THE 12th INTERNATIONAL SCIENTIFIC CONFERENCE
THE SOCIETY FOR ACUTE MEDICINE

Bournemouth International Centre
20 – 21 September 2018

Fly tipping – negotiating with …ologists

Darren Green, Acute Physician, Salford Royal NHS Foundation Trust

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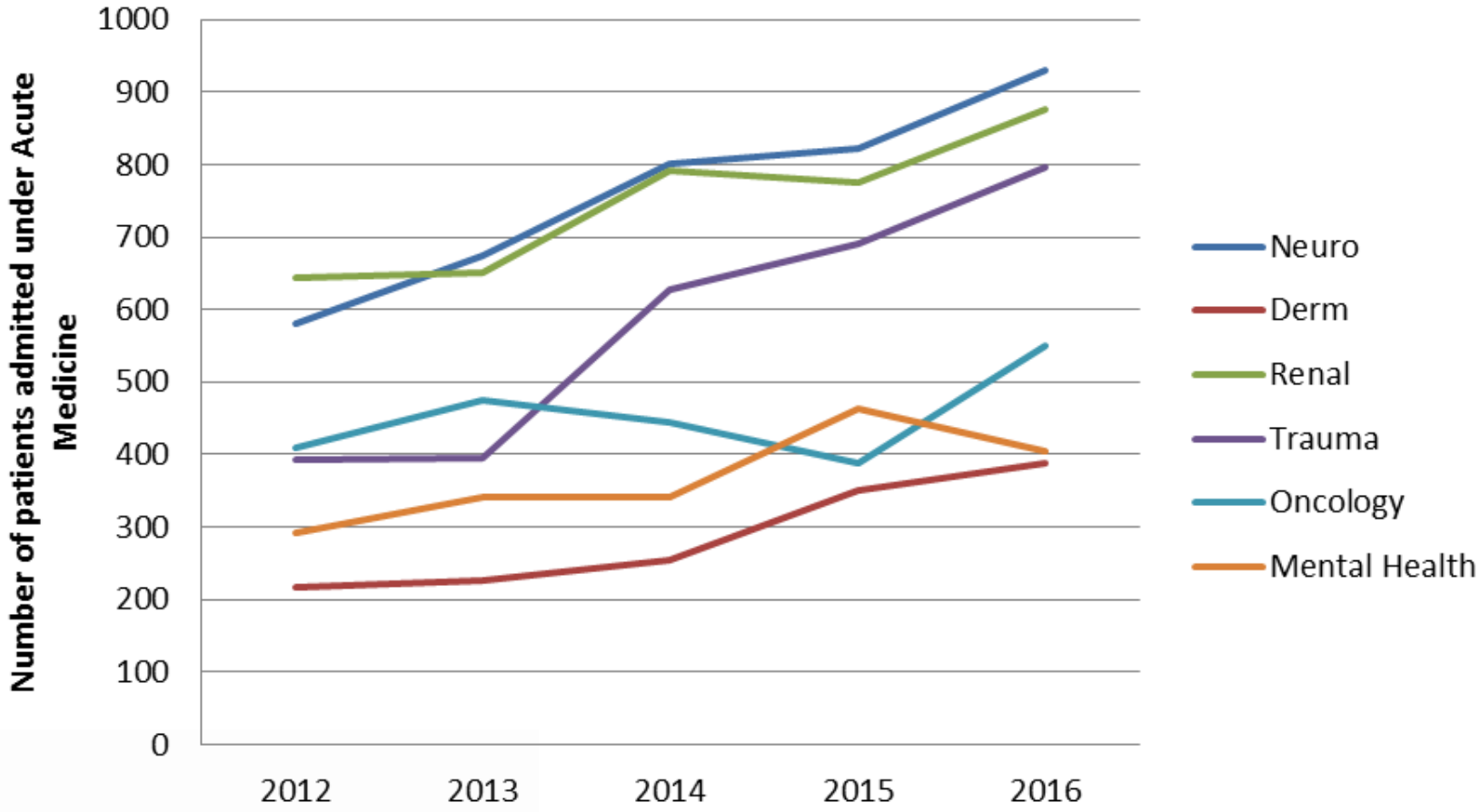
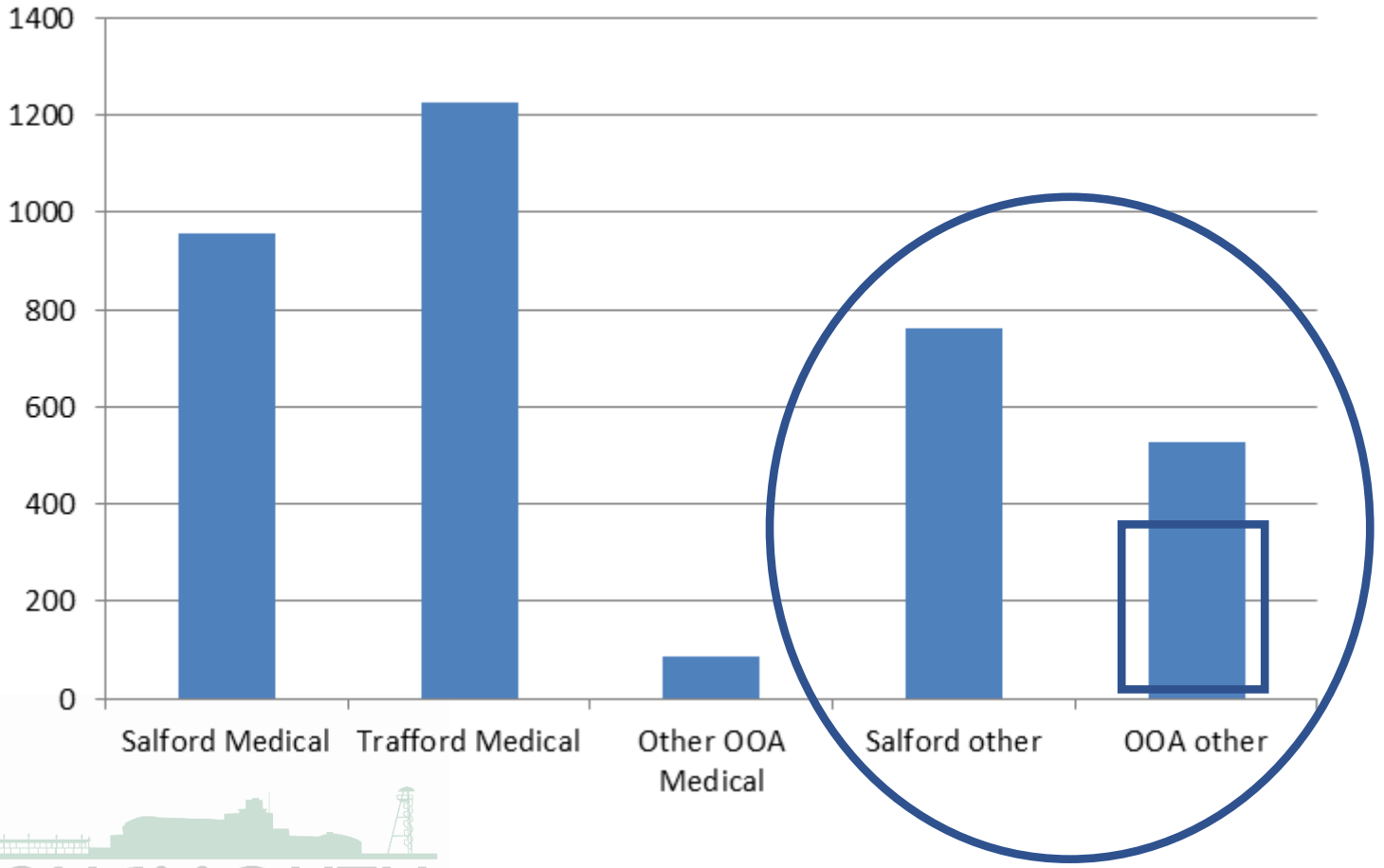
The problem


