Welcome to Acute Medical Unit
A Junior Doctors Guide-August 2020

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Introduction

Welcome to the Acute Medical Unit at Darent Valley Hospital! As you already know the unit is based on the 3rd floor beside Chestnut ward which consists of 30 Beds (3 side rooms, and 5 cubicles). The unit was recently refurbished.

This guide will hopefully give you all the essential information and tools you need in order for you to have a great time and learning experience on Acute Medical Unit!

Meet the team

Consultants:

Dr Lanitha SRIKUGAN – Consultant physician, Diabetes and endocrinology with interest in Acute Medicine

Dr Noshaba KHILJEE –Consultant physician, Nephrologist with interest in Acute Medicine

Dr Rehan SHAMIM – Locum Consultant in Acute Medicine with interest in Cardiac Syncope

Dr Fidelis ABEDO –Consultant Physician, Diabetes and Endocrinology-Lead for Acute Medicine

Dr Cynthia MOHANDAS-Consultant Physician, Diabetes and Endocrinology, with interest in Acute Medicine

Dr Dora AFFAM –Consultant in Acute Medicine with interest in Diabetes Medicine

Dr Sebastian URRUELA - Consultant in Acute Medicine

Dr Saeedur RAHMAN- Consultant in Acute Medicine with Interest in Stroke Medicine

Specialty Doctors:

Dr Rajiv SINGH –Specialty doctor in Acute Medicine & Dr Rizwan Muhammad ZAFAR – Specialty doctor in Acute Medicine

Dr Amir HAYAT-Specialty doctor in Acute Medicine & Dr Anan Syed SHAFQART -Specialty doctor in Acute Medicine

Dr Vacant -Specialty doctor in Acute Medicine & Dr Vacant- Specialty doctor in Acute Medicine-AEC

Dr Elaine HALES-Locum Specialty doctor in Acute Medicine-AEC

Trainees:

Dr Robert LAURENSON-GPST1 & Dr Clarisse NIERE-GPST2

Dr Sze Ki SO ACCS CT1 & Dr Conor WALSH-ACCS CT1

Dr Hamish HAMILTON-FY2, Dr Stephanie MOORE- FY1, Dr Dheeraj NARENDRA - FY1

Taster Day Psychiatry FY1s: Dr Jyneva KANOR (Monday), Dr Maximilian FEND (Wednesday) & Dr Charlotte HUANG (Thursday)

IDT Physio/OT and Pharmacists present daily on AMU with a significant input in the care of the patients

Acute Medicine Matron: Vacant

Acute Medical Unit Ward Manager Mark SHILLINGFORD

Ambulatory Emergency Care Sister: Sharron CHATTENTON

The Typical Week

AMU is a unit with a very high turnover. It is known for its great team and at the forefront of this is the nursing staff that simply are like no other in the hospital! They have excellent knowledge of patients and common acute medical presentations and you should utilise and seek their advice whenever possible!
This unit has a variety of patients presenting to the hospital, the majority of the patients are the new patients admitted to the hospital who are referred from Emergency Department, direct GP referral either through Ambulatory Care Unit or through Emergency Department.
The nurses on this ward usually split the patients between them by bay and ensure that all required blood tests, ECGs, basic vital observations, and other tight regular observations are done and clearly documented.
The nurse in charge of AMU updates the **patients list daily**, which as you can see is usually the F1's job! This frees up the junior staff to have jobs and discharges done promptly ensuring the smooth turnover of patients and excellent quality of patient care.

In a normal fashion and on a week day 2 Acute Physicians start the round on AMU at 08.00 am. They will split the patients between themselves. The Consultants will start PTWR first but always will prioritise patients according to their clinical needs, or any deteriorating patient who is flagged up by the nurse in charge. They will then review the rest of patients on AMU.

Junior doctors have decided to take up their rota themselves as 2 of them start at 08.00 on AMU daily, and they finish at 16.00. Their role is to accompany the Consultant on the round, documenting the findings, plan, and performing the jobs created by the PTWR. The rest of the team (the Registrars and the rest of SHOs) join at 09.00 am. On the start of the shift they will divide the patients between themselves. Put their names against the bed numbers. Their role would be to prepare the patients notes with all relevant and up to date information required for every single patient.

For the purpose of continuity of care we prefer that the junior doctors will review the patient they have been seeing during the same week or prior to.

