MANAGING ON CALLS, REFERRALS, ESCALATION AND HOSPITAL AT NIGHT

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Timings and Nomenclature

Depending on which department timings may be different

- Medicine On calls usually 13 hour shifts-
  NIGHT 9pm to 10 am
  DAY 8.30am to 9 pm
- ED: variable(12 to 8 or 1 to 9 or 2 to10)
- On Team: Consultant , SpR (Registrar- ST3/ Senior Clinical Fellow), SHO(Senior House Officer/Clinical Fellow/ Trust Grade/IMT1/2/FY2/FY3) and F1(foundation year 1)

Tips for a successful On Call

Objective 01

Team Work and making sure your team is okay

Objective 02

Delegating and asking for help

Objective 03

Empathy and Responsibility

Before On Calls

- Have a good day/night of rest
- Try to arrive 5-10 mins before your shift starts so you have time to change and get acquainted
- print out the handover
- carry food and water--M&S Foods, Pret etc all close at 6.30pm
- Identify roles , priorities and names of your team--usually Whatsapp group to join--or at least make a note of the bleeps and contact numbers

HANDOVER

- Collect your bleep from your previous colleague who will be handing over to you--red bleeps are cardiac arrest bleeps--and the cardiac arrest team has a huddle after the handover at 9.30pm/9.15 am morning
- Handover usually SpR to SpR ; and for ward cover in Medicine will be ward cover to ward cover SHO
- Consists of outstanding jobs from the list, reviewing sick patients, following up on urgent bloods/imaging
- If you are carrying a arrest bleep-to attend a cardiac arrest call promptly

Structured Handover Model /Approach-SBAR

SBAR can be used very effectively to escalate a clinical problem that requires immediate attention, or to facilitate efficient handover of patients between clinicians or clinical teams.

SBAR stands for:
Situation
Background
Assessment
Recommendation

These are the key building blocks for communicating critical information that requires attention and action – thus contributing to effective escalation and increased patient safety

Handover Model /Approach-SBAR

S	**Situation:** I am (name), (X) nurse on ward (X) I am calling about (patient X). I am calling because ... I am concerned that ... (eg blood pressure is low/high, pulse is XX, temperature is XX, Early Warning Score is XX)
B	**Background:** Patient (X) was admitted on (XX date) with ... (eg MI/chest infection) They have had (X operation/procedure/investigation) Patient (X)'s condition has changed in the last (XX mins) Their last set of observations were (XX) Patient (X)'s normal condition is ... (eg alert/drowsy/confused, pain free)
A	**Assessment:** I think the problem is (XXX) And I have ... (eg given O_2/analgesia, stopped the infusion) OR I am not sure what the problem is but patient (X) is deteriorating OR I don't know what is wrong but I am worried
R	**Recommendation**: I need you to ... Come to see the patient in the next (XX mins) AND Is there anything I need to do in the meantime? (eg stop the fluid/repeat the observations)

The Bleep

- Good to clip it on your scrubs/lanyard/pocket
- have your own system of making a jobs list-I usually have a manual paper-which has 2 columns-Bleeps and sick patients to review
- to bleep: 88--->the number you want to bleep--->the extension that you want to be called back on
- Try bleeping back as soon as you can--you never know if the bleep is just for a prescription or for a really sick patient

MEDICAL

SHOs

- St James SHO(bl 6406)-Covers St James Wing
  - seperate AMU SHO for AMU
- Lanesborough SHO (bl 6030) covers the wing and also clerks in any Haem/Oncology patient

During On calls

- When you return a bleep/arrive to a ward

-introduce yourself to the nursing staff and patient
- review the patient/ the job
- let the NS know when you are done and what action if any they have to take
- let them know how to contact you

- If you are ward cover-can get bleeped for the wards you are covering in your wing
- If you are clerking--you are seeing new patients coming to the A&E

APPS that are your best friends:

