Medical triage to specialty guidelines

Brighton and Sussex University Hospitals NHS Trust

Please ensure that the reason for referral to specialty is clearly documented on the list

COTE

- Rockwood ≥5 (unless clear single organ pathology more appropriate to another specialty)
- Clear long stay/complex discharge over 80 years. This includes patients with fractures not being managed surgically. However, MUST NOT ACCEPT PATIENTS IN A NECK COLLAR (unable to manage on medical wards)

Acute Medicine: All patients on L5 not under another specialty

- Likely short stay (<48 hrs) with no clear single organ failure fitting into another specialty
- Those needing specialty reviews e.g. acute Neurology, Dermatology and Rheumatology
- Drug overdoses
- Feeding tube issues not requiring endoscopy including refeeding
- Anorexia

Note: if <80yrs and it is unclear whether they should be acute med or frailty please discuss in the morning meeting

Resp

- Exacerbation of known chronic lung disease, especially if respiratory failure is present
- Complicated CAP (parapneumonic effusion or suspected empyema, lung abscess or cavitation)
- First presentation of pleural effusion requiring IP mx
- Suspected lung cancer for work up
- Suspected TB
- Haemoptysis (unless trivial/proven 2° PE)
- Spontaneous pneumothorax

Endo

- 1° endocrine disorders inc complications of diabetes
- Electrolyte disturbance: non-malignant ↑Ca, severe ↓Ca, severe ↓Na ≤ 115 (non-frail)
- Patients with pituitary disease and / or diabetes insipidus (we can always co-care if this is not their primary problem, but should be involved)

Transfers

- Leve 6A: **Acute Med**
- Level 8 Tower: **Endo**
- L10 Tower, Level 8A E & W and L9 Millennium: **Gastro**
- Trafford Ward: **Renal**
- Courtyard: **ID**
- Chichester/Jowers/Vallance/Emerald wards: **COTE**
- Overton: **Respiratory**
- Baily: whichever specialty is most appropriate

Cardiology

- Suspected acute coronary syndrome
- Primary cardiac arrhythmia
- CCF

Renal

- Nephrotic syndrome
- AKI requiring renal replacement therapy
- AKI with Ix suggesting intrinsic renal disease
- Haemodialysis / Peritoneal dialysis / Renal transplant patients (without a 1°problem most appropriately managed by another speciality)

Gastro

- Decompensated liver failure
- Obstructive Cholangitis (i.e. will require ERCP)
- Bloody diarrhoea or probable IBD
- Malaena for consideration of OGD

Oncology

- Patients receiving active oncology treatment, admitted with related issues e.g. febrile neutropaenia, drug/ disease related complications, progression of disease

Haematology

- Patients well known to haematology undergoing active treatment
- If a patient needs to be triaged to haematology, they need to be informed with a bleep at 9am

Stroke

- Ischaemic stroke
- Haemorrhagic stroke – intraparenchymal haemorrhage (not SAH or SDH)
- Crescendo TIA

ID: All patients on Courtyard

Non-medical specialties

- Surgeons: acute abdominal pain of unclear cause, acute cholecystitis, PR bleeds, truncal cellulitis, rib fractures → Note: chronic pancreatitis should be managed by usual team
- Upper limb cellulitis: Ortho
- Urology: post-operative or post-instrumentation complications. Discuss frank haematuria.
- Traumatic head injury - Surgeons unless neurosurgery required

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