University Hospitals of Derby and Burton NHS Foundation Trust

Acute Medicine Telephone Triage Service

Purpose

The Acute Medicine Consultants provide a service for their Primary Care colleagues to support the appropriate referral of patients to the correct speciality. They also provide clinical advice when appropriate and ensure patients are directed to the correct secondary care teams including the Ambulatory Care Centre. This service can also receive calls from our community hospitals and in-patient speciality teams in secondary care.

Service availability

Monday to Friday 10am–6pm (non-public holiday)

All suspected adult Acute Medicine referrals and requests for advice are directed to the nominated Consultant Physician via Bed Bureau (BB). Outside these times and when the Consultant is not available calls will be taken by the MAU Registrar.

Out of hours:

Via Bed Bureau (01332 789099), available 24/7.

Referral Criteria

1. The Acute Medicine consultants welcome discussions regarding all adult patients who meet the following criteria: (Patients aged 16-17 may choose between referral to adult or paediatric services):

    a. Urgent clinical problem where the presumed diagnosis lies within the remit of general / acute medicine
    b. Potential requirement for assessment with a view to in-patient admission
    c. Potential requirement for rapid same-day investigation within Ambulatory Care
    d. Advice needed to identify most suitable ongoing patient management in primary care

2. A clinical assessment should have been undertaken by the referrer prior to discussion with the acute medicine consultant. This will usually be a face-to-face review, but may sometimes take the form of a video or telephone consultation.

3. If the referrer is unsure whether acute referral is necessary (for example trainee medical staff or non-medical practitioners) then it would usually be appropriate for them to seek advice from their clinical supervisor prior to discussion with acute medicine.

4. Unstable patients, including those with ongoing chest pain suspected of having a heart attack, will be re-directed (usually via 999) to the Emergency Department. They should ideally be sent with an accompanying letter. The shift lead in ED should be contacted if it felt that the case warrants specific discussion.

Who can refer?

The acute medicine team is happy to discuss patients with clinicians from the following groups:

- Consultants
- General Practitioners / Trainees
- SAS Doctors / Registrars
- Advanced Clinical Practitioners
- Nurse Practitioners / Specialist Nurses
- Community Matrons
- Paramedics

Clinicians are asked to use the SBAR system for referring patients to a hospital specialist (see attached poster). Referrals will not be taken from non-clinical staff (e.g. secretaries, healthcare assistants, receptionists, ambulance technicians).

Referral letters must accompany the patient or be emailed to Bed Bureau via their secure NHS email address: dhft.bedbureaurdh@nhs.net.

Outcomes:

Following discussion between the referring clinician and the Acute Medicine consultant, the outcome will usually be one of the following:

a) Patient accepted to MAU for further assessment (same day or elective)
b) Patient accepted to ACC / DVT clinic for further assessment (same day or elective)
c) Patient directed to ED (via 999 if required)
d) Advice given for ongoing management in usual place of residence
e) Referrer advised to liaise with another medical speciality consultant – this may be via on-call or via Clinician Connect (See below)
f) Referrer advised to liaise with a non-medical speciality team (eg surgery)
g) Referrer advised to seek alternative plan (eg SPOA, hospice etc)

The referring clinicians and the Acute Medicine consultants should aim to formulate a plan as promptly as possible and with the minimum complications for all involved, especially the patient. If it is possible to avoid an acute admission then this should be done, but where secondary care review is deemed necessary, it should be remembered that it is better for patients to be seen as early as possible.

Other speciality advice:

Most specialities are part of Clinician Connect, which aims to reply to semi-urgent queries within 48 hours by phone or email. Clinician Connect is accessible through Bed Bureau. Most specialities will also have a Consultant or Registrar on call for urgent advice.

Referral guidance regarding specific conditions:

- **Abdominal pain** – Patients presenting with abdominal pain as their primary complaint should be considered for discussion with the surgical team.

- **Alcohol withdrawal** – Mild withdrawal symptoms should be managed with advice to reduce intake gradually and referral to community alcohol services. Patients with severe symptoms at risk of life-threatening complications will need admission (this should be via ED if they are violent/aggressive or acutely confused). Medicine does not provide elective detox and patients requesting this should be referred to community services.

- **Anaemia** – Acute severe symptomatic anaemia will usually be accepted to Acute Medicine with the exception of lower GI bleed (Surgery), epistaxis (ENT) and menorrhagia (Gynaecology).

    - Please note that practice has changed and we do not routinely give blood transfusions for iron deficiency anaemia.

    - **Intravenous iron pathway** – New onset symptomatic iron deficiency Hb < 80 g/L may be considered for intravenous iron via ACC if no active bleeding and already tried/unsuitable for oral supplementation.

    - **Transfusion dependent patients** should have top ups / intravenous iron arranged by their parent speciality via day case units.