Number of patients admitted under Acute Medicine
1000
900
800
700
600
500
400
300
200
100
0
2012
2013
2014
2015
2016
Neuro
Derm
Renal
Trauma
Oncology
Mental Health

The problem


1400
1200
1000
800
600
400
200
0
Salford Medical
Trafford Medical
Other OOA Medical
Salford other
OOA other

2005

- Dialysis patient with……..
  - Pneumonia
  - Osteomyelitis
  - UTI
  - Metallic valve SBE
  - Stroke

2018

- Dialysis patient with…….
  - Sepsis unknown source
  - Transplant UTI
  - SoB, bibasal creps, missed dialysis
  - Peritoneal dialysis with abdo pain
  - Possible hypersensitivity to dialysis membrane
  -

2018

- Dialysis
  - Sepsis uni
  - Transplan
  - SoB, h
  - Perito s with
  - Possible hypersensitivity to dialysis membrane
-

What's changed

- 2005: obsessive ownership (probably excessive)
    - 8 registrar
    - Separate SHO on call rota
    - Small clinic burden
    - 2 wards + HDU + drop in

What's changed

- 2018: staff and service changes (probably excessive)
    - 4 registrar
    - Limited junior cover
    - HUGE outreach clinic burden
    - 1 ward, no HDU, no drop in

Response:

- The service cannot sustain increasing workload, a cross-departmental strategy needs to be developed

Response:

- We only take patients if their acute illness is caused by their renal disease

Response to response:

- We (Acute Medicine) only take renal patients if the presenting problem definitely isn't caused by their renal disease

The usual argument for saying no

We wouldn't admit the patient if they were in a DGH and we treat the rest of this hospital the same as other DGHs so we're not taking them.

We treat all patients the same, no matter where they are.

Straw man

Your argument

Clinically, you are the most appropriate person

The patient wants to see you

GMC good practice favours you seeing them

You are available to see them

You just walked past the ward

You were carrying a coffee

Their retort

Let’s create a different scenario that isn’t actually what’s happening. Let’s pretend they’re in another hospital that doesn’t have a tertiary team on site. I’m going to use that situation to justify my standpoint rather than directly addressing your request.

Their retort

And I’m not even going to comment on the fact that we are inconsistent about who we transfer from a DGH.

And I know we don’t treat all patients the same no matter where they are, because if we did, we’d never admit anyone directly here.

