

Welcome to

Kent and Canterbury Hospital

East Kent Hospitals University 
NHS Trust

*Urology and Vascular
Surgical Services Division*

Induction information



Urology, Vascular & Interventional Radiology Department
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Doctors list for VASCULAR & UROLOGY

August 17

			Consultant	
<u>On-call code (for on-call purposes only)</u>			Clinical Supervisor	Bleep
<u>Vascular</u>				
V4	CT3-5	Lola Ogunanya	N Wilson (Clinical Lead)	7200
V1	CT3-5	Timothy Nash	T Rix	7219
V3	CT3-5	Alex Bull	J Senaratne	7207
V5	CT3-5	Aftab Alam Khan	T Rix	7210
V2	CT3-5	Vacant - Adel Ataalla	A Khushal	7204
JS	FY2	Ashling Hill	J Senaratne	7201
TR	SHO	Charlie Mokwe	T Rix	7211
AK	FY2	TBC	A Khushal	7221
MS	SHO	Kamal El-Rashid	M Shirazi	7124
TR	FY1	Vacant	T Rix	7199
AK	FY1	Sophie Bloomfield	A Khushal	7205
JS	FY1	James Westwick-Pain	J Senaratne	7212

On Call Bleeps = Vasc Reg 7601, FY2, 7602, FY1, 7603, SG Urologist 7604

<u>Urology</u>				
U1	FY2	Natalia Glibbery		7214
U2	FY2	Xin Ho		7216
U3	SHO	Vacant –Locum (Abolore Shittu)		7202
U4	SHO	Vacant - Locum (Syed Kazmi)		7213
U1	FY1	Nyimasata Sanyang		7217
U2	FY1	Enya Cooney		7218
U3	FY1	Vacant		7206
SPR 1	Liz Osinibi		Educational Supervisor - Mr Eddy	
SPR 2	Neophytos Petrides		Educational Supervisor - Mr Krishnan	
SIM	Ass. Sp Adrian Simoes		Education Supervisor for FY1's	
RAJ	Ananth Rajagopalan			
DOM	Darius Domanaitis			
SUR	Vacant			
PEN	Vacant			
VAR	Branislav Varga			
KRAT	Ulrich Kratzer			

On Call Bleep for Urology Staff Grade - 7604 (for off site on-call use mobile through switch)

Urology Consultants

M Thomas

N Shrotri

H Evans

B Eddy

E Streeter

Clinical Lead

Education Supervisor for FY2's

R Krishnan

G Papadopoulos

J Hale

Pejman Kheirandish

For Urology Staff Grades, Registrars and Consultants go through switch to contact them on their mobiles.

BLEEP & RADIO PAGE NUMBERS:- DIAL 2000 - ENTER BLEEP NUMBER THEN YOUR EXTENSION.

WELCOME TO KENT WARD

Hi and welcome to Kent Ward. We hope you enjoy your time with us. Here are a few things to help you settle in. Please come and introduce yourself to the team, I can assure you this will stand you in good stead! If you are unfamiliar with the department layout I will ensure you get a tour on your first day

WARD ORGANISATION

The ward has 22 beds and a trolley bay that is used Monday to Friday for day case admissions. We will give you a tour of the ward to orientate you to the ward layout hopefully on your first day.

We use a team nursing approach so the ward is generally split into two, Beds 1 - 10 and 11 - 22. The nurses allocated to these patients can be identified by a board outside bays 1 and 2. Names and photographs are used to make it easy for you to find who you are looking for.

There are three ward sisters, one of them will accompany the ward round on a daily basis

We are a PRODUCTIVE WARD. If you have any comments or suggestions regarding improvements then either join the weekly meeting on Wednesday at 1pm or speak to one of the sisters

We have protected mealtime between 12 and 1pm every day. During this time you are not permitted to see any patients for routine interventions.

PATIENT NOTES

The system we use involves just the current episode. All medical records for each discipline are kept in folders in a rack by the nurse's station. Old notes are kept in a cupboard below this. Please return folders to their rightful place when you have finished with them.

TCI'S

We have a folder on the desk with the TCI lists in. The names are also written on the patient status board the day before. All TCIs need to be clerked on admission. If in doubt ask Linda or Faye. Please ask your Registrar for advice regarding the admission and requirements of **IR** patients

USEFUL CODES - please do not give these out to anyone else

Photocopier - 8269

Main store cupboard - C5780Z

Toilet door - 143

SINGLE SIGN ON and ELECTRONIC DISCHARGE NOTIFICATION

You must have a Smart Card and Novell login details. If your card needs to be unlocked then please ask Elaine or Lynne. We are now using the EDN system. You must obtain a login and a password. There is a huge pressure on beds every day so please be proactive and ensure they are completed as soon as possible to ensure that we can discharge patients promptly.

WARFARIN

As we have Haematology on site we only prescribe loading doses for Warfarin. New patients must have a blue Triple form. After this the lab provide a white card and the doses are prescribed on that. Please do not be tempted to use sticky labels.

GENERAL INFORMATION

Dress code - smart please, no trainers and bare below the elbow. No watches or jewellery.

Resource room - is used for your morning handover. You have access to a PC and telephone and can be useful as a quiet area to speak to relatives or write notes etc. Please remember that all staff use this room for breaks, meetings and study sessions so it must not be used between 12 - 3. You can book the room via Linda for official meetings. Confidential material must not be left in this room unattended. This room must be left tidy.

Tea and coffee- is available but please make sure you wash your mugs after use.

Mess - we don't do mess on Kent ward!!!! You have been warned.

COW's need to be plugged in once the ward round is over, otherwise they will not work

Linda and Faye - our two ward clerks be nice to them they will be very useful to you throughout your stay

Clinical waste bins - are only found in the sluice, please use orange bags at the bedside. These can be found on the wall in the sluice.

We have an excellent team of nurses on the ward. Trust them they will only call you when they need you.

If you need any help or advice at all then please come and find me, my door is always open.

Good luck,

Ward Manager.

BLEEP NUMBERS:- DIAL 50 THEN ENTER BLEEP NUMBER

	SECRETARY	SITE	EXT	EMAIL
<u>UROLOGY</u>				
<i>Mr M Thomas</i>	<i>Sharon Williams</i>	<i>KCH</i>	<i>722-4360</i>	Milanthomas@nhs.net
<i>Mr B Eddy</i>	<i>Nicola Phelan</i>	<i>KCH</i>	<i>722-8768</i>	beneddy@nhs.net
<i>Mr H Evans</i>	<i>Carey Le Long</i>	<i>KCH</i>	<i>722-4241</i>	Jwh.evans@nhs.net
	<i>Laura Lynch</i>	<i>QEQMH</i>	<i>62989</i>	
<i>Mr Krishnan</i>	<i>Jenny Welfare</i>	<i>KCH</i>	<i>722-4362</i>	rkrishnan1@nhs.net
<i>Mr E Streeter Clinical Lead</i>	<i>Mary Williams</i>	<i>KCH</i>	<i>722-4359</i>	Edward.streeter@nhs.net
<i>Mr Popadopoulos</i>	<i>Jane McKinnon</i>	<i>KCH</i>	<i>722-4285</i>	<i>01227 783024</i>
	<i>Laura Lynch</i>	<i>QEQMH</i>	<i>62989</i>	
<i>Mr N Shrotri</i>	<i>Alison Brandon</i>	<i>KCH</i>	<i>722-4285</i>	nshrotri@nhs.net
	<i>Anne Cross</i>	<i>QEQMH</i>	<i>62823</i>	
<i>Derry Unit Co-ordinator</i>	<i>Jenny Dorell</i>	<i>RVHF</i>	<i>73097</i>	<i>01303 854485</i>
<i>Derry Unit Reception</i>	<i>Denise Punnett</i>	<i>RVHF</i>	<i>44429</i>	<i>01303 854485</i>
<u>VASCULAR</u>				
<i>Mr N Wilson</i>	<i>Faye Newman</i>	<i>KCH</i>	<i>722-5397</i>	Noel.wilson@nhs.net
<i>Mr T Rix</i>	<i>Hannah Sarginson</i>	<i>KCH</i>	<i>722-4259</i>	Robert.insall@nhs.net
<i>Mr Khushal</i>	<i>Catherine Plaistowe</i>	<i>KCH</i>	<i>722-4231</i>	amjadkhushal@nhs.net
<i>Mr L Senaratne</i>	<i>Karen Matheson</i>	<i>KCH</i>	<i>722-3196</i>	Jawaharlal.senaratne@nhs.net

Other useful Urology and Vascular Numbers:-

Noel Wilson	Vascular Clinical Lead	722 5154
Ed Streeter	Urology Clinical Lead	722 4359
Chris Hudson	Divisional Director	722 853
Tina McKay	General Manager	722 2789
Caroline Crowe	Operations Manager	722 8638 Mo 07919692626
Ellie Batt	Deputy Operations Manager	722 2508
Laura Miller	Business Admin Manager	722 2625
Angela Hayward	Directorate Secretary	722 8641
Gemma Oliver	Senior Matron	7223014 / Bleep 7836

Contact for Consultants and Staff Grades can be made through switchboards on their mobiles, dial 0 for switch.

ON-CALL BLEEP PROCEDURE

On-call junior doctors will hold an on-call bleep in addition to their individual one. These should be handed on to successive on-call personnel. The on-call numbers are as follows:

FY1	Bleep number 7603
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FY2	Bleep number 7602
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Vasc Registrar	Bleep number 7601
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Urol Staff Grade	Bleep number 7604
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Dial 2000 from any internal phone and you will be prompted to enter user (bleep no required) then the phone number you wish bleep user to contact.

if you suspect that your bleep is not working please ask in switch room for replacement batteries.

At the end of your placement please ensure that your bleep has been left in the tray in the switch room.

KCH CONSULTANT TIMETABLE – UROLOGY

	Monday		Tuesday		Wednesday		Thursday		Friday	
Mr Eddy	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
	Admin	SPA	KCH - OPD KBED01	TRUS	Theatre KCH 4	MDM		OPD RVHF FBED01 Con & reg	Th 4	Th 4
Mr Streeter	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
	Derry Unit Prost/bladder FSTRE01 Con only	SPA	KCH OPD KSTRE01 Con&Reg	Th 4	off	MDM	TH 4	Th 4		
Mr Thomas	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
	Th 4	KCH Theatre 4	QEQM OPD QMTH01		Th 5	MDT	OPD KCH KMTH01		CPD	
Mr Evans	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
		Th 5	KJEVA01 Con only	Th 4	Audit KCH HEVAH01	MDT	QJEVA01		SPA	Admin/manage ment
Mr Shrotri	AM	PM	AM	PM	AM	PM	AM	PM	AM	
	OPD QEQM QNSHR01 – Con & reg				KCH Theatre 2	MDT	OPD KCH KNSHR01	Admin KCH	Audit Governance KCH	
Mr Krishnan	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
	KCH Th 2			HRKP01 WK 3 (MG) HRK01 Con & reg Wk 1, 2,4 &5	KRK01 Con & reg wk 2,3,4 & 5 KRKP01 Wk 1	MDT			KCH Th 5	KCH Th 5
Mr Simoes	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
	Th 5		QEQM - OPD QASIM01	TRUS Clinic	Urology suite	MDT	QUROLP0 1 WK 3 QASIM02	SPA	KCH Theatre	
Jemma	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
	HJHAL01		FJHAL01			MDT				
Georgios	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
					RVHF - FGHAL01	MDT	WHH- HWC01	WHH - HUROL01	KUROL01	

KCH CONSULTANT TIMETABLE – VASCULAR

Mr Shirazi	Monday	Tuesday	Wednesday	Thursday	Friday
AM	KMSHI01	ON CALL	Theatre 3 wk 1, 3 & 5	KCH Th 2 wks 1,3,5	ON CALL
PM	BHD – BMSHI01 WK 2,4 & 5 KMSHI02 WK 1 & 33	ON CALL	Theatre 3 wk 1, 3 & 5	KCH Theatre 2	ON CALL
Mr Senaratne	Monday	Tuesday	Wednesday	Thursday	Friday
AM	Varicose Veins – VAU KCH	ADMIN	MDM KCH Theatre 6 Wk 1, 3 & 5 Theatre 3 wk 2 & 4	On Call KCH – Renal Access KRENAL10 /KVASAC01 (Wk 2,4 & 5) Teaching wk 1 & 3	QEQM QJSEN01 -Con & Reg
PM		Renal Th 2 admin/Training	KCH Theatre 2 Wk 1, 3 & 5 Theatre 3 wk 2 & 4	On Call Admin	QEQM QNVJC01 (CC- Claire Mears)
Mr Wilson	Monday	Tuesday	Wednesday	Thursday	Friday
AM	KCH Th 3 wk 5 KCH Th 6 wk 1 & 3 Off 2 nd & 4 th Monday			KCH Theatre 3	
PM	KCH Th 3 wk 5 KCH Th 6 wk 1 & 3 Off 2 nd & 4 th Monday			KCH Theatre 3	
Mr Khushal	Monday	Tuesday	Wednesday	Thursday	Friday
AM	KCH Endoscopy (On Call) – Email – Melissa Beldou, Alison Guy, cc Tracy Couchman On-Call		QEQM Theatre	OPD Estuary View EAKHU01 Wks 2,4 and 5 con & reg	KCH Theatre 3
PM	KCH Theatre 3 Wks 2 & 4 am & pm On-Call	OPD at Estuary View EAK01 Wk 1, 3 & 5 KCH OPD KAKHU01 Wks 2 & 4	QEQM Theatre	Admin	KCH Theatre 3
Mr Rix	Monday	Tuesday	Wednesday	Thursday	Friday
AM	HTRIX01 Con & Reg wk 2, 3, 4 & 5	Theatre 3	ON CALL	KVASAC02	On-call
PM	HTRIX02 WHH Foot Clinic wk 3	Theatre 3	ON CALL	Theatre 2 wk 2 & 4 Admin	On-call

NO LEAVE WILL BE APPROVED FOR THE LAST WEEK OF THE ROTATION EXCEPT IN EXCEPTIONAL CIRCUMSTANCES

Registrars & Staff Grades – Check your team and colleagues leave bookings first. If you need to take leave when due to be on call you must organise and internal swap and this must be indicated on your leave form and the person agreeing to swap must sign. Forms must indicate if activity to be reduced or cancelled and clinic code affected. Leave to be agreed and form signed by the lead Consultant (and Division Director if less than 8 weeks in exceptional circumstances)

F2

1. You are entitled to 9 days annual leave during this rotation, leave cannot be carried over to your next rotation, please ensure you take all of your entitlement during your time here.
2. No leave to be taken on your weekend on-call unless you organise internal swap and you must inform switchboard, BAM or Operations Manager. You must get the person you are swapping with to sign your leave form or confirm by email to say they have agreed this.
3. No locums are sought for F2's. F2's to organise swap for on-call days which must be put on the form and signed for by doctors agreeing to swap.
4. Leave to be authorised by your Consultant.
5. Leave requests must be handed in after your first week as your leave entitlement for KCH site/Directorate must be taken in the time you are here. **IF YOU DO NOT TAKE YOUR LEAVE QUOTA YOU WILL LOOSE IT – PLEASE BE AWARE THAT YOU CANNOT CARRY YOUR LEAVE OVER TO ANOTHER SITE OR DIRECTORATE.**
6. No annual leave will be approved for the last week of the rotation except in exceptional circumstances.

F1

1. Check your Registrar and F2 are not on leave and check your F2 is not on a week of nights or on call daytime at weekend as they are off on the Monday and Tuesday.
2. Check no other F1 is on leave – no more than one F1 on annual leave at the same time.
3. No locums are sought for F1. No leave to be taken on weekend on-call unless you organise an internal swap and you must inform switchboard and your BAM you must get the doctor you are swapping with to sign a swap form and leave form.
4. Leave requests must be handed in after your first week as your leave entitlement must be taken during your rotation in our Directorate – **IF YOU DO NOT TAKE YOUR LEAVE QUOTA YOU WILL LOOSE IT – YOU CANNOT CARRY LEAVE FROM ONE DIRECTORATE TO ANOTHER.**
5. No annual leave will be approved for the last week of the rotation except in exceptional circumstances.

FORMS CAN BE OBTAINED FROM YOUR BUSINESS ADMIN MANAGER

YOU MUST NOTIFY THE BAM OF ALL ON CALL CHANGES/INTERNAL SWAPS IN ORDER TO LOG THEM AND NOTIFY THE NECESSARY PEOPLE

SICKNESS REPORTING

Who to contact

Contact the BAM on ext 722-2625 if she is not available contact the Operations Manager on ext 722-5300 or mobile via switchboard. You should explain the reason for your absence and also bleep the on-call Consultant and the rest of the on-call team to inform them and inform the Hospital Manager if during out of normal hours.

When to Contact

By 8:00 am in order to allow cover arrangements to be made if necessary. If you are too ill to telephone personally you may request someone to do so, on your behalf – **it remains your responsibility to ensure they do.**

How Often to Contact

You should contact your Business Admin Manager each morning before 8:00am and your team again in the 3rd day of absence. If absence is continuing after the 7th day you should contact your manager then and on a regular basis after that.

Returning to Work

If you are returning from sickness absence you should inform the BAM or Operations Manager as soon as possible. If you have been on sick leave immediately prior to annual leave you should confirm that you are fit before going on annual leave. When you return to work you will need to see Operations Manager to sign a sickness/return to work form.

Certificates

If sickness continues after the 3rd day you will need to complete a self-certification form to cover from the 1st to the 7th day of absence. A Medical certificate will need to be obtained to cover the 8th and subsequent days of sickness absence. Certificates should be forwarded to your manager.

Sickness Occurring During Annual Leave

Contact the BAM and your consultant as soon as possible by phone, a GP certificate will also be required if you wish to claim back your annual leave. If your date of return to work is likely to be affected or, if abroad you should write to your manager at the earliest opportunity, your manager will require a certificate from the 1st day of illness and will agree an alternative holiday date on your return.

Sickness of Dependants

Sick leave is applicable only when you are unable to attend work your self. If a dependant is ill you should contact your manager urgently and arrange to take leave in line with Trust Policy. Failure to follow the correct reporting procedure will result in absence being treated as unauthorised and occupational sick pay will not be payable, and may also result in formal disciplinary action. Sickness leave amounting to more than two weeks in any six months post will result in that post NOT being recognised for training, the whole six months will need to be repeated.

Weekly training sessions

Every Wednesday, unless otherwise indicated, there will be a Journal Club at 8am for Vascular in the Admin Dept and there will be training sessions held in the Middle Grade room at 2pm for approximately for 1 hour for Urology. The Urology Consultant on-call will be responsible for the teaching.

Vascular and IR Consultants will be welcome to pick up teaching sessions.

For each training session junior doctors will bring cases for discussion.

There will be the opportunity to discuss professional matters as well as cases.

Attendance will be marked at every meeting.

On-call trainees should make every effort to attend the sessions unless they are called away.

Doing the “write” thing

A recent audit of doctor’s note keeping highlighted what is good and bad about documentation within Surgery.

What was done well?

- Putting a date against each entry in the notes.
- Using permanent dark ink to write in the notes.
- Documentation of presenting problems.
- Recording the patient’s assessments.
- Writing a plan of care for the patient.

What needs to improve?

- Legibility
- Full patient details (including hospital number) given on each page of note keeping.
- Documenting the time you make each entry in the notes.
- Signing each entry and clearly printing your name underneath along with your grade.
- Documenting the medical history and admission medication.
- Documenting discussions with the patient or carer about the plan of treatment.

A full report is available from the clinical audit office at KCH

Remember good clinical note keeping is essential because:

The purpose of the health record is to ensure that those coming after you can see what has been done, or not done and why and by whom. This will ensure not only that patient care is not compromised but also that any decisions made can be justified or reconsidered at a later date.

A GUIDE TO CLINICAL GOVERNANCE FOR STAFF

Clinical Governance is simply about safeguarding standards and continually improving patient care. This is achieved through:

- Openness and accountability
- Monitoring and evaluation
- Patient centred service provision

Its about looking at what we do and asking

- Is it safe for patients and staff?
- Is there a better way to do it?
- Are there gaps in the skills we need to dot it?

The Trust strives to make sure that systems are in place to support clinical governance in maintaining and improving the quality of care we provide.

For example, ensuring we learn form comments and complaints, incidents and near misses, to reduce the risk of these happening in the future.

WHO IS RESPONSIBLE?

The quality of service is so important in the NHS that the Chief Executive now has a legal responsibility for providing high quality services. However, clinical governance focuses on the patients experience and a good patient experience is dependent on the actions of all staff.

So clinical governance is EVERYONES responsibility, you play an important role.

Involving patients, carers and the public is also a key component of clinical governance. Patients can provide their own expert views on a range of issues such as:

- Living with their condition
- Access to services
- How services can be developed
- Developing patient information.

HOW DOES IT WORK? – FRAMEWORK

Clinical governance is a framework, which covers a number of processes that together provide a picture of the quality of the services provided. The Government has drawn up a set of national standards that will be used to assess the quality and equity of health services provided locally. There are seven key areas of standards. Each area includes what healthcare organisations should be achieving now (core standards) and what they should be aiming to achieve in the future (development standards).

1. Safety

Safety is about systems to understand, monitor and minimise the risks to patients and staff and to learn from mistakes.

2. Clinical and Cost Effectiveness

Clinical and cost effectiveness is about systems to ensure that approaches and treatments' used by the Trust are based on the best available evidence e.g. research, literature, local or national guidance. This includes guidance issued by the National Institute for Health and Clinical Excellence (NICE).

3. Governance

Governance includes systems to ensure that:

- Money is not wasted
- Staff are well qualified and trained
- Information is kept confidential (but is available when and where it is needed)

- Staff can raise any concerns and that these are acted upon.

4. Patient Focus

Patient focus is about putting the patient first. This includes:

- Treating patients with dignity and respect
- Providing information and proper explanation of all aspects of care
- Encouraging patients to take part in decisions about their care
- Ensuring patients know how to raise any concerns about their care.

5. Accessible and Responsive Care

Accessible and responsive care is about everyone having equal opportunity to access treatment that is responsive to the particular local problems, without experiencing unnecessary delay or inconvenience. This includes providing choice as much as possible and taking into account the views of patients and carers.

6. Care Environment and Amenities

Care environment and amenities is about providing healthcare in a place that is clean and well looked after, is suited to the patients needs, for example children should not be cared for in adult wards and gives the necessary level of privacy. Patients are allocated beds in single sex bays whenever possible.

7. Public Health

Public Health is about working with other organisations to improve the health of local people and those with the poorest health, and being able to deal with major incidents such as flu epidemic, a serious accident or a terrorist attack.

WHAT IS MY ROLE?

Everyone has an important part to play to make clinical governance a success.