    - **Transfusion** – NICE guidance recommends restrictive transfusion thresholds for those who do not have major haemorrhage, acute coronary syndrome, or require recurrent transfusions. This threshold is 70 g/L, with a post transfusion target of 70 – 90 g/dL. [https://www.nice.org.uk/guidance/ng24].

- **Ascites** – Known liver patients with diuretic-resistant ascites requiring recurrent paracentesis (and no other acute issue) can be referred to Liver Specialist Nurses during working hours to arrange drainage on the Elective Procedures Unit (EPU).

- **Back pain** – All patients presenting with their primary complaint as back pain should be discussed with Trauma & Orthopaedics. Suspected spinal cord compression should follow the agreed emergency pathway (via the Emergency Department).

- **Cardiac chest pain** – Prolonged suspected cardiac chest pain (lasting more than 15 minutes) or symptoms suggestive of unstable or crescendo angina requires urgent hospital assessment.

    - Stable symptoms can usually be referred to the Rapid Access Chest Pain Clinic.
    - If the patient is pain free and has an ECG with no new changes, following discussion with the Acute Medicine Consultant, they may be directed to MAU or ACC with appropriate advice if they were to deteriorate on route.
    - If the patient is having ongoing suspected cardiac chest pain that has not settled at time of referral they should go directly to ED via 999 ambulance.

- **Cancer** – Suspected malignancy can usually be managed by 2WW referral to the appropriate speciality. The patient should only be referred to Acute Medicine if they also have a medical emergency / urgent problem requiring hospital treatment.

- **Cord compression** – Suspected cord compression should go to ED. There is a metastatic spinal cord compression facilitator who may be involved to arrange management thereafter.

- **Cellulitis** – Most cellulitis requiring IV antibiotics is accepted by Medicine.

  Exceptions:
  - Cellulitis of the hand (Hand Surgery)
  - Cellulitis of the abdominal wall (Surgery)
  - Cellulitis localised to a single joint which could represent a septic joint (T&O)
  - Periorbital cellulitis (Ophthalmology)
  - Wound infections (Surgery)
  - Abscesses (Surgery)
  - Suspected necrotising fasciitis (Surgery)
  - Ulcers – Venous by Community Tissue Viability Nurses, Arterial by Vascular Team and Diabetic Ulcer by Diabetic Foot Clinic.

- **Chemotherapy patients** – Should have emergency phone number for complications (24/7). GP's can also ring the advice line for advice (24/7), RDH 01332 788947, QHB 0300 123 3636.

  CDU (shared between Oncology and Haematology) is open Mon-Fri until 7pm with the last admission to Oncology 5pm and Haematology 4pm. Weekends 9am-4pm. Oncology patients may be seen on 303 by the Registrar.

  Admission outside these times would be via MAU.

- **Dermatology** – If the patient has suspected erythroderma, severe acute vasculitis or is systemically unwell, they may be seen in ACC or MAU. All stable patients should be discussed with the Dermatology Registrar based at LRCH during weekday working hours (before 4pm Mon-Fri).

- **Urgent and emergency diabetes referrals :**

  - **New T1DM –** If not suspected DKA the point of contact is the Diabetic Specialist Nurse via Clinician Connect who will arrange same day review.
  - **Diabetic foot infections –** Referrals are generally seen in foot clinic within 48 hours. If referrals are received Mon, Tues or Thurs patients are usually seen in clinic on the Wed or Fri. If the call is received on a Wed or Fri and GP feels the patient needs urgent review they should contact Medical Speciality OPD regarding same day review in clinic.
  - **Hyperglycaemia –** In an otherwise well patient, this can be discussed directly with the Diabetes Team.

- **DVT** – Usually direct to ACC and seen on the same day of referral. Please see the DVT referral pathway.

  - Immobile / bedbound patients will usually need to be discussed with a clinician for elective admission via MAU Mon-Fri for Doppler Ultrasound (with bridging anticoagulation in the community).

- **Electrolyte disturbances and abnormal blood results** – Please follow helpful shared care pathology guidelines regarding electrolytes and other pathology results considered to be a medical emergency: http://www.derbyhospitals.nhs.uk/primary/pathology/shared-care-pathology-guidelines/

- **Geriatric Medicine –** Intermediate care, urgent social support, and therapies are available in the community via single point of access (SPA). For complex cases that cannot be resolved via SPA and do not clearly need medical admission, the Consultant Geriatrician can be contacted 9am-5pm via RDH switchboard.

- **Haematology –** Haematology Consultants / Registrars (shared rota) are happy to speak with GPs directly via switchboard.

- **Haematuria** – Should be referred to Urology unless clearly secondary to coagulopathy or thrombocytopenia.

- **HIV and sexual health** – GU Medicine is based at LRCH. CD4 counts and viral load results are kept in a database accessible via GU Medicine.