- Microguide
- BNF for medication indications contraindications renal dosing and doses
- INDUCTION for all the numbers/bleeps
- UpTpDate or NICE for recent guidelines
- Our own St George's Intranet has all guidelines on the Grey Book

(if you search for intranet on the internet bar or simply click the home icon)

- GEEKY MEDICS
- MIND THE BLEEP

Basic Structure for Review:

- **Ward Review:**

-A-E approach
-after A-E, check patient investigations
bloods
relevant imaging
previous documentation
-order whatever relevant tests
-check medications he is on
-check observations

		Assessment	Management
Step 1	A Airway	• Is The Airway Clear? • Is The Airway Maintained? • Can The Patient Speak? • Are Their Airway Noises? • Is There Air Movement?	• Patient Positioning • Suction / Postural Drainage • Consider Airway Manoeuvres • Consider Airway Adjuncts
Step 2	B Breathing	• Respiration Rate • SpO^2 • Respiration Pattern • Chest Symmetry • Accessory Muscles • Patient Colour	• Patient Positioning • Oxygen Therapy • Assisted Ventilation
Step 3	C Circulation	• Manual Pulse • Blood Pressure • Colour • Capillary Refill Time	• Patient Positioning
Step 4	D Disability	• AVPU • Temperature • Blood Sugar • FAST • Pupils • Pain	• Glucose Supplements • Temperature Management • Pain Management
Step 5	E Expose	• Perform Head to Toe Examination, Front And Back	• Manage Abnormal Findings Appropriately

YOU SHOULD ALWAYS ONLY ASSESS AND TREAT WITHIN YOUR SCOPE OF PRACTICE

Basic Structure for Review:

- Clerking:
- Check details and ambulance/LAS summary first
- take history from patient in usual format with

-presenting complain
-HPC
-Past medical History
-Medications and Allergies--very important to record exactly what allergic recation the patient has--rash/anaphylaxis
-Family history
-recent GP/ hospital appointments
-Examination : systemically
-relevant investigations so far
-your clinical impression
-your management plan
-Once you have a plan and discussed with Senior-order tests/ make prescriptions and ensure you have informed the nursing staff to get those done--remember the patient is now your responsibility

ESCALATION AND REFERRALS

- If you are concerned a patient is very unwell/ rapidly deteriorating or needs a higher/specialist lever of care-- DO NOT HESITATE TO ESCALATE!!
- PATIENT SAFETY IS ALWAYS KEY--IT IS GOOD PRACTICE TO ASK FOR HELP AND SUPPORT
- Registrars and Consultants are very approachable
- Escalation must be TIMELY, FOCUSED, ACCURATE
- Remember we are junior doctors and not expected to handle everything alone --- it is better to be safe than in doubt
- If you are feeling any uneasiness or doubt--that is a sign to escalate!

ESCALATION AND REFERRALS

- **Escalation ladder/support:**

-first speak to your registrar
-Med Reg bleep 6613
-Advanced nurse practioners- bl 7740
-surgical reg bl 7370

-if it is a cardiac arrest --put out a call 2222 (can be put out even in peri arrest)
-CCOT CRITICAL CARE OUTREACH TEAM: Bleep 8772
-Anesthetist bleep: 6111

When to refer: when patient has high NEWS score or in a peri arrest situation

Chart 1: The NEWS scoring system

Physiological parameter	Score 3	2	1	0	1	2	3
Respiration rate (per minute)	≤8		9–11	12–20		21–24	≥25
SpO_2 Scale 1 (%)	≤91	92–93	94–95	≥96			
SpO_2 Scale 2 (%)	≤83	84–85	86–87	88–92 ≥93 on air	93–94 on oxygen	95–96 on oxygen	≥97 on oxygen
Air or oxygen?		Oxygen		Air			
Systolic blood pressure (mmHg)	≤90	91–100	101–110	111–219			≥220
Pulse (per minute)	≤40		41–50	51–90	91–110	111–130	≥131
Consciousness				Alert			CVPU
Temperature (°C)	≤35.0		35.1–36.0	36.1–38.0	38.1–39.0	≥39.1	