Digression: arguable cases

- Cardiac sounding che during haemodialysis

- Patient with heart + SoB, AKI due to loop

Digression: arguable cases

- Cardiac sounding chest pain during haemodialysis

- Patient with heart  + SoB, AKI due to loop

Their retort

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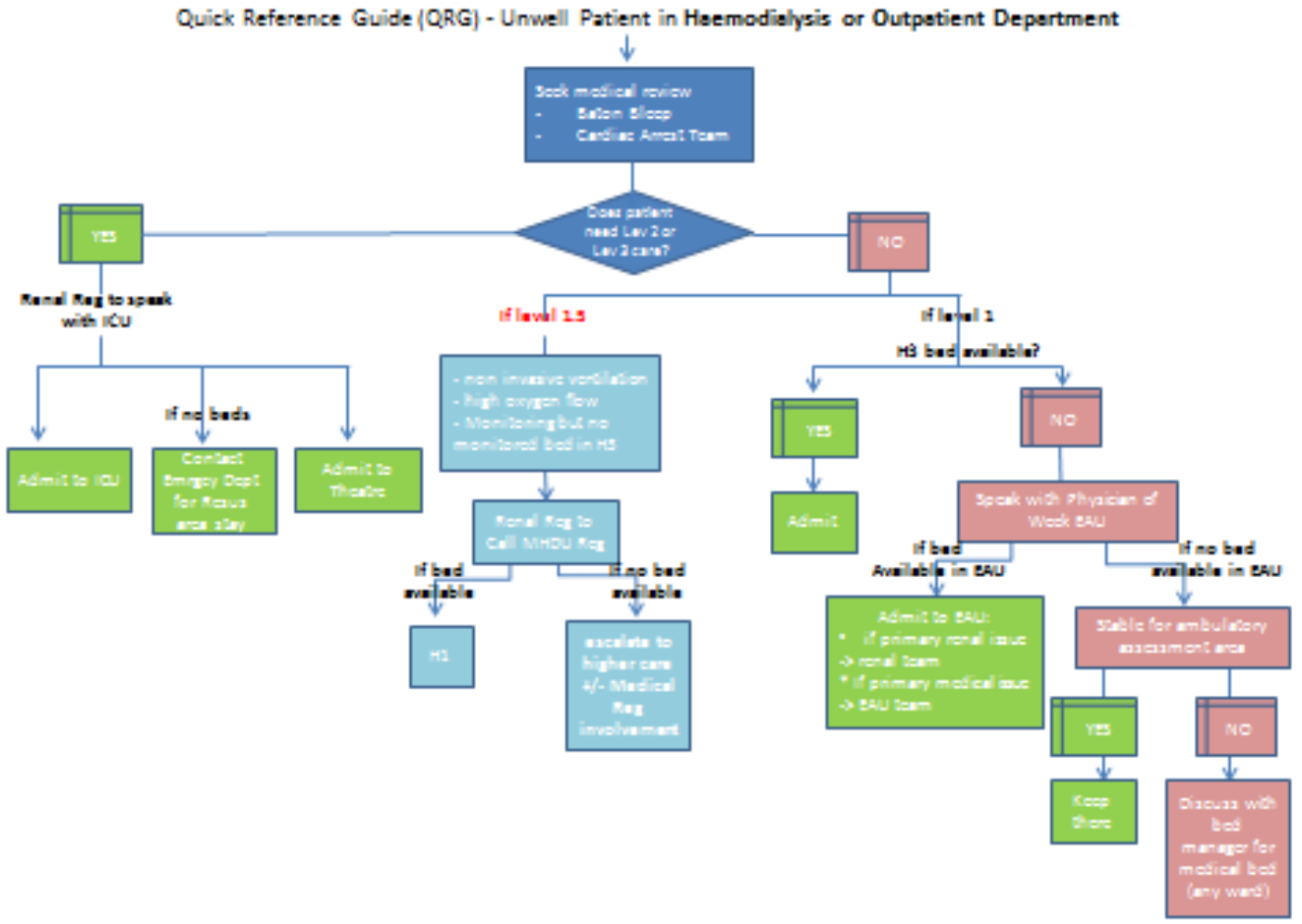
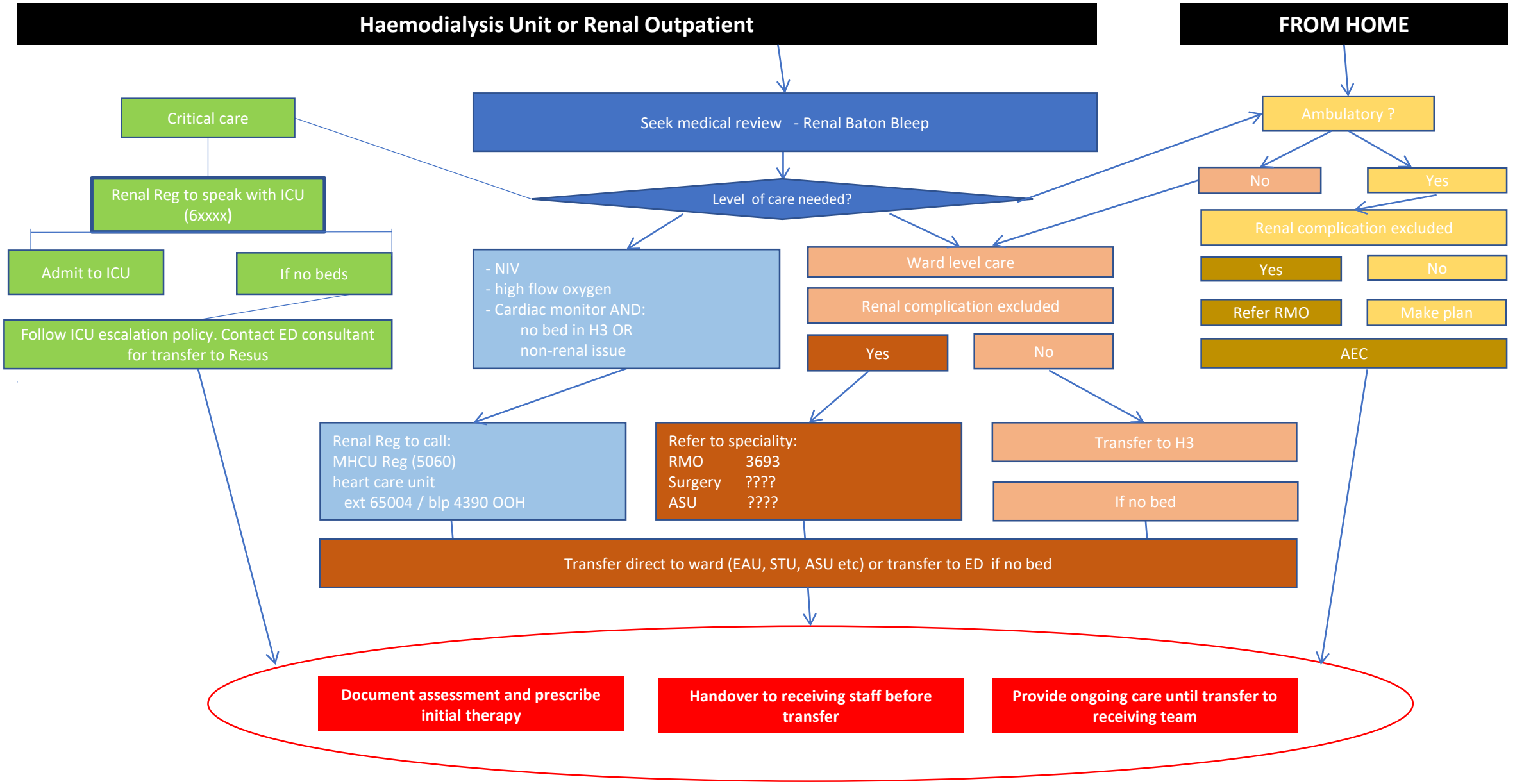
And I know we don’t treat all patients the same no matter where they are, because if we did, we’d never admit anyone directly here.

