**Members of the On-call team**

Other members of staff that could help with clerking but should not be relied on (if their workload permits):

* MAU F1
* Ambulatory care IMT

**Members of the weekend On-call team**

‘SHO’ 1 0900 – 2130

‘SHO’ 2 0900 – 2130

Tier 2 Doctor 0900 – 2130

AMU IMT 0800 – 1600

Medical ST3+ 0900 – 2130

AMU F1 0900 – 2130

Twilight F1 1600 – 0000

Ward Cover F1 0900 – 1900

Cardiology Consultant (COW) 0900 – 1300

Medical Consultant 0800 – 1200

Medical Consultant 0800 – 1800

GIM On call Consultant 0800 – 2200

Stroke Consultant 24/7

SSU Consultant 0800 -1200

Gastroenterology Consultant (GOW) Offsite via switch

**Accessing the on call rota**

You can access the medical on call rota using the shared drive (s drive)> Public > Medical staff rota> Medicine on-call rotas.

**Cardiac arrest**

To put out a cardiac arrest call dial ‘**2222**’

Members of the cardiac arrest team:

* Medical Registrar
* 2nd on
* Medical F1
* Anaesthetics junior doctor
* ODP
* Critical Care Outreach

It is reasonable for any member of staff to summon the cardiac arrest team for peri-arrest situations

**Minimum clerking standards**

Prior to PTWR the following should be completed for all medical take patients

* Full clerking and examination
* All sections of clerking proforma completed
* EMAR completed + IV fluids/ insulin/ anticoagulation charts completed as necessary
* Basic investigations i.e Bloods, ECG, Radiology ordered
* Immediate treatment started
* VTE assessment
* Oxygen target saturations prescribed, whether on oxygen therapy or not
* Utilisation of appropriate pathways

**Handover**

Handover is at 09:00 and 21:00 in the handover room on ward 46.

* Each member of the team should introduce themselves and their role
* Handover sick patients
* Handover patients waiting to be clerked/ to come in
* Handover outstanding tasks; delegate specific tasks to specific doctors
* Any staffing/ capacity concerns i.e. bed status of CCU/ ITU etc.

When handing over use SBAR, handover will be documented by the consultant leading it, using a standardised proforma.

**Learning while on call**

* Ask the consultant/ SpR who is on shift with you for CBD’s/ACAT's etc.
* Read up on interesting cases you see whilst you are on call
* If you are unsure of something don’t be afraid to ask

**F1 Medicine**

It is important you feel you are able to ask your seniors for support and escalate sick patients appropriately. The hospital uses a graded NEWS response so please familiarise yourself with the NEWS chart to recognise when a patient is deteriorating. Think sepsis if the NEWS is 5. Patients with NEWS of 8 should be reviewed by the registrar.

See table below for you should call when a patient is unwell:

**NEWS - 5** SHO/ Registrar

**MEWS - 8** Registrar

**Peri-arrest patient** Registrar/ Crash call

**F1 AMU week day (Short day)**

Monday - Friday

08:00 – 16:00 (there will be occasions where you may be asked to work 09:00-17:00)

**F1 AMU week day (Long day)**

Monday - Thursday

09:00 – 21:30

Collect the 2601 bleep from the AMU plastic box. *This is the crash bleep; you hold this until 16:00 when the twilight F1 will bleep you to pick it up.*

Attend handover in the handover room on ward 46 at 09:00; here you will be assigned to a consultant after handover is complete you will go on ward round in 2 AMU bays with your consultant. You will be given a list of patients on AMU and can kindly ask a ward clerk if this has not been done. For ward round you must get a computer, make sure you have enough proformas/ for the patients you will see and try to order investigation/ complete jobs as you go round.

17:00-21:30

AMU doctors from the day may approach you and handover outstanding jobs. You will be asked to review patients if they are deteriorating. There are always doctors coming on and off the ward, you can ask them for help if you are struggling. Alternatively you can bleep:

Second on: 2787

Medical registrar: 2603

If you have the time you can help complete discharge summaries that have not been done from the day. Follow the last plan and book all the tests/ follow up if they have not yet been done.

21:00-21:30

Attend evening handover in the handover room on ward 46, handover any patients you think the night team should be aware of.

**F1 AMU weekend**

**Friday**

09:00-17:00

You will be based on your normal ward holding the crash bleep.

17:00-21:30

You are based on AMU and hold your own bleep; AMU doctors from the day may approach you and handover outstanding jobs. It is helpful to print out your own list of AMU patients. You will be asked to review patients if they are deteriorating. There are always doctors coming on and off the ward, you can ask them for help if you are struggling. Alternatively you can bleep:

Second on: 2787

Medical registrar: 2603

If you have the time you can help complete discharge summaries that have not been done from the day. Follow the last plan and book all the tests/ follow up if they have not yet been done.