You can help by:

- Keeping good clear records and making sure you follow confidentiality guidelines
- Reducing the risk of infection by ensuring a clean environment and good hand washing practices
- Involving patients in the decisions about their care
- Treating each patient and client as an individual e.g. by ensuring timely administration of medicines appropriate to the patients needs
- Using the incident reporting system to register any incidents or “near misses”
- Voicing your concerns where you think standards are below accepted levels by talking to your team line manager or completing an incident form
- Making suggestions for improvement if you can see how things could be done better
- Making sure you and your colleagues are using the most up-to-date evidence relevant to your practice
- Learning from experience and encouraging people to share good practices and experience
- Continuing to develop your skills through regular appraisal and personal development planning
- Taking part in internal and external clinical audit programmes

If you would like further information about the contents of this information please contact East Kent Hospital University Foundation Trust's Clinical Governance Team – Tel 01227866417 or extension 722-4347

Generic standards for note keeping within the patient health record

- Records should be written in English
- Records should be factual, consistent and accurate. Where records are professional opinion, this should be clearly stated.
- Records should be written as soon as possible after contact has occurred, providing current information on the care and condition of the patient in chronological order. Where possible, the records should be written with the involvement of the patient or carer.
- All entries should be chronological and without unnecessary gaps.
- Records should be legible.
- Records should be written in permanent dark ink, preferably black. Records should be readable on any photocopies.
- Should an error be made it is essential that it is not completely obliterated, for example with correction fluid or any other obliterating agent. Errors should be crossed through with a single line, the written statement 'written in error' should be made, and the entry signed, dated and timed.
- Additions to the record should be dated, timed and signed.
- Ditto marks should not be used.
- All entries should be signed with full signature, not initials. Initials may be used if a signature sheet is included within the health record. The name and designation of the health care professional should be legibly printed (UPPER CASE) along side at each entry, or on a signature sheet, for that episode of care. The bleep number should be included.
- All entries in the record should be accurately dated and timed. The 24 hour clock must always be used.
- Where clinical records are dictated and typed, they should be checked, dated and signed off by the author. Staff who do not operate this system understand that they are accountable for any errors or omissions made on their behalf.
- Entries by unqualified staff should be countersigned by a qualified member of the staff when care/outcome deviates from the plan.
- Abbreviations or jargon should not be used.
- Records should not include irrelevant speculation or offensive statements.
- Every page in the record should include the patient's full name and hospital number. This includes typed notes.
- Frequent record entries should be made where patients present with complex problems show deviation from the normal, require more intensive care than normal, or in other ways give cause for concern.

For most patients, the following 5 categories for information should be noted daily:-

- **Date, time and place:**
"place" can be combined with "who", eg reviewed on Kent ward by Mr "X", Dr "Y" and.....
- **Who is attending, for what and why – the who, what and why:**
"Who" includes all those present, not just the medical staff or the most senior, identified by name, including patients relatives etc.
"what" the patients is there for, eg elective open aneurysm repair post op day 2, pre-op elective right carotid endarterectomy, or emergency transfer with gangrene of the toes (which) left foot, etc
"why" can be, eg a routine round, an emergency call (give the reason) a visit to give information to patient/relatives, etc.
- **The current status of the patient:** Record all that is relevant, eg comfort/pain, diet, bowel action, observations, wounds, mobility, stability, etc including test results.
- The current **problem list** for the patient including relevant past and present make special note of any complication or new problem.
- The **action plan:** Make this holistic and include estimated plan and date for discharge, also include ongoing plans, especially dressings, drugs, suture removal, follow up plans – even if "none", also record provision and duration for sick notes.

FOR LONG-STAY PATIENTS: The first 2 above categories are obligatory in each note entry but the remaining 3 may not be required in full at every entry and may be abbreviated, eg for current status to "no change" or "status quo" for problem list or action plan to "problems/plan as of (date)". All 5 should be noted at least once on every 2nd page and so be visible wherever the notes are opened.

EAST KENT UROLOGY DEPARTMENT EMERGENCY PROTOCOLS

The East Kent Urology team provides a 24 hr Urology service.

From 0800 to 1800 hrs Urology Emergency referrals are taken by the Urology middle grade on-call.

From 1800 to 0800 emergency referrals to the Urology department are taken by the on-call Vascular / Urology F2 or CT trainees.

Between 0800 and 1800 the Urology middle grade on-call has no timetabled activity apart from being on-call. The middle grade will therefore provide direct support for the F1, F2 and CT Urology and vascular trainees. This means going to the ECC to see patients as and when they arrive. This ensures early middle grade level input and enables supervision and training for the F1, F2 and CT trainees who will go to the ECC with the On-call middle grade.

Out of hours, the middle grade is on call from home and can be contacted by the Urology/Vascular F2 or CT trainees for advice or to attend the hospital. There is also a Consultant on-call 24/7/365 who can be contacted via switchboard if required.

ARRANGING TRANSFER TO THE UROLOGY INPATIENT UNIT

Patients requiring emergency admission for Urological problems are all admitted to the Urology inpatient unit on Clarke ward at the Kent and Canterbury Hospital. If Clarke ward is full then Kent and Marlowe may be used. Urology emergencies are not to be admitted to other wards if at all possible.

All Urological emergency referrals must be discussed with the On-call Urology F2 / CT trainee prior. If it is likely that admission is required, then the Urology trainee should first discuss the case with the middle grade on-call. Patients in whom the main reasons for admission are medical or social should be referred to and admitted under the medical or care of the elderly teams at their local hospital. When a Patient has been accepted by the Urology team, the patient's details must be recorded and passed to the site co-ordinator for organisation of transfer or admission.

NORMAL HOURS (8-6) inform the KCH site co-ordinator on bleep 901.

OUT OF HOURS (6pm – 8am, weekends & bank holidays) inform the KCH site co-ordinator on bleep 520.

The site co-ordinator will identify a bed on the KCH site and confirm this with the nursing staff currently managing the patient. If necessary the patient may first go to the Emergency Care Centre. Transport will be organized by the nursing staff on the unit where the patient is being transferred from.

From 0800 to 1800 when an emergency referral arrives at the ECC at K&C, the middle grade Urologist on-call must be informed of the patient's arrival at once so that he can come to the ECC and perform the initial assessment. The F1 and F2 on-call must come with the middle grade for teaching and training. From 1800 to 0800 the On-call Uro/Vascular F2/ST trainee on call is to perform the assessment and discuss each case with the on-call middle grade as per the emergency guidelines.

ARRANGING UROLOGY INPATIENT REVIEW

URGENT ADVICE can be obtained by calling the on-call Urologist via switchboard. If an F2 trainee needs more senior advice, the middle grade on-call is available all day with no other commitment and should give advice.

REQUESTS FOR UROLOGY INPATIENT REVIEW are made by fax to the Urology Fax number 01227 783136.

The on-call consultant will arrange inpatient review by the next Urology team visiting the site

ARRANGING UROLOGY FOLLOW UP APPOINTMENTS

FAX REQUESTS for Urology outpatient appointments are to be seen by the on-call Consultant or Middle grade and appropriate appointments made or advice given.

PATIENTS PRESENTING TO A&E DEPARTMENTS

AT QEPMH & WHH (WALK-IN AND AMBULANCE)

The pathways for patients presenting to A&E depend on the particular problem being addressed. Possible pathways are:

- Simple treatment only, patient discharged and GP review requested if appropriate.
- Simple treatment only, Urology outpatient review required – Fax request to Urology fax number
- Simple treatment i.e. catheterize, but patient has other problem e.g. CCF that requires admission to their local Hospital.
- Patient requires specialist Urology advice – contact Urology Hotline
- Patient requires specialist inpatient management – arrange transfer to the inpatient Urology unit.

AT KCH - URGENT CARE CENTER (UCC)

Between 0800 and 1800 the ECC staff should contact the on-call Urology middle grade when a Urology emergency patient arrives in the ECC or if they require Urological advice on a “walk-in” patient. The Urology middle grade will go directly to the ECC and assess the patient on arrival. The on-call F1, F2 and CT Urology / vascular trainees will accompany the middle grade. If the patient does not appear to have a Urological problem, the patient remains under the care of the ECC team for referral or further assessment. Any appropriate advice or help regarding possible diagnoses and further referral will be provided, especially if there is suspicion of a ruptured Abdominal Aortic Aneurysm or other intra-abdominal catastrophe.

GP REFERRALS - TO GENERAL SURGERY AT WHH AND QEPMH

Patients that are referred to the on-call general surgical teams at WHH and QEPMH may turn out to have Urological problems. On arrival in A&E at the QEPMH and WHH the on-call General Surgical F2 will assess the patient. If a Urological diagnosis is suspected, appropriate initial treatment and investigation are arranged. If a urological diagnosis is confirmed, the case is discussed with the Urology on-call team to determine which pathway is used.

TO THE UROLOGY TEAM AT KCH

GP referrals can be made directly to the on-call Urology team. If it is appropriate for a GP referral to come directly to the Urology unit for assessment, the patient's details must be taken and the ECC informed of the expected admission. The on-call middle grade, F2 and F1 will assess the patient promptly. The important exceptions are:

ACUTE TESTICULAR PAIN IS A GENERAL SURGICAL EMERGENCY.

These cases should normally go to the nearest hospital that has a general surgical acute take for assessment by the on-call general surgical team. **This has always been the case in East Kent.** Any walk-in patient who has acute scrotal pain will be triaged by the nurses in the ECC and normally sent straight to WHH or QEPMH by blue light ambulance if they do not have their own transport. This system applies at the Buckland Hospital Dover and has been agreed at Urology reconfiguration discussions with the Medical Director in 2004. If there is doubt as to whether transfer, assessment and exploration can be achieved within the 6 hour window from the onset of symptoms then the on-call Urology team should be contacted to manage the patient appropriately.

PAEDIATRIC EMERGENCIES patient aged ≤ 16.

There are no paediatric inpatient beds on the KCH site therefore no paediatric in-patient admission can be made. GPs are advised to send paediatric cases to WHH and QEPMH. If an acute Paediatric Urological problem presents to the ECC at K&C, the triage team will normally redirect the patient to WHH and QEPMH for assessment by the A&E team or the paediatric and General Surgical teams on call at those sites. This may require blue light ambulance transfer. The Urology Consultant on-call will advise the teams at QEPMH and WHH regarding local treatment at the Acute Surgical sites or whether transfer should be made to, the paediatric Urology unit at Lewisham, Evelina Hospital or UCH. If a paediatric trauma case is found to have renal damage with haemodynamic instability requiring exploration, the case should be taken to theatre by the on-call surgical team at once. The Urology consultant on-call should be contacted and he will attend the theatre to advise on renal reconstruction or nephrectomy. If observation is required this should be under the general surgical team at the trauma site with Urology advice. Cases may be transferred to a paediatric Urology unit if this is felt appropriate.

IN-PATIENT REFERRALS

If an inpatient on any Hospital site needs to have urgent Urological advice, the team looking after the inpatient should discuss this case with Urology middle grade on-call. If inpatient review or Urology follow up is required please fax the request to the Urology FAX number (01227 783136). Urological Emergencies arising in in-patients should be managed according to the condition-specific guidelines. There are several possible pathways:

- Advice may be given regarding investigation and treatment that can be implemented by the patient's current team. Investigation results may be discussed and an appropriate management plan organized by telephone.
- If an outpatient review is all that is needed, please fax the referral request to the Urology Fax number.
- Arrangements for the patient to have Urology review on the ward by an Urologist on their next site visit.
- The patient may be booked into an appropriate Urology clinic at the Hospital of admission.
- The patient may need to have specialist urological investigation on that admission. This may be accomplished by the patient coming to KCH, having the procedure or investigation and returning to their ward of admission.
- The patient may need transfer to KCH for specialist Urological management.

THEATRE REFERRALS

Occasionally the need will arise for emergency Urological advice or intervention in the Operating Theatres at either WHH or QEPMH. The team requiring assistance should first contact the HOTLINE. If it is felt that on-site intervention is needed, the middle grade or Consultant on-call will travel and provide on-site advice or assistance.

UROLOGY CONSULTANT ON CALL – There is always a Urology consultant on call.

PROTOCOL FOR ASSESSMENT

GENERAL POINTS ON PATIENT ASSESSMENT (Use for all patients)

The objective is to make a diagnosis and arrange appropriate management for all patients. A diagnosis is made from the history, the examination and the investigations.

HISTORY TAKING

Take a full history. Do not assume for example that loin pain must be renal colic, or there is a risk of missing diagnoses such as appendicitis, cholecystitis, aneurysm, diverticulitis, pulmonary embolism, back strain or drug seeking.

Define the presenting complaint(s), noting cardinal symptoms of Pain, Bleeding, Retention, Vomiting, Constipation etc. In female patients note the date of LMP and enquire about possible pregnancy where appropriate. Then decide WHICH BODY SYSTEMS might cause the symptoms. Obtain full details of cardinal symptoms especially pain – describe the onset, time course, duration, exacerbating and relieving factors and radiation.

Be SYSTEMATIC – having decided which systems might cause the above symptoms perform rigorous direct questioning on these systems. Always ask about previous history both Medical and Surgical. Do not forget Family, Social, Smoking, Drinking and allergy history.

EXAMINATION

Patients must be examined thoroughly. This includes basic observations such as pulse, blood pressure and temperature – don't just copy these off the nursing notes, check them yourself – they may have changed or your findings may be different. All patients with a possible abdominal complaint MUST have a digital rectal examination performed as part of the base-line assessment. Failure to perform a DRE would be indefensible in the case of any medico-legal action.

Make a note of General appearance, Pulse, Blood pressure, Temperature, JACCO

CVS – JVP, heart sounds, pulses, bruits.

CHEST – Trachea, movements, Percussion, Breath sounds.

ABDOMEN – remember to look, feel, percuss then auscultate. Start with the genitalia (a chaperone must be present for female patients), Check the groins, then move to Liver, Spleen, Right kidney, Left kidney and check the aorta. Percuss and feel for the bladder. Listen – bowels and bruits.

A DIGITAL RECTAL EXAMINATION MUST BE PERFORMED: This excludes faecal impaction and rectal tumours. You should note anal tone and sensation and examine the rectum 360 degrees. In males feel anteriorly for the prostate noting shape, size, surface, edge, consistency and if it is tender (prostatitis). If it feels the size of a Ping-Pong ball = 20g, billiard ball = 40g, tennis ball = 60g. Then feel superiorly for tenderness and peritonism. In female patients check for cervical excitation.

CNS – check sensation, power and reflexes.

INVESTIGATIONS

Do not forget the basics. Omitting the Dipstix for sugar is a classic and embarrassing omission. If emergency investigations are ordered, the results must be checked and written in the notes.

Urine – Dipstix, MSU, CSU. P test in female patients.

Blood – FBC, U&E, amylase, LFT, sugar, culture

Basic Imaging – CXR, AXR, KUB (show pubic symphysis and D11)

Complex Imaging – IVU, U/S abdomen, CT, MRI, Nuclear Medicine.

REVIEW ALL PREVIOUS IMAGING ON PACS

Diagnoses such as Aortic aneurysms may be obvious on previous CT or other scans. Stones may be visible on a previous film but not on current films indicating probable renal colic.

WRITE IN THE NOTES

BE LEGIBLE, Record the date, time and your name and bleep number in CAPITALS.

Make a concise note of the History, Examination, Differential diagnosis, Investigations and results.

Record a management plan and give precise details of referrals or follow up arrangements.

Sign the entry.

COMMUNICATE

When on-call you must discuss your findings with your immediate superior and escalate any queries or serious problems to an appropriate level in the on-call team. You must communicate with the nursing staff in A&E or the ECC as to the proposed management of the patient. Inform the Kent and Canterbury Hospital site co-ordinator regarding all admissions and ensure the ward staff have clear instructions regarding frequency of basic observations and the proposed management.

MANAGEMENT OF UROLOGICAL EMERGENCIES

CONDITION	URINARY RETENTION
DEFINITIONS	<p>ACUTE RETENTION – PAINFUL inability to pass urine</p> <p>CHRONIC LOW PRESSURE – Painless inability to void. The residual urine volume is >1 litre and may be several litres, with normal creatinine</p> <p>CHRONIC HIGH PRESSURE – Painless with residual urine volume > 1 litre and may be several litres but there is high bladder pressure with back-pressure on kidneys causing renal failure, dehydration, concealed anaemia and diuresis after catheterisation – this is a very ill patient and MUST be admitted to the Urology ward for close fluid balance monitoring.</p> <p>OVERFLOW – Continuous dribble due to chronic retention.</p> <p>CLOT RETENTION – Due to heavy haematuria – see haematuria section</p> <p>FEMALE – due to Urethral stenosis, genital infection, herpes, pelvic masses, neurological causes.</p>
CAUSES	<p>Prostatic enlargement – Benign and malignant</p> <p>Bladder neck stenosis, Urethral stricture, Urinary tract infection, constipation, blood clot, anaesthesia, abdominal surgery, neurological, spinal cord compression, drugs, foreign bodies.</p>
SYMPTOMS	<p>Cannot pass Urine, Lower abdominal pain, Lower abdominal swelling</p> <p>Increasing difficulty in passing urine over a few weeks “crescendo prostatism”</p>
OTHER HISTORY	<p>CO-MORBIDITY – Cardiovascular and Respiratory.</p> <p>SOCIAL HISTORY - Current social support, Family support</p> <p>PREVIOUS UROLOGY, MEDICATION</p>
EXAMINATION	<p>Pulse, Blood Pressure, Temperature, Cardio-respiratory system.</p> <p>Abdomen – EXCLUDE other causes of abdominal pain and mass such as AORTIC ANEURYSM</p> <p>Digital Rectal Examination – perform after catheter insertion in cases of retention</p>
INITIAL INVESTIGATION	<p>Urine – CSU, Bloods – Cr&E and FBC are essential.</p> <p>Other blood tests according to clinical indications (Sugar, LFTs, Amylase, CRP)</p>
INITIAL TREATMENT IS TO PASS A CATHETER STAT. THIS MUST BE DONE IN THE A&E AT ONCE BY THE A&E DOCTOR OR TRAINEE SEEING THE PATIENT.	<p>CATHETERISE AT ONCE using a soft 12 – 16 Fr Catheter with a 10 ml balloon. Ensure that urine drains before inflating the balloon. Let the bladder drain. Slow decompression techniques in chronic retention are not necessary as diuresis and haematuria are inevitable in high pressure retention.</p> <p>When drainage stops and the bladder is empty RECORD THE VOLUME DRAINED.</p> <p>FAILED CATHETER If the catheter will not pass, note how far it went in. If on the WHH or QE/QMH site, contact the on call general surgical team for consideration of a supra-pubic catheter (provided there is no history of Bladder Cancer or haematuria). All General Surgical Registrars should be competent at supra-pubic catheter insertion and willing to help relieve a very distressed patient. At KCH contact the on-call Urology/Vascular BST.</p> <p>If there is a history of Bladder cancer or haematuria, please discuss with the Urology Middle Grade on call and do not attempt supra-pubic catheterisation.</p> <p>SEPSIS – patient with Temperature > 38.5 must be managed along the trust guidelines for sepsis (blood culture, iv antibiotics). These patients may need to be admitted to their local ITU/HDU if not fit for transfer to KCH.</p>
<p>PATHWAYS</p> <p>SEND A FAX TO THE UROLOGY FAX NUMBER 01227 783136 TO ARRANGE OPD do not use the internal post</p> <p>UROLOGY ADVICE ONLY</p> <p>NOTIFY THE UROLOGY BLEEP 7602 FOR ADMISSION</p>	<p>DISCHARGE HOME WITH UROLOGY OPA ARRANGED BY FAXING DETAILS TO UROLOGY FAX AFTER DISCUSSION WITH 7602 - FIT PATIENTS, NO CO-MORBIDITY, NORMAL U&E, NO DIURESIS and GOOD SOCIAL SUPPORT.</p> <p>Teach the patient and carers how to use a leg bag, night bag and flip-flo valve. Fax a copy of the A&E or ECC notes with all details including residual urine volume and DRE findings, to the Urology FAX number. If the residual urine volume is < 800 – 1000 ml, a trial of voiding after a period of bladder rest will be organized. If the residual volume is > 1000ml an urgent appointment to discuss surgery will be made. While we will endeavour to arrange a timely appointment, please do not promise an appointment within a set time frame such as 2 weeks.</p> <p>ADMIT UNDER APPROPRIATE HCOOP / MEDICAL TEAM - PATIENTS WITH NORMAL U&E and NO DIURESIS BUT WITH CO-MORBIDITY REQUIRING ADMISSION, For these patients the Urology emergency is over once the catheter is passed. These patients should be admitted under HCOOP, medical or other teams at their local hospital for optimisation of their co-morbidity and attention to social support needs. Urological treatment will be arranged subsequently. Inform the Urology Bleep of the admission.</p> <p>TRANSFER TO UROLOGY UNIT AT KCH - PATIENTS WITH RAISED CREATININE, UTI, HEAVY HAEMATURIA, DIURESIS FOLLOWING CATHETERISATION.</p> <p>FEMALE RETENTION - This should be discussed with the Hotline as admission is usually required. Pelvic Ultrasound and a cystoscopy with EUA and urethral recalibration are required.</p>

CONDITION	HAEMATURIA AND CLOT RETENTION
DEFINITIONS	<p>DIPSTICK HAEMATURIA = MSU needed. Usual in UTIs, only 80% of renal colic cases. False + ve is common eg due to menses or catheterisation . Must confirm with MSU.</p> <p>MICROSCOPIC HAEMATURIA = Red blood cells seen on microscopy only.</p> <p>URETHRAL BLEEDING – Frank blood at urethral meatus.</p> <p>MACROSCOPIC HAEMATURIA = Blood and / or clots visible in the urine.</p> <p>INITIAL HAEMATURIA = first part of stream – often prostatic in origin</p> <p>PAN HAEMATURIA = all of stream – bladder or renal in origin</p> <p>CLOT RETENTION – Heavy bleeding resulting in blood clot obstructing bladder outlet.</p>
CAUSES	<p>THE HAEMATURIA SIEVE</p> <p>Any cause of bleeding from urinary tract including clotting disorders, warfarin treatment, renal parenchymal disease, UTIs, TCC, Kidney and Bladder Tumours, trauma.</p>
SYMPTOMS	<p>Blood and or clots in urine. Difficulty in passing urine with clots if heavy. Long stringy clots suggest renal origin causing clots in ureter</p> <p>UTI – Dysuria, frequency, Urgency, loin pain</p> <p>Lower abdominal pain and swelling with clot retention</p>
OTHER HISTORY	<p>CO-MORBIDITY – Cardiovascular and Respiratory.</p> <p>SOCIAL HISTORY - Current social support, Family support.</p> <p>SMOKING AND EXPOSURE TO CHEMICALS</p> <p>PREVIOUS UROLOGY – Of renal colic, bladder cancer, prostatism, trauma, sexual history.</p> <p>MEDICATION – WARFARIN, Aspirin, Clopidogrel</p>
EXAMINATION	<p>Pulse, Blood Pressure, Temperature</p> <p>Cardio-respiratory system</p> <p>Abdomen – Check for palpable / percussible bladder indicating clot retention</p> <p>Digital Rectal Examination</p>
INITIAL INVESTIGATION	<p>Urine – CSU / MSU if there is UTI or dipstick haematuria</p> <p>Bloods – U&E FBC Group and Save.</p> <p>Other blood tests according to clinical indications (Sugar, LFTs, Amylase, CRP)</p> <p>Further investigation of haematuria will be arranged by the Urology department.</p>
TREATMENT OF HAEMATURIA	<p>Depends on the cause.</p> <p>Obvious UTIs should be treated with appropriate antibiotics.</p> <p>All patients with Haematuria, particularly Clot retention, heavy haematuria with clots, shock or anaemia must be discussed with the on call Urologist via the “HOTLINE”. They may need transfer to the inpatient unit at KCH. All cases of haematuria require urgent specialist Urological referral for investigation to exclude urological malignancy.</p>
TREATMENT OF CLOT RETENTION	<p>CATHETERISE using a 20 Fr 2 way catheter. Perform vigorous bladder washout using saline until all clots are removed. Once the clot is evacuated, further washouts may be needed to prevent further blockages. It may be necessary to change the 2 way catheter to an irrigating catheter.</p> <p>If unable to catheterise – Call the Urology team to arrange immediate transfer to KCH by blue light ambulance.</p> <p>NEVER USE A SUPRA-PUBIC CATHETER IF THERE IS HAEMATURIA OR A HISTORY OF BLADDER CANCER</p>
PATHWAYS FOR HAEMATURIA SEND A FAX TO THE UROLOGY FAX NUMBER 01227 783136 TO ARRANGE OPD OR CALL THE UROLOGY BLEEP 7602 IF ADMISSION REQUIRED	<p>1. DISCHARGE HOME WITH URGENT UROLOGY APPOINTMENT FOR HAEMATURIA INVESTIGATION BOOKED VIA HOTLINE OR UROLOGY FAX</p> <p>Microscopic Haematuria</p> <p>Mild Macroscopic haematuria with no clots, no anaemia or no shock</p> <p>2. TRANSFER TO KCH AFTER CATHETERISATION AND WASHOUT</p> <p>Clot retention</p> <p>Heavy haematuria with clots</p> <p>Clinically significant anaemia</p> <p>3. RESUSCITATE, STABILISE, THEN TRANSFER TO KCH IF FIT FOR TRANSFER</p> <p>Hypovolaemia and shock – patients can present with a very low Hb</p> <p>Immediate management may need to be on the WHH or QEPMH site with transfer once the patient is stable.</p>