We are aiming to implement RCP recommendations having two ward rounds daily on AMU with an aim to improve the quality care, minimise the risk of miss diagnosis, early interventions and review of the results and their management. Currently we do not have a second ward round on AMU because of the inadequate resources, but instead we have a half an hour board round. This is led by the Consultant in the presence of the Nurse-In-Charge and the rest of the team at 15.00. On the

board round the team will be required to update about the plans agreed on the ward round earlier that morning.

The team also identify the following:

1. New patients
2. Patients needing review urgently
3. Patients that could potentially go home
4. Those patients (new or old) that is suitable for IDT, Physio and OT
5. Patient's plan for the day
6. Patients who are potential for a prolonged admissions
7. Patients who need specialty input
8. Any serious incident overnight such as falls, delirium etc.
9. Any Medical Emergency Team call overnight

This will allow the ward round to be more structured and smoother for the doctors and of course has safety net.
After reviewing the patients the team will gather around 11.30-12.00 for a hand over, the team will be of at least one consultant to discuss each single patient. The expectation is that (if no exceptions) the majority of the patient are seen by the Consultant, so the hand over should be quick. The Nurse-In-Charge will be part of the hand over. The discharge decision must be consultant decision and this needs to be clearly documented in the notes.

Use the daily AMU ward round sheets and make sure every segment is complete to enhance safe and effective patient care.

The patients who are on AMU will stay under the care of admitting/on-call consultant on the day of admission. The patients who are discharged from AMU either home or to any other community facilities must be discharged under the care of the AMU day Consultant.

If on the day there is just one Consultant and the consultant has not seen the patient on that day, then the patient must be discharged under the care of the last AMU Consultant who has physically seen and planned the patient.

Remember that no patient can be discharged under the care of any other consultants (admitting/on call Consultant) unless the patient was seen the night before and a clear plan was made by the on call/admitting consultant for discharge in the morning (such as patient waiting for their carer or keys, transport etc.).

Over the weekend there is a discharge registrar who will review patients for discharges identified throughout the week. Their role is to assess the already identified patients for discharge and ensure a safe discharge. These patient must be discharged under the care of the last Consultant physically seen the patient.

The Friday round sheet must be filled in for every single patient on AMU. The electronic hand over must be filled in for every single patient who needs a review by either an SHO or Registrar on a daily basis especially over the weekend.

Acute Medical Unit timetable:

Weekdays	AM	PM
Monday	Dr Abedo + Dr Khiljee	Dr Abedo
Tuesday	Dr Affam + Dr Urruela	Dr Affam
Wednesday	Dr Shamim + Dr Affam	Dr Shamim
Thursday	Dr Shamim + Dr Mohandas	Dr Mohandas
Friday	Dr Urruela + Dr Abedo/Dr Affam	Dr Abedo/Dr Affam
Saturday	First on call Consultant	
Sunday	First on call Consultant	

Ambulatory Emergency Care Unit:

Ambulatory Emergency Care Unit is an integral and vital part of Acute Medical Unit and Emergency Department. The service has been running since July 2014.It was relaunched in October 2017 with extended 14 hour opening. It is a Consultant led service and staffed by acute medicine and emergency department middle grades. AEC has three consulting rooms, two trolleys and three chairs for ambulant patients.

The patients presenting to AEC can be clerked by the junior doctors under supervision of the registrars and also the Acute physicians. AEC is an excellent opportunity for junior doctors to learn how to perform abdominal paracentesis, pleural tap, and in the near future elective lumbar punctures under supervision.

Ambulatory Care Unit is a service driven by the following:

1. **Passive**-patient are referred to ACU from ED and Primary Care
2. **Pull**- Clinical staff working on ACU identify patients for ACU on a daily basis
3. **Pathway**- patients are managed according to an agreed clinical pathway with direct inclusion criteria
4. **Process**-ACU is an integral part of emergency care system with direct acceptance of all clinically appropriate patients