21:00-21:30

Attend evening handover in the handover room on ward 46, handover any patients you think the night team should be aware of.

**Saturday and Sunday**

09:00

You hold your own bleep for both days. You attend handover at 09:00 in the handover room on ward 46.

You will then do 2 bays on ward round and any patient that is in EAU with a consultant and then use the rest of the day to complete the jobs. Try to get TTO’s done on the ward round as the pharmacy closes early on weekends. The junior doctor on call doing the other two bays on the ward round may be asked to go and clerk, this means you may get asked to review patients you have not seen on the ward round.

When sat at the computers nurses may approach you for jobs. Some doctors find it useful to ask the nurses to write down their jobs on a piece of paper if they are busy. Make sure you clarify the name of the patient who in “bed x” as there is a quick turnaround/ moving around in AMU and it is easy to prescribe something for the wrong patient.

21:00-21:30

Attend evening handover in the handover room on ward 46, handover any patients you think the night team should be aware of.

**F1 ward cover**

**Saturday and Sunday** 08:00-19:00

08:00

Go to AMU and collect both the AMU list and the weekend review list from the reception, then join the AMU consultant on ward round. Write any jobs that are not completed on ward round on the AMU list as you will be handing these jobs over to the AMU F1 at hand over.

09:00

Collect the 2601 bleep from the AMU plastic box Friday 09:00. *This is the crash bleep, you hold this until 16:00 when the twilight F1 will bleep you to pick it up.*

Morning handover is in the handover room on ward 46 and starts at 09:00, you will be given a copy of the weekend review list and you must discuss with the second on how the jobs are going to be split between you both.

Other doctors have found this system useful; Often the F1 may do the “none physical weekend r/v” of patients, such as checking bloods then reviewing the patient physically if needed. Whilst reviewing patients on the ward you should also check with all the nurses whether there are any jobs on the ward that need doing on that day to save you from having to return.

You should visit every medical ward during the course of the day, these are:

33, 34, 42, 43, 48, 49, 50, 51, CCU

It is a good idea to keep a system and if a ward bleeps you for none urgent jobs to let them know you are working your way around the hospital.

You may be also asked to review a patient who is deteriorating as you are working your way around the hospital. Once you have reviewed this patient, it may be a good idea to return to the ward you have come from to finish jobs there and carry on working around the hospital in a system, as oppose to getting hijacked by the jobs on the ward you have just walked on to. This will mean that you are less likely to miss jobs or get confused as to what you have done on each ward.

You will hand over any outstanding jobs to the MAU F1.

16:00

F1 twilight will pick up bleep at 1600. You then have 3 hours to finish off jobs including what you agreed to complete from the weekend r/v list.

It might be a good idea on the next day to start at the other end of the hospital as sometimes the wards at the end of the list do not get seen until very late if you are busy.

Handover jobs to second on and F1 twilight if you don’t manage to finish them at 1900.

**Your duties**

Review wards patients and weekend review patients

Review sick patients

Escalate problems as needed

**F1 Twilights**

16:00 – 00:00

7 Twilight shifts in a row - followed by Monday off and 11am start Tuesday.

Bleep 2601 to collect the crash bleep; 2601 is the crash bleep, you hold this until 00:00 and then return it to AMU at the end of your shift.

You will get bleeped from different wards with jobs, it is good to be organised and keep a list by ward to prioritise incoming jobs.

When you collect the bleep from the ward cover F1 at the weekend it is good to discuss outstanding jobs and divide them between yourselves.

**Medical ‘SHO’**

**(F2, IMT, ACCS, GPST)**

**The Working day**

**1ST On (Days)** 09:00- 21:30

**2nd On (Days)** 09:00 – 21:30

**1ST On (Nights)** 21:00 – 09:30

**2nd On (Nights)** 21:00 -06:00

Attend handover at 0900 and 2100 in Ward 46 Handover room.

You can access the rota via the shared drive on any of the trust computers using the following link:

S:\Public\Medical Staff Rota

Both the morning and the evening handover take place in the Handover room on Ward 46.

**First on (Days) – Bleep 2735**

As the first on, you will be the ‘list holder’. The ward clerks on AMU can print a proforma out for you. The list proforma enables you to keep track of the medical admissions and referrals. As the ‘list holder’ for the acute take, you will be responsible for making sure that all medical patients are seen and have their case reviewed by a consultant (Post-Take). You will be responsible for assigning patients to the various members of the on-call team for clerking, clerking patients yourself and usually be the first port of call for any queries regarding the medical patients admitted that day.