When to refer: when patient has high NEWS score or in a peri arrest situation

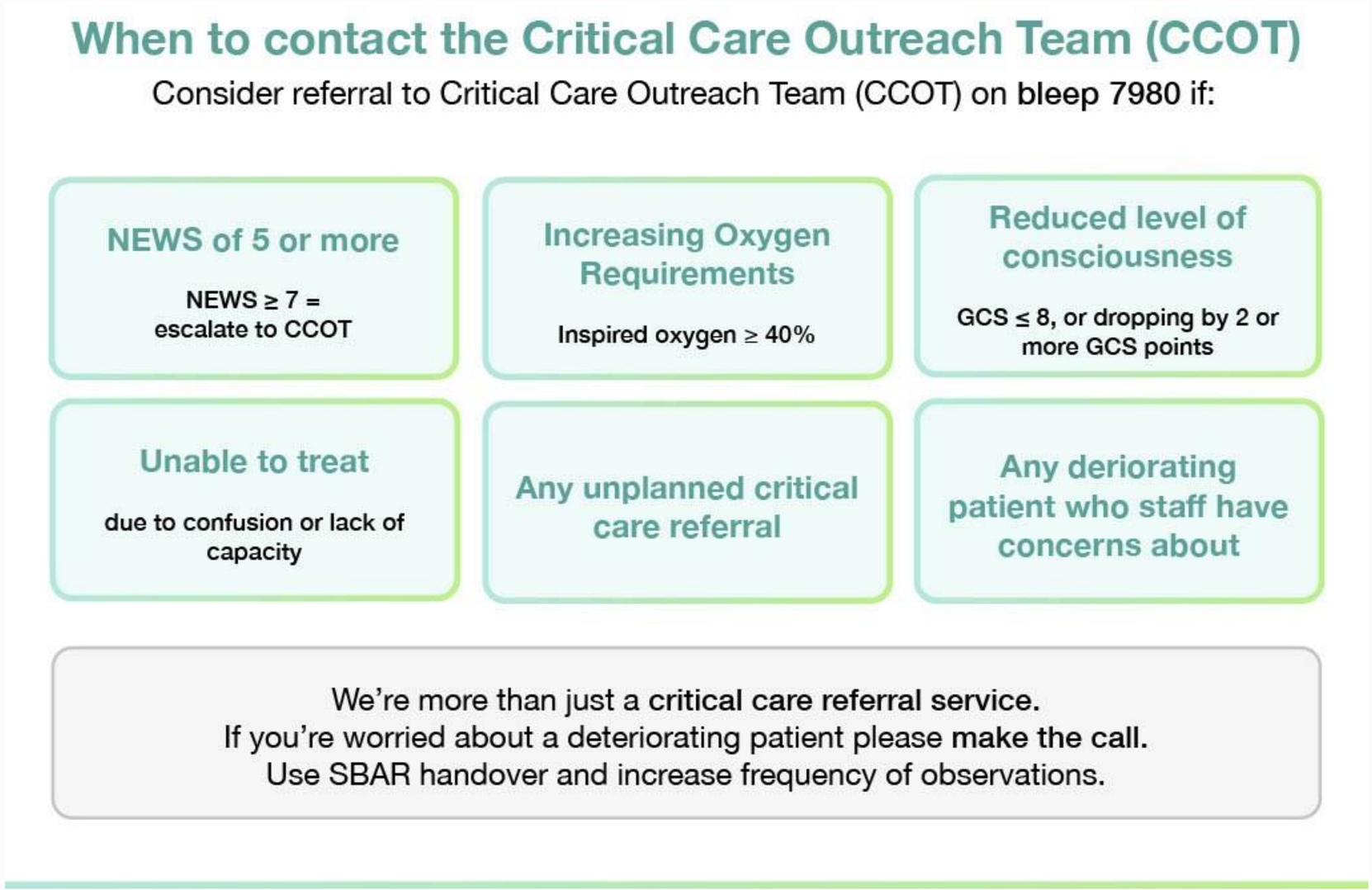
Chart 2: NEWS thresholds and triggers

NEW score	Clinical risk	Response
Aggregate score 0–4	Low	Ward-based response
Red score Score of 3 in any individual parameter	Low–medium	Urgent ward-based response*
Aggregate score 5–6	Medium	Key threshold for urgent response*
Aggregate score 7 or more	High	Urgent or emergency response**

* Response by a clinician or team with competence in the assessment and treatment of acutely ill patients and in recognising when the escalation of care to a critical care team is appropriate.

**The response team must also include staff with critical care skills, including airway management.

Consider referral to Critical Care Outreach Team on bleep 7980/8772 if:



Consider referral to Critical Care Outreach Team on bleep 7980/8772 if:

►All ward referrals for Unplanned Admissions to ICU will now go through the Critical Care Outreach Nurse – Bleep 7980

►Resus Huddle: 09.15am outside Monckton Well

►SBAR handover over the phone.

►Patient assessed by parent team and relevant treatment/investigations started: ABG, CXRay ordered. If peri-arrest please call us straight.

►DISCUSS and DOCUMENT TEP EARLY.

►Specific reason to refer patient: deterioration requiring review/advice, not ‘to be aware of’.

►Any member of staff can refer to CCOT, including nursing staff.

►If increasing O2 requirement and performing ABG, please do not leave patient on room air.

Is your patient scoring on EWS? Do they have, or are they likely to have, an infection?

Red Flag Sepsis

Responds only to voice or pain/ unresponsive
Systolic B.P ≤ 90 mmHg (or drop >40 from normal)
Heart rate > 130 per minute
Respiratory rate ≥ 25 per minute
Needs oxygen to keep SpO2 ≥92%
