Fly tipping – negotiating with ...ologists

Darren Green, Acute Physician, Salford Royal NHS Foundation Trust
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Darren Green, Nephrologist, Salford Royal NHS Foundation Trust
The problem

![Graph showing the number of patients admitted under Acute Medicine from 2012 to 2016. The graph includes data for Neuro, Derm, Renal, Trauma, Oncology, and Mental Health departments.]
The problem
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 patient with...

• Sepsis unknown source

• Transplant UTI

• SoB, bibasal creps, missed dialysis

• Peritoneal dialysis with abdo pain

• 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 chest pain during haemodialysis

- Patient with heart failure / CKD + SoB, AKI due to loop
Digression: arguable cases

• Cardiac sounding chest pain during haemodialysis

• Patient with heart + SoB, AKI due to loop
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.
What has to happen for there to be change
Unwell renal patient QRG

Quick Reference Guide (QRG) - Unwell Patient in Haemodialysis or Outpatient Department

- Seek medical review
- Saloon Sepsis
- Cardiac Arrest Team

- Does patient need Level 2 or Level 3 care?

YES
- Renal Reg to speak with ICU

- If no beds available
  - Admit to ICU
  - Contact Emergency Department for return to stay

- Admit to Theatre

NO
- Level 1.5

HI bed available?

YES
- Non-invasive ventilation
- High oxygen flow
- Monitoring but no monitored bed in HD

NO
- If level 1.5
- Renal Reg to call Medical Reg

- If no bed available
- Admittable to higher care if Medical Reg involvement

If bed available
- Admit to ICU

NO
- Speak with Physician of Ward BAU

- HI bed available?

YES
- Admit to BAU
  - If primary renal issue
  - If primary medical issue
  - BAU team

NO
- Stable for ambulatory assessment area

- Discuss with bed manager for medical bed (if any ward)
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