*Please check the list in AMU, the board on GPU, the computer in the A&E store cupboard and take ED referrals*

**Taking Referrals**

As first on, it is your job to filter any inappropriate referrals; this can be quite difficult as one may ask “What is an appropriate referral?”. If you feel that the patient may need an assessment by another speciality before coming medically, it is often reasonable to request that (in the case of ED referrals). For example a patient with septic shock that is not responding to fluid resuscitation may first need discussion with Critical Care for inotropic support. Furthermore, it is reasonable to ask ED if patients are responding to any treatment e.g. with sepsis or asthma. Another example is abdominal pain, if the history doesn’t sound particularly medical, it is reasonable to request ED to request a surgical opinion. Useful things to ascertain from the referrer would be:

- *Working Diagnosis*

- *Investigations so far*

- *Treatment so far*

- *Observations*

Check with hospital policy that the patient is appropriate for medicine if unclear whether should be referred to another speciality.

If you are unsure ask the referring ED doctor to discuss with their senior and to refer to the Medical Registrar.

**First on responsibilities**

Clerking patients (A&E, EAU, AMU, GPU)

Receive referrals from A&E

In charge of list and delegation of patients for clerking

**Top Tips**

DVT patients– Refer to vascular,

Dialysis patients – Inpatient dialysis must be discussed with Arrowe Park and will remain under A&E until being transferred as there are no IP dialysis beds unless they need ITU

Hemodynamically unstable Upper GI Bleeds need to be discussed with surgeons

Stroke patients will normally be seen by the stroke co-ordinator and sent to Ward 33 these patients still require clerking and eMAR prescribing

**Interprofessional Standards**

The Medical Director has sent a Memo to all doctors regarding taking referrals which is reproduced below:

11th January 2019

*Dear all,*

***Professional standards in specialty referrals***

*I understand how challenging it is to work in an ED environment. We all know that the effectiveness of clinical referrals to specialties following ED assessment is a crucial element of safe care. I want to support you in being able to make any appropriate referral to a specialty colleague in a professional, constructive manner. I likewise want to know about any situation where that hasn’t occurred so I can look into the reasons why and improve things for all concerned.*

***Referrals to specialty clinical colleagues***

*If you are making a referral to a colleague for specialty assessment, I expect that both clinicians in the call will conduct a professional conversation. The referral must include both people clarifying who they are, what grade they are and what the intended outcome of the call will be (“Hi, it’s Dr X here calling from ED, who am I speaking to? I am referring a patient to you who requires assessment for possible admission / who requires an urgent clinic appointment / who I want advice please regarding their management”).*

*Where referrals have been made, and transfer to an assessment area is to occur,* ***it is imperative that the patient has appropriate analgesia and fluids prescribed before they leave the ED area and that the clinical handover to the specialty team confirms that this has been done.***

*Of course,* ***no*** *patient should be transferred whose physiological scoring renders this unsafe.*

*We will* ***not*** *tolerate argument, rudeness or any other non-constructive conduct in any referral calls.* ***If this is the case then the relevant consultant on call for that specialty must be contacted immediately, day or night, to facilitate resolution and I would like please to be notified by email of the staff concerned and the details of what went wrong.***

***Hand-backs to ED following a specialty assessment***

*Wherever a patient has been referred for specialty assessment, and that specialty then decides they are not the appropriate specialty to manage that patient,* ***it is the responsibility of that specialty to refer the patient onwards – patients must not be ‘referred back’ to ED****. I need please to be alerted by email to any scenario in which this is a problem so I can act appropriately to support the ED referrals process.*

***Seeking an opinion from a specialty***

*I do not support us asking F2-level clinical staff for a specialty opinion on the management of any patient under the care of ED.* ***If ED staff require specialty clinical opinions from inpatient teams then this is for the Middle Grade or Consultant in that specialty team to provide, so please do not ask our F2 doctors to do this.*** *We have on-call cover from senior doctors in all specialties so there should not be any circumstance in which a senior opinion cannot be obtained. If senior staff are in theatre, for instance, then escalation to the consultant can be made. There will always be occasions when all the senior team are occupied with a clinically urgent case, in which scenario the patient can be* ***transferred to an assessment area pending specialty review.***

*I hope these comments and expectations are clear. I am open to all feedback on this, but we must move forwards on these aspects alongside many others, and I will do all I can to support you.*

*Darren A Kilroy M.Ed. MBA PhD*

*Acting Medical Director*

*Divisional Medical Director (Planned Care and Clinical Variation)*

*Countess of Chester NHS Foundation Trust*

**Specialty acceptance and transfer**

Please see ‘guideline for specialty acceptance and transfer’ for full guidance, see common conditions below:

**Who may want to contact you?**

As the person overseeing the take, you will get bleeped by different people throughout the hospital, these include:

* Accident + Emergency (Referring medical patients or nurses with a query)
* Primary Care Unit (Either asking for advice or referring a patient) 09:00-18:00 Voip 3478, OOH to medical registrar
* Clinics (Patients may be admitted from clinic) – Medical SpR

**GP Referrals**

Medical patients that are referred by GPs need to go through Single Point of Access (See Flowchart), as far as SHO 1 is concerned, these patients will appear on the A3 Board at the AMU reception and it is their responsibility to ensure that these patients are clerked by the medical team. This board of patients is populated by The Bed Bureau Team (between the hours of 0800 – 2000) and the Clinical Site Co-Ordinators

*Tip: It is a good idea to check this board periodically to see how many GP referrals there are and copy these names onto your ‘list’.*

**GPU**

GPU has ambulatory care and a trolley area, it is for medical patients who do not require require ED treatment/monitoring in Majors or Resus.