Non-blanching rash, mottled/ ashen/ cyanotic
Not passed urine in last 18 hours
Urine output less than 0.5 ml/kg/hr
Lactate ≥2 mmol/l
Recent chemotherapy in past 6 weeks

- Initiation of the Sepsis Six to be completed as soon as possible, but always within 60 minutes- take blood, urine and sputum cultures if indicated.
- IV antibiotics- write a review date for 48 hours
- Review by competent decision-maker, such as a doctor grade ST3 or above, immediately.
- Telephone conversation with consultant immediately following initial review.
- Referral to critical care or document why not

SEPSIS

The Sepsis Six

1 High-flow oxygen to maintain oxygen saturation >95%
2 Blood cultures and consider source control
3 Intravenous antibiotics
4 Intravenous fluid resuscitation
5 Check haemoglobin and serial lactates
6 Hourly urine output measurement

If after delivering the Sepsis Six, patient still has:

- systolic BP <90 mmHg
- reduced level of consciousness despite resuscitation
- respiratory rate over 25 breaths per minute
- lactate not reducing

or if patient is clearly critically ill at any time

Refer to Intensive Care Unit

Radiology and Imaging:

- All scans need to be ordered
- Xrays do not need vetting; however CT , US scans and MRI needs vetting--to discuss with Radiology on call- why this patient needs that particular scan (ext 0168/4290)
- Make sure you have mentioned all the pertinent information bloods, clinical history while ordering the scan
- NG Tube- once a NG Tube is in and we cannot get accurate aspirate pH(less than 5)- Chest XR needs to be ordered, reviewed , reported and feed started within 2 hours--so ensure you are on top of that!!
- all images can be reviewed on PACS--which should be on your toolbar--if PACS not working can contact them on 2665

