Forth Valley Royal Hospital
Department of Cardiology

JUNIOR MEDICAL STAFFING

CARDIOLOGY PATIENTS IN CRITICAL CARE

Catherine Labinjoh
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Welcome to Critical Care. We are delighted to have you as part of our team looking after Cardiology patients within critical care. The Cardiology service is busy, with a rapid turnaround of patients and frequent transfers to and from tertiary centres. This requires excellent teamwork and communication. If you are uncertain don't hesitate to ask us for help. We want to help you to help us provide the best possible care for our patients. You'll find a list of team members and their contact details below.

Consultants

Dr Catherine Labinjoh (Clinical Lead)
Dr Allan Bridges
Dr Stephen Glen
Dr Allister Hargreaves
Dr Gareth Padfield
Dr James Spratt

Senior Charge Nurse: Sister Carolyn Probert

Senior Cardiovascular Pharmacist: Anne Mitchell

Specialist Nursing Services: Catherine Mondoa Nurse Consultant & Cardiology Manager

- **Heart Failure ANPs:**
  Frances Kennedy, Jennifer Flanagan , Laura Mackintosh, Kerrie McKellar
  - Page Number 1231
  - Ext 66980

- **Cardiac Rehabilitation:** (office on Cardiology Ward)
  Lindsay Jamieson Senior Physiotherapist FVRH 01324 566349
  Brenda Haggerty Cardiology Specialist Nurse The Peak 01786 469819
  Shirley Watkins Cardiology Specialist Nurse
  Clare Mellis Cardiology Specialist Nurse
  Evonne McLuskey Cardiology Specialist Nurse
  Kirsty Hughes Physiotherapist

- **Cardiology Day Unit:**
  Julie Macdonald ext 67232

- **Cardiology Investigation Manager/Senior Physiologist**
  Joanne Cusack 66970

Cardiology Patients within Critical Care
The majority of patients within the critical care unit are cared for by the critical care team with variable degrees of input from other specialties. However, a small number of patients are hosted in critical care under the direct responsibility of a cardiology consultant. These patients do not have traditional level 2 care needs but are cared for in critical care because of higher-need cardiac conditions, typically unstable angina, acute coronary syndrome or unstable dysrhythmia. They may be referred to as "CCU patients within critical care". As an FY doctor you will be involved in the care of these patients alongside the nursing staff but senior medical staff from critical care would not usually be involved. If you are uncertain about whether a patient is a critical care patient or a "CCU" patient please ask. Patients with level 2 needs and above would usually be managed in the usual critical care fashion, with input from cardiology and/or other specialties as required.

Cardiologist of the Week
The cardiology on call rota is distributed to Critical Care teams at least one week in advance. A cardiology consultant is on call each weekday. They will be responsible for assuming responsibility for the care of any patients transferred into critical care before 4pm (and who have not already been reviewed on that admission by one of the other consultants). The on call cardiologist will typically conduct a daily ward review during which they will review any patients newly admitted to the ward.

Individual cardiology consultants retain responsibility for their own patients (as designated on eWard) unless they are on leave/absent, in which case the patients will have been formally handed over to one of the other consultants. Any urgent queries regarding these patients should be directed to the on-call consultant. Individual consultants will typically undertake 2-3 ward rounds each week depending upon patient load. As consultants have outpatient, procedural, management and other commitments, the timing of ward rounds will vary.

FY1 Duties

As an FY1 you will be a key member of the team caring for cardiology patients and we are keen for you to be involved in all aspects of patient management. A brief assessment of the patient's clinical status at the time of arrival into the ward is essential but it is not necessary to repeat a full clerk-in. Please familiarise yourself with the investigation and management plan for each patient, ensuring that planned investigations have been requested and any outstanding results have been documented and acted on appropriately. As such, attendance on ward rounds is advised/desirable when possible. The ward FY1 is responsible for generating immediate discharge letters (IDLs) and transfer letters (see below).

Discharges **-** *(see appendix 1)*
Patients expected to be discharged that delay should be flagged up to the consultant cardiologist to be seen early on the ward round so as to minimise delays (please speak to senior nurse in cardiology ward or bleep consultant directly). It is important that we should also identify any planned discharges for the following day. Discharge letters/ prescriptions for these patients (please use Cardiology Standardised Discharge Template) should, whenever possible, be completed the day prior to discharge so as minimise delays in discharging patients. Please ensure the discharge letter accurately states the patient's diagnosis. If unsure, check with the middle grade staff or consultant.

Supervised Learning
Cardiology patients within critical care provide an opportunity to learn about more complex cardiac conditions. You may wish to base some of your supervised learning events around these clinical opportunities and as such, consultant cardiologists would be very happy to provide teaching, feedback and assist with SLEs at your request.