Both ANPs, AMU doctors and on call team clerk patients on this unit. There is a GPU exclusion criteria displayed on the wall of GPU behind ward clerk. The Acute Medicine Consultant for GPU is on VoIP 2001 for any advice/post-takes.

Patients may be admitted via our ‘Ambulatory Care Unit’ which runs weekdays from the UTC near the main hospital entrance. These patients will also need to be post-taked and will usually be transferred to GPU.

**How to keep ‘the list’ up to date?**

Keeping the list up to date is very important so patients are not lost in the system. Check on Meditech with the patient’s CC number, to see if the patient has registered for their care episode on a particular day. Occasionally, you may get a bleep from ED, AMU or GPU to let you know that a patient has arrived and needs clerking.

**Where to find patients?**

Unfortunately, patients can be spread out through the hospital meaning you need a reliable way to find where they are, you can search for them on Meditech (See Previous Section) which will tell you their current location. You can also use option 2 (PCI) on meditech to find patients in ED using the ED screen.

**Post-Take Ward Round (PTWR)**

After you have seen a patient and have a working diagnosis, you should order any relevant investigations and start any treatment for your patient, you should also prescribe their regular medications on eMAR. Once these things have been done you should contact the on-call consultant to have your patient reviewed, they may change your management plan and create some more jobs, which it would be your responsibility to do.

The PTWR is an excellent learning opportunity, if you need ACATs or CBDs it would be worth letting them know beforehand so these assessments can be carried out.

At around 19:00, the night consultant takes over and will continue to post take patients until handover at 21:00. Patients seen during the night shift will have their post-take ward round in the morning.

***Jobs to be completed for each patient prior to PTWR***

*Clerked*

*Order basic investigations*

*VTE*

*eMAR*

You will be given the consultant bleep at handover, when you are ready to post take bleep the consultant. As first on, it helps to liaise closely with the consultant throughout the day to ensure the PTWR runs smoothly.

**Second on (Days) – Bleep 2787**

As second on, your day will generally be split into three parts:

0900-1200 – You will either be on your own ward, clerking patients or helping out with the ward round on EAU (generally the case on Fridays)

1200-1700 –Clerking

1700 – 2100 – Supporting the Twilight FY1 and/or clerking

**Weekend Working**

If you are covering the medical wards, there is normally a weekend handover list which the MAU ward clerk will print out and leave by the reception. Essentially, it is a list of the patients the day team feel need a weekend review; this could include anything from checking blood tests, reviewing patients or reviewing them prior to discharge. Again, there is no particular way to do this; some SHOs like to go around with the FY1 and some like to split up, it helps to be systematic in the way you cover the jobs on the weekend review list as you will you invariably be bleeped to review patients on the wards. The ward cover FY1 will hold the 2601bleep until 1600 when the twilight FY1 starts (so between 1600 – 1900 there are three doctors allocated to the wards.).

**Working at Night**

There is a useful RCP publication on working night shifts The Royal College of physicians have produced a useful guide to working the night shift, follow the link below:

[http://www.agamfec.com/pdf/MIR/Guardias\_Supervivencia.pdf](http://www.google.com/url?q=http%3A%2F%2Fwww.agamfec.com%2Fpdf%2FMIR%2FGuardias_Supervivencia.pdf&sa=D&sntz=1&usg=AFQjCNHvXp3ZhlNokLdx-_hIRKiwnwcBKw)

The system at nights is slightly different in that each shift is only 10 hours, as a result you will be holding both bleeps for two hours during each shift.

* SHO 1 (2300 – 0930) Holding the List
* SHO 2 (2100 – 0600) Covering Wards and/or clerking
* Med SpR (2100 – 0930)

As Second on, it is useful at the start of the shift that you have an up to date list of all the patients waiting to be clerked, so go to the board and make sure all the names are on your list. During the first two hours, there is also the Twilight House Officer, so any jobs handed over could possibly be delegated to them e.g. if a patient who has been clerked is awaiting the bloods/CXR.

As First on, you will be finishing later, so at 0600, SHO 2 will hand over any jobs/concerns from the wards. This is particularly important during weekend nights when they won’t be routinely reviewed by their day team and it will be looked after by the weekend on call team.

* **Acute Take IMT**

14:00-00:00

The main responsibilities are to clerk patients and support the take. Take the Tier-2 cardiac arrest bleep at 21:00 (or 9:00 if Tier 2 not a IMT) so that you may get cardiac arrest experience.