- **Neurosurgery** – All patients with neurosurgical problems and a significantly reduced Glasgow Coma Score should be admitted via ED.

    - Stable / no significantly reduced GCS patients with suspected spontaneous intracranial haemorrhage or space occupying lesion can be assessed by Acute Medicine.
    - Trauma should not be directly admitted to Medicine.
    - Head injuries should be referred either through ED or Surgery.
    - Our local Neurosurgical unit is QMC Nottingham.

- **Oncology** – Oncology Registrars will take calls via switchboard up to 7pm on weekdays. At weekends there is a Registrar or Associate Specialist until 5pm. Patients on systemic cancer treatment (chemotherapy, tyrosine kinase inhibitors, immunotherapy etc.) attending between 9am-6pm Mon-Fri or 9am-4pm weekends will usually be able to be assessed by the Oncology team on CDU or 303 by arrangement.

- **Palliative care** – The Nightingale Macmillan Unit (NMU) runs a dynamic waiting list and admissions are prioritised based on patients' clinical needs. Patients are usually admitted for difficult symptom control and/or complex psychological problems.

    - Due to the number of admission requests for symptom control, patients comfortably dying with no specialist palliative care needs may not be a clinical priority. It may be appropriate for patients with acute, potentially reversible problems to be admitted to MAU for treatment despite their progressive underlying disease.
    - To request admission to NMU, Mon-Fri 9am-5pm phone 86060; out of hours call the Palliative Medicine Consultant on-call via switchboard.

Other specialist Palliative Care services:

- Community Palliative Care Team will assess urgent referrals within 2 days, the consultant and Registrar can also assess people at home.
- Enhanced Nursing Homes Beds for Palliative Care: 9am-5pm, Mon to Fri: 07799337704.
- Palliative Medicine Outpatient clinics at RDH and in the community, urgent referrals will be seen within 1 week. Referrals can be emailed to dhft.pallmedsecs@nhs.net.
- 24-hour nurse-held telephone advice line primarily for patients and carers known to the service in the community.
- 24/7 access to a Palliative Medicine Consultant
  - Mon-Fri 9am-5pm via Palliative Medicine Secretaries (ext 88794).
  - Out of hours via switchboard asking for the Palliative Medicine Consultant on-call.

- **Papilloedema** – Possible papilloedema patients identified by community optometrists have their retinal images transferred to ophthalmology for review and exclusion of pseudo-papilloedema. If presenting to the GP, patients should be referred directly to ophthalmology for urgent review and should not be referred to Medicine.
- **PEGs** – Blocked / dislodged PEGs can usually be discussed with the Nutrition Specialist Nurses during normal working hours.
- **PR / lower GI bleed** – if requiring assessment / admission will be referred to Surgery.
- **Pulmonary embolism** – Suspected PE at low risk of life threatening complications (calculated using the simplified PESI score) may be managed via ACC. High risk patients will usually need to be investigated as an inpatient.
- **Postpartum** – Complications in the immediate postpartum period should go to Obstetrics. MAU does not have facilities for nursing mothers.
- **Pregnancy** – Patients of 20+ weeks' gestation should be referred to Obstetrics. Under 20 weeks' gestation, they may be referred to Medicine but only for non-O&G related problems.
- **Rheumatology** – Advice is usually available directly from the on-call Rheumatology Consultant Mon-Fri 9am-5pm via switchboard.
- **Renal –** Renal Assessment Unit, RAU, will accept referrals for patients who need urgent assessment.
- **Social issues** – Should not be referred to Medicine other than in exceptional circumstances. Intermediate care, urgent social support, and therapies are available in the community via single point of access. Help for vulnerable people with poor housing conditions can be accessed through the council via http://www.derby.gov.uk/healthyhousing

- **Stroke / TIA** – Potential candidates for thrombolysis (can be performed up to 4.5 hours from time of onset) should be blue-lighted to ED. Other suspected strokes and high risk TIAs should be referred direct to Stroke team. Low risk TIAs to TIA Clinic. Stroke patients should not be referred to MAU.

- **Urine infections / pyelonephritis** – Can be referred to MAU, except for those patients listed below who need to be referred to **Urology:**

    - Known or suspected renal calculi, nephrostomies
    - Known abnormalities of the renal tract
    - Frank haematuria
    - Blocked suprapubic catheter
    - UTI in males < 50 years, or pyelonephritis in males
    - Sepsis/UTI post urological operation/procedure

Development of SOP:	Dr Emily McDonald - Assistant Clinical Director, Acute Medicine Dr Nicola Cooper- Consultant Physician & Clinical Associate Professor in Medical Education Dr Shaun Nakash - Consultant Physician Dr Emily McDonald - Consultant Physician Dr Seema Kumari - Consultant Physician
Approved By:	Acute Medicine Business Unit 15/05/2020
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Key Contact:	Dr S Din - Assistant Clinical Director, Acute Medicine