Ambulatory Emergency Care Unit timetable

Monday	09.00 – 17.00 11.00 – 19.00 13:00—21:00 10.00 – 19.00	ED SpR ACU SpR ED SPR Acute Physician of the day Dr Srikugan
Tuesday	09.00 – 17.00 11.00 – 19.00 13:00—21:00 10.00 – 19.00	ED SpR ACU SpR ED SPR Acute Physician of the day Dr Shamim
Wednesday	09.00 – 17.00 11.00 – 19.00 13:00—21:00 10.00 – 19.00	ED SpR ACU SpR ED SPR Acute Physician of the day Dr Rahman
Thursday	09.00 – 17.00 11.00 – 19.00 13:00—21:00 10.00 – 19.00	ED SpR ACU SpR ED SPR Acute Physician of the day Dr Urruela
Friday	09.00 – 17.00 11.00 – 19.00 13:00—21:00 10.00 – 19.00	ED SpR ACU SpR ED SPR Acute Physician of the day Dr Affam/Dr Abedo

Inpatient Transfers

Acute Medical Unit is a unit with a huge turnover of patients, the majority of the patients will stay on the unit for 24-72 hours and discharged home, the others are moved to the specialty wards once stable. The patients who deteriorates during their stay will be escalated to ITU/HDU or Palm ward for intensive medical treatment.

As the majority of inpatient transfers occurs out of hours, any patient potential for deteriorating needs to have a written hand over documented in the notes (we use a red stamp) with a clear – provisional or proved diagnosis and treatment escalation plan.

Unwell inpatient transfers during working hours needs discussion with the receiving ward and a formal verbal and written handover.

1. **Cardiology:** In patient urgent referrals are done on PAS.

Tips: Do it before 11am for better and safer outcome for the patients, as the cardiology consultants review the patients on AMU quite early.

2. **Gastroenterology:** Referrals are done by calling or bleeping the gastroenterology registrars
3. **Renal:** Referrals are done by calling the renal registrars although the AKI alert system will identify any patient consequently the team will review.

4. **Respiratory:** In patient urgent referrals are done on PAS. There is a daily COPD ward round carried out by respiratory consultant on AMU.
5. **Neurology:** Referrals are done by sending a clinical letter to neurology secretary by fax, and they will review the patients the next day.
6. **Haematology:** Referrals are made by calling the on call haematology Consultant or by calling the haematology registrars on their bleep.
7. **Care of Elderly:** Referrals are done by sending a letter to the COE secretary although there is almost always daily COE consultant attendance on CDU for any COE review.
8. **Diabetes and Endocrinology:** Referrals are made by calling the diabetes nurse specialist or registrars or Consultants.
9. **Dermatology, ENT and ophthalmology:** Referrals need to be communicated in written and for urgent cases patient either needs to be transported to Medway hospital.
10. **Rheumatology:** Referrals are done by sending a clinical letter to the secretary.
11. **Surgical, Orthopaedics and Gynae and obstetrics:** Referrals are made by bleeping the on call team registrars or SHO
12. **ITU:** Referrals are made by bleeping the on call registrars on 230
    TIP: Discuss with the consultant and do it ASAP as patient can deteriorate rapidly

13. **Psychiatrist:** Referrals are made by calling the psych liaison team for assessment.

In certain scenarios you may be required to arrange a referral to other trusts, such as St Thomas Hospital or Kings College Hospital for patients such as:

1) Any vascular limb ischaemia critical or non-critical
2) Any intracranial bleed, including any brain tumour
3) Any organ transplant patient

Referrals to KCH is done electronically, including referrals for neurosurgical MDT.

Tip: You need to register with your NHS email account to get an access (log in and password) for the electronic referrals!!
Referrals to St Thomas Hospital is done over the phone, so you need to pick the phone up and speak to the bleep holder or on call relevant specialty registrar.

LP Proforma must be printed out from PAS and filled in for every single LP performed.

You can find this on PAS under the neurology section-LP.
Please refer to the Lumbar puncture guidelines on Adagio for more information.

Requesting/Accessing Investigations and Procedures

PAS – This is used to request most investigations e.g. radiology, Ultrasound, nuclear medicine etc. Remember contrast forms for imaging requiring contrast, otherwise there will be delays!

PACS – Is used to view the results of the investigations ordered including angiographic images and clips

Path lab – View blood results/cultures/serology

TOMCAT – View cardiology procedures (angiography, pacemakers etc.)

Discharges

The types of patients that will be discharged are:

1. Those that have made a recovery and are fit to go home (e.g. patients who were admitted for observations overnight, including neuro observations, BM monitoring, BP and Pulse monitoring)
2. Those that were seen by specialty teams and have a plan for discharge without any need for specialty ward admission.
3. Patients who have a mild infection, such as UTI, low CURB score stable Community Acquired Pneumonia, or high CURB score pneumonia after 48 hours of IV antibiotics fir for discharge and follow up in clinic, low TIMI score chest pain patients, Troponin negative low risk chest pain patients.
4. Those with social admission waiting for placements.
5. Those are waiting for community rehab beds
6. The decision is made by the Consultant of the day on AMU and this needs to be clearly documented in the notes.
7. Patients discharged home or to other facilities such as rehabilitations facilities need to be discharged under an AMU Consultant.

EDNs (Electronic Discharge Notice, aka TTOs/Discharge Summaries)

This is a document which is completed electronically which serves as an official discharge letter for the patient. It also serves a few other important purposes:

1. Information for the patient regarding their diagnosis and advice on the future management of their condition i.e. medications, alarm symptoms etc.
2. The GP will usually be sent a copy of the EDN via email and so therefore this document serves as an important communication tool between the hospital team and the GP. If any further investigations are required, tests need or follow up appointments etc., it is usually under “Instructions for GP” within the EDN. To give examples, the most common instructions for the GP are to arrange repeat U+Es if started on new medications, outpatient referrals and warfarin checks etc.
3. Pharmacy –it important that the medications is filled in correctly specifying which medications are new, which are old and which have been changed. Liaise with the ward pharmacist who would be more than happy to help!
4. Specialty team follow up – Remember to always specify which specialty team is to follow up a patient.
5. Continuity of care is very important in maintaining quality patient care so if a patient is admitted and seen by on call Consultant, but already has a follow appointment with specialty team Consultant (which you will find a lot!), it would make sense to copy them into the patients EDNs for follow and inform them of their admission so they are updated.

To summarise if all these main points are implemented on EDNs you find that this document becomes very useful for AE, on call team and importantly your team! You’ll find many times a patient may be readmitted in the future that you already have seen and so having a goof EDN

first time round will make their management easier and your writing of the second EDN much easier!

Tip: Try and have the patient's medical history in category of diagnosis filled out in the diagnosis section of the EDN and any investigations, ECHOs, CXRs/CTPAs, etc. fill out in the procedure section of the EDN for easy access of the reader.

Specify in the EDN if hospital at home team (HAHT) are to be involved in the discharge and contact and liaise with them before the patient is discharged! HAHT are a group of specialised nurses who train and help continue the treatment of patients at. They commonly continue prescribing LMWH until a patient's INR is therapeutic whilst on Warfarin, providing nebulizers, repeating U&Es, FBCs, monitoring breathing, BMs, BP and Pulses, and providing IV Antibiotics for non-septic stable patients with cellulitis and UTIs. They can also repeat bloods and monitor renal function/liver function etc. when patients are started on new medication. Please liaise with them-they are always helpful.

Teaching opportunities:

The weekly teaching programme on AMU is a combined one with the renal and respiratory team. This does occur every Monday on Poplar unit and is carried out either by registrars or a Consultant (renal, respiratory or AMU). In these sessions you are actively involved in teaching, teaching relevant topics such as sepsis, AF, congestive heart failure, interesting cases from previous experience etc.

The ambulatory Care Unit will offer you to actively participate in performing certain procedures such as pleural taps, abdominal paracentesis, lumbar punctures etc.

General Advice

It may be worth refreshing you memory of common ECGs by reading "ECG made Easy". I would also recommend light reading guidelines for management of:

1. Heart Failure
2. Atrial Fibrillation
3. ACS
4. PE, DVTs
5. Sepsis, including neutropenic sepsis
6. Community Acquired/Hospital Acquired Pneumonia
7. COPD
8. Asthma
9. Dementia, delirium
10. Pyelonephritis
11. Inflammatory Bowel disease-Crohns disease, Ulcerative Colitis
12. Cellulitis
13. Infective diarrhoea, C.Diff
14. Malignancy
15. Haematology and blood disorders such as Anaemia, Thrombocytopenia
16. TIA/CVA
17. Alcohol Withdrawal syndrome

18. Deliberate Self Harm- drug overdoses

These are the most common presentations…….

Tip: Always fill in Medication charts in CAPITAL LETTERS to avoid confusion and errors!