**Tier 2**

**Tier 2 week day**

13.30-21.30

0900-1330: Ward duties on regular ward. Attend handover at 09.00 to introduce yourself to the take and then return to ward. You don’t have to stay for the whole handover. Pick up the cardiac arrest bleep behind the AMU reception desk if you are IMT to ensure you get cardiac arrest experience.

13:30 -21:00 Support the acute take by clerking patients

21:00-21:30 Handover to the night team in the handover room on ward 46

Weekday on call duties:

- Clerking patients

- Senior support of juniors throughout on call period

**Tier 2 weekend/ bank holiday**

09:00-21:30

09:00-09:30 Attend handover in the handover room on ward 46

09:15-21:00 Attend ward round on AMU, and then once ward round is over, handover jobs to the AMU FY1 and support the first on with clerking.

21:00-21:30 Handover to the night team in the handover room on ward 46

Weekend/ bank holiday on call duties:

- Assist with AMU ward round in the morning

- Clerking of patients admitted on general take

- Review of unwell patients admitted on general take

- Review of unwell patients admitted on general take

- Review of unwell patients on AMU and support of junior doctors as necessary

**Medical Registrar**

**ST3+ Week day**

09:00-21:30

09:00-09:30 Attend handover in the handover room on ward 46, collect the bleep from the night ST3+.

09:15-21:00 On call work

21:00-21:30 Handover to the night team in the handover room on ward 46

**ST3+ Weekends/ Bank holidays**

09:00-21:30

09:00-09:30 Attend handover in the handover room on ward 46, collect the bleep from the night ST3+.

09:15-11:30 Ward round on CCU with cardiology consultant

11:30-12:30 Ward round on RSU (ward 48)

12:30-21:00 General on call work

21:00-21:30 Handover to the night team in the handover room on ward 46

**ST3+ Night shift**

21:30-09:00

21:00-21:30 Handover from the day team in the handover room on ward 46. Collect the bleep from the day ST3+

21:30-08:00 General on call work

08:00-09:00 Ward round AMU with on call consultant

09:00-09:30 Attend handover in the handover room on ward 46

Additional night shift duties include:

- Senior review of any patients handed over from day team that haven’t been post taked.

- Clerking of patients along with first on

- **On call duties**

- Carry the cardiac arrest bleep and lead the crash team

- Assist with the ward round on EAU

- Take ward referrals from non-medical specialties

- Give advice over the phone to non-medical specialties

- Medical review of unwell patients in ED/ Resus Clerking of patients with first on, second on and middle grade

- Supervising juniors as well as keep control of the take

- Teaching

**The 8am OGD Slot**

The gastroenterologists have agreed to provide an urgent GI bleed endoscopy slot at 8AM. A GI bleed endoscopy coordinator has been identified and should be contactable on VOIP 3872. A GI bleed nurse rota has also been agreed to facilitate the 8AM GI bleed slot.

*Practicalities of utilising the 8am OGD Slot*

It is crucial that the patient be in the endoscopy department *and* ready to be scoped by 8am, to minimize impact on the endoscopy unit and the gastroenterologist. This service is being provided in addition to existing clinical activity for the endoscopy unit and the gastroenterologist. The patient needs to be cannulated, consented and stabilized with a view to starting the procedure at 8AM in the endoscopy unit.

It is key that the on-call medical SPR liaise with the endoscopy GI bleed coordinator before 7:30AM about patients admitted with a GI bleed. The endoscopy GI bleed coordinator should also bleep the on-call medical SPR at 7:30AM, so that every effort is made for potential GI bleeds to use that slot. At the night medical handover meeting, potential GI bleeds should be flagged. The site coordinator should also handover any potential GI bleeds to the on-call medical SPR before 7:30AM.

If no patients are identified, then the 8AM slot should not be filled with diagnostic OGDs, to prevent unnecessary delays to starting service lists at 8:30AM.

Only one patient can be physically scoped in that 8AM slot, be it in the endoscopy department or in theatres. All referrals will need to be coordinated by the GI bleed coordinator so that two bleeds are not organised simultaneously, in theatres and in the endoscopy unit. Also, to ensure an endoscopy nurse is available to assist with the scope.

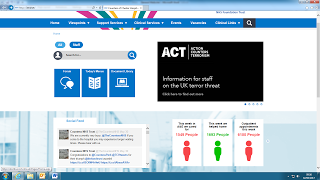
*If the patient needs endoscopy in theatre:*

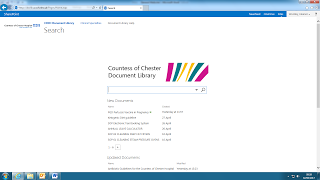
Patients with fresh haematemesis or who are unstable will be scoped in theatre. The anaesthetists have agreed to support this, provided their involvement is restricted to patients that require intubation. All other patients should be scoped in the endoscopy unit.