What has to happen for there to be change

Unwell renal patient QRG




Haemodialysis Unit or Renal Outpatient
FROM HOME
Critical care
Seek medical review - Renal Baton Bleep
Ambulatory ?
Renal Reg to speak with ICU (6xxxx)
Level of care needed?
No
Yes
Renal complication excluded
Admit to ICU
If no beds
- NIV
- high flow oxygen
- Cardiac monitor AND:
no bed in H3 OR
non-renal issue
Ward level care
Renal complication excluded
Yes
No
Yes
No
Refer RMO
Make plan
AEC
Follow ICU escalation policy. Contact ED consultant for transfer to Resus
Renal Reg to call:
MHCU Reg (5060)
heart care unit
ext 65004 / blp 4390 OOH
Refer to speciality:
RMO 3693
Surgery ????
ASU ????
Transfer to H3
If no bed
Transfer direct to ward (EAU, STU, ASU etc) or transfer to ED if no bed
Document assessment and prescribe initial therapy
Handover to receiving staff before transfer
Provide ongoing care until transfer to receiving team

Advice to OOH juniors

After 9pm, you are likely to be asked to clerk and manage patients being admitted under renal, with remote or direct input from the renal registrar depending on the specific case. Occasionally, we may be asked to provide cover between 5pm and 9pm if the renal registrar has a more urgent patient to assess.

Agreeing change bilaterally

- Understand their predicament
- Make them understand yours
- Give concessions
- Focus on communication not ownership
- Remember the patient
- Don’t let change be driven by adverse events

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