CONDITION	LOIN PAIN ? RENAL COLIC
DEFINITION	The pain caused by sudden obstruction of a ureter.
SYMPTOMS	Sudden onset of severe pain starting in the renal angle and radiating to the iliac fossa, testis, penis or labium. The intensity varies with nausea, restlessness and vomiting. It is the worst pain they have ever had. The pain history may not fit a classic description.
OTHER HISTORY	Check for rigors, pyrexia, dysuria, cloudy urine, previous renal colic and positive family history of stones. Check for Cardiovascular and Respiratory co-morbidity and diabetes. The history must be taken with enitor e to the list of differential diagnoses below.
EXAMINATION	Pulse, Blood Pressure, Temperature must be recorded. The patient is grey, sweaty and is very restless and continually moving around. This obvious picture is never forgotten once seen. The renal angle is tender, not the para-spinal muscles. All systems must be examined with reference to the list of differential diagnoses below.
DIFFERENTIAL DIAGNOSIS	Cardio-respiratory system – pneumonia, Pulmonary emboli, chest wall pain, Bornholm's Gastro-intestinal system – aortic aneurysm, pancreatitis, diverticulitis, Appendicitis, cholecystitis, constipation etc Gynaecological – Ruptured ectopic pregnancy, torsion of ovarian cyst, mittelschmerz Urological – Pyelonephritis, Pelvi-ureteric junction obstruction, Renal or ureteric tumour Musculo-skeletal – check for acute back strain or other causes of back pain
PRELIMINARY TESTS	Investigate as for Acute abdominal pain – consider the all the differential diagnoses above. Urine – There may or may not be dipstick haematuria. This does not make the diagnosis. Do an MSU Bloods – IMMEDIATE Creatinine, electrolytes and FBC are essential especially WBC. Other blood tests according to clinical indications (Sugar, LFTs, Amylase, CRP) If pyrexial perform blood cultures and clotting studies. X-Ray – get a plain film supine abdominal film (remove clothing and in males ensure the penis is not overlying the bladder) and an erect chest X-ray stat (except in pregnancy and keep to the 10 day rule in female patients of child bearing age). EMERGENCY IVU – If renal colic is suspected, this must be confirmed by an emergency 2 shot IVU, unless contra-indicated, whatever the time of day or night. See the list of contra-indications below and the suggested alternative investigations. It is not necessary to have requests for an emergency IVU validated or approved by a Consultant Radiologist or Consultant Urologist.
PATHWAYS IN A&E and ECC	<u>AT William Harvey and Queen Elizabeth the Queen Mother Hospitals</u> A&E Doctors or the on-call surgery F2/CT trainee will make an initial assessment and investigate as above. <u>At Kent and Canterbury Hospital (Emergency Care Centre)</u> If renal colic is suspected, the ECC team should notify the Urology bleep 7602. The on-call Vascular / Urology team will go to the ECC and manage the patient. GP REFERRALS DIRECT TO KCH GPs may refer cases of suspected renal colic directly to the on-call Urology team at KCH. This MUST be via the Urology bleep.
EMERGENCY 2-SHOT IVU This uses 2 films only and takes 25 minutes. Delayed film can be done after transfer to KCH. Remember the 4 hour A&E target.	AIM OF THE 2-SHOT IVU: is to determine if there is a Urological problem or not. The simple question is whether or not there is obstruction or other Urological problem. CONTRA-INDICATIONS FOR IVU INCLUDE: iodine allergy, asthma, seafood allergy, renal failure – check the creatinine, hepatic failure, myeloma, Diabetics treated with metformin and Pregnancy – 1 st trimester absolute, in the 2 nd and 3 rd trimester a 2 film IVU is permitted. If IVU is contraindicated then perform a KUB (except in pregnant ladies) and discuss with the Hotline. If a Radiographer feels an IVU is not required please call the Middle grade on-call to discuss this – eg if a patient with recent admission and an IVU returns with more pain, a KUB may suffice. THE 2 SHOT EMERGENCY IVU Achieve adequate venous access by wide bore butterfly or venflon. If a plain abdominal film has not already been done get a KUB X-ray as a control film to show the pubic symphysis and D11 (renal areas). Repeat the film if these are not shown or penetration is inadequate. Give contrast according to local Hospital guidelines (if in doubt use 100ml Niopam 320) This is a parenteral drug and should be prescribed and given by an appropriately qualified member of staff. This may be the A&E Doctor or the Surgical BST on call depending on local Hospital practice. The Doctor who gives the injection stays with the patient for at least 5 minutes in case of contrast reaction. The patient must never be left unattended. Immediate or 5 minute films are not necessary, the yield of renal tumours is low and the aim of the investigation is to identify obstruction. A POST MICTURITION KUB is taken at 20 minutes post injection – this must be post micturition.

HOW TO INTERPRET AN EMERGENCY IVU	<p>First look at the control film. Examine the bones starting with the vertebrae and moving to the ribs and pelvis. Study the soft tissues, the psoas shadow, bowel pattern and renal shadows. Look closely down the line of the ureter which runs from the tip of the transverse process of L2 down over the remaining transverse processes, over the sacro-iliac joint and then round the pelvic side wall to enter the bladder medially. Make sure the pubic symphysis is shown, there are no clothing artefacts (zips, buttons) and in males that there is no genital artefact overlying the bladder.</p> <p>Then look at the 20-minute post micturition film. Ensure the pubic symphysis and D11 are shown and that the bladder is not full of contrast and obscuring the lower ureter. Make sure there are two kidneys. Study the non-symptomatic side looking at the renal cortex and pelvicalyceal system. There may still be a faint nephrogram (dye in the cortex) that outlines the shape of the kidney. You should see a pyelogram (dye in the pelvicalyceal system), peristaltic segments of the ureter and contrast in the bladder. Study the symptomatic side – if there is a urological problem, you will observe a difference between the normal and abnormal side. There may be no excretion, a delayed nephrogram, delayed pyelogram or even leakage of contrast outside the kidney. The pelvicalyceal system will be wider than the normal side with clubbing of the calyces. Follow the line of the ureter looking for dilatation or a stone, comparing with the control film to ensure that any pelvic calcifications are outside the line of the ureter. The well rounded calcifications often seen in the pelvis are phleboliths, due to blood vessels seen end-on. Stones in the lower third of the ureter are usually less symmetric.</p> <p>NORMAL IVU – If both ureters and kidneys are normal and similar to the other side, the diagnosis is not renal colic. Other abnormalities of the Urinary tract may be found. If the IVU appearances are normal, the patient remains under the General surgical team (WHH and QEPMH) or ECC team (KCH) for further assessment regarding the wide range of possible diagnoses.</p> <p>ABNORMAL IVU – If there is delayed excretion on one side, this indicates obstruction. Give pain relief as recommended below. If obstruction or other urinary tract abnormality is suspected, the Urology team should be contacted for immediate management advice. If renal colic is confirmed, the criteria for admission below should be used. Other Urological conditions may also warrant admission.</p>
PAIN RELIEF	Give Voltarol 100 mg PR or im stat unless contra-indicated. Use morphine if NSAID fails. DO NOT USE PETHIDINE EVER.
NB PLEASE	If the patient is, has been or becomes febrile, or has a high white cell count, or a history of temperatures or rigors, contact the UROLOGY BLEEP 7602 at once, do blood cultures, clotting studies and commence parenteral antibiotics.
PATHWAYS FOR PATIENTS WITH RENAL COLIC	
<u>CRITERIA FOR DISCHARGE WITH URGENT UROLOGY OPA</u>	<u>ABSOLUTE CRITERIA FOR ADMISSION</u> Temperature, raised WCC, SEPSIS Solitary kidney – ABSOLUTE Severe pain needing opiates – <u>RELATIVE INDICATIONS FOR ADMISSION</u> nausea or vomiting Stone > 4mm Complete obstruction on IVU Poor renal function
Stone < 4mm – 95% will pass spontaneously No infection (temperature or raised wcc) Incomplete obstruction on IVU Pain settles on voltarol	
TREATMENT FOR DISCHARGED PATIENTS Give supply of voltarol SR 75mg bd 2 week appointment in the local Urology clinic with KUB X-Ray on arrival. Patient MUST be told to re-attend if pain returns or high temperatures develop Micturate through a tea strainer – rinse after!	TREATMENT FOR ADMITTED PATIENTS IV fluids if vomiting Clotting studies and blood culture if pyrexial Appropriate analgesia as above Anti-emetic Sieve the urine
PATHWAYS ONCE RENAL COLIC IDENTIFIED	DISCHARGE CRITERIA MET – A request for an urgent follow up appointment with KUB Xray on arrival should be faxed to the Urology Fax number 01227 783136 ADMISSION CRITERIA MET – all patients must be discussed with the on-call Urology team and the films reviewed on PACS. Use the admission protocol described earlier. AT KCH If the site of obstruction is not demonstrated clearly on the 20 minute film, delayed post-micturition films are performed after transfer to KCH. These are taken at 2 hrs, 4 hrs, & 8hrs etc until the contrast has reached the obstruction or further specialist investigations are ordered.

CONDITION	RENAL TRAUMA
DEFINITION	<p>1 – 5% of all trauma cases will have renal trauma.</p> <p>Severity scale:</p> <p>1 Contusion or non expanding subcapsular haematoma</p> <p>2 Non-expanding peri-renal Haematoma</p> <p>3 Cortical laceration < 1cm deep without urinary extravasation.</p> <p>4 Laceration into collecting system or vascular injury to segmental artery or vein with contained haematoma</p> <p>5 Shattered kidney or renal pedicle injury or avulsion</p>
CAUSES	<p>BLUNT</p> <p>The majority – often associated with injuries to other adjacent organs. The patient may be shocked and need resuscitation. The vast majority of blunt renal trauma will settle on conservative management.</p> <p>PENETRATING</p> <p>Stab and gunshot</p>
HISTORY	Time and Setting of injury.
OTHER HISTORY	Past renal surgery, known renal abnormalities
EXAMINATION AND IMMEDIATE TREATMENT	<p>IS THERE SHOCK – Check Pulse & Blood Pressure</p> <p>OTHER INJURIES – Chest, back, abdominal contents</p> <p>IMMEDIATE TREATMENT – If shocked, resuscitate along ATLS protocols and treat associated injuries.</p> <p>Look for fractures, particularly of 12th rib / transverse processes which suggest a considerable force and should alert you to the possibility of other injuries to spleen, lung and abdominal contents.</p>
INVESTIGATION	<p>HAEMODYNAMICALLY STABLE PATIENTS</p> <p>URINE – inspect urine, perform dipstick</p> <p>BLOOD – Hb U&E, Cross match</p> <p><i>CT SCAN WITH CONTRAST MUST BE PERFORMED IF THERE IS</i></p> <p>Macroscopic Haematuria</p> <p>Hypotension</p> <p>Severe rapid deceleration</p> <p>Associated injuries.</p> <p>ADVISE ON CALL UROLOGY TEAM AT KENT AND CANTERBURY HOSPITAL IF ANY RENAL INJURY IDENTIFIED ON CT SCAN.</p> <p>HAEMODYNAMICALLY UNSTABLE</p> <p>Get on call surgical team and contact Urology consultant on-call as patient may need exploration.</p>
TREATMENT	<p>RESUSCITATE</p> <p>IDENTIFY ALL INJURIES</p> <p>CALL APPROPRIATE TEAM – SURGERY, ORTHOPAEDICS</p>
PATHWAYS	<p>INDICATIONS FOR ADMISSION AND OBSERVATION UNDER GENERAL SURGICAL / OTHOPAEDIC TEAMS AT TRAUMA CENTRE HOSPITALS WHH & QEPMH</p> <p>Macroscopic Haematuria</p> <p>Microscopic haematuria >5 rbc/hpf,</p> <p>hypotension</p> <p>Severe rapid deceleration</p> <p>associated injuries</p> <p>INDICATIONS FOR STAT EXPLORATION (TRANS-ABDOMINAL) CONTACT UROLOGY CONSULTANT ON CALL</p> <p>Resuscitation fails</p> <p>Haemodynamically unstable, development of shock despite resuscitation</p> <p>INDICATIONS FOR ANGIOGRAPHY AND EMBOLISATION</p> <p>Ongoing bleeding from the kidney</p>
LOG THIS PATIENT WITH THE UROLOGY BLEEP 7602	

CONDITION	BLADDER RUPTURE
DEFINITION	Extraperitoneal or Intraperitoneal Rupture of the bladder
CAUSES	TRAUMATIC – Blunt trauma, especially RTA causes 80 – 90% SILENT - A patient gets drunk and passes out. The bladder ruptures due to overdistension
HISTORY	TRAUMA is usually obvious SILENT may be hard to diagnose so remember it as a cause of lower abdominal pain and voiding difficulty, even a cystogram may fail to diagnose it and it is found on cystoscopy for the inevitable haematuria.
OTHER HISTORY	Previous bladder surgery especially cystoplasty
EXAMINATION	Haematuria, Abdominal tenderness, Suprapubic bruising, Abdominal distension Extravasation of urine into scrotum or abdominal wall
INVESTIGATION	INDICATIONS FOR CYSTOGRAM Pelvic Fracture and Macroscopic Haematuria Microscopic haematuria and anterior rami fracture or severe ring disruption Use 350 ml of contrast.
TREATMENT	RESUSCITATE MANAGE OTHER INJURIES THINK OF BLADDER RUPTURE
PATHWAYS LOG THIS PATIENT WITH THE UROLOGY BLEEP 7602 FOR ADVICE REGARDING WHICH PATHWAY IS USED	TRAUMATIC ADMIT UNDER GENERAL SURGEONS / ORTHOPODS SILENT REFER TO UROLOGY UNIT AT KCH

CONDITION	PELVIC FRACTURE URETHRAL DISTRACTION INJURY
DEFINITION	A serious urethral injury, often with complete disruption.
CAUSES	Extreme force results in distraction of the bulbar urethra from the prostate
HISTORY	There are almost always other major injuries which take priority. Manage these patients according to ATLS guidelines.
OTHER HISTORY	If the patient cannot pass urine, blood is present at the urethral meatus or a catheter will not pass in a major trauma patient, suspect urethral injury
EXAMINATION	SHOCK due to other injuries and fractures Blood at the penile meatus
INVESTIGATION	CALL THE UROLOGY CONSULTANT ON CALL AT ONCE – Perform urethrogram using 20 ml of water soluble contrast in the resuscitation area using the mobile X – Ray machine If the urethra appears intact then you may try to catheterise the patient using a soft 12 Fr catheter. Use NO FORCE. If a catheter will not pass then supra-pubic drainage is required. The on-call Urology team should be notified.
TREATMENT	RESUSCITATE Other major injuries take priority. A catheter may have to wait until a suprapubic catheter is sited at laparotomy.
PATHWAYS	ADMIT UNDER ORTHOPAEDIC TEAM UROLOGY CONSULTANT ON-CALL WILL PROVIDE SPECIALIST ADVICE

CONDITION	ASSORTED GENITAL EMERGENCIES
FORESKIN STUCK IN ZIP	Infiltrate with Local Anaesthetic and Unzip!
PHIMOSIS = Unable to retract foreskin due to scar tissue	If the patient cannot pass urine, or access is needed to the external urethral meatus for catheterisation, the foreskin is infiltrated with local anaesthetic and a Dorsal Slit made. Several dextron or vicryl sutures are used to close the skin edges.
PARAPHIMOSIS = Foreskin stuck in retracted state.	This causes considerable pain and swelling of the glans. It can usually be reduced by wrapping the glans in a gauze swab, squeezing hard to reduce glanular oedema for 60 seconds and then reducing the foreskin. Topical hydrocortisone ointment 1% and simple SAVLON cream twice daily for 2 weeks may help to minimize scarring of the prepuce and maintain elasticity. Since a circumcision may be needed, the patient should be instructed to see their GP after 6 weeks to assess if Urological referral is needed. DORSAL SLIT: If a paraphimosis will not reduce, the on-site surgical registrar should perform a dorsal slit procedure in the A&E department. Local anaesthetic is infiltrated under the tight band which is incised longitudinally and then sutured transversely using 3/0 vicryl rapide. The patient is advised to see their GP after 6 weeks to decide if Urological referral for a formal circumcision is needed.
TORN FRENULUM	Due to inadequate lubrication and over-enthusiastic intercourse. The bleeding usually stops on manual pressure for 5 minutes but a stitch may be needed in the frenular artery if this is torn.
HUMAN BITE	This requires proper anti microbials as appropriate for human bites (Flagyl). Suturing is contraindicated due to risks of sepsis. Dressings and regular review with antibiotic therapy is usually adequate. If the bite is very severe, contact the on-call Urology team for advice.
PRIAPISM = A persistent painful erection, seen following injection of drugs for impotence, during a sickle cell crisis and in leukaemia.	After 4 hrs of erection insert a 19 gauge (green) butterfly into the corpora and aspirate 20 ml of blood. This will usually result in de-tumescence. If this fails then a weak phenylephrine solution of 200 micrograms in 2 ml normal saline should be injected intracavernosally. The patient will usually be carrying a sheet of information which will include details of this approach. Should this fail, contact the UROLOGY Bleep 7602 at once.
FRACTURE OF PENIS = Rupture of the corpus cavernosum	This is caused by over-enthusiastic intercourse or trauma. The usual story is "well Doctor, I turned over in bed this morning and it went crack!" This is of course may not be the real story! If a minor degree of bruising leave alone. If severe with de-tumescence and haematoma formation, repair is advised. Refer to Urology at KCH at once.
PENILE DEGLOVING	De-gloving penile injuries are typically seen in motorcyclists who crash and catch the penis as they fly over the handlebars. The de-gloved corpora must be covered with Scrotal or abdominal skin. Repair can be performed later.
TESTICULAR TRAUMA	MILD TRAUMA Manage conservatively with analgesia and rest. SEVERE PAIN AND SWELLING This suggests testicular rupture and haematoma. There is a high risk of testicular atrophy due to pressure inside the tunica. These patients should be admitted under the local general surgical team for exploration, evacuation of haematoma, excision of necrotic tissue and closure of tunica.
PENETRATING INJURIES OF PENIS AND SCROTUM	Should be explored, debrided and closed. If injuries are complex Urological input may be required.
FOURNIER'S GANGRENE	This is often fatal if not managed aggressively by radical excision of dead tissue and debridement with full antibiotic cover and ITU/HDU support. Always discuss with Urology Bleep 7602.
POST TRUS INFECTIONS	Trans-rectal Ultrasound guided prostatic biopsy is performed to investigate suspected prostate cancer. All patients are given prophylactic antibiotics but infection, sepsis and urinary retention can still occur. Retention is managed as outlined above. Patients with infective complications and sepsis may need admission for parenteral antibiotic therapy. If they are very ill, admission to the local hospital and ITU/HDU support may be needed.

ACUTE SCROTAL PAIN

THIS IS A GENERAL SURGICAL EMERGENCY

CONDITION	TESTICULAR TORSION
DEFINITION	Infarction of the testicle due to twisting of the testicle on its vascular pedicle .
CAUSES	There is a BILATERAL anatomical defect where the testis has a longer than normal pedicle. This allows the testicle to twist resulting in ischaemia and infarction. This is irreversible after 4 – 6 hrs. Torsion occurs at any age but is mostly peri-pubertal. Remember that epididymitis is unusual in children. Approximately 20% of testicular tumours present with pain or swelling but this is not usually of extremely sudden onset.
SYMPTOMS	SUDDEN ONSET OF SEVERE CONTINUOUS PAIN IN THE TESTICLE IS TORSION UNTIL PROVEN OTHERWISE. THE DIAGNOSIS MAY NEED TO BE MADE ON IMMEDIATE EXPLORATION NO URINARY SYMPTOMS
OTHER HISTORY	There may be RIF pain and vomiting only leading to misdiagnosis of appendicitis. The testicle may rise up towards the groin. SLOW onset suggests epididymitis Dysuria suggests epididymitis
EXAMINATION	Tender, hot, swollen red testis. The whole testis and epididymis is swollen and very tender. Stand the patient up and examine the contralateral testis, if the lie is horizontal then the anatomical defect is present.
INVESTIGATION	IMMEDIATE SURGICAL EXPLORATION BY THE ON CALL GENERAL SURGICAL TEAM AT THE HOSPITAL OF PRESENTATION. ULTRASOUND IS NOT HELPFUL DO NOT WASTE TIME WITH THIS INVESTIGATION
TREATMENT	CASES OF SUSPECTED TESTICULAR TORSION MUST BE MANAGED BY IMMEDIATE SURGICAL EXPLORATION THIS IS MANDATORY AND MUST BE PERFORMED WITHIN 4 – 6 HOURS OF THE ONSET OF PAIN DETORSION AND BILATERAL FIXATION within 6 hours of the onset of pain. An enitior e testicle should be detorted and observed for re-vascularisation. ORCHIDECTOMY WITH CONTRALATERAL FIXATION if necrotic testicle found or if re-vascularisation does not occur. DRAINAGE OF FLUID IF EPIDIDYMO-ORCHITIS FOUND – this will relieve the pressure within the tunica vaginalis, improves the circulation, enables antibiotics to work effectively and relieves pain. HISTORY > 6 HOURS – If the history is of more than 6 hours duration then the testis will already be dead. Exploration and orchidectomy must still be performed urgently to fix the normal side and to avoid infertility secondary to auto-immune orchitis on the normal side
PATHWAYS	GP REFERRALS: GPs should refer patients with acute scrotal pain to the General Surgical teams at WHH or QEPMH. GPs contacting Urology at K&C will be referred on to the General Surgical teams at WHH or QEPMH. A&E ATTENDERS AT QEPMH and WHH: Walk in patients with acute scrotal pain are seen by the A&E Doctors who MUST refer to the on-call General Surgery BST with EXTREME URGENCY KCH UCC Any walk-in patient who has acute scrotal pain will be triaged by the nurses in the UCC and normally sent straight to WHH or QEPMH by blue light ambulance if they do not have their own transport. This same system applies at the Buckland Hospital Dover and was been agreed at Urology reconfiguration discussions with the Medical Director in 2004. If there is doubt as to whether transfer, assessment and exploration can be achieved within the 6 hour window from the onset of symptoms then the on-call Urology team should be contacted to manage the patient appropriately.

