Valid for East of England Hyperbaric Unit and Whipps Cross Hyperbaric Unit

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EMERGENCY REFERRALS and ADMISSIONS

(see also SOP on ICU referral flowchart)

INTRODUCTION

All patients treated within the Hyperbaric Oxygen Facility are referred with conditions for which either:

1). Evidence of the clinical effectiveness of Hyperbaric Oxygen exists and is accepted by the referring agency, the Lead Clinician or his/her representative *or*

2). A protocol exists, and is followed, in respect of a clinical trial/ Registry. 3). A patient is only accepted if staff and equipment are available, and an appropriate hospital bed is available.

REFERRAL PROCEDURE

a). Referrals are received from several agencies:
- Accident & Emergency Departments
- Other consultants
- Diving Medicine advice lines (i.e. Institute of Naval Medicine, DDRC)
- HART team
- Self-referrals, mainly for decompression illness

b). Telephone contact should be made initially with the Hyperbaric Duty Doctor, or with the Supervising Chamber Operator. In either case, contact is made with the other team members without delay. In every case, the caller's name and telephone number are recorded by the team-member first called. A mobile telephone number is helpful for contact during transport to the Hyperbaric Unit.

See appendix 1 for the callout procedure for East of England hyperbaric unit

LHM referrals are received by the hyperbaric duty Dr, LHM duty supervisor or during daytime also the patient administrator.

c). The availability of appropriate staff for each referral is checked before any patient is accepted (see below). This may be clear from information established before the referral is received.

d). If the clinical condition of the patient is such that the Unit is unable to accept them, or if the patient needs to be treated in an alternative hyperbaric facility, the Hyperbaric Duty Doctor contacts the alternative hyperbaric facility, to expedite the referral. In case of ventilated patients, the Dr on call/ Medical Director to be called immediately.

e). Clinical advice regarding the immediate treatment of the patient is offered, except where the patient is to be referred to another hyperbaric facility. A record is kept of any telephone advice given, together with the patient's name, and filed in the patient's case notes. Where the patient does not require hyperbaric oxygen treatment, the advice given is recorded in the 'telephone consultation' file.

f). The Supervising Chamber Operator may be able to expedite transport of the patient to the Hyperbaric Unit by suggesting an appropriate alternative to NHS Ambulance Services. Patients are advised not to drive themselves to the Unit, especially if unaccompanied. Directions via road or public transport can be faxed to the referring agent. Patients are delivered to the Accident & Emergency Department unless the duty Dr gives instructions to bring the patient directly to the hyperbaric unit.

g) The Hyperbaric Duty Doctor advises the Clinical Site Manager that the (named) patient is en-route to LHM, in case of telephone calls from relatives and friends.

h). The Hyperbaric Duty Doctor, assume responsibility for the patient only on arrival at the Hyperbaric Unit. A verbal and written, handover is given to clinical staff of the Hyperbaric Unit before any escort team is allowed to depart.

i). The Hyperbaric Duty Doctor supervises any immediate clinical support for the patient, before proceeding to specific assessment. The local clinical teams are consulted without hesitation by the Hyperbaric Duty Doctor. Any intercurrent illness, actual or suspected, prompts such a referral; and the opinion and recommendation of any such hospital staff are recorded by them in the patient's clinical records.

j). The patient is admitted under the care of the Lead Clinician or in his absence the duty Doctor. If the patient is admitted to our Hospital, they are under the care of the team in charge of the ward or ICU. The hyperbaric Lead Clinician /duty Dr will give every possible support the team requires, and attend in person if so requested.

k). The assessment of the patient requires normal standards of confidentiality and may require the use of the office facilities.

l). Investigations, including CT or MRI scans, together with in-patient services, are accessed directly by the Hyperbaric Duty Doctor, and recorded on the services data sheet for each patient, for subsequent billing purposes.

m). The hyperbaric treatment requires a written prescription in the patient's clinical records, and a form of consent consistent with practice in our Hospitals.
n). Relatives are kept informed of progress, in person or by telephone, in accordance with the patient's wishes, or if the patient is unable to consent to this with the next-of-kin, according to good general clinical practice.

DURING THE COURSE OF TREATMENT

a). The Hyperbaric Duty Doctor is present during the whole of the treatment. This generally means that he/she remains at least in the hospital. The Hyperbaric Duty Doctor may need to remain in the Department throughout the treatment, either in order to supervise clinical activities, or to act as a member of the minimum treatment team, and sometimes taking the role of Chamber Operator or Attendant if suitably qualified.

b). Changes in the planned treatment schedule are recorded, with reasons, in the patient's clinical records.

c). All adverse events occurring during treatment are recorded in the patient's clinical records, and any other reports (such as incident report forms) are written and submitted without delay. All side effects, e.g., barotrauma of the middle ear, are reported to the Medical Director for statistical purposes.

d). The Hyperbaric Duty Doctor follows the Standard Operating Procedures, with particular respect to clinical decision-making.

AT THE END OF A TREATMENT

a). The Hyperbaric Duty Doctor re-assesses the emergency patient at the end of any single treatment and records his/her findings in the patient's clinical records. This record includes a decision about any further treatment required, its nature and when it is due to be given. These decisions are shared with the Supervising Chamber Operator, to plan appropriately. Elective patients are assessed after each 10th treatment or earlier if required.

b). A decision to admit the patient to our hospitals or another hospital is usually made during the first treatment, leaving sufficient time for arrangements to be made. The Hyperbaric Duty Doctor, or another member of the team, contacts the Clinical Site Manager, requesting a bed and specifying any requirements (such as a ground floor ward for a para-suicidal patient). If no suitable bed is available, another hospital is contacted. Occasionally the patient may need to wait for a bed, it may be necessary to move the patient to the Accident & Emergency Department, so that the staff of the Hyperbaric Unit can be released, but if no capacity in A&E, the hyperbaric staff will have to stay with the patient.

c). If no suitable bed is available locally, the patient may need to be transferred back to the referring hospital or agency.

d). The Hyperbaric Duty Doctor remains contactable directly by the nursing staff in the ward where the patient is admitted. Trainee doctors are only involved in ward management of the patient through such an admitting consultant.

AT THE END OF A COURSE OF TREATMENT

a). A letter of advice is given to any patient being discharged home, and an appointment for follow-up agreed and recorded in the patient's clinical records at the time where indicated. The date of any follow-up is given in writing in the patient's discharge advice letter and is also recorded in the Diary.

b). A patient being returned to the referring hospital or agency requires a discharge summary to go with the patient. This urgent task takes priority over any other non-clinical duties, as it facilitates safety and good communication.

Appendix 1: call out protocol for JPUH