**Useful guidelines**

You can access the intranet using the link below or via the homepage on internet explorer from any trust computer and clicking on the link to the document library. (These links will only work if this page is accessed on a hospital networked computer)

[http://doclib.xcoch.nhs.uk/Pages/Specialty.aspx](http://www.google.com/url?q=http%3A%2F%2Fdoclib.xcoch.nhs.uk%2FPages%2FSpecialty.aspx&sa=D&sntz=1&usg=AFQjCNFAsJNodPpKn2LJCj5k4o4SqtzGMA)





Guidelines you will commonly use whilst on call include:

Sepsis

[http://doclib.xcoch.nhs.uk/Documents/Sepsis%20Pathway%20updated%202015.docx](http://www.google.com/url?q=http%3A%2F%2Fdoclib.xcoch.nhs.uk%2FDocuments%2FSepsis%2520Pathway%2520updated%25202015.docx&sa=D&sntz=1&usg=AFQjCNH6emtzim5C94C70ick3gevW3Cd_g)

[http://doclib.xcoch.nhs.uk/Documents/Sepsis%20Care%20Bundle.docx](http://www.google.com/url?q=http%3A%2F%2Fdoclib.xcoch.nhs.uk%2FDocuments%2FSepsis%2520Care%2520Bundle.docx&sa=D&sntz=1&usg=AFQjCNG3tqweFsYFQvnuJXiZPtRvq3NvdQ)

Antibiotics

[http://doclib.xcoch.nhs.uk/Documents/Antibiotic%20Guidelines%20for%20the%20Countess%20of%20Chester%20Hospital.doc](http://www.google.com/url?q=http%3A%2F%2Fdoclib.xcoch.nhs.uk%2FDocuments%2FAntibiotic%2520Guidelines%2520for%2520the%2520Countess%2520of%2520Chester%2520Hospital.doc&sa=D&sntz=1&usg=AFQjCNETxlunEnwhEJa03laSA8NQmurptw)

AKI

[http://doclib.xcoch.nhs.uk/Documents/AKI%20(Acute%20Kidney%20Injury)Network%20Manual.pdf#search=AKI](http://www.google.com/url?q=http%3A%2F%2Fdoclib.xcoch.nhs.uk%2FDocuments%2FAKI%2520%28Acute%2520Kidney%2520Injury%29Network%2520Manual.pdf%23search%3DAKI&sa=D&sntz=1&usg=AFQjCNH7p2ylVydXbSy2Rh03bRCGmbMvWQ)

ACS

[http://doclib.xcoch.nhs.uk/Documents/Cat\_1\_Chest\_pain\_primary\_PCI%202016.pdf#search=ACS](http://www.google.com/url?q=http%3A%2F%2Fdoclib.xcoch.nhs.uk%2FDocuments%2FCat_1_Chest_pain_primary_PCI%25202016.pdf%23search%3DACS&sa=D&sntz=1&usg=AFQjCNGXZ3bnd8eXgquDN7aUpcOeescgfA)

[http://doclib.xcoch.nhs.uk/Documents/LHCH%20ACS%20Referral%20Form.doc](http://www.google.com/url?q=http%3A%2F%2Fdoclib.xcoch.nhs.uk%2FDocuments%2FLHCH%2520ACS%2520Referral%2520Form.doc&sa=D&sntz=1&usg=AFQjCNHTub1crbaPtehiYR_mrWgKRRi9DA)

AF

[http://doclib.xcoch.nhs.uk/Documents/AF%20Pathway%202016.pdf#search=AF](http://www.google.com/url?q=http%3A%2F%2Fdoclib.xcoch.nhs.uk%2FDocuments%2FAF%2520Pathway%25202016.pdf%23search%3DAF&sa=D&sntz=1&usg=AFQjCNENpnMWu6YHYCDn88Trk6pMX6fRkw)

Decompensated Liver Failure

[http://doclib.xcoch.nhs.uk/Documents/Decompensated%20Chronic%20Liver%20Disease%20Care%20Bundle%20The%20first%2024%20hours%20pathway.docx](http://www.google.com/url?q=http%3A%2F%2Fdoclib.xcoch.nhs.uk%2FDocuments%2FDecompensated%2520Chronic%2520Liver%2520Disease%2520Care%2520Bundle%2520The%2520first%252024%2520hours%2520pathway.docx&sa=D&sntz=1&usg=AFQjCNG5wwyW-BRYwuDzLK-fJMeiTKyPuA)

High INR

[http://doclib.xcoch.nhs.uk/Documents/Management%20of%20Patients%20with%20a%20High%20INR%20Clinical%20Guideline.doc](http://www.google.com/url?q=http%3A%2F%2Fdoclib.xcoch.nhs.uk%2FDocuments%2FManagement%2520of%2520Patients%2520with%2520a%2520High%2520INR%2520Clinical%2520Guideline.doc&sa=D&sntz=1&usg=AFQjCNEKnmDM8Gg-jZilZM7k3ubYFb5bxw)