In-patient Referrals
Angiography:

- Inpatients For both GJNH and RIE, use the SCI gateway referral form found in drawer 4 of the metal cabinets next to the telemetry monitor in the cardiology ward. Once completed take the form to the cardiology department secretaries (Colleen and Lynn), found in the cardiology outpatients next to the lab pods. They will send it over to the selected tertiary centre. If both absent send to Mrs Easton, Cardiology Secretary, 2nd floor clinical offices.
  For RIE the cardiology coordinator should be contacted on 07815 911663
  Remember you NEED to include a GRACE 1.0 score on the referral form or it will not be sent.
  https://www.outcomes-umassmed.org/grace/acs_risk/acs_risk_content.html
  Quote the risk of death or MI at 6 months (lower left box, number, not percent, http://gracescore.co.uk/risk-stratification)

- Outpatient referral to GJNH is exactly the same as for inpatients.

- Outpatient referral to RIE, request to Mrs Liz Baxter 0131 242 1848. liz.baxter@nhslothian.scot.nhs.uk. A copy of the discharge letter should be sent by email. NHS Lothian DO NOT accept outpatient referrals via SCI gateway.

Cardiac Devices:

- Pacemakers referrals, phone the cardiology coordinator on 07815 911663. The nursing staff will often assist with this.
- ICD and CRT referrals should be discussed with the Cardiology Consultant

Discharges (see appendix 1)
Every day you should plan for discharges following the completion of the daily ward rounds. Whenever possible the IDL (please use Cardiology Standardised Discharge Template) should be completed in draft form not later than the day prior to the patients discharge. Please ensure the discharge letter accurately states the patient's diagnosis. If you are not sure check with the middle grade staff or consultant.

Outpatient Investigations: It is important that any planned outpatient investigations are requested prior to discharge and that this is documented clearly in the case notes/ immediate discharge summary.

Outpatient/ Clinic Follow-up: Any follow-up arrangement should be clearly documented. When a Consultant has requested follow-up in his/her clinic then the discharge letter must be passed to Linda Hatton in the Cardiology Outpatient Dept.
Other specialty involvement: Where another specialty has been involved in in-patient care please forward a copy of the discharge letter to them.

Deaths
The team who have looked after the patient during life should issue the Death Certificate after discussion with the patient's consultant about cause of death. This certificate should normally be handed to the relatives in person **9.00am – 5.00pm Monday to Friday**. If a death occurs out with these times the Death Certificate should not be issued until a member of the patients team is available to discuss the death, unless under exceptional circumstances.

The General Practitioner and the patients Consultant **MUST** be informed of the death as soon as possible. The call to the patient's GP should also be documented in the case notes.

The case notes of deceased patients are kept for 14 days on the ward. The names of deceased patients must be recorded on the black clipboard kept in the plastic box – this is to facilitate the completion of Morbidity and Mortality forms, which are completed by the registrars.

Medical Unit Meetings

- **Monday 12:30pm** – Medical Division Meeting/ Grand Round. Lunch will be provided. Lecture Theatre. Medical Education Centre, Level 3

Further Educational Opportunities

Echo Meeting: Every Tuesday at 1215pm- 1pm Cardiology Seminar Room 2
Heart Failure MDT: 1st Tuesday of every month at 0830, cardiology ward MDT room
Cardiology Day Unit – DC Cardioversion, cardiac loop recorder implantation, TOE – variable. Please ask

Sickness Absence Protocol

In the event of being unable to attend work due to illness please let us know providing as much notice as is possible. We would also ask that individuals contact the charge nurse / medical staff on the ward to inform them if they are unable to come to work, if possible.

Quality Improvement

There should be ample opportunity during the course of your attachment to participate in medical audit and clinical improvement exercises. We would suggest that junior doctors should approach individual consultants early in the course of their attachments to find out what projects may be available.

Appendix 1.
(thanks to *Killian Mac a' Bhaird & Patrick Scott)*

STANDARDISED DISCHARGE LETTER TEMPLATE FOR DISCHARGES (and TRANSFERS) FROM CARDIOLOGY WARD

Dear Doctor,
…….was admitted to Forth Valley Royal Hospital on ../../20.. with (symptoms - chest pain/shortness of breath/productive cough etc). Brief synopsis of presenting complaint leading to admission
Diagnosis: (check with Consultant)*
Previous Medical History:
Investigations – to be included whether performed or not:
ECG –
Troponin – *highest*
Chest x-ray –
Echo *(LV function preserved or reduced?)*
Management: (e.g. initial treatment, admission to cardiology ward, which medical staff saw the patient/implemented management plan)
Driving advice:§
Changes to medications: Including new dose
Follow up: (e.g. heart failure team, post-PCI clinic, post-pacemaker insertion clinic, consultant outpatient clinic etc)
GP Actions: (e.g blood test, further review)

Yours sincerely,

FY1 to ……..Consultant name

***Discharge Diagnosis:** It is **important** that for accurate coding, the diagnosis list includes the main presenting diagnosis **FIRST** and pre-existing co-morbidities in order of importance within the diagnosis section (not in free text).
Please comment on **HEART FAILURE** as heart failure with reduced ejection fraction (<50%) or reduced ejection fraction, not just heart failure.

§ Driving advice can be located at https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals. This is particularly important in patients with a diagnosis of myocardial infarction or syncope but may be relevant in other conditions, including heart failure. There are special conditions for schedule 2 licence holders (bus and HGV drivers). Please include driving advice in all letters where applicable