracic aortic aneurysm (+ve CTA -> cardiothoracic GJNH)

EMERGENCY MEDICINE

• Head injury
• Acute alcohol intoxication (not withdrawal)
• Recreational Drug excess – uncomplicated requiring short-term admission

MEDICINE

• Asthma, chest infection DVT (non-ambulatory) +/- PE
• Primary lung tumour
• Respiratory failure
• Spontaneous pneumothorax
• Pleural effusion (including 2° to surgical primary tumour)

• Disseminated unknown primary malignancy (inc bone mets)

• Hepatitis, ALD, cirrhosis
• Painless (non obstructive) jaundice
• Inflammatory bowel disease (unless suspected perf – General Surgery)
• Infective vomiting and diarrhoea (refer to ID initially)
• Haematemesis and melaena (follow GI bleeding protocol)

• Acute confusion / delirium Altered conscious level
• Stroke or suspected stroke Dizziness, blackouts

• Frequent falls (inc those with minor # *: inform Ortho Trauma coordinator to arrange ortho review + written plan in notes on Medical ward – fracture that ED staff would normally DC and refer for VFC FU)
• Poor mobility due to frailty Arthritis, atraumatic joint pains Septic arthritis (prosthetic joint – Ortho)

• Cellulitis (except upper limb - plastics)
• Diabetic foot infection (inc osteomyelitis)
• Back pain/PUO + suspicion of discitis/osteomyelitis
• Sacral pressure sore (inc underlying osteomyelitis)
• Diabetic metabolic decompensation, hypoglycaemia, Metabolic emergencies, hypercalcaemia

• Renal failure
• Self poisoning
• Alcohol withdrawal

• Lower UTI (inc catheter) (no renal angle tenderness)

• Neutropenic sepsis (consider BOC admission or consider base tumour specialty admission – for MDT liaison)

GENERAL SURGERY

• Acute abdomen /Abdominal pain (inc gastritis) / Pancreatitis
• Abdominal trauma - Axillae/Groin/Buttock/Perineal stabbing (within "Victorian Swimsuit")
• Ischaemic bowel / Intra-abdominal sepsis

• Chest wall injury (inc flail segment and simple traumatic pneumothorax)
• Complications of disseminated surgical cancers (unless chemotherapy related)

• Constipation with abdominal pain PR bleeding (fresh / not melaena)
• Peri-anal/pilonidal abscess
• Non-infective vomiting and diarrhoea
• Cholecystitis, obstructive jaundice
• Dysphagia / Oesophageal food bolus (above thoracic inlet = ENT)

• Uncomplicated pyelonephritis
• Lateralising loin pain

• Necrotizing fasciitis (follow protocol - GS first point of contact, but dual specialty review and input depending on anatomical location-plastics/urology/ortho)

UROLOGY

• All acute testicular pain <40 years must be seen by Urologist (<16y to RHC Paeds Surgeon)
• Suspected penile fracture
• Retention (if not suitable for ambulatory management)
• Visible haematuria
• Complicated pyelonephritis (PMH or imaging suggests urological obstruction)
• Renal colic (image proven <1 year)
• Advanced Prostate Ca with a current urological presentation

GYNAECOLOGY

• Significant vaginal bleed / Pelvic pain / Pelvic inflammatory disease
•Ectopic pregnancy/1st trimester miscarriage
•Vulval abscess/1 herpetic infection
•Procidentia requiring packing
•Symptomatic gynae malignancy

OBSTETRICS

Assuming intra-uterine pregnancy established, all other pregnancy related problems inc: hyperemesis/ suspected DVT/PE will usually be accommodated via mat assessment.

ORTHOPAEDICS

• Fracture requiring operative intervention
• #NOF (unless requires Level 2+ care) and suspected #NOF
• Fracture requiring admission due to 'social' reasons (e.g. inability to use usual walking aid, inability to WB, transport issue)
• Pubic ramus fracture
• MSK back pain & suspected CES
• Vertebral # requiring further investigation +- management
• Osteomyelitis (exc diabetic foot/ sacral pressure sores)
• Septic arthritis in prosthetic joint/olecranon bursitis/abscess
• Limb stabbing/wounds (outwith "Victorian Swimsuit" - GS)

PLASTIC SURGERY

•Burns (requiring discussion / admission to Burns Unit – See Burn Referral SOP)
• Deep bites to face or upper limb
• Facial Lacerations with soft tissue loss (nb if facial fracture or dental injury refer MaxFax)
• Facial Lacerations with Facial Nerve and or Parotid Duct involvement (nb if facial fracture or dental injury refer MaxFax)
• Hand Fractures requiring surgery (as per joint GRI Ortho / Plastic Surgery Specific Management document)
• High pressure injection injuries
• Necrotising soft tissue infection of upper limb
• Replantation / Revascularisation
• Significant Degloving Injuries
• Soft tissue loss requiring reconstruction

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 team for review/management
• BOC helpline referrals – agreed for SATA assessment. (i.e. chemo side-effects).
• Patients with known cancer and related complications of oncological management will be admitted to the team managing the overall cancer treatment/MDT
•Facial fractures/dental – refer Maxillofacial Team