DVT

[http://doclib.xcoch.nhs.uk/Documents/Deep%20Vein%20Thrombosis%20Management%20Guideline%20V1%202015.docx](http://www.google.com/url?q=http%3A%2F%2Fdoclib.xcoch.nhs.uk%2FDocuments%2FDeep%2520Vein%2520Thrombosis%2520Management%2520Guideline%2520V1%25202015.docx&sa=D&sntz=1&usg=AFQjCNEBwpD1bwgv_eaSBWg2T4cSlqFa9Q)

Blood transfusion

[http://doclib.xcoch.nhs.uk/Documents/Blood%20Transfusion%20-%20Collection%20and%20administration%20of%20blood%20components.doc](http://www.google.com/url?q=http%3A%2F%2Fdoclib.xcoch.nhs.uk%2FDocuments%2FBlood%2520Transfusion%2520-%2520Collection%2520and%2520administration%2520of%2520blood%2520components.doc&sa=D&sntz=1&usg=AFQjCNFvVEXNl5FSQycDwnnlOvTZYpEIRQ)

**Cardiovascular:**

Acute Coronary Syndrome:

[http://doclib.xcoch.nhs.uk/Documents/Cat%202%20Chest%20Pain%20NSTEACS%20pathway%202015.pdf](http://www.google.com/url?q=http%3A%2F%2Fdoclib.xcoch.nhs.uk%2FDocuments%2FCat%25202%2520Chest%2520Pain%2520NSTEACS%2520pathway%25202015.pdf&sa=D&sntz=1&usg=AFQjCNHoH7zwMqayylcK5AI_2r8zDPedKA)

Giant Cell Arteritis:

[http://doclib.xcoch.nhs.uk/Documents/Giant%20Cell%20(Temporal)%20Arteritis%20Diagnosis%20and%20Management%20Guidelines.doc](http://www.google.com/url?q=http%3A%2F%2Fdoclib.xcoch.nhs.uk%2FDocuments%2FGiant%2520Cell%2520%28Temporal%29%2520Arteritis%2520Diagnosis%2520and%2520Management%2520Guidelines.doc&sa=D&sntz=1&usg=AFQjCNHBe0gM8GfqgkD0TWEPAVIeRVbhTw)

Pulmonary Embolism:

[http://doclib.xcoch.nhs.uk/Documents/Oral\_and\_parenteral\_anti-coagulation\_for\_inpatients\_at\_COCH\_2014.docx](http://www.google.com/url?q=http%3A%2F%2Fdoclib.xcoch.nhs.uk%2FDocuments%2FOral_and_parenteral_anti-coagulation_for_inpatients_at_COCH_2014.docx&sa=D&sntz=1&usg=AFQjCNF6FpgPrZWTjXeGnsKQ8Jnk8RjtNA)

Tinzaparin Dosage (Particularly useful for treatment doses):

[http://doclib.xcoch.nhs.uk/Documents/Oral\_and\_parenteral\_anti-coagulation\_for\_inpatients\_at\_COCH\_2014.docx](http://www.google.com/url?q=http%3A%2F%2Fdoclib.xcoch.nhs.uk%2FDocuments%2FOral_and_parenteral_anti-coagulation_for_inpatients_at_COCH_2014.docx&sa=D&sntz=1&usg=AFQjCNF6FpgPrZWTjXeGnsKQ8Jnk8RjtNA)

**Gastrointestinal:**

Upper GI Bleed:

[http://doclib.xcoch.nhs.uk/Documents/Upper%20GI%20Bleed%20Pathway.pdf#search=ogd](http://www.google.com/url?q=http%3A%2F%2Fdoclib.xcoch.nhs.uk%2FDocuments%2FUpper%2520GI%2520Bleed%2520Pathway.pdf%23search%3Dogd&sa=D&sntz=1&usg=AFQjCNHjmXxDa1h4c5gYiBkP4gsm7fv29Q)

**Metabolic Medicine:**

Diabetic Ketoacidosis:

[http://doclib.xcoch.nhs.uk/Documents/Adult%20Diabetic%20Ketoacidosis%20Guidelines.docx](http://www.google.com/url?q=http%3A%2F%2Fdoclib.xcoch.nhs.uk%2FDocuments%2FAdult%2520Diabetic%2520Ketoacidosis%2520Guidelines.docx&sa=D&sntz=1&usg=AFQjCNH8S1jlZlG6iLTfZMfe0rFZVJhrOw)

Hyperglycaemia Management:

