After Hours Inpatient Medical Cover Proposal

We are keen to support the membership to develop a sustainable management plan for non-urgent after-hours inpatient requests that:

1. Avoids an AH call to the GP responsible for the patient and
2. Avoids adding additional workload to AH A&E staff

This will support better patient care given the likely increase in A&E workload and higher acuity that will make it impractical for the MO to leave A&E to deal with non-urgent ward issues.

The current model offers Code Blue and Deteriorating Patient Service 24 hours, seven days a week. All routine inpatient care and clinical care plans are managed by the admitting GP Practice.

After Hours, weekends (specifically - Sunday) and public holidays are to be managed through communication of Clear Care Plans and access to a Doctor of the admitting Practice who can provide clinical advice for scenarios which do not fall within a Deteriorating Patient Scenario.

With Clear Care Plans documented, inclusive of medication chart reviews and clinical handover (GP to A/E doctor discussion if necessary), it is anticipated that unnecessary call outs will reduce over time. This would better support continuity of care.

Our understanding is that Admitting GPs are seeking a sustainable model whereby they cover their patient during core hours Monday - Friday and alternate supports are in place to cover patients overnight and on weekends/public holidays.

Summit Health is working with CHSA to look into options that can best support admitting GPs, however this will take time.

MET and Code Blues will always be covered by the EDcare Doctor 24/7. As an interim arrangement, Summit Health - via the EDcare service - is offering the following medical cover arrangements, checklist and protocols to standardise the approach for notifying GPs of AH issues and managing overnight issues:

Medical Cover Responsibilities 7 Days a Week
8am - 8pm
Admitting GP undertakes all clinical care of their admitted patient including IV orders, drug charts and standing drug orders. Admitting GP can only utilise EDcare Doctor on a doctor-