CONDITION	EPIDIDYMITIS/ORCHITIS
DEFINITION	Infection of the testis and / or epididymis
CAUSES	Typically in a young adult. 40% are due to Chlamydia. Often seen in older men due to outflow tract obstruction.
SYMPTOMS	Slow onset of pain which may be localised to epididymis. There may be Symptoms of UTI.
OTHER HISTORY	Ask about sexual partners and recent intercourse. In older men ask about voiding function and previous urological problems
EXAMINATION	The patient may have a fever and tachycardia. The normal side lies vertically. In epididymitis the swelling and tenderness is localised in the epididymis.
INVESTIGATION	DIPSTIX – Suggests a UTI. MSU – Must be done prior to antibiotic treatment. FBC – The WBC may be elevated. ULTRASOUND – Always organise an ultrasound to check for testicular tumours 20% of which present with pain. Always get follow up as below. A&E staff must be very confident that the diagnosis is not torsion before sending home any patient with a diagnosis of Epididymitis
TREATMENT	Younger men need tetracycline and augmentin or Ciprofloxacin and a GUM referral with their partner. Older men need Augmentin or ciprofloxacin and a Urological outpatient appointment. If the patient is septic, take blood cultures, start iv antibiotics and arrange transfer to KCH A scrotal abscess should be drained by the on call surgical team.
PATHWAYS	If STD suspected, refer to GUM clinic, Urology OPD after the U/S – fax request to Urology Fax Number. Admission to the Surgical ward may be required if there is systemic sepsis. Abscess formation requires surgical drainage by the on-site surgical team.

These protocols are kept under continuous review and can be updated and modified should any improvement be felt necessary.

Please contact Mr JWH Evans the Urology Lead clinician if you have any questions or suggestions.

Lectures on Urology emergencies, specifically directed at F1, F2 and CT surgical trainees, can be arranged with 8 weeks notice.

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PERIOPERATIVE MANAGEMENT OF ANTIPLATELET THERAPY

EAST KENT HOSPITALS UNIVERSITY NHS TRUST

GUIDELINES PERIOPERATIVE MANAGEMENT OF ANTIPLATELET THERAPY

Background:

Antiplatelet medication is used routinely for the primary prevention of cardio and cerebrovascular events. They are also indicated as secondary prevention following such an event or prevention of events following interventional treatment such as coronary artery stenting

Surgery is linked to activation of acute phase reaction with increased platelet adhesiveness and decreased fibrinolysis. Involvement of pro-inflammatory and prothrombotic conditions may increase C-reactive protein, plasminogen activator, and fibrinogen. These conditions may lead to acute coronary syndromes and acute cerebrovascular events.

Antiplatelet drugs therefore are an important therapy to consider in the Perioperative period.

Evidence would suggest that routinely stopping these drugs may be harmful in a number of patient groups.

Drugs:

Aspirin. (acetylsalicylic acid) blocks the action of platelet COX-1 at doses of 50-150mg/day. The ability of platelets to function normally is restored after 4-5 days, but the effect on platelets lasts for the duration of the life of the platelet (7-10 days). The drug may be used in primary prevention if the risk of vascular events is high, or given as secondary prevention after a cardiovascular event.

Aspirin up to 300mg/day is not a contraindication to regional or central neuro-axial blockage unless combined with LMWH

Clopidogrel (plavix) is an ADP-receptor antagonist. It can be used in unstable angina, and following stent insertion. It has a role in management of peripheral vascular disease. It may be combined with aspirin after coronary revascularisation or for patients who are non-responders to aspirin therapy. The effect of the drug on platelets is irreversible, and although the drug has a short half life the effect, as with aspirin, can last for 7-10 days.

Clopidogrel treatment is an absolute contraindication to regional / neuro-axial blockade in all but the most exceptional circumstances.

Statins. This group of drugs affects platelet aggregation due to an effect on nitric oxide production. Use of these drugs should be continued during surgery.

PERIOPERATIVE MANAGEMENT OF ANTIPLATELET THERAPY

Coronary Revascularisation

Following percutaneous coronary intervention patients are at a high risk of restenosis. This is prevented by dual antiplatelet combination therapy of Aspirin and Clopidogrel. The duration of this combination therapy will vary depending on the procedure and the type of stent used.

There are essentially two types of cardiac stents – bare metal stents (BMS) and drug eluting stents (DES). The drug used in DES may vary but the use of antiplatelet drugs is essentially the same in this type of stent.

The evidence would suggest that all patients with BMS should have dual antiplatelet therapy for 4-6 weeks. Patients with DES should have dual therapy continued for 12 months. This time may be increased in patients with complications or associated disease.

Withdrawal of antiplatelet drugs.

The abrupt withdrawal of antiplatelet drugs leads to a rebound effect with pro-thrombotic actions, increased thromboxane A₂ and decreased fibrinolysis.

Stopping antiplatelet medication after percutaneous coronary intervention (PCI) leads to a high level of stent occlusion and associated mortality.

Aspirin should be continued for life after stent insertion, the withdrawal of this medication can lead to stent occlusion even many years after PCI.

Haemorrhagic risk

The risk of bleeding is increased with antiplatelet drugs however the data regarding their use in surgery is far from clear.

Low dose aspirin does increase bleeding during the surgical operation. However there appears to be no increase in morbidity or mortality associated with this increase in bleeding. Most surgeons are unable to differentiate patients on aspirin from those not on aspirin. During major surgery – hip arthroplasty and TURP – there was an increased transfusion rate.

Dual therapy also increases the rate of bleeding, but again not the mortality or morbidity – except in neurosurgical operations..

The increase in surgical blood loss with aspirin is 2.5 – 20%

The increase in surgical blood loss with dual therapy is 30-50%

PERIOPERATIVE MANAGEMENT OF ANTIPLATELET THERAPY

Risk of continuing or stopping antiplatelet drugs.

Risk of continuing antiplatelet medication

1.
Increased risk of bleeding
 2.
Increased rate of blood transfusion – with risk associated with this transfusion.
 3. Risk associated with the non-availability of neuro-axial blockade if indicated.
- Risk of stopping antiplatelet medication

Risk of stopping antiplatelet medication

1.Rebound effect of increased platelet adhesiveness with associated increase in coaguability associated with surgery. The patients underlying condition may also lead to an increase in coaguability – diabetes / cancer.

2.Increased risk of infarction and death rates

3. If stopped during the re-endothelialisation phase post stenting the risk of infarction increase is up to 35% with a mortality of 20-40%

4. Risk associated with Cerebrovascular events in the perioperative period
Lead and Author Tony Beaumont, CD Anaesthetics

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	2. Uploaded to intranet

**Algorithm for the management of patients
on antiplatelet medication:**

Patient on Aspirin alone: (75-150mg)

1. Primary prevention (patient with no history of MI CVA Stent insertion etc.

Stop Aspirin 7 days prior to surgery

2.

Secondary prevention – after MI, CVA, Stent insertion, peripheral vascular disease.

Continue Aspirin during all surgery

Patient on Aspirin (75 – 150mg/day) and Clopidogrel (75mg/day)

1.

High Risk Patients. Patients within 6 weeks of Myocardial Infarct Percutaneous Cardiac Intervention(PCI), Bare Metal Stent (BMS) insertion or CVA or patients less than 12 months after insertion of a Drug Eluting Stent (DES) or patients with stents judged by the cardiologists to be “high risk”

DO NOT STOP DRUGS. Only perform vital surgery and accept increased blood loss

Posterior eye surgery may need Clopidogrel stopped and alternatives considered – contact the cardiology department for advice

2.

Low risk patient. Patients with BMS after 12 weeks, or patients who have not had stents inserted during PCI after 12 weeks uncomplicated MI's after 12 weeks or CVA's after 12 weeks

Stop Clopidogrel

Maintain Aspirin therapy during the operation.

Notes on management of bleeding during surgery in the presence of antiplatelet medication

No drugs will reverse the effects of antiplatelet medication. Clopidogrel has a short half life (4 hours) so any free drug will have gone in around 12 hours. After this time any fresh platelets will maintain their effectiveness.

Platelet transfusions should be considered in uncontrolled bleeding.

Aprotonin has been demonstrated to reduce the bleeding associated with Clopidogrel although this drug does not restore platelet function.

DDAVP (desmopressin) can be used to improve platelet function on aspirin. However it has to be used with caution if there is a history of CVA, IHD/MI or uncontrolled hypertension.

Dr Tony Beaumont
Clinical Director Anaesthetics
February 2009

EAST KENT HOSPITALS UNIVERSITY NHS TRUST

POLICY FOR THE TRANSFER OF PATIENTS FOR SPECIALIST CARE WITHIN EKHUT

1. Introduction:

1.1. These guidelines detail best practice in relation to inter hospital transfer of patients and their records for care that can not be provided as an inpatient on any particular site

1.2. This policy provides guidance to all healthcare professionals involved in patient transfer across the different sites in the Trust

1.3. The prime concern of the Trust is to ensure patient well-being and to provide optimal care during the transfer period and to deliver the patient safely and appropriately to the receiving unit.

2. Statement:

2.1. The transferring unit and consultant remain responsible for the provision of care until the patient arrives and is accepted by the receiving unit.

2.2. Before transfer the transferring consultants' team must have made arrangements for transfer and acceptance with the receiving team.

2.2.1.

During working hours this should usually be at consultant to consultant level. The referring consultant should have assessed the patients suitability for the treatment proposed in the accepting unit.

2.2.2.

Out of working hours the consultants involved must be informed, and agree to the decision to transfer, and accept the patient.

2.3. Patient agreement to transfer should be documented. In emergency situations when a patient is unable to agree to transfer, where possible, the next of kin should be informed of the decision to transfer. Consent of the relatives is not always required.

2.4. Relatives should be made aware of the transfer decision as soon as practical by the referring unit.

2.5. All patient records should accompany the patient in line with any recommendations from the Health Records Committee.

3. Principles:

3.1. During a transfer patients should be treated and cared for in such a way as to maintain dignity, patient safety, respect of individual needs, necessary treatment and care and contact with appropriate staff.

3.2. Special care may be needed for transfer of older patients. During cold weather care of temperature control must be considered.

3.3. Transfers should not normally be made out of working hours except in emergency situations. Ideally transfers should take place BEFORE 4pm.

4. Professional roles

4.1. Medical staff at the transferring hospital are responsible for:

- Discussion with the receiving hospitals team
- Making the transfer decision following consultation with the patient
- Informing the next of kin of the decision and reason for transfer as appropriate with the consent of the patient.
- Liaising with the receiving hospital and agreeing transferring arrangements and expected time of arrival
- Ensuring that the receiving unit has the full details of the patients condition and requirements
- Ensuring that all the relevant documentation is completed and up to date, and that the drug chart is completed. A clinical summary must be prepared.
- Identify appropriate staff to accompany the patient if required. If change of treatment is anticipated to be required DURING the transfer medical staff should accompany the patient, if no treatment change is anticipated during the transfer a member of nursing staff may accompany the patient. In the case of acute/emergency patients being transferred during active treatment (eg continuing resuscitation) the experience and capability of the individual nominated to accompany the patient should be assessed by the responsible clinical consultant.

Anaesthetic staff will only accompany patients on inter-ICU transfer or for patients who are intubated and ventilated. These patients have very special requirements and reference should be made to the admission discharge and transfer policy for ICU. Patients “at risk” of needing ventilatory support should be referred to the ICU team in the referring hospital for advice.

- Identify the urgency of the transfer and ensure that this communicated to ambulance control

POLICY FOR THE TRANSFER OF PATIENTS FOR SPECIALIST CARE WITH EKHUT

- Ensuring that the patient is as stable and prepared appropriately for the transfer
- The consultant in charge of the patient at the transferring hospital has full clinical responsibility for the care of the patient until the patient is in the receiving hospital.

4.2.Nursing staff are responsible for:

- Contacting ambulance control with relevant information to ensure the appropriate ambulance for transfer.
- Discussing the transfer arrangements with the nursing staff at the receiving hospital
- Obtaining a time for the transfer ensuring that ambulance control understand the appropriate clinical urgency
- Stating the method of transfer i.e. Stretcher, chair, and specialist equipment – for example to assist with the bariatric patient etc.
- Identify nursing staff with sufficient experience and skills to accompany the patient if necessary.
- Ensuring that a full explanation is given to the patient and/or relative
- Providing nursing support
- Assist in the preparation of the patient for transfer.
- Ensuring that appropriate documentation is complete
- Ensuring that patient's property and valuable accompany the patient and are detailed in the documentation.
- Ensuring that any medication and equipment is available during the transfer;
- Providing holistic patient centred care during the transfer;
- Ensuring appropriate documentation accompanies the patient on transfer
- Monitoring and recording the patients condition during transfer
-

5. Documentation to be transferred with the patient

2. in order to ensure that all relevant information is communicated from one hospital to another it is essential that the following information is transferred

- The patients notes
- Patients drug chart
- Any relevant tests that are not available on the Trust's computer systems – i.e. hand written results of ECHO's Ultrasound etc

POLICY FOR THE TRANSFER OF PATIENTS FOR SPECIALIST
CARE WITH EKHUT

- Patients that are MRSA +ve or have C Diff. should be communicated to the receiving hospital

1. Patient identity

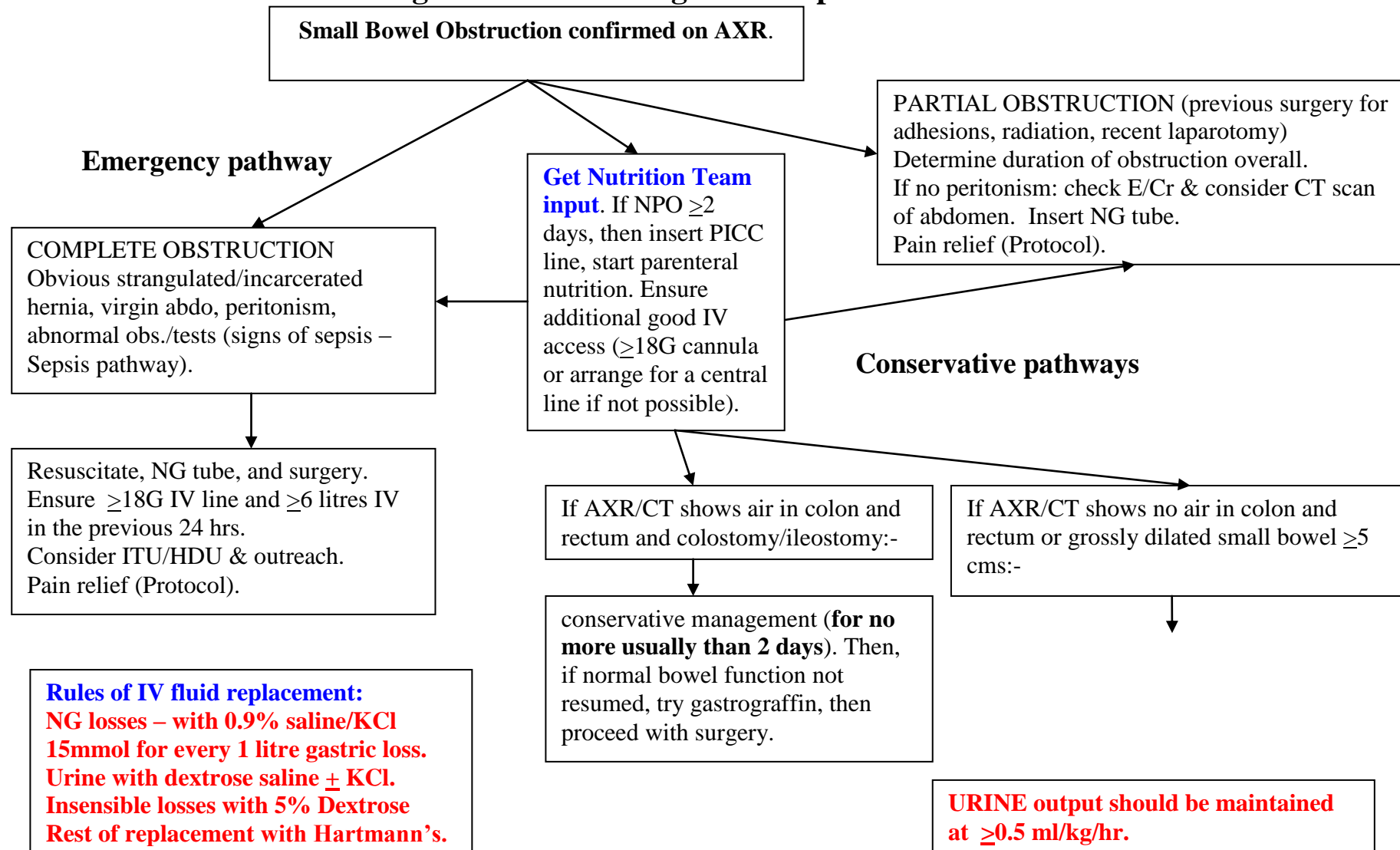
3. Patients MUST have two identification bands on in line with Trust policy. These must state the patients name, date of birth and hospital number.
- 5.3. Allergy bands – where appropriate should be in place prior to transfer.

6. Staff returning to the referring unit

4. When the ambulance transport is not returning to the transferring unit the Hospital switchboard will arrange transfer back. This may be the hospital's Health Hopper or a local taxi firm

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Guideline for surgeons on the management of patients with small bowel obstruction



www.ekclinicalauditservice@nhs.uk

**Information on Clinical Audit
For Trainee Doctors at
East Kent Hospitals NHS Trust**

It is essential that you read this information when you start within this Trust if you wish to be involved in clinical audit during your placement.

What is Clinical Audit?

‘Clinical Audit is the systematic peer evaluation of the quality of patient care based on the explicit and measurable standards of care for the purpose of demonstrating and improving patient care.’

- Clinical audit is a specific methodology that compares current practice against agreed best practice.
- A clinical audit project must have pre-set standards of best practice against which current practice is compared.
- Clinical audit is not a data trawl to find out, for example how often something occurs, or who does what. This may be audit (as in taking stock of what is happening) but it is not clinical audit.

The East Kent Clinical Audit Service works within this definition of clinical audit, and does not have the resources to support other projects outside this definition.

What is the difference between clinical audit and research?

Clinical audit identifies whether the right thing is being done, whereas research answers the question ‘what is the right thing to do’.

For further clarification of the differences, refer to the leaflet ‘difference between clinical audit, research and evaluation’ available from www.ekclinicalauditservice.nhs.uk.

How do I know whether a project is clinical audit?

Ask yourself three questions about the project:

- Is the purpose of the proposed project to improve the quality of patient care locally?
- Will the project involve measuring practice against pre-defined standards of best practice?

- Does the project involve anything being done to patients which would not have been part of their normal routine management?

If you can answer ‘yes’ to the first two questions and ‘no’ to the third, it is safe to assume that your project conforms to the requirements of clinical audit.

If it is not clinical audit it will either be research, an evaluation, or a project that sits on that grey area between research and audit. They will not have the support of the clinical audit service. Such projects will need to be registered with the R&D department.

What is Clinical Audit?

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- A clinical audit project must have pre-set standards of best practice against which current practice is compared.
- Clinical audit is not a data trawl to find out, for example how often something occurs, or who does what. This may be audit (as in taking stock of what is happening) but it is not clinical audit.

The East Kent Clinical Audit Service works within this definition of clinical audit, and does not have the resources to support other projects outside this definition.

What is the difference between clinical audit and research?

Clinical audit identifies whether the right thing is being done, whereas research answers the question ‘what is the right thing to do’.

For further clarification of the differences, refer to the leaflet ‘difference between clinical audit, research and evaluation’ available from www.ekclinicalauditservice.nhs.uk.

How do I know whether a project is clinical audit?

Ask yourself three questions about the project:

- Is the purpose of the proposed project to improve the quality of patient care locally?
- Will the project involve measuring practice against pre-defined standards of best practice?
- Does the project involve anything being done to patients which would not have been part of their normal routine management?

If you can answer ‘yes’ to the first two questions and ‘no’ to the third, it is safe to assume that your project conforms to the requirements of clinical audit.

If it is not clinical audit it will either be research, an evaluation, or a project that sits on that grey area between research and audit. They will not have the support of the clinical audit service. Such projects will need to be registered with the R&D department.

If the project involves a patient survey, this needs to be registered with the Clinical Governance Team (extension 73678). Once again such a project, unless it is specifically linked to a clinical audit project, will not be supported by the clinical audit service.

What is involved in doing a clinical audit project?

- Communicating with and involving others who may play a part in delivering the care you wish to audit.
- Agreeing clear objectives so that the audit is focused and addresses specific issues. A key consideration is ‘how will the results of this audit be used to change or improve practice?’
- Defining standards of best practice (these may be set out in National Royal College or local guidelines or protocols; National Service Frameworks (NSF); NICE guidance; DoH guidance).
- Identify the data items that need to be collected.
- Identifying your patient group (often from clinical coding, information systems, local registers or databases, or identifying relevant cases as they are seen in the hospital)
- Collecting data.
- Analysing and reporting achievement of the standards
- Making recommendations on what needs to change if achievement of standards is poor.
- Implementing the recommendations – an action plan should be drawn up to identify how this will be done.
- Re-audit at a later date to identify whether the changes have resulted in improvement in care.
-

Depending on the project you become involved in, your role may only cover some of these stages.

How is clinical audit organised within this Trust?

Different trusts have different arrangements for managing and supporting clinical audit so it is important that you understand how it is organised here as it may differ from other trusts you have worked in.

Each directorate or major sub-specialty has a clinical audit lead. The clinical audit leads are members of the trusts Clinical Audit & Effectiveness Committee. The clinical audit lead manages and reviews their directorates or specialty’s clinical audit activity. A list of the directorate & specialty audit leads is available on the audit service website.

The Trusts Clinical Audit & Effectiveness committee is multi-professional. It currently meets every other month.

Each year this trusts, in conjunction with the Eastern & Coastal Kent Primary Care Trust, develops a programme of clinical audit projects. Topics for inclusion are derived from National Service Frameworks (NSF), NICE, Department of Health, Royal Colleges and other professional bodies, national targets and priorities, local health commissioners and health providers priorities, adverse events, complaints and patient/public involvement.

The trust expects an audit project to involve all the hospital sites within the Trust that provides the service being audited. It does not normally approve single site audits.

During the year other topics for clinical audit may arise. Such projects need to be discussed with the directorate/specialty clinical audit lead and the East Kent Clinical Audit Service. New topics should be submitted to the Trusts Clinical Audit & Effectiveness Committee for approval using the clinical audit project proposal form. This proposal form can be down loaded from the clinical audit services website.

In deciding whether to approve the proposal, the committee considers whether:

- **The project meets the criteria for clinical audit**
- **The topic is a priority for the Trust**
- **The methodology is robust**
- **The project involves all those that need to be.**

The committee also decide whether assistance form the East Kent Clinical Audit Service, if requested is granted.

What are my options if I want to undertake a clinical audit project?

Options include:

- **Involvement in projects on the clinical audit programme. These projects are likely to be consultant led. The clinical audit service will organise these projects across the trust team. Trainee doctors will be recruited onto these projects at each of the hospital sites and will work as part of a team.**
- **Small single site projects that can be undertaken in real-time on the wards. These are primarily intended for Foundation Year 1 doctors to give them an introduction to clinical audit methodology, through other grades of trainee doctors can participate. The audit service has a number of topics' in mind, but is open to suggestion of others. The criteria for these projects are that:**
 - **The standards of best practice are based on an existing trust guideline or policy**
 - **The incidence of cases that can be included in the audit is high so that the doctor can identify an adequate sample size by visiting one or two wards on one or two occasions.**
 - **The data can be collected from information on the ward.**

What do I have to do if I wish to undertake an audit during my placement?

- **Complete the registration form and submit it to your local clinical audit service within 6 weeks of the start of your placement**

- Discuss your options with your consultant, the clinical audit lead for the directorate or sub-specialty, and the clinical audit service.
- Choose and start your project early in your placement. There will be bulletins on audit service website to inform trainee doctors of any audits that are due to start that they can put themselves forward to be involved in.#
- Comply with the Data Protection Act, and the trusts Case Note Management Guidance. You will be given a leaflet about your responsibilities when you become involved in a clinical audit project. This leaflet is also available for download from the audit services website
- Complete your project before the end of your placement. If you are unable to do this, then you should inform the clinical audit service and directorate or specialty clinical audit lead. You must ensure that all work that has been completed is left with the trust for someone else to complete.
- A report of the results should be submitted to your consultant or the consultant responsible for your project, your clinical audit lead and the clinical audit service.