TEAMWORK

- Ensure you are respectful and kind towards all the staff-including nurses, porters, colleagues, other departments
- Ensure you have taken breaks and checked in with your colleagues as well
- Nursing staff are your best friends and allies:

Very valuable asset
Be kind and respectful
Treat as equals not subordinates
Involve in care and decision making: esp NIC!
Offer to help if you can
Consider how would your actions affect them

End Of Life Care:

- Might see patients with treatment escalation plan on wards for who further invasive interventions considered inappropriate/not in best interest
- Focus of medical and nursing care is on patient’s comfort and dignity
- Family and loved ones to be called
- Close coordination with palliative care team: look for specific note from the team

Capacity and Consent:

- Out of our scope today:
- Patients should be asked for consent prior to any medical intervention including physical examination
- Patients with capacity have the right to refuse even if it sounds irrational
- Try to explain the intervention in detail including the benefits and risks
- Explore the reasons for refusal:
- Document every discussion:

VTE(venous thromboembolism) prophylaxis and form

- always ensure all patients have their VTE assessment forms filled- if they are not filled you will usually get a pop up
- you can find the form on Ad Hoc on the taskbar--> assessments---> VTE --->Record
- Usually hospital policy is dalteparin 5000 units SC daily every evening
- Unless patient has renal dysfunction--in which case calculate creatinine clearance and prescribe unfractionated heparin 5000 sc BD
- When in doubt--always ask the Pharmacist on call
- Complete policy found on Intranet
- if anticoagulation not an option--at least ensure TED stockings

Outstanding care every time

St George's University Hospitals NHS
NHS Foundation Trust

1. Introduction

The purpose of this policy is to ensure that all inpatients over the age of 16 admitted to St George's University Hospitals NHS Foundation Trust are assessed for risk of developing venous thromboembolism, that the risk assessment is documented and that appropriate prophylaxis is administered in compliance with NICE Clinical Guidance - Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism.

This policy supersedes all prior relevant clinical and non-clinical policies, protocols and guidelines within the Trust. This policy applies to all areas and all Trust staff involved in the care of inpatients over the age of 16.

2. Status and Purpose

This document is part of the Trust's policies and is applicable to all clinical staff.

This policy describes the necessary measures introduced and implemented to ensure that:

- All adult inpatients undergo venous thromboembolism (VTE) risk assessment on admission within 14 hours, after 24 hours of admission and when their clinical condition changes throughout their hospital stay.
- Patients assessed as requiring pharmacological VTE prophylaxis are prescribed it as soon as possible and within 14 hours of admission
- Those patients identified as at risk of VTE receive appropriate information and advice to prevent VTE on admission and on discharge from hospital
- The Trust can achieve a reduction in fatal VTE, non-fatal VTE and the long term sequelae of VTE by the use of effective thromboprophylaxis.
- The outcomes are measured by root cause analysis (RCA) of all cases of VTE occurring within 90 days of hospital admission.
- The VTE risk assessment figures, the appropriate prophylaxis audit data and the results of RCA are reported to the relevant bodies, including the Hospital Thrombosis Group (HTG), Medicines Optimisation Group (MOG), Patient Safety Quality Group (PSQG) and NHS Improvement.

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- The seven NICE VTE prevention quality measures from 2010 are audited and reported with appropriate action taken to address any deficiencies in service quality.
- Appropriate clinical investigation is carried out if acute VTE is suspected and that correct management of the patient is implemented as a result of the outcome of any investigation.
- A training programme is provided to health care providers who are involved in prevention and treatment of VTE in line with their training needs.

Resuscitation and DNAR TEP conversation:

- all patients who are admitted- check in form browser or GP /community records or ask pt /NOK if they have TEP form--it is policy that each patient should have one filled out
- if they do not have one--the conversation can be hard but it must be had
- can record it on i clip--Order--add order--resuscitation staus
- My colleague will speak in detail about this.....

THANK YOU!!

Any questions/comments? The floor is up for discussion now