[http://doclib.xcoch.nhs.uk/Documents/Management%20of%20Hyperglycaemia%20on%20the%20ward%20advice%20for%20Junior%20Medical%20Staff%202015.docx](http://www.google.com/url?q=http%3A%2F%2Fdoclib.xcoch.nhs.uk%2FDocuments%2FManagement%2520of%2520Hyperglycaemia%2520on%2520the%2520ward%2520advice%2520for%2520Junior%2520Medical%2520Staff%25202015.docx&sa=D&sntz=1&usg=AFQjCNE_e9Gngvhb2Nz0vMFaApudGLlpfw)

Hyperkalaemia Management:

[http://doclib.xcoch.nhs.uk/Documents/Hyperkalaemia%20management%20guidelines.doc](http://www.google.com/url?q=http%3A%2F%2Fdoclib.xcoch.nhs.uk%2FDocuments%2FHyperkalaemia%2520management%2520guidelines.doc&sa=D&sntz=1&usg=AFQjCNG3lytbQ-8WAu7ngKJ6aAByxOnz_A)

Hypomagnesaemia

[http://doclib.xcoch.nhs.uk/Documents/Hypomagnesaemia%20-%20Guidelines%20for%20management.doc](http://www.google.com/url?q=http%3A%2F%2Fdoclib.xcoch.nhs.uk%2FDocuments%2FHypomagnesaemia%2520-%2520Guidelines%2520for%2520management.doc&sa=D&sntz=1&usg=AFQjCNHrgiOs9xZWvezXSkSmtDW84QHm0A)

Hypocalcaemia

[http://doclib.xcoch.nhs.uk/Documents/9.5%20Minerals%20v2.doc](http://www.google.com/url?q=http%3A%2F%2Fdoclib.xcoch.nhs.uk%2FDocuments%2F9.5%2520Minerals%2520v2.doc&sa=D&sntz=1&usg=AFQjCNGb9mCaa7vfJJ9jB9b-pukSLJ3mgg)

Hypercalcaemia

[http://doclib.xcoch.nhs.uk/Documents/Hypercalcaemia%20management.doc](http://www.google.com/url?q=http%3A%2F%2Fdoclib.xcoch.nhs.uk%2FDocuments%2FHypercalcaemia%2520management.doc&sa=D&sntz=1&usg=AFQjCNGBESDvI7o4-POmYBCSZPiaECcH4A)

IV Potassium Policy (Useful for suggested infusion rates)

[http://doclib.xcoch.nhs.uk/Documents/Intravenous%20Potassium%20Administration%20Policy%202014.doc](http://www.google.com/url?q=http%3A%2F%2Fdoclib.xcoch.nhs.uk%2FDocuments%2FIntravenous%2520Potassium%2520Administration%2520Policy%25202014.doc&sa=D&sntz=1&usg=AFQjCNHPB_xD6I63bmmlIrhmhRkm4FmZdA)

**Microbiology**

Antibiotic Guidelines:

[http://doclib.xcoch.nhs.uk/Documents/Antibiotic%20Guidelines%20for%20the%20Countess%20of%20Chester%20Hospital.doc](http://www.google.com/url?q=http%3A%2F%2Fdoclib.xcoch.nhs.uk%2FDocuments%2FAntibiotic%2520Guidelines%2520for%2520the%2520Countess%2520of%2520Chester%2520Hospital.doc&sa=D&sntz=1&usg=AFQjCNETxlunEnwhEJa03laSA8NQmurptw)

**Elderly Medicine:**

Delirium (useful section on drugs used in the management):

[http://doclib.xcoch.nhs.uk/Documents/DELIRIUM%20–%20PREVENTION,%20RECOGNITION%20AND%20TREATMENT.docx](http://www.google.com/url?q=http%3A%2F%2Fdoclib.xcoch.nhs.uk%2FDocuments%2FDELIRIUM%2520%25E2%2580%2593%2520PREVENTION%2C%2520RECOGNITION%2520AND%2520TREATMENT.docx&sa=D&sntz=1&usg=AFQjCNHlxLAEav9yq_8mTSVSMDsQzY87xg)

[http://doclib.xcoch.nhs.uk/Documents/Anxiety%20and%20confusion%20management%20guidelines.doc](http://www.google.com/url?q=http%3A%2F%2Fdoclib.xcoch.nhs.uk%2FDocuments%2FAnxiety%2520and%2520confusion%2520management%2520guidelines.doc&sa=D&sntz=1&usg=AFQjCNFmPERQjHJawbyMEC4c2FiP1VHsWA)

[http://doclib.xcoch.nhs.uk/Documents/Behavioural%20and%20Psychological%20Symptoms%20in%20Dementia%20Guidelines%2020](http://www.google.com/url?q=http%3A%2F%2Fdoclib.xcoch.nhs.uk%2FDocuments%2FBehavioural%2520and%2520Psychological%2520Symptoms%2520in%2520Dementia%2520Guidelines%25202012.docx&sa=D&sntz=1&usg=AFQjCNG0reoivXpYcQCE7iBBQfUfSehpbA)