Do I get any recognition for being involved in clinical audit?

Yes. The clinical audit committee awards certificates to those participation in clinical audit. The certificate identifies the audit topic and the skills you have demonstrated in undertaking the project. The certificate will be signed by either the Chair of the Clinical Audit Committee or the Trust Board Director. However the certificate will only be issued for those projects that are registered with the clinical audit committee.

What if I don't follow this process?

- The clinical audit service will only provide advice and support if you have registered with them within 6 weeks of the start of your placement.
- The clinical audit service will not support you if you do not start your project at least 8 weeks before the end of your placement.
- You will come up against barriers if you proceed with a clinical audit project that has not been submitted and approved:
 - Clinical information and other data application managers will only provide you with patient identifiable data for approved audits.
 - Medical records will only provide you with health records for approved audits
- If you do not comply with the Data Protection Act then it is you personally who will be accountable, not the Trust.
- If you undertake a project that is research and do not follow the correct procedure, you will breach research governance.
- You will not be awarded a clinical audit certificate for your CV.

How can the clinical audit service help me?

The clinical audit service on each of the main sites can provide clinical audit advice on such issues as:

- What your options for audit involvement are

- How to submit a proposal
- How to plan a project
- How to identify the patient group
- Where to get information you may require for your project
- Advice on analysis, reporting and presentations
- Obtaining health records (a maximum of 50 per site for an audit proposed by a trainee doctor audit)
- How to overcome barriers you may encounter during your project.

Clinical Information Leaflets

The East Kent Clinical Audit Service is currently developing a series of information leaflets. These will be available from their website. The topics include:

- EKCAS – who we are and what we do
- Clinical audit: confidentiality and ethics
- What is clinical audit?
- Differences between clinical audit, research and evaluation
- How to submit a proposal for a clinical audit project
- How to plan an audit
- How to set aims and objectives
- How to set standards and criteria
- How to select an audit sample
- How to collect clinical audit data
- How to analyse your clinical audit data
- How write the audit report
- How to present your clinical audit project
- Action planning to implement recommendations from audit
- Case not management (East Kent Hospitals NHS Trust)

How do I contact the clinical audit service?

There are clinical audit offices on the main hospital sites:

- QEQM (ext 62125) opposite the post room at St Peters road entrance
- KCH (ext 74847) on the ground floor of the 1937 building off the corridor signposted towards the Birthing Unit
- WHH (ext 88251) next to the recreational room of residence block D.

How do I find East Kent Clinical audit Service website?

At www.ekclinicalauditservice.nhs.uk

How can I get training on clinical audit?

Training on clinical audit is included in the Foundation doctors educational programme for both year 1 and year 2.

Alternatively look on the website to see what other training is available

Pills for Ills

Information on Drugs & Therapeutics – July 2009

CHARTING ON THE NEW DRUG CHART

The old chart should no longer be presented to you for use, but if it is please ask nicely for the old stock to be destroyed. This will minimize confusion, as we have had a few reports of the occasional doctor using the new antibiotic section for regular medications. We have also had staff administering the antibiotics past the fifth stop day, even when the instruction and intent is clear. Even so the new antibiotic section has been very successful. So much so that some are interpreting the first regular medication page as solely for thromboprophylaxis. The intention was to let you tick the box if you have done a thromboprophylaxis risk assessment the first time you see a patient. The three spaces below can be used for any regular medication.

Some medications need to be given at different times to the default times suggested in the drug chart. There is space to allow you to change the time from say 18.00 to 16.00 by crossing out the incorrect time and inserting in the case of regular medications below the correct time. Prescribers are reminded that if they do not want a drug administered at a particular time, like a weekly bisphosphonate given daily, they should score out the days when it is not to be given rather than just write weekly. This is much safer, and decreases administration error.

There is actually more space for regular medications in the new drug chart than the old. Unnecessarily having two drug charts on the go at once is dangerous.

Oxygen is still very poorly charted. We will be adding a specific section as a reminder in due course. In the mean time when you do chart oxygen do not write 15L as your script. Staff administering oxygen have found this confusing as ward oxygen flow tubes have a top indicated flow of 14 l/min. Incidentally did you know that there is no evidence for routine benefit from oxygen in myocardial infarction uncomplicated by pulmonary oedema, or for that matter stroke, uncomplicated by respiratory complications, and some evidence for harm. But please use oxygen when the patient has low oxygen saturation.

Due to drug chart design issues it is not acceptable to ever chart **a regular medication** to be given both parenterally and by another route. This policy may help prevent the “never must happen event” of oral medications being given parenterally. We also recommend that if fluids commence administration on a different day to them being charted the date of administration is given as well as the time. The present drug chart design that just prompts “time” will be improved in due course as accurate documentation of fluid balance is important.

DRUG PROMOTION

Some preparations may be promoted as a medical device. They still must go through formal approval mechanisms which may well include the Drugs and Therapeutics committee. We expect all biomedical representatives to adhere to the ABPI guidance even if their company is not a member of the ABPI. This means that free samples can not be offered for patient use bypassing the Trust and a few other rules. These are not nearly so strict as the laws just enacted by the American State of Vermont banning most forms of promotion with gifts and setting up a state register of all allowed payments and gifts to health professionals and institutions.

TRUST MEDICINES SAFETY ISSUES

Never must happen events are those considered so serious that their occurrence must be minimized by specific system actions that can justify special procedures in prescribing, administration and supply. We wish to reduce background events associated with:

- **Known Allergy.** The frequency of patients being charted a penicillin with documented allergy is actually increasing in this Trust and we do not think this is just better reporting. Staff must adopt an automatic process of checking the allergy box with every new medicine charted and administered to the

patient. If you get into the routine, you may prevent the death from true penicillin allergy that we know is indefensible if the allergy has been documented.

- **Sedation.** There is a new Sedation Policy <http://www.ekhut.nhs.uk/EasysiteWeb/getresource.axd?AssetID=61909&type=Full&servicetype=Attachment>. However policy alone will not prevent inappropriate dosing, poor prescribing practice and inadequate access to reversing agents if things do go wrong. Are you clear on relevant Trust guidelines and practice, particularly with parental drugs that can cause sedation such as midazolam ?.
- **Anticoagulation:** We are aware of a recent fatal incident in another Trust where a combination of poor communication and inadequate monitoring in the context of medication changes lead to a fatal outcome. Have you done the BMA learning modules on anticoagulation which represent the minimal standard of knowledge expected of prescribers? (see SUPPORT MATERIAL below). Are you, your team and your patients clear on all relevant local arrangements, which for example could be different for an institutionalized patient or one for a different locality.
- **Insulin.** – see May learning from Incidents Letter. <http://www.ekhut.nhs.uk/EasySiteWeb/getresource.axd?AssetID=62306&type=full&servicetype=Attachment> Wrong preparations and wrong doses can be very dangerous
- **Methotrexate** and other immunosuppressive prescribing – see May learning from Incidents Letter. F1s may now never prescribe or transcribe.

FUNDING DRUG TREATMENTS

For the total context all doctors are strongly recommended to read the newly published document “A guide to finance for hospital doctors” at <http://www.aomrc.org.uk/> or www.audit-commission.gov.uk/health. However in particular developments in funding of drug treatments will impact on process and what you are expected to know about NHS medicines and advise patients. The DoH document “Guidance on NHS patients who wish to pay for additional private care” makes explicit that only once all avenues of NHS funding have been explored should a doctor suggest that the patient’s only option is to pay privately for a treatment. It makes explicit that you must make all reasonable attempts to know the local NHS status of a drug when you wish to prescribe it. This information will be increasingly easily available on PCT and speciality commissioning websites. Some decisions relevant to new medicines on the market will be made in shorter timeframes. We can not expect that always this will result in NHS access to a drug for a particular indication. Where such a decision has been made or the drug as a new one to market since 2004 is unfunded by default, complaints from a patient have been deflected back to the doctor who had told the patient “others” were at fault when they had not undertaken their responsibilities. The **Individual Funding Request** process will be initiated across the South East and have stricter application of the criteria for exceptionality and rarity. For secondary care all other drug funding not met by tariff will have to go through the standard in year and yearly service development rounds that can be frustrating and may be more difficult as the recession bites. Pharmacy and the Drugs and Therapeutics committee can help and regret that the support of the Trust for the use of a drug does not mean that funding immediately follows.

MEDICINES ISSUES

5. **Clopidogrel and PPIs.** The present evidence is that all proton pump inhibitors impair the antiplatelet action of clopidogrel. Within the Trust the default position is that “**No PPIs should be used in patients newly commenced on clopidogrel unless the decision is documented for individual patient reasons and conveyed to primary care**”. This has been supplemented by interim guidance that ranitidine at a minimum daily dose of 300mg in normal adults is a reasonable first option where low dose aspirin is co-prescribed with clopidogrel or if both oral acid suppression treatment and clopidogrel need to be coprescribed. **If use of a proton pump inhibitor is essential** in a patient on clopidogrel, oral pantoprazole has some epidemiological evidence to suggest it may be a better choice than omeprazole or lansoprazole.

The following advice was issued by the MHRA and supplemented by the National Prescribing Centre.

- The need for PPI therapy in patients who are also taking clopidogrel should be reviewed
 - Only use these medicines concomitantly when essential.
 - Prescribe PPIs strictly in line with their licensed indications.
 - Check that patients who are taking clopidogrel are not buying over-the counter omeprazole.
 - Continue to follow NICE guidance on prescribing clopidogrel.
 - Stop either the clopidogrel if it is being used outside NICE guidance or beyond the recommended period, or the PPI, or both.
 - If the original reason for using clopidogrel was due to intolerable gastrointestinal symptoms on aspirin alone, changing the prescription to aspirin plus a PPI would seem a reasonable approach
 - other medicines for the treatment of gastrointestinal disorders (such as H2 blockers or antacids) would not be expected to interact with clopidogrel.
- * The PCT has issued **prescribing advice for NSAIDs** including coxibs in June. At <http://www.shepwaypct.nhs.uk/EasySiteWeb/GatewayLink.aspx?allId=62041>
- *The doctor ordering a procedure involving **bowel preparation** is from September expected to have assessed the patients suitability for the bowel preparation to be used. More information on Trustnet at <http://www.ekhut.nhs.uk/home-page/for-staff/a-z-departments/pharmacy/drugs-and-therapeutics-committee/medicines-safety/bowel-preparation/>
- * **Insulin glargine (Lantus®) and cancer risk.** East Kent diabetiologists endorse the official EASD line which is not to withdraw patients from Glargine but to await the result of further studies. Patients who, despite being aware of the lack of robust evidence linking glargine with cancer, remain uncomfortable and insist on withdrawal, will be allowed to make this informed decision and have an alternative long acting preparation discussed.
- ***Formal safety issues**
- See MHRA at <http://www.mhra.gov.uk/> if you use: antiepileptics, antipsychotics, bisphosphonates, long-acting b-agonists in COPD, exenatide , abacavir , priadel liquid, aliskiren, methylphenidate and atomoxetine.
 - See NPSA at <http://www.npsa.nhs.uk/patientsafety/alerts-and-directives/> if you use midazolam and bowel preparation,

SUPPORT MATERIAL FOR CLINICAL TEACHERS & LEARNERS

See <http://www.ekhut.nhs.uk/home-page/for-staff/a-z-departments/pharmacy/drugs-and-therapeutics-committee/support-material/> . You can also access E-learning modules on anticoagulation and iv fluids in children from there.

GUIDELINES for the VASCULAR TEAM ON

WHAT TO DO WITH PATIENTS ADMITTED FOR CAROTID ENDARTERECTOMY

1. All need a repeat duplex on the morning of surgery at 08:00-08.30 (preferably) or the afternoon before. These are usually requested by Vascular Nurse at pre-assessment but you need to double check and make sure the patient gets down promptly to Ultrasound for the scan. The result then needs relaying to the SpR and Mr Insall/Mr Senaratne. Scans are done by a senior Sonographer or Consultant, usually Jane Stovold or an Interventional Radiology Consultant.

2. All regular medication INCLUDING ASPIRIN AND DIPYRIDAMOLE should be continued and taken on the morning of surgery. The only exception is if an elective patient is on combined ASPIRIN AND CLOPIDOGREL: the Clopidogrel should be stopped 7 days pre-operatively but the Aspirin continued. If an elective patient arrives for surgery and is still taking both Aspirin and Clopidogrel then you must let the SpR and Mr Insall/Mr Senaratne know as the patient may be cancelled due to high risk bleeding or a platelet transfusion ordered if going ahead. For emergency patients on both drugs, a pool of platelets should be ordered in advance.

Ensure on high dose Statin (e.g. Simvastatin \geq 40mg).

3. All need 40mg Enoxaparin subcut. At 6pm on night of admission and whilst in hospital (20mg if Creatinine >170).
4. ALL PATIENTS SHOULD BE GIVEN CLOPIDOGREL 75MG AT 6PM ON THE EVENING BEFORE SURGERY.
5. The patient will spend ≥ 4 hours in HDU or recovery and then may return to the ward if stable. Watch for signs of neck haematoma and hypertension. If systolic BP >170 , inform SpR/anaesthetist due to risk of stroke/re-perfusion injury (look for headaches and fits). Patient will need BP control with Labetolol or GTN bolus/patch/infusion (viz Guideline for Post-op Management).
6. The patient may (rarely if Clopidogrel given as instructed above) come back with a Dextran 40 infusion 500ml for 12 hours post-op (antiembolic) unless they are in renal failure (Dextran contraindicated) or bleeding has been a problem. If there is excessive wound bleeding or a haematoma, this should be controlled with pressure and the SpR/SHO on call informed.
7. Most patients are discharged the next morning. No *routine* post-op bloods and follow up at 6-8 weeks in clinic HRI01 for Mr Insall or QJSEN01 for Mr Senaratne with a Duplex US carotids booked at their local hospital at 4-6 weeks.
8. Antibiotics: Gentamicin (2.5 -3.0 mg/kg IV) and Flucloxacillin (1gram IV) in theatre, then 3 further doses of Flucloxacillin 1 gram IV 6 hourly (Gentamicin and Clarithromycin 500mg in theatre plus one extra dose of Clarithromycin 500mg IV 12 hours later if penicillin allergy).

MANDATORY TRAINING			
Subject	When	Who	How
Fire safety	Annual	All staff	E-learning – go to www.nhslearn.com Core Training Day organized by Directorates, Course organized by Health and Safety Contact Maurice Kirkham on ext. 88768
Manual Handling	Initial session as part of Corporate Induction Programme and then updated Annually	All staff	E-learning or updates by Link trainers (patients or loads – job dependent) Contact Cynthia Horncastle ext. 43603 to arrange link training
Infection Control	Annual	All staff	E-learning at www.nhslearn.com Or contact ext. 88079 for a training course
Resuscitation Training	Annual	Clinical staff	Hospital Life Support/Paediatric Hospital Life Support is the basic level of annual resus training that is required by all clinical staff. Once the e-learning element is completed, please contact your local Resus Officer – K&C = Sue Chapman sue.chapman@ekht.nhs.uk QEQM = Glenn Whitney glenn.whitney@ekht.nhs.uk WHH = Nick Bailey nick.bailey@ekht.nhs.uk Buckland and WHH = Peter Samworth peter.samworth@ekht.nhs.uk Immediate Life Support is the next level up from HLS and is aimed mainly at trained nurses, F1 doctors and those regularly in charge of wards.

			For ILS/ILS Recertification and all national resuscitation courses please contact jane.daulman@ekht.nhs.uk
Administration of Blood Transfusion	Annual	Staff administering blood	Included in Clinical Awareness and further training course updates available through online training http://www.learnbloodtransfusion.org.uk/ For further details please contact ext. 81801
Data Confidentiality	2 Yearly	All staff	E-learning at www.nhslearn.com or contact ext. 73760
Freedom of Information	2 Yearly	All staff	E-learning www.nhslearn.com
Diversity and the workplace	5 Yearly	All staff	E-learning www.nhslearn.com or contact ext 73637
Clinical Governance	2 Yearly	All staff	E-learning at www.nhslearn.com or contact ext 73637

Customer Service Training	Included in Corporate Induction and then updated every 5 years	All staff	Training course	Refer to E ducation and Training Prospectus
Conflict Resolution Training	Once only	All Front Line staff	Attending one day course	Email CRT Training or contact Jean Craig Ext. 62186
Advancing Clinical Skills	Assessed at appraisal	Job specific	Learning pack,	Ward Managers Helen O'Keefe, Ext. 86120

			training course	
Child Protection	Dependent on role	Staff dealing with children	Part of induction, further courses for updates	Penny Jedrzejewski, Chris Bayliss Ext. 43517
Protection of Vulnerable Adults	Role dependent – to be updated annually	Staff who deal with Vulnerable Adults	Consult prospectus	Tricia Bennett, Ext. 62550
Using Clinical Equipment	Department specific	Dept specific	Training course, workshop	Ward Managers
Health and Safety rep	Please see prospectus	One rep per dept	Please see prospectus	Refer to Education and Training Prospectus
Clinical Awareness	First week in Trust	Clinical Staff	Resourcing	Email Resourcing
Induction Day	First week in Trust	All staff	Resourcing	Email Resourcing

Car Parking

Forms can be found on the Trust website. Please ensure you have read and understood the car parking policy and parking rules. Incomplete forms will be sent back to you causing delay

Completed forms are to be sent to Parking Management Services, Ross House, Ross Way, Folkestone, CT20 3UJ, forms can be sent via internal post.

- ☺ Hot Parking – available to staff required to use their car on business travel on 12 or more occasions per month
- ☺ Peak Permit – these are standard permits for staff who meet qualifying criteria as stated in the parking policy
- ☺ Off Peak – These permits are available to all staff and are valid from 18:00-08:00 Mon-Fri and 21-7 weekends and bank holidays
- ☺ Temporary – These are available for staff and students employed on a temporary basis and will be valid for a maximum period of 10 weeks. Payment in advance for the duration of the permit will be required

Holders of staff parking permits will be charged according to the type of permit they receive and the hours that they are contracted to work. These charges will be at the rates prevailing which are published throughout the Trust the annual charge for a permit will be based on the following

- ☺ Staff that work 20 hours per week or more and permit type e.g. Peak or Off Peak
- ☺ Staff that work less than 20 hours per week and permit type e.g. Peak or Off Peak

No permit will be issued until salary deduction form has been submitted for staff paid by Finance Consortium giving permission for monthly deductions to be taken or by cheque for those paid by outside organisations. It is the responsibility of the applicant to notify parking management when a permit is to be cancelled or not reapplied for in order for deductions from salary may be cancelled. This information will be given to applicants with their car parking permit

If a permit is issued during the permit year, the applicant will be charged on a full monthly basis for the remainder of the year. The charges will be applicable to all permanent staff permits.

Permits are valid only in the vehicles listed on the permit application and shown on the parking permit. Alterations to the registration numbers must only be carried out by parking management staff for which there will be no charge. All holders of staff permits must only park in the areas designated for the permit they hold. Staff permits are not valid in Pay & Display car parks. It is the responsibility of all staff wishing to park on Trust premises to ensure they understand the parking rules. If a penalty notice is issued to a vehicle which is parked in contravention of these rules ignorance of the rules will not be accepted as mitigation and the penalty charge will stand.

No Smoking

- **No one including staff, patients and visitors are permitted to smoke in the hospitals, grounds, vehicles and other buildings owned by East Kent Hospitals University NHS Foundation Trust.**
- **Neither staff, patients nor visitors are able to smoke in their own vehicles in the Hospitals grounds**
- **Staff are not permitted to smoke when they are on Trust duty**
- **Infringement of this policy will be considered a disciplinary offence.**
- **The East Kent Stop Smoking Services will provide advice and support for staff. Those who wish to stop smoking will be helped to access individual or group support and nicotine replacement therapies as appropriate. They can be contacted on 0800 849 4444.**
- **Staff can smoke off site during their break. Please consider our neighbours.**
- **Staff also has a responsibility to remind any staff member, patient or member of the public they see smoking in hospital grounds of the policy.**
- **This policy can be found on the Trust Website**

GUIDELINES FOR POSTOPERATIVE PATIENT MANAGEMENT OF CAROTID ENDARTERECTOMY

The following guidelines apply during time in recovery, HDU, and on the ward.

All patients regardless of anaesthetic type will go to theatre recovery for about 30 minutes until the patient is fully awake and their airway secure with no bleeding.

Recovery/HDU

Continuous ABP, pulse oximetry, & ECG.

The systolic BP should not be lower than 95mmHg; if the patient is drowsy or there is poor urine output, the SBP may need to be higher.

The systolic BP should not be greater than 180mmHg.

Management of hypertension

Ensure adequate analgesia.

Nifedipine 10mg sublingual.

Labetalol 5-10mg iv if the pulse rate is greater than 55bpm.

GTN 5mg patch will often lower BP slowly; an infusion titrated to BP can be used in HDU.

Hydralazine 5-10mg diluted in 10ml normal saline given slowly.

Observe BP carefully to ensure patient does not become hypotensive.

Management of hypotension

A BP of less than 95mmHg should be treated; exclude bleeding.

Bolus 250-500ml Volplex.

Glycopyrrolate 200mcg if HR less than 50bpm.

Bolus of metaraminol 0.5-1.0mg prn; if needing multiple boluses will need vasopressor infusion of, eg. Phenylephrine 10mg in 50ml, titrated to BP which may be given peripherally.

Management of heart rate

Give 200mcg glycopyrrolate if less than 45bpm.

Level of consciousness

Record GCS, motor, & sensory function ¼hrly for 2 hours then, if stable, 2 – 4hrly.

Inform medical staff of any deterioration in neuro signs and then monitor ¼hrly.

Wound management

Check for bleeding or haematoma ¼hrly for 2 hours then, if stable, 2 – 4hrly; leave dressing intact if no bleeding or haematoma.

Fluid management

Record urine output and all input on fluid chart.

If the patient develops signs of cerebral ischaemia, haemostasis is adequate, and renal function normal, then give **DEXTRAN 40** 500ml over 12 hours via pump.

Patients may drink in recovery when stable or fluids may be given iv (Hartmann's).

Guidance for Inpatient Discharge

Abbreviations: EDD – expected date of discharge
EDN – electronic discharge notification (discharge letter)

- Trust policy is for an EDD to be set and recorded in the clinical notes at admission for all patients
- The EDD should then be adjusted in line with a patient's progress as needed
- Planning for discharge should begin at preassessment for elective patients and at admission for emergency patients, many relevant issues, such as the need for transport, community nursing, or social care input can hold up discharge if not considered and resolved in advance
- When agreeing an EDD, ensure that all relevant issues are considered by discussion with senior medical, nursing, physiotherapy, occupational therapy, and social care staff together with the patient and their family
- Prepare the EDN in advance and update as required:
 - in the past, discharge times have often been delayed awaiting discharge paperwork and then additionally by the need for prescription medicines to be supplied from pharmacy
 - aim to complete the EDN at the latest on the day before expected discharge
- Ensure that the EDN contains all relevant information by completing all domains, and that all information is accurate by reference to the clinical records and to senior medical and nursing staff
- Ensure that any changes in ongoing care are both noted and explained
- On the daily business round, ascertain the requirements for follow up investigations and clinic appointments:
 - see list in “Guidance for Trainees” for clinic codes
 - ensure that investigations are booked
 - ensure that the patient is aware of pending investigations and clinics
- Ensure that the nursing team and ward clerk are aware of these discharge plans, the ward clerk will then make the correct arrangement for clinics, overbooking if required will only be arranged on medical instruction
- If in any doubt about discharges, seek Consultant advice.

EAST KENT HOSPITALS NHS TRUST
GUIDELINES FOR PRE-OPERATIVE/PROCEDURE SITE
MARKING
PREVENTING WRONG SITE PROCEDURES

1. Preparation and pre-operative marking of a patient for theatre is the responsibility of the medical staff, and the ultimate responsibility of the Consultant. **This should be undertaken by the surgeon/operator performing the operation.** However, this duty may be delegated to a suitably experienced doctor below Consultant grade, with the agreement of the Consultant.
2. The operative site must be marked for all applicable procedures that require consent. This includes procedures carried out by all clinicians, including physicians and radiologists. The term “surgeon” is used, in this policy, to denote ALL clinician groups.
6. When pre-operative marking is to be carried out, a full check of the patient details against the patient’s clinical records must be carried out by the responsible surgeon. The check will include:

The patient’s name
Date of birth
Address
Hospital number

4. The details of the procedure must be identified from the clinical records and based on the Consultant’s last entry relating to the procedure to be undertaken. Procedure details must NOT be taken from the typed operating list.
5. The clinical record must be examined for a current patient consent form, or clear evidence that the patient has given express verbal consent to the procedure being performed.
6. A signed consent form must carry the details of the procedure to be undertaken, and any information given to the patient at the time the procedure was explained and consent obtained.
7. The details of the procedure must have been clearly written in the medical notes, be unambiguous and not abbreviated in any way:

Right
Left
Bilateral
Toes and / or fingers should be named e.g. Index.

Treatment Algorithm for Vasospastic Disorders

1. treat any underlying condition (check FBC, ESR, glucose, lipids, clotting screen, thrombophilia screen, autoimmune screen, Rheumatoid factor, ANCA, anti-DNA, cold agglutinin)
2. stop smoking
3. lifestyle measures (clothing, vibration, stress, causative drugs)
4. start aspirin 75mg daily
- 5a. calcium channel blockers: Nifedipine modified release 5-20mg bd, felodipine 2.5-10mg bd, diltiazem 30-120mg tds
- 6a. angiotensin II receptor antagonists: losartan 50mg od (beware pregnancy)
- 6b. phosphodiesterase inhibitors: pentoxifylline 400mg tds, sildenafil 50mg tds, tadalafil 10-20mg od
- 6c. endothelin receptor antagonists: ambrisentan 2.5-10mg od
- 6d. NO donors: GTN cream or patch, l-arginine 2-6gram daily
- 6e. adrenergic receptor blockers: prazosin 1-2mg tds, thymoxamine 40-80mg qds
- 6f. other oral drugs: naftidrofuryl 100-200mg tds, inositol nicotinate 100mg tds, antioxidants (ascorbic acid, probucol), fluoxetine, calcitonin gene related peptide, Ginkgo biloba
7. complementary therapies: laser, acupuncture
8. LMWH, local anaesthetic block (bupivacaine)
9. intravenous drugs: epoprostanol and iloprost (prostacyclins)
10. surgery: debridement/amputation, adventitial stripping, sympathectomy

Ref.: New lines in therapy of Raynaud's phenomenon. Lambova SN & Müller-Ladner U. Rheumatol Int (2009); 29:355-363

GUIDELINES FOR BLOOD TRANSFUSION REQUIREMENTS

These recommendations assume a normal preoperative [Hb] (>10d/dl)

OPERATION	RECOMMENDATION
Gastrointestinal	
Abdoperineal Resection	4 units
Anterior Resection	G&S
Sigmoid Resection	G&S
Hemicolectomy - Right or Left	G&S
‘Ostomies	G&S
Oesophagectomy	4 units
Gastrectomy	2 units
Pancreatectomy	4 units
Vascular	
Aortic Aneurysm - elective	4 units
Aortic Aneurysm - emergency	10 units + 6 units FFP
Aortic Bypass	2 units
Axillofemoral Bypass	G&S
Femorofemoral Bypass	G&S
Femoropopliteal Bypass	G&S
Femoral embolectomy/endarterectomy	G&S
Leg Amputation	G&S
General Surgery	
Cholecystectomy	G&S
Mastectomy	G&S
Hernia Operations	Nil
Varicose Veins	Nil
Thyroidectomies	G&S
Urology	
TURP	G&S
Retropubic Prostatectomy	2 units
Bladder Neck Incision	Nil
TURBT	Check with Urologist
Nephrectomy	2 units

ANTIBIOTICS

East Kent Hospitals NHS Trust – Empirical Antimicrobial Therapy Guidelines

Consultant Microbiologists and other contacts

Dr J Q Nash, WHH	Ext. 723-6788	Dr E Ndawula, 722-2869
Dr G Calver, WHH	Ext. 723-6779	Dr E Ndawula 725-4435
Dr F Mühlischlegel, WHH	Ext. 88635	Medicines Inf0 723-6001
Pharmacy KCH	Ext. 722-4263	Pharmacy QEQM 725-3196
Pharmacy WHH	Ext. 723-8005	

For more detailed antibiotic advice contact:

9. TrustNet – Pharmacy subweb, click on D&T Committee, then Antimicrobial Guidelines Homepage.
10. Consultant Microbiologist
11. Pharmacy
12. BNF provides further information on drugs and contraindications

GENERAL PRINCIPLES:

- Always take appropriate specimens before commencing antibiotic therapy (except in meningitis when treatment is first priority).
- Do not use antibiotics unnecessarily. They have unseen side effects and can predispose to colonisation with resistant organisms.
- Use oral antibiotic therapy whenever possible. This will be cheaper and reduces the risk of cannula site infections. ***When IV antibiotic therapy is used – review daily and change to oral therapy at the earliest opportunity*** (generally 48 hours after fever has responded).
- Advice on the management of complex infections is available from the local Consultant Microbiologist.

GENTAMICIN PRESCRIBING:

ONCE DAILY DOSING:

A large body of evidence now supports the use of once daily Gentamicin therapy in place of the older BD and TDS regimens.

Advantages include:

- High peak levels (correlate with successful therapy in experimental models of infection)
- Lower toxicity
- Equivalent or greater efficacy
- Convenience
- Reduced cost

The theoretical basis for using once daily dosing is that Gentamicin and other aminoglycosides exert a ‘post antibiotic effect’ (PAE) which continues to inhibit the growth of bacteria for some hours after exposure.

Contraindications:

- Renal failure
- Infective endocarditis (low dose BD regimens preferred)
- Previous history of aminoglycoside toxicity

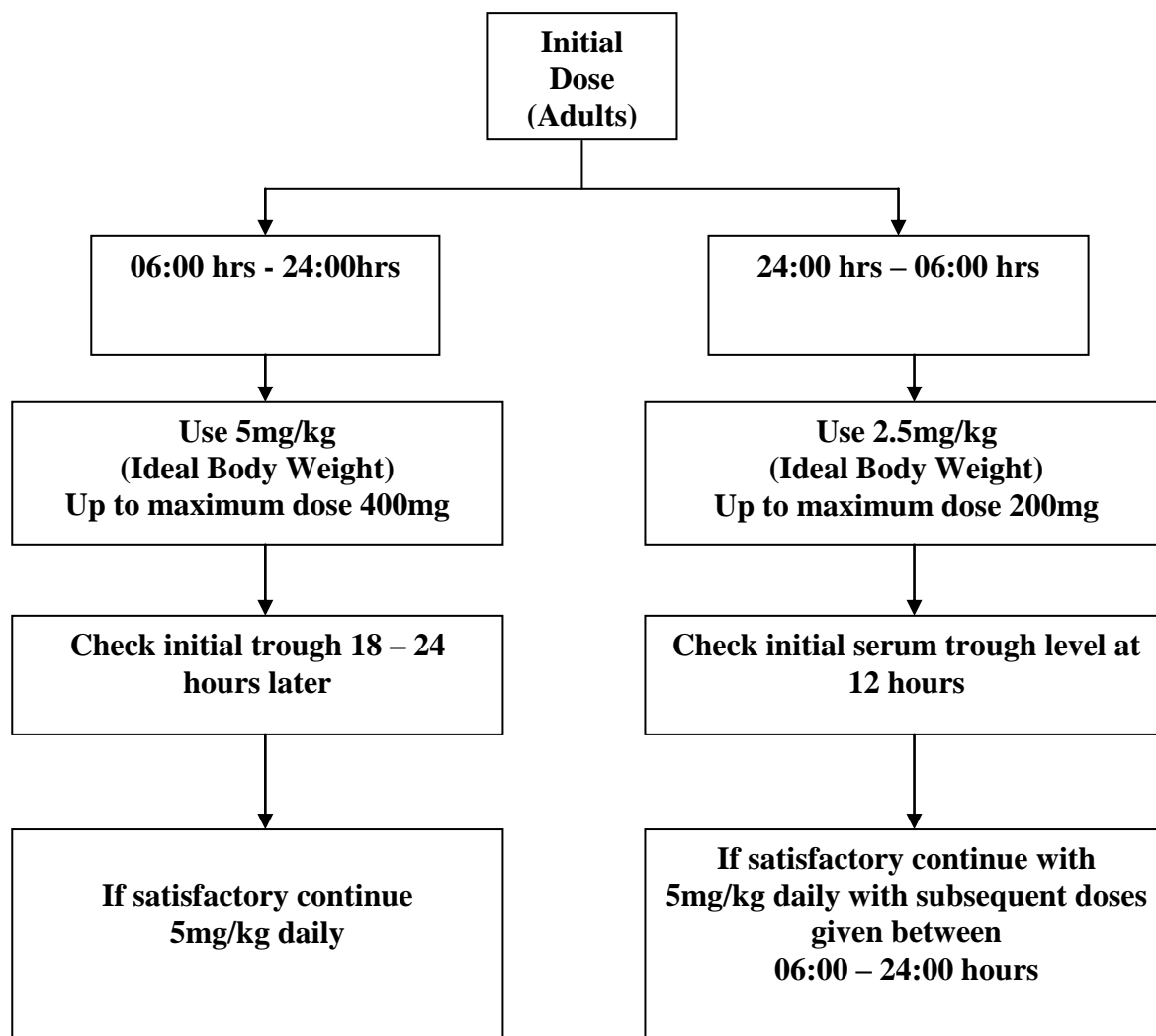
Caution:

- Other nephrotoxic drugs prescribed (eg Vancomycin, Cyclosporin)

- Age > 70 years

We recommend that the dosing schedule is adjusted as described below to ensure that serum assays can be carried out when the laboratory is open. The basic principle is that when the 1st dose is given between 24.00hrs and 06.00hrs, then a 12hr (half normal) dose is given. The dose is then increased to the full once daily dose after 12hr thus allowing trough levels to be collected when the laboratory is open. ***There are other dosing schedule options. Please discuss with pharmacy or microbiology for specific patient advice.***

Do not use actual body weight for obese patients (20% > IBW) when calculating the gentamicin dose. Use a modified, dose-determining weight which can be calculated by the microbiologist / pharmacist where necessary.



(Specimens must be in the Laboratory before 16:00)

Gentamicin levels:

Advice is available from microbiologist / pharmacist regarding how often gentamicin levels are required, when to sample and interpretation of results for individual patients. Additional monitoring (eg. Renal function) is also required; refer to microbiologist / pharmacist for advice on additional monitoring if necessary

Interpretation of Gentamicin blood levels (once daily adult regimen)

Trough level	< 1 mg/l	Satisfactory
Trough level	> 1 mg/l	Unsatisfactory. Refer to microbiologist / pharmacist for advice

Gentamicin BD (if recommended by Microbiologist):Both Pre-dose (trough) level **and** Peak (1 hr post dose) levels are required (obligatory)

Trough level	<1 mg/l	For infective endocarditis
Peak (1 hr post dose)	3 – 5 mg/l	For infective endocarditis
Trough level	< 2 mg/l	For Gram negative sepsis
Peak (1 hr post dose)	5 – 8 mg/l	For Gram negative sepsis

Gentamicin dosing for paediatrics: Refer to 'Medicines for Children' handbook, Pharmacy, Paediatrician or Microbiology.

Antibiotic guideline – summary

CNS INFECTION			
Meningitis	- Adults	Ceftriaxone	2g 12 hourly IV
	- Children	Ceftriaxone	80mg/kg (max 2g) 12 hourly IV
	- Neonates	Cefotaxime + Amoxycillin	50mg/kg 30mg/kg 12 hourly IV 8 hourly IV
Brain Abscess		Ceftriaxone + Benzylpenicillin+ Metronidazole	2g 1.2g 500mg Once daily IV 4 hourly IV 8 hourly IV
Encephalitis		Aciclovir	10mg/kg 8 hourly IV
Comment: Always contact Microbiologist			
UTI			
Cystitis	Co-amoxiclav or Trimethoprim	375mg 200mg	8 hourly PO 12 hourly PO
Pyelonephritis	Co-amoxiclav or Ciprofloxacin	1.2g 500mg	8 hourly IV 12 hourly PO
Comment: For pregnant women Cephalexin orally or Ceftriaxone IV if unable to take oral therapy.			

RESPIRATORY TRACT			
Severe community acquired pneumonia (CAP)	1st Line Co-amoxiclav + Clarithromycin Pen allergy see below	1.2g 500mg	8hrly IV 12 hourly PO
Severity indicators:		CURB-65 assessment	
Confusion		Treat as 'severe pneumonia' when three or more severity indicators are present.	
Urea>7mmol/L	<input type="checkbox"/>		
Respiratory rate > 30/minute	<input type="checkbox"/>		
BP low systolic<90 or diastolic<60	<input type="checkbox"/>		
65 or more yrs of age	<input type="checkbox"/>	If no new Xray shadows present consider possibility of infective exacerbation of COPD [see below]	

Comments

1. Penicillin allergic (rash only) replace Co-amoxiclav with Cefuroxime 1.5g 8hrly, and then Cefixime if going to oral.

2. Severe Penicillin allergy (anaphylaxis) use IV Levofloxacin 500mg bd (consultant microbiology approval needed). Change to oral Moxifloxacin as soon as possible (usual dose 400mg daily)

Uncomplicated community acquired pneumonia Most cases are pneumococcal – use oral therapy whenever possible	<u>1st line choice</u> Amoxycillin <u>Penicillin allergy</u> Moxifloxacin	1g 400mg	13. hourly IV/PO once daily PO
Comments: 1. If <i>Legionella pneumophila</i> suspected send urine for antigen detection 2. If <i>Staphylococcal pneumonia</i> likely, add Flucloxacillin 2g 6 hourly IV			
Severe hospital acquired pneumonia (on ventilator, immunosuppressed, etc) 1 st Line	Tazocin + Gentamicin	4.5g 5 mg/kg	8 hourly IV Once daily IV
Comment: 1. Penicillin allergic or MRSA suspected Teicoplanin +Gentamicin 2. Long-stay COE patients should be managed as for community acquired pneumonia but with a high index of suspicion for MRSA			
Infective exacerbation of COPD	Co-amoxiclav or Cefixime or Doxycycline	625mg 200mg 100mg	8 hourly PO BD PO BD PO

SKIN AND SOFT TISSUE INFECTIONS			
Cellulitis (&Erysipelas)	Benzympenicillin +	1.2g	6 hourly IV
Comments: 1. Most cases are Streptococcal but Flucloxacillin 500mg 6 hourly should be added if Staphylococcal infection is suspected. 2. Clarithromycin 500mg BD should be used when there is allergy to Penicillin			
Necrotising fasciitis	Benzympenicillin + Clindamycin	2.4g 1.2g	4 hourly IV 6 hourly IV
IV Site Infection/ Superficial wound infection	Flucloxacillin	500mg	6 hourly PO
Infected ulcer/pressure area	Flucloxacillin	500mg	6 hourly PO
Comment: 1. Consider addition of Metronidazole if there is an anaerobic infection 2. Replace Flucloxacillin with Clarithromycin if allergic to Penicillin			
Septic arthritis or osteomyelitis (oral therapy when fever down) If Penicillin allergic:	Flucloxacillin + Fucidin	1g 500mg	6 hourly IV 8 hourly PO
	Clindamycin	600mg	6 hourly IV

GI TRACT INFECTION			
Spontaneous peritonitis	Tazocin	4.5g	8 hourly IV
Comment: 1. Consider addition of Gentamicin 5mg/kg (once daily) if in septic shock 2. For CAPD peritonitis – follow Renal Unit Policy 3. If Penicillin allergic, then Ciprofloxacin 400mg IV BD & Metronidazole IV 500mg TDS			
Perforated viscus/faecal peritonitis	Tazocin + Gentamicin + Metronidazole	4.5g 5mg/kg 500mg	8 hourly IV Once daily IV 8 hourly IV
C. difficile diarrhoea/colitis	Metronidazole Vancomycin	400mg 125mg	8 hourly PO QDS PO (to use if 2 relapses on Metronidazole.)

MISCELLANEOUS CONDITIONS			
Gram negative septicaemia Normal immune system	Tazocin	4.5g	8hrly IV
Neutropenic sepsis	Tazocin + Amikacin	4.5g 15 mg/kg	8 hourly IV Once daily IV [check levels]
Cholangitis	Tazocin	4.5g	8 hourly IV
Endocarditis	Benzympenicillin + Gentamicin	1.2g 80mg	4 hourly IV 12 hourly IV

FOR MORE DETAILED ADVICE TELEPHONE THE CONSULTANT MICROBIOLOGIST

To view policy on TrustNet, go to Pharmacy subweb, click on D&T Committee, and then click on Antimicrobial Guidelines Homepage.

September 2005
Review August 2006

ANTIMICROBIAL GUIDELINE UPDATES OCTOBER 2005

PYOGENIC LIVER ABSCESS SECTION 1.13	Meropenem IV 1g TDS This replaces Ceftriaxone which now has restricted use within the trust.
ACUTE NECROTISING PANCREATITIS SECTION 1.14	Meropenem IV 1g TDS This is a new addition to the policy.
UNCOMPLICATED COMMUNITY ACQUIRED PNEUMONIA SECTION 3.2	Amoxicillin PO 1g TDS Clarithromycin has been removed from this treatment regime. Evidence for which can be found in the full version of the policy
LEGIONELLA SECTION 3.3	Levofloxacin IV 500mg BD This replaces Clarithromycin & Rifampicin
NECROTISING FASCITIS SECTION 11.5.2	Clindamycin IV 0.6 – 1.2g QDS + Meropenem IV 1g TDS
M.R.S.A. CATEGORY F SECTION 3	Due to new draft national guidelines, this whole section has been reviewed. Please see full policy for prescribing information.

The full policy should be available on all wards and departments. It is also accessible on TrustNet via the Pharmacy, D&T or Microbiology sub-webs.

Helen Gisby
Specialist Clinical Pharmacy Technician, East Kent Hospitals NHS Trust, October 2005

GUIDELINES ON ANTIMICROBIAL PROPHYLAXIS

1. Aims of the guidelines

- To prevent or reduce the risk of infections through the use of antimicrobial drugs.
- To remind doctors and other healthcare staff of the common indications for chemoprophylaxis.
- To outline the rationale of choosing particular drugs and doses, but taking into account the different prescribing habits of clinicians in East Kent Hospitals NHS Trust. To establish components of rational therapy (eg choice of drug, number of doses, timing of first dose, etc) as standards for future audits and assessment of quality of care.

B. Scope of the guidelines

The guidelines do not include:

- a. indications for specialised areas, eg prevention of infections in neutropenic patients. These will be found in the relevant guidelines for the specialties (see page 43).
- b. rare indications in this country, eg prevention of recurrence of rheumatic fever, diphtheria etc. Details of these can be found in the BNF.
- c. the use of local antimicrobial drugs in arthroplasty (eg in cement) and antibiotic-bound arterial prostheses. It is up to the individual surgeon to assess the efficacy of these agents.

14. indications whose efficacy has not been fully established.

For expert advice regarding prophylaxis not given in the guidelines, please contact the Consultant Microbiologists.

For further advice concerning dosages, contact the Pharmacists. Information on side effects and contraindications can be found in the BNF and enitor et of data sheets.

C. Principles of chemoprophylaxis

- a. The infection to be prevented must be known.
- b. Prophylaxis should target known organism(s).
Prophylaxis does not need to cover all actual or potential pathogens as long as the more virulent bacterial spectrum is covered. [31]
- c. The antimicrobial drug used should have high antimicrobial activity against the targeted organism(s). The drug should be associated with a minimum level of toxicity.

15. Adequate tissue/blood levels of the drug at the site of contamination or colonisation should be achieved.

- e. Timing is crucial in order to achieve the high concentrations at the time of maximum contamination.[32][33]
- f. The duration of therapy should only cover the ‘high risk’ period which is usually less than 24 hours.
- g. There should be a clear distinction between treatment of an established infection (for which prolonged therapy is required) and chemoprophylaxis.
- h. The regimen used should be cost-effective [34].

D. Departmental guidelines for easy accessibility

Individuals or departments can extract parts of the guidelines relevant to them, print the extracts on A4, laminate them and hang them in a convenient place for easy access, eg anaesthetic rooms for the anaesthetists. When the revised guidelines are issued, old extracts should be replaced with new ones.

16. Prevention of infection following surgical procedures

The basic principles of perioperative surgical prophylaxis are well established.[35]

Procedure	Main Organism(s)/ Infection(s)	Drug	Adult Dose*/Route	Frequency	Duration/ no. of doses	Timing of 1 st Dose
1. <u>Biliary tree surgery</u> [36]						
17. ERCP	Coliforms Pseudomonas /Septicaemia	Ciprofloxacin	200mg IV or 750mg (po)		1	At induction 1 hour before
18. Others, including Cholecystectomy	Coliforms Streptococci Anaerobes/wound infection Septicaemia Risk Factors: Elderly (>70yrs) Stones Previous surgery, instrumentation of biliary tree, obstructive jaundice	Cefuroxime [37] + Metronidazole or Co-amoxiclav or Gentamicin + Metronidazole	1.5g IV then 750mg IV 500mg IV 1.2g IV then 600mg IV 1.5mg/kg (then not to exceed 80mg) (as above)	8 hourly 8 hourly 8 hourly 8 hourly	1-3 1-3 1-3 1-3	At induction At induction At induction At induction
19. <u>Eye</u> Cataract operation	Staphylococci Streptococci /Endophthalmitis Risk Factors: Blepharitis (exclude) Breach of posterior capsule [38]	Use of topical 5% aqueous povidone iodine solution [39] + Cefuroxime [40]	125mg Subconj		1	Immediate pre-op period Immediate pre-op period Immediate pre-op or post op period

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Information on the dose for children for the few procedures in this section can be obtained from the Compendium of Fata Sheets or BNF

Procedure	Main Organism(s)/ Infection(s)	Drug	Adult Dose*/Route	Frequenc y	Duration/ no. of doses	Timing of 1 st Dose
3. <u>Gastrointestinal Tract</u>						
20. Appendicectomy and Colorectal surgery	E.coli, B.fragilis/Peritonitis, Wound infection Septicaemia	Cefuroxime + Metronidazole [41]	1.5g IV 500mg IV or 400mg (po)		1 1 1	At induction At induction 24 hrs before surgery for oral therapy
b. Oesophago- gastrectomy [42]	Streptococci Staph aureus Anaerobes /Wound infection Chest Infection (until extubated)	Cefuroxime + Metronidazole	1.5g IV then 750mg IV 500mg IV	8 hourly 8 hourly	1-3 1-3	At induction At induction

4. Head & Neck Surgery a. Laryngectomy and other neck cancer operations b. Mandibular fractures	Staphylococci Streptococci Oral anaerobes [43] /Wound infections Osteomyelitis	Cefuroxime	1.5g IV then 750mg IV	8 hourly	3	At induction
		+ Metronidazole [44]	1g PR or 500mg IV	8 hourly	3	At induction

Information on the doses for children for the few procedures in this section can be obtained from the Compendium of Data Sheets or BNF

Procedure	Main Organism(s)/ Infection(s)	Drug	Adult Dose*/Route	Frequency	Duration/ no. of doses	Timing of 1 st Dose
5. Obstetrics & Gynaecology 21. Caesarean section [45] [46] (elective and non-elective) b. Vaginal hysterectomy [47] c. Other gynaecological procedures including abdominal hysterectomy (discretion of the Clinician)	Streptococci, Staph. Aureus, Anaerobes /Wound infection, Endometritis, Septicaemia <u>Risk Factors:</u> Early ruptured membranes, no. of pre- op vaginal exams, presence of meconium Streptococci, Staph aureus, Anaerobes/ Wound infection, Septicaemia	Cefuroxime	1.5g IV		1	At induction
		or Clarithromycin if allergic to Pen/Cephalosporins	500 mg IV		1	At induction
		Cefuroxime [48]	22. g IV		1	At induction
		Or Clarithromycin (if allergic to Cefuroxime)	500mg		1	At induction
23. Orthopaedics Arthroplasty – THR, TKR Internal fixation of fractures with pins, screws etc. Traumatic open fractures	Staphylococci [49] /infection around implants (prophylaxis does not prevent late haematogenous infection of the prosthetic joints) Osteomyelitis	Cefuroxime [50]	1.5g IV then 750mg IV	8 hourly	1-3	At induction for TKR, allow at least 10 min between injections and inflation of the anesthetist or with Premed
		or if allergic to pen/cephalosporins Clarithromycin then Erythromycin	500mg IV 500mg (po)	 6 hourly	 2	 With Premed

	If the patient is colonised with MRSA or if there is an MRSA outbreak (as assessed by the Infection Control Team) or high risk** patients for MRSA	Teicoplanin	400 mg IV		1	1 hour prior op or with premed
7. Urological Operation						
a. Cystoscopy, Prostatectomy [51] (infected urine)	Coliforms UTI, Septicaemia	Gentamicin	1.5mg/kg IV		1	At induction
					1	
b. Transrectal prostate biopsy [52]	Coliforms Enterococci Anaerobes /UTI, Septicaemia	Ciprofloxacin	500 mg (po) then 500 mg (po)	12 hours after 1 st dose	1	12 hours preop
8. Vascular Surgery (Grafts) [53] [54]						
	Straphylococci Streptococci, Coliforms /Infection of the graft, Wound infection, Septicaemia	Cefuroxime or if allergic to Pen/Cephalosporins	1.5g IV		1	At induction
		Teicoplanin + Gentamicin	400mg 1.5mg/kg IV		1 1	At induction At induction
	Screen leg ulcers etc for MRSA, if positive modify prophylaxis to include Vancomycin	Teicoplanin + Gentamicin	400 mg IV 1.5mg/kgIV		1 1	1 hr prior At induction

24. Information on the doses for children for the few procedures in this section can be obtained from the Compendium of Data Sheets or BNF

** Transfers from other hospitals, frequent re-admissions, transferred from nursing/residential homes and history of MRSA

Procedure	Main Organism(s)/ Infection(s)	Drug	Adult Dose*/Route	Frequency	Duration/ no. of doses	Timing of 1 st Dose
Other Operations						
25. Amputations (limbs, toes)	Clostridium sp (above knee), Staphylococci	Cefuroxime + Metronidazole	1.5g IV then 750mg IV or IM 500mg IV	8 hourly 8 hourly	1-3 1-3	At induction At induction
		If allergic to Pen/Cephalosporins				
		Clarithromycin + Metronidazole	500mg IV 500mg IV	12 hourly 8 hourly	1-2 1-3	At induction At induction
26. Temporary Pacemaker wire insertion	Staph aureus, including MRSA	Flucloxacillin or Teicoplanin (if MRSA likely)	1g IV 1g IV		1 1	Just before the procedure 2 hrs before procedure

* Information on the doses for children for the few procedures in this section can be obtained from the Compendium of Data Sheets or BNF

27. **Prevention of endocarditis following certain surgical procedures in patients with heart valve lesions, septal defect, patent ductus or prosthetic valve**
[55]

The main organisms are Streptococci and Enterococci. The risk of endocarditis is associated with the procedures listed below. The risk of colonisation with Amoxycillin resistant organisms is increased when there is a recent history of (h/o) penicillin therapy (more than a single dose in the previous month). Gentamicin is added for some procedures to widen the antimicrobial spectrum.

Category	Procedure and type of anaesthesia	Special risk	Drug	Dose for adults/route	Dose for children/route	No. of doses	Timing of 1 st dose
1	Dental or upper respiratory tract procedures, under local or no anaesthesia	none	Amoxicillin	3g (po)	<5yrs 750mg (po) 5-10yrs 1.5G (po)	1 1	1 hour before procedure
2	Dental or upper respiratory tract procedures, under local or no anaesthesia	Allergic to penicillin or history of penicillin therapy	Clindamycin	600 mg (po)	<5yrs 50mg (po) 5-10yrs 300mg (po)	1 1	1 hour before procedure
3	Dental or upper respiratory tract procedures, under general anaesthesia	none	Amoxicillin or Amoxicillin or Amoxicillin	1g IV then 500mg po 6 hours later 3g (po) then 3g asap after the procedure 3g (po)	<5 yrs 250mg IV then 125mg po 6 hours later. 5-10 yrs 500mg IV then 250mg po 6 hours later. <5 yrs 750mg (po) 5-10 yrs 1.5g (po) then as above asap after the procedure	2 2 1 1 1 1	At induction 4 hours before 4 hrs before procedure
4	Dental or upper respiratory tract procedures, under general anaesthesia. Or Dental or upper respiratory tract procedures, under local or no anaesthesia or All Genito-urinary procedures	Had endocarditis before or have prosthetic valve Had endocarditis before none	Amoxicillin + Gentamicin	1g IV then 500mg po 6 hrs later 120mg IV	<5 yrs 250mg IV then 125mg po 6 hours later. 5-10 yrs 500mg IV then 250mg po 6 hours later. 2mg/Kg	2 2 1	Just before the procedure Just before the procedure
5	Dental or upper respiratory tract procedures, under general anaesthesia or Any patients in category 4 above, who are allergic to penicillin or history of penicillin therapy	Allergic to penicillin or history of penicillin therapy	Vancomycin + Gentamicin or Clindamycin (do not use if undergoing enitor-urinary procedure)	1g IV over at least 100mins 120mg IV 300mg IV over at least 10 mins then 150mg IV 6 hrs later	<10yrs 20mg/Kg 2mg/Kg <5 yrs 75mg IV over 10mins then 30mg IV/po 6hrs later 5-10yrs 150mg IV over 10 mins then 75mg IV/po 6hrs later	1 1 2 2	2 hours before induction At induction At induction
6	Obstetric, gynaecological or gastro-intestinal procedures (prophylaxis only required for patients who have had endocarditis before or who have prosthetic heart valve)		As for Genito-urinary procedures. See category 4 above, or category 5 above for patients who are allergic to penicillin or history of penicillin therapy.				

28. **Prevention of secondary cases of meningococcal meningitis/septicaemia** [56] [57]

The main rationale for prophylaxis is to eradicate the meningococcus from the carriers before it causes more infections.

High concentrations of the drugs used are achieved in saliva and nasal secretions [58] [59] [60].

	Categories of contacts	Drug	Dose for adults	Dose for children (under 16 yrs)	Duration/ No. of doses	Timing of 1 st dose
1	Household contacts including lodgers, resident guests and others who lived and slept under the same roof as index case.	Ciprofloxacin [61] Rifampicin	500mg (po)	Ciprofloxacin is contra indicated in children <12 ≤1 yr 5mg /Kg (po) 12 hourly 1-12 yrs 10mg/Kg (po) 12 hourly 12-16 yrs 600mg (po) 12 hourly	1 2 days	As soon as the clinical diagnosis or laboratory diagnosis is made. Some contacts are given the drugs when they come to visit the index case in hospital.
2	People living in the close proximity, for example dormitories in boarding schools, military establishments, etc.					
3	Girl/boyfriend of index case where a kissing relationship existed.					
4	Children in a pre-school group, primary or secondary. Schools where the contact has been prolonged for more than 4-6 hrs in a closed confined space					
5	Healthcare staff whose mouth or nose is directly exposed to infections, respiratory droplets/secretions, with a distance of 3 ft from the patient.					
6	Index case ((before discharge to eradicate the organism from the nasopharynx to prevent reintroducing the organism to close contacts)					
7	Pregnant contact.	Ceftriaxone* (for pregnant contact) <i>*Not licenced for this indication, therefore counselling should be given.</i>	250mg IM		1	

29. Prevention of other infections

[illegible]

For details of this and other vaccines, refer to the Trust Guidelines for Prevention of Infection in Hyposplenic and Asplenic Patien

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- a. The infection to be prevented must be known.
- b. Prophylaxis should target known organism(s).
Prophylaxis does not need to cover all actual or potential pathogens as long as the more virulent bacterial spectrum is covered. [31]
- c. The antimicrobial drug used should have high antimicrobial activity against the targeted organism(s). The drug should be associated with a minimum level of toxicity.

31. Adequate tissue/blood levels of the drug at the site of contamination or colonisation should be achieved.

- e. Timing is crucial in order to achieve the high concentrations at the time of maximum contamination.[32][33]
- f. The duration of therapy should only cover the ‘high risk’ period which is usually less than 24 hours.
- g. There should be a clear distinction between treatment of an established infection (for which prolonged therapy is required) and chemoprophylaxis.
- h. The regimen used should be cost-effective [34].

32. **Departmental guidelines for easy accessibility**

Individuals or departments can extract parts of the guidelines relevant to them, print the extracts on A4, laminate them and hang them in a convenient place for easy access, eg anaesthetic rooms for the anaesthetists. When the revised guidelines are issued, old extracts should be replaced with new ones.

33. Prevention of infection following surgical procedures

The basic principles of perioperative surgical prophylaxis are well established.[35]

Procedure	Main Organism(s)/ Infection(s)	Drug	Adult Dose*/Route	Frequenc y	Duration/ no. of doses	Timing of 1 st Dose
1. <u>Biliary tree surgery</u> [36]						
34. ERCP	Coliforms Pseudomonas /Septicaemia	Ciprofloxacin	200mg IV or 750mg (po)		1	At induction 1 hour before
35. Others, including Cholecystectomy	Coliforms Streptococci Anaerobes/wound infection Septicaemia <u>Risk Factors:</u> Elderly (>70yrs) Stones Previous surgery, instrumentation of biliary tree, obstructive jaundice	Cefuroxime [37] + Metronidazole or Co-amoxiclav or Gentamicin + Metronidazole	1.5g IV then 750mg IV 500mg IV 1.2g IV then 600mg IV 1.5mg/kg (then not to exceed 80mg) (as above)	8 hourly 8 hourly 8 hourly 8 hourly	1-3 1-3 1-3 1-3	At induction At induction At induction At induction
36. <u>Eye</u> Cataract operation	Staphylococci Streptococci /Endophthalmitis <u>Risk Factors:</u> Blepharitis (exclude) Breach of posterior capsule [38]	Use of topical 5% aqueous povidone iodine solution [39] + Cefuroxime [40]	125mg Subconj		1	Immediate pre-op period Immediate pre-op period Immediate pre-op or post op period

Information on the dose for children for the few procedures in this section can be obtained from the Compendium of Data Sheets or BNF

Procedure	Main Organism(s)/ Infection(s)	Drug	Adult Dose*/Route	Frequenc y	Duration/ no. of doses	Timing of 1 st Dose
3. <u>Gastrointestinal Tract</u>						
37. Appendicectomy and Colorectal surgery	E.coli, B.fragilis/Peritonitis, Wound infection Septicaemia	Cefuroxime + Metronidazole [41]	1.5g IV 500mg IV or 400mg (po)		1 1 1	At induction At induction 24 hrs before surgery for oral therapy
b. Oesophago- gastrectomy [42]	Streptococci Staph aureus Anaerobes /Wound infection Chest Infection (until extubated)	Cefuroxime +	1.5g IV then 750mg IV	8 hourly	1-3	At induction
		Metronidazole	500mg IV	8 hourly	1-3	At induction
4. <u>Head & Neck Surgery</u>						
a. Laryngectomy and other neck cancer operations	Staphylococci Streptococci Oral anaerobes [43] /Wound infections Osteomyelitis	Cefuroxime +	1.5g IV then 750mg IV	8 hourly	3	At induction
b. Mandibular fractures		Metronidazole [44]	1g PR or 500mg IV	8 hourly	3	At induction

Information on the doses for children for the few procedures in this section can be obtained from the Compendium of Data Sheets or BNF

Procedure	Main Organism(s)/ Infection(s)	Drug	Adult Dose*/Route	Frequency	Duration/ no. of doses	Timing of 1 st Dose
5. <u>Obstetrics & Gynaecology</u>						
38. Caesarean section [45] [46] (elective and non-elective)	Streptococci, Staph. Aureus, Anaerobes /Wound infection, Endometritis, Septicaemia <u>Risk Factors:</u> Early ruptured membranes, no. of pre-op vaginal exams, presence of meconium	Cefuroxime or Clarithromycin if allergic to Pen/Cephalosporins	1.5g IV 500 mg IV		1 1	At induction At induction
b. Vaginal hysterectomy [47]	Streptococci, Staph aureus, Anaerobes/ Wound infection, Septicaemia	Cefuroxime [48]	1.5 g IV		1	At induction
c. Other gynaecological procedures including abdominal hysterectomy (discretion of the Clinician)		Or Clarithromycin (if allergic to Cefuroxime)	500mg		1	At induction
39. <u>Orthopaedics</u>						
Arthroplasty – THR, TKR Internal fixation of fractures with pins, screws etc. Traumatic open fractures	Staphylococci [49] /infection around implants (prophylaxis does not prevent late haematogenous infection of the prosthetic joints) Osteomyelitis If the patient is colonised with MRSA or if there is an MRSA outbreak (as assessed by the Infection Control Team) or high risk** patients for MRSA	Cefuroxime [50] or if allergic to pen/cephalosporins Clarithromycin then Erythromycin Teicoplanin	1.5g IV then 750mg IV 500mg IV 500mg (po) 400 mg IV	8 hourly 6 hourly	1-3 1 2 1	At induction for TKR, allow at least 10 min between injections and inflation of the enitor et or with Premed With Premed 1 hour prior op or with premed
7. <u>Urological Operation</u>						
a. Cystoscopy, Prostatectomy [51] (infected urine)	Coliforms UTI, Septicaemia	Gentamicin	1.5mg/kg IV		1 1	At induction
b. Transrectal prostate biopsy [52]	Coliforms Enterococci Anaerobes /UTI, Septicaemia	Ciprofloxacin	500 mg (po) then 500 mg (po)	12 hours after 1 st dose	1	12 hours preop
8. <u>Vascular Surgery (Grafts)</u>						
[53] [54]	Straphylococci Streptococci, Coliforms /Infection of the graft, Wound infection, Septicaemia	Cefuroxime or if allergic to Pen/Cephalosporins Teicoplanin	1.5g IV 400mg		1 1	At induction At induction

	Screen leg ulcers etc for MRSA, if positive modify prophylaxis to include Vancomycin	+ Gentamicin	1.5mg/kg IV		1	At induction
		Teicoplanin +	400 mg IV		1	1 hr prior
		Gentamicin	1.5mg/kg IV		1	At induction

40. Information on the doses for children for the few procedures in this section can be obtained from the Compendium of Data Sheets or BNF

** Transfers from other hospitals, frequent re-admissions, transferred from nursing/residential homes and history of MRSA

Procedure	Main Organism(s)/ Infection(s)	Drug	Adult Dose*/Route	Frequency	Duration/ no. of doses	Timing of 1 st Dose
<u>Other Operations</u>						
41. Amputations (limbs, toes)	Clostridium sp (above knee), Staphylococci	Cefuroxime	1.5g IV then 750mg IV or IM	8 hourly	1-3	At induction
		+				
		Metronidazole	500mg IV	8 hourly	1-3	At induction
		If allergic to Pen/Cephalosporins				
42. Temporary Pacemaker wire insertion	Staph aureus, including MRSA	Clarithromycin	500mg IV	12 hourly	1-2	At induction
		+				
		Metronidazole	500mg IV	8 hourly	1-3	At induction
		Flucloxacillin or Teicoplanin (if MRSA likely)	1g IV 1g IV		1 1	Just before the procedure 2 hrs before procedure

* Information on the doses for children for the few procedures in this section can be obtained from the Compendium of Data Sheets or BNF

43. **Prevention of endocarditis following certain surgical procedures in patients with heart valve lesions, septal defect, patent ductus or prosthetic valve** [55]

The main organisms are Streptococci and Enterococci. The risk of endocarditis is associated with the procedures listed below. The risk of colonisation with Amoxycillin resistant organisms is increased when there is a recent history of (h/o) penicillin therapy (more than a single dose in the previous month).

Gentamicin is added for some procedures to widen the antimicrobial spectrum.

Category	Procedure and type of anaesthesia	Special risk	Drug	Dose for adults/route	Dose for children/route	No. of doses	Timing of 1 st dose
1	Dental or upper respiratory tract procedures, under local or no anaesthesia	none	Amoxicillin	3g (po)	<5yrs 750mg (po) 5-10yrs 1.5G (po)	1 1	1 hour before procedure
2	Dental or upper respiratory tract procedures, under local or no anaesthesia	Allergic to penicillin or history of penicillin therapy	Clindamycin	600 mg (po)	<5yrs 50mg (po) 5-10yrs 300mg (po)	1 1	1 hour before procedure
3	Dental or upper respiratory tract procedures, under general anaesthesia	none	Amoxicillin or Amoxicillin or Amoxicillin	1g IV then 500mg po 6 hours later 3g (po) then 3g asap after the procedure 3g (po)	<5 yrs 250mg IV then 125mg po 6 hours later. 5-10 yrs 500mg IV then 250mg po 6 hours later. <5 yrs 750mg (po) 5-10 yrs 1.5g (po) then as above asap after the procedure	2 2 1 1 1 1	At induction 4 hours before 4 hrs before procedure
4	Dental or upper respiratory tract procedures, under general anaesthesia. Or Dental or upper respiratory tract procedures, under local or no anaesthesia or All Genito-urinary procedures	Had endocarditis before or have prosthetic valve Had endocarditis before none	Amoxicillin + Gentamicin	1g IV then 500mg po 6 hrs later 120mg IV	<5 yrs 250mg IV then 125mg po 6 hours later. 5-10 yrs 500mg IV then 250mg po 6 hours later. 2mg/Kg	2 2 1	Just before the procedure Just before the procedure
5	Dental or upper respiratory tract procedures, under general anaesthesia or Any patients in category 4 above, who are allergic to penicillin or history of penicillin therapy	Allergic to penicillin or history of penicillin therapy	Vancomycin + Gentamicin or Clindamycin (do not use if undergoing enitor-urinary procedure)	1g IV over at least 100mins 120mg IV 300mg IV over at least 10 mins then 150mg IV 6 hrs later	<10yrs 20mg/Kg 2mg/Kg <5 yrs 75mg IV over 10mins then 30mg IV/po 6hrs later 5-10yrs 150mg IV over 10 mins then 75mg IV/po 6hrs later	1 1 2 2	2 hours before induction At induction At induction
6	Obstetric, gynaecological or gastro-intestinal procedures (prophylaxis only required for patients who have had endocarditis before or who have prosthetic heart valve)		As for Genito-urinary procedures. See category 4 above, or category 5 above for patients who are allergic to penicillin or history of penicillin therapy.				

44. **Prevention of secondary cases of meningococcal meningitis/septicaemia** [56] [57]

The main rationale for prophylaxis is to eradicate the meningococcus from the carriers before it causes more infections.

High concentrations of the drugs used are achieved in saliva and nasal secretions [58] [59] [60].

	Categories of contacts	Drug	Dose for adults	Dose for children (under 16 yrs)	Duration/ No. of doses	Timing of 1 st dose
1	Household contacts including lodgers, resident guests and others who lived and slept under the same roof as index case.	Ciprofloxacin [61] Rifampicin	500mg (po)	Ciprofloxacin is contra indicated in children <12 ≤1 yr 5mg /Kg (po) 12 hourly 1-12 yrs 10mg/Kg (po) 12 hourly 12-16 yrs 600mg (po) 12 hourly	1 2 days	As soon as the clinical diagnosis or laboratory diagnosis is made. Some contacts are given the drugs when they come to visit the index case in hospital.
2	People living in the close proximity, for example dormitories in boarding schools, military establishments, etc.					
3	Girl/boyfriend of index case where a kissing relationship existed.					
4	Children in a pre-school group, primary or secondary. Schools where the contact has been prolonged for more than 4-6 hrs in a closed confined space					
5	Healthcare staff whose mouth or nose is directly exposed to infections, respiratory droplets/secretions, with a distance of 3 ft from the patient.					
6	Index case ((before discharge to eradicate the organism from the nasopharynx to prevent reintroducing the organism to close contacts)					
7	Pregnant contact.	Ceftriaxone* (for pregnant contact) <i>*Not licenced for this indication, therefore counselling should be given.</i>	250mg IM		1	

46. **For details of this and other vaccines, refer to the Trust Guidelines for Prevention of Infection in Hyposplenic and Asplenic Patients.**

Post-Procedural Management of Patients Undergoing Vascular Interventions Via Femora Artery or Vein Puncture

Initial Post – Procedural Management:

1. Patients who have had femoral artery or vein punctures for any vascular diagnostics or intervention must have established haemostasis prior to transfer back to the ward.
2. Haemostasis may be achieved through either the use of a vascular closure device (VCD) or manual compression
3. (MC). Haemostasis in venous procedures will be achieved by MC.
4. If the patient has had a VCD deployed then they may sit upright 30 minutes later.
5. If the patient has had MC to achieve haemostasis following an arterial puncture, then they must remain supine (or <30 upright) following transfer onto their bed for > 4 hours
6. Patients who have MC to achieve haemostasis following a venous puncture may sit upright immediately following transfer to their bed.
7. The IR nurses will check the puncture site once the patient has been transferred to the recovery area.
8. The IR Nurses will hand over to the ward nurse who is collecting the patient whether the patient has had either MC or VCD, with an explanation of the advised post-procedural care.

Ward Management

- 2.1 Patients who have had:
- Carotid/Neurovascular Intervention
 - Renal Artery Intervention
 - Below Knee Arterial Intervention lasting >2 hours
 - Fibroid embolisation
 - Tumour embolisation
 - Any other procedure lasting >2hours

MUST remain in-patients overnight, and CANNOT be considered as day-cases

- 2.2 Patients who have had uncomplicated
- Iliac artery⁶ intervention with VCD
 - Femoro-popliteal arterial intervention with VCD
 - Diagnostic angiography
 - Diagnostic venography or venous intervention

MAY be considered as day-cases and be discharged the same day (specify who will decide?)

- 2.3 Patients who have had either an arterial diagnostic procedure or intervention and had a VCD may mobilise 2-3 hrs post-procedure.
- 2.4 Patients who have had an arterial diagnostic procedure and had MC must remain in bed for at least 4 hours.
- 2.5 Patients who have had an arterial interventional procedure and had MC must remain in patients in bed overnight, and CANNOT be considered as a day case.
- 2.6 Patients who have had a venous diagnostic procedure or intervention and had MC may mobilise within 2 hours post-procedure and MAY be considered as a day case.

These protocols will be monitored and audited and, as such, may be subject to change

Safe transfer of patients

Dear All

Attached is a meta analysis of a number of serious clinical incidents concerning cross site transfers. In more than half the decision making was at a very junior level and the acuity of the patient was not fully appreciated leading to harm. In no case could any documentation of the handover of care be identified. The meta analysis was presented to the Clinical Management Board and the recommendations from it were accepted in full.

1. Before a transfer to another site or a tertiary provider, the patient must be assessed by a registrar (as a minimum) and their consultant must be made aware of the planned transfer and the reasons for transfer. Handover to the other site should be to a registrar (as a minimum) and if a consultant to consultant conversation has not happened, then the receiving registrar needs to make their consultant aware that a patient is transferring to their care.
 2. A record of conversation concerning transfer must be filed in the notes in SBAR format (see attached), this should include clear documentation that the receiving team understand what is expected of them.
 3. Prior to transfer, a patient safety checklist needs to be completed (sections for both doctor and nurse) to ensure that the basic safety checks have been done.
47. If a patient has a VIEWS of >6, then ITU or outreach assessment should be sought before transfer and if following this the transfer is agreed, the patient should either be transferred to ITU at the receiving site or to A&E resus for reassessment, before making a final decision as to the safest place to care for individual.

We have had requests from primary care that the SBAR and checklist are also completed when transferring to community hospitals.

Whilst the meta analysis was about across site transfers, the Clinical Management Board felt that the SBAR communication and Consultant involvement in decision making should also apply to inter team transfers.

The paperwork has been trialled and is already being implemented in A&E's and ECC but applies equally to wards.

Please can you have a look at documents attached and ensure that your teams implement them. We need to get this right to prevent further serious harm to patients and we will be auditing transfers in April to ensure that these criteria are being met.

Many thanks for your help with this.

Paul

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 CT1 3NG
 01227 766877 ext 74030 Direct line 01227 866424

Doctors Checklist for transfer of care to another site





(To be completed by doctor immediately prior to transfer to another site)

<div style="font-size: 48px; color: red; font-weight: bold;">S</div> <div style="font-weight: bold;">Situation</div>	Patient name:		
	NHS number:		
	Date of birth:		
	Date of transfer:		
	Time of transfer:		
	Site transferring patient:		
	Ward transferring patient:		
	Consultant:		name & awareness of transfer: Yes / No
	Name of doctor arranging transfer:		
	Position of doctor arranging transfer:		(minimum registrar grade):
	Speciality of transferring doctor:		
	Contact number & signature:		
	Name of doctor receiving referral:		
	Position of doctor receiving referral:		(minimum registrar grade):
	Speciality of receiving doctor:		
	Contact number:		
	Consultant of receiving doctor:		name & awareness of transfer: Yes / No
Site receiving patient:			
Ward receiving patient:			
<div style="font-size: 48px; color: red; font-weight: bold;">B</div> <div style="font-weight: bold;">Background</div>	Reason for transfer:		
<div style="font-size: 48px; color: red; font-weight: bold;">A</div> <div style="font-weight: bold;">Assessment</div>	Patient status at time of transfer:		
		Hb: If below 7 or actively bleeding discuss management with receiving team	Result
		K: If greater than 6.5 mmols/L then treat prior to transfer and re-check	Result
		Glucose: If below 3 mmols/L then treat prior to transfer and re-check	Result
		VEWS: If greater than 6 then discuss with transferring site Outreach / site co-ordinator / ITU team prior to transfer. If remains 6 on transfer then take to ITU / A&E resus on receiving site	Result
		Other abnormal results: Comment and note plan to normalise	
		Vomiting: Yes / No Action to be taken:	
<div style="font-size: 48px; color: red; font-weight: bold;">R</div> <div style="font-weight: bold;">Recommendation</div>	Plan for transfer:	Oxygen:	Yes / No Note percentage
		IV access:	Yes / No Note type
		Intravenous fluids:	Yes / No Note type
		Drugs prior to transfer:	Yes / No Note type
		Drugs during transfer:	Yes / No Note type
		Monitoring:	
		Cardiac:	Yes / No
		BP:	Yes / No
		Pulse:	Yes / No
		Fluid balance:	Yes / No
		Observation frequency:	Note frequency

Nursing Checklist for transfer of care to another site

(To be completed by nurse immediately prior to transfer to another site)

		Yes	No	n/a	Comments:		
<div style="font-size: 48px; color: red; margin: 0;">A</div> <p style="margin: 5px 0;">Assessment</p> <p style="margin: 5px 0;">Patient status at time of transfer:</p>	Patient assessed by registrar of relevant accepting speciality				If not then transfer cannot occur until assessed		
	Patient stabilised and safe to transfer					<p>If VEWS of 6 or above then patient must be discussed with Outreach / site co-ordinator / ITU team prior to transfer. If remains or becomes 6 on transfer then take to A&E resus / ITU on receiving site</p>	
	Risk assessment scored (circle risk level): escort requirements NB: If response falls into shaded area then follow recommendations below:				<div style="display: flex; justify-content: space-around;"> <div style="width: 10%; text-align: center;">0</div> <div style="width: 10%; text-align: center;">1</div> <div style="width: 10%; text-align: center;">2</div> <div style="width: 40%; text-align: center;">3</div> </div>		
	Patient aware and understands reason for transfer						
	NOK / Carers aware of transfer				Note here who		
	ID bands check completed:						
	Resus status discussed:				Note here outcome of discussion		
	Allergy bands present:						
	Any infection risks				Note here if precautions required		
	Patient nil by mouth / or swallowing difficulties :						
	Vomiting:						
	NG tube:						
	Oxygen therapy.				Note here % given:		
	Urinary catheter insitu						
	IV access and/or infusion in situ: 1. 2.				Note here rate per hour of each:		
	Notes/Records/test results with patient/blood forms						
	Medications – note when last given 1. 2. 3. 4.				Please remember to send any prescribed medications or patients own		
	Pressure areas assessed				Note here any damage		
	All equipment available and in working order						
	Additional information						
Observations on transfer:							
Resp:	Temp:	Pulse:	O2 Sats:	BP:	conscious level	Pain score:	VEWS:
<div style="font-size: 48px; color: red; margin: 0;">R</div> <p style="margin: 5px 0;">Recommendation</p>	<p>Re-assess patient once transport arrives to ensure patient is safe and all management actions have been performed. Record observations.</p> <p>Level 3 Risk requires registered nurse/midwife/doctor escort – contact Matron or site clinical manager for support and advice.</p> <p>Level 2 Risk requires registered nurse/ midwife escort (or refer to RA tool).</p> <p>Level 1 Risk requires HCA/MCA/clinical support worker.</p>						

<u>Handover requesting transfer of care to another team</u> (To be completed prior to handover request to another team)			Tick as items discussed on phone
 Situation	Date of handover: Time of handover: Name & grade of doctor receiving handover: Site receiving handover:		
	Consultant requesting transfer: Patient name: NHS number: Date of birth: Date & time of admission to current site: Diagnosis:		
 Background	Reason for / problems on admission to current ward / department:		
 Assessment	Treatment to date / progress / events:		
 Recommendation	Suggested plan of action / management recommendations from other team:		
	Agreed plan of action following referral to other team:		
Name of referring doctor: _____ Grade of referring doctor: _____ GMC number: _____ Contact number: _____ Signature: _____			

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: CLINICAL MANAGEMENT BOARD – 12 February 2014

SUBJECT: Analysis of datix flagged cross site transfers.

REPORT FROM: Dr M C Webb. Associate Medical Director Patient Safety

PURPOSE: Discussion

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

Following on from a number of serious incidents involving cross site transfers there was a decision to carry out a meta-analysis of datix reported incidents to identify learning.

SUMMARY:

The evidence suggests we are not compliant with stated trust policies on transfers.

In addition we do not appear to have embedded actions from previous RCA's highlighting the importance of regular observations and calculation of early warning scores in A&E.

Recommendations are that:

1. All patients should be assessed pre transfer by a registrar (as a minimum) and be discussed with their Consultant.
2. Patients should be handed over to a registrar (as a minimum) at the receiving site and if a consultant to consultant discussion hasn't taken place then they should make their consultant aware of planned transfer.
3. The medical handover must be documented in SBAR format.
4. All patients should have ViEWs calculated and if >6 outreach or ITU should review before transfer.
5. All patients should have a patient safety transfer checklist completed before transfer. If when completing the checklist it becomes evident that the patient is not currently safe to transfer then transfer should be delayed until the patient is made safe.
6. The current trust policies need updating to reflect these changes and need to be communicated to all clinical staff.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

Failure to act will impact on trusts stated patient safety objectives

FINANCIAL IMPLICATIONS:

Failure to ensure safe transfers will leave patient open to claims of negligence

LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:

Failure to ensure safe transfers will leave patient open to claims of negligence and will affect reputation of trust

PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES

N/A CMB ACTION REQUIRED:

to consider the recommendations and either support, reject or modify CONSEQUENCES OF NOT TAKING ACTION:

- (a) On going risk of patient harm

DATIXWeb - AN INTRODUCTION TO ELECTRONIC (INTRANET BASED) INCIDENT REPORTING

East Kent Hospitals University NHS Foundation Trust has invested in software to assist with improving Risk Management

practices within the Trust. This piece of software is called DATIXWeb, and is used to report incidents electronically. The Risk and Legal Services Department has designed a form that you can access through the Trust Intranet site. You do not need a login to report an incident, it takes a few minutes to complete and, when submitted, is on its way for investigation immediately.

ADVANTAGES OF DATIXWEB

On submission of your incident form, the designated manager will be notified by e-mail. In addition to this, other managers within the trust that need to know about your incident will also be informed immediately (e.g. A fire incident will be copied to the Fire Safety Officer). You will also receive an e-mail from the system providing you with a reference number (as you don't have a paper copy anymore).

WILL YOU HEAR ANYTHING AS A RESULT OF THE REPORTED INCIDENT?

A feedback function has been built into the investigation part of this system, and all levels of investigators into the incident are encouraged to keep the incident reporter informed.

ANY OTHER GOOD POINTS?

As this system is electronic there will no longer be delays in terms of incidents being sent to correct people, or being lost in filing systems, or even lost in the post. Line managers will have a certain time period to investigate incidents. If after several days no action has been taken a third tier manager should take over the investigation. This third tier manager will differ across the divisions / departments within the Trust. It is now possible for an investigation to start on the same day the incident occurred.

WHO IS CONDUCTING THE TRAINING AND WHERE CAN I FIND OUT FURTHER INFORMATION?

Training is being conducted by Nichola Earle, Datix System Manager. You can contact her on ext 73068 or via e-mail incident-reporting@ekht.nhs.uk or Nichola.EARLE@ekht.nhs.uk There is some useful information on the Incident Reporting page of the Staff Intranet.

WHEN CAN YOU START USING THE SYSTEM?

You can use the system immediately, however incident investigators will require a login. To find out if your line manager has registered as an investigator, either ask them, or open up an incident form and go to the second to last section called Investigating Manager, click on the drop down and see if their name is there. (The list is alphabetic by surname – there is a box at the top of the list in which you can start typing your manager's surname and it will highlight their name in the list.) If it is, you can start using the system. If their name is not in the drop-down list, or they have not been trained, there are drop in sessions they can attend which are advertised in Trust News or via E-mail Administrator. If it is difficult for them to attend these, contact the Datix System Manager (Nichola Earle).

HOW TO GET STARTED:

1. ACCESSING THE ON-LINE INCIDENT REPORTING FORM

Click on the incident icon (on the right) which can be found on the East Kent Hospitals University NHS Foundation Trust's Intranet site at the bottom of the Staff Home page and then click on the words **Report an Incident**. Alternatively enter the following address in the address bar on the internet: <http://datixweb.ekht.nhs.uk/live/index.php>

2. MANDATORY INCIDENT INFORMATION and IMPORTANT RULES ABOUT FREE TEXT SECTIONS

Mandatory fields are indicated by and must be completed in order to submit the form. Please follow the instructions provided on the report form itself as well as those contained in this handout. **Rules for Descriptive (free text) sections:** try to keep descriptions brief, only include the facts i.e. no opinions and adhere to the confidentiality rules, as these descriptive (free text) sections are reportable externally.

3. DETAILS OF THE PERSON AFFECTED (or potentially affected in a 'Near Miss')

If a person has been directly affected (physically or psychologically) – enter this person's details first (there may be more than one person affected). The person affected could be a patient (Clinical Incident), Staff member (Non Clinical Incident) or Visitor (Non Clinical Incident). You can indicate in this section if any injuries have been sustained by the person affected or if the incident relates to loss, theft or damaged property you can answer Yes or No.

4. INCIDENT DETAILS

Describe where the incident occurred, who manages the services offered in that area, what happened and what action was taken. In addition add in the incident classification (incident type, category and sub-category), result and severity of the incident. If you are not sure what to put in a particular box, click on the '?' for additional help. Dependant on the coding you input you may be presented with additional questions or sections. These are now included on the incident form to reduce the time you spend completing additional forms or being contacted by investigator/s for further information.

Reporting Deaths to the Coroner

The coroner has a statutory duty to investigate certain deaths - even where you know the cause of death, these are deaths where the cause is:

- violent or unnatural
- unknown
- in custody or other state detention (including DoLS authorisations)

Delay reporting a death to the coroner causes considerable distress for relatives, may delay registration of deaths and can cause funerals to be cancelled

The following deaths should be discussed with the coroner's office, where death:

- is of unknown cause
- cannot readily be confirmed as due to natural causes
- occurs during an operation or before full recovery from an anaesthetic
- may be related to a medical procedure or treatment whether invasive or not
- may be related to lack of medical care or medical miss-management
- is due to drug or solvent abuse, overdose or self-injury
- may be linked to an accident (whenever it occurred)
- is due to an industrial disease or in any way related to employment (at any time)
- may be related to neglect or self-neglect
- may be linked with an abortion
- occurs while detained under the Mental Health Act or other state custody or detention
- occurs where a DoLS authorisation is in place (Deprivation of Liberty Safeguarding)
- occurs under any suspicious circumstances or history of violence
- occurs and there are any unusual or disturbing features of the case

Reporting deaths to the coroner

- **K&CH** and **QEQMH** contact the North East Kent coroner's office - **03000 410603**
- For the North East Kent coroner's office you may use the pre-referral form
- **WHH** contact the Central & South East Kent coroner's office - **03000 410 804**

Reporting deaths to Kent Police: report deaths where:

- you have any concerns about the circumstances of the death
- the identification of the deceased is unknown
- details of Next of Kin are unknown

Urgent Care Centre and (Minor Injuries stream and Minor Illness Stream)

Some patients will be referred into the AMU from the UCC (Primary Care/Minor Illness stream) using the agreed criteria and agreement with the AMU Clinician in Charge.

Streaming Nurse undertakes appropriate rapid assessment

- This may include temperature, pulse, respiratory rate, Oxygen saturation, BP, ECG, urine dip test etc. Assessment is dependent on presenting condition.
- Patient is then streamed to appropriate health care team (see streaming guidelines)
- It is the streaming nurses responsibility to ensure every patient is either seen by appropriate health care team in a timely way or transferred to another site safely or discharged with an appropriate plan e.g. pharmacy, own GP appointment etc.

Acute Medical Unit

The Patient Journey

Patients who are cared for in the UCC will either be discharged or referred to another service



Overview of Single Reception Desk

Brief Description	<ul style="list-style-type: none"> There is a single reception desk where all arrivals (ambulance and walk-ins) will be booked in, to attend a service at the Kent & Canterbury Hospital Urgent Care Centre –
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	<p>open 24hours a day</p> <ul style="list-style-type: none"> The type of patients that arrive via ambulance are defined by the agreed criteria with SECAMB (see criteria in Pathways and Protocols section) and the type of patients that arrive as 'walk-ins' are unselected, as patients decide themselves to attend 		
Patient Flow and Criteria	<ol style="list-style-type: none"> All patients will be booked in and will then wait for a rapid nurse assessment to allow the nurse to stream them into RED, BLUE, GREEN, PURPLE or WHITE stream EXCEPT for the following situations: Call Nurse to see patients before registering them if the patient looks very ill or seriously injured, or if patients present with conditions outlined below: <ul style="list-style-type: none"> Life threatening conditions such as Stroke <ul style="list-style-type: none"> Face -can they smile does one side droop? Arm – can they lift both arms, is one weak? Speech – Is their speech slurred or muddled? Time – Act quickly straight through to Red stream Chest pains Severe difficulty in breathing, unable to speak a full sentence Severe abdominal pain Allergic reaction with swelling of the tongue Heavy bleeding from any part of the body <p>Ensure any patients sent straight through to the AMU/MIU are escorted through – either by reception or calling for help from a nurse in the MIU</p> Straight to the BLUE Minor Injuries stream: <table border="1"> <tr> <td> <ul style="list-style-type: none"> All injuries Wound infections All wounds Minor burns and scalds Foreign bodies. Minor head injuries </td><td> <ul style="list-style-type: none"> Children over one year old with a minor injury Insect and animal bites Sprains and strains Minor eye injuries Broken bones Injuries to the back, shoulder & chest </td></tr> </table> 	<ul style="list-style-type: none"> All injuries Wound infections All wounds Minor burns and scalds Foreign bodies. Minor head injuries 	<ul style="list-style-type: none"> Children over one year old with a minor injury Insect and animal bites Sprains and strains Minor eye injuries Broken bones Injuries to the back, shoulder & chest
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IT Systems	<ol style="list-style-type: none"> All patients will be booked onto the A&E Module of PAS (to record their attendance) which automatically populates the eCascad system. <u>ONLY GP EXPECTED</u> can be admitted straight onto PAS without being booked onto the A&E Module as an 'attend' Patients will either be directed to a stream by the receptionist (using receptionist part of the Streaming Guidelines document) or they will be left 'un-streamed' and await the rapid assessment nurse to decide which stream they should be seen in Once streamed they will wait to be called by the relevant clinician 		
Key staff roles and responsibilities	<p>The receptionist team are responsible for:</p> <ul style="list-style-type: none"> Efficiently and accurately booking in all patients who arrive at the reception desk Ensuring the patients stream is recorded correctly and accurate capture of admitting patients 		
	Supporting Documentation: 'Streaming Guidelines' document		

Exception reporting - Step by step guide

Use our step by step guide to exception reporting, including when to flag up work that has varied from your agreed work schedule, who should be on the receiving end of your reports, how to submit an exception report, and at what stage.

What you should exception report?

Exception reporting will allow you to quickly and easily flag up if your actual work has varied from your agreed work schedule (the plan for your work and training including the rota template).

You should exception report issues as they arise, which can include:

- differences in the total hours worked from what was set out in the work schedule, including the prospective estimate of hours actually worked while non-resident on-call
- rest breaks not taken (at least one 30-minute paid break for a shift rostered to last more than five hours, and a second 30-minute paid break for a shift rostered to last more than nine hours)
- educational or training opportunities missed
- levels of support available during service commitments

This will facilitate timely adjustments to be made to your working patterns where needed, as well as getting sign off for either time off in lieu or additional pay if you've been required to work beyond your scheduled hours.

Exception reporting is every trainee's right and responsibility. There are no restrictions on what should be reported or indeed how many reports can be submitted. Furthermore, there is no pre-authorisation or sign-off process required before an exception report can be submitted.

Exception reporting is the mechanism to ensure that training can be safeguarded, workloads kept manageable and safeguards maintained both for your health and the safety of the patients you look after.

Who to submit an exception report to

Exception reports should be sent to your educational supervisor. In addition, the reports should copy in the guardian of safe working for issues related to safe working practices or the director of medical education (DME) for issues related to training, in some cases it may be both.

Where it is deemed to be of benefit to trainees, an educational supervisor may elect to nominate a clinical supervisor to receive exception reports on their behalf, due to their knowledge of the department and rota. However, this should only be agreed in accordance with local negotiating policy and with consent from the junior doctors affected. Any such arrangement should be explained to trainees in advance, and the educational supervisor retains overall accountability for the process.

How to submit an exception report

Exception reports must be sent electronically.

There may be variation between employers in the exception reporting tools used, such as email, mobile or desktop apps, or other technology. However, employers must have a system in place – paper forms are not a permitted mechanism.

If the exception reporting software your employer has in place is faulty or not accessible at the time, you should still submit an exception report through other means, for example by email as a temporary solution until software problems are resolved. Software problems should not be used as an excuse not to exception report.

Training on the local exception reporting technology must be provided by your employer and should take place during working hours.

When to submit an exception report

Any variation from the planned working hours or training opportunities in your work schedule should trigger an exception report.

You should submit the exception report as soon as possible after the exception takes place; this should be done within a maximum of 14 days (or 7 days when making a claim for payment).

When you are required to work additional hours, ideally you would seek authorisation for this beforehand from your manager, but this isn't always possible. If that is the case, submit an exception report and the extra hours can be authorised retrospectively. As outlined above, the claim should be submitted within 7 days of the event, and your manager must deal with it within 7 days of submission.

In circumstances where the additional hours you were required to work result in a breach of rest requirements (the required 11 hours' continuous rest between rostered shifts is reduced to less than 8 hours) this should be highlighted in the exception report and marked as urgent, so that all practicable steps can be taken to ensure that time off in lieu can be authorised within the 24 hours after the shift.

Circumstances concerning an immediate and substantive risk to the safety of patients or the trainee making the report are outlined in the next topic page of this overview.

EXEPTION REPORTING FLOW CHART

Exception Report Flow Chart: Safe Working Issue

KEY:

Responsibility of the trainee

Responsibility of the educational supervisor

Responsibility of the guardian

Exception reporting system function

Outcome

Timeframe

Closed

Your actual work varies from your agreed work schedule



You raise an exception report - within 7 days of the event if payment requested, 14 days if not



Sent to educational supervisor → Copy to guardian of safe working

Your educational supervisor reviews & discusses the reasons with you within 7 days of receiving report

Additional work was a result of workplace requirements (default position)



Payment or TOIL agreed as appropriate or → you decide whether to request a work schedule



Review

You decide that the variation does not require action-

But the report will be logged and monitored for future trends

Closed

You decide whether to request a work schedule review

Guardian assesses whether a fine is required within 14 days

Guardian notified NO or YES Guardian levy the fine within 7 days

Included in the guardian's quarterly report

Exception Report Flow Chart: Training Issue

KEY:

Responsibility of the trainee

Responsibility of the educational supervisor

Responsibility of the DME

Exception reporting system function

Outcome

Timeframe

Closed

An issue arises resulting in one of the educational or training opportunities in your work schedule being missed or disrupted

You raise an exception report → within 14 days of the event.

Sent to educational supervisor → Copy to DME



Your educational supervisor reviews & discusses the reasons with you what actions are needed to address the issue within 7 days of receiving report



The outcome is communicated to you in writing after the meeting



You decide whether the issue, even if a 'one-off' event, impacts your training and therefore requires a work schedule review? - YES..... IF NO – CLOSED



You request a work schedule review

A work schedule review should be triggered Included in the DME's annual report Copy to DME

DME will review and identify whether improvements to your training experience are need

Work schedule review flow chart

Key:

Responsibility of the trainee

Responsibility of the educational supervisor

Responsibility of the guardian

Responsibility of the DME

Outcome

Timeframe

Closed

Request a work schedule review



Your educational supervisor meets or corresponds with you within 7 days of requesting the review Closed



The outcome is communicated to you in writing after the meeting



You agree with the outcome → Closed → Included in the guardian's quarterly report OR Included in the DME's annual report

You disagree with the outcome



You request a level 2 review of the work schedule within 14 days of the outcome



The level 2 review panel meet with you within 21 days



The outcome is communicated to you in writing after the meeting



You agree with the outcome → Closed → Guardian notified (for working hours issues) or DME notified (for training issues)

You disagree with the outcome



You request a level 3 review of the work schedule within 14 days of the outcome



The level 3 review panel meet with you within the local grievance procedure timescale



The final and binding outcome is communicated to you in writing after the meeting



Guardian notified (for working hours issues) or DME notified (for training issues)



Guardian notified (for working hours issues) or DME notified (for training issues)

The outcome may suggest one or more of the following options:

- Compensation or TOIL • Prospective amendments to your work schedule
- Departmental changes – ie. Timings and processes for ward rounds, handovers and clinics.
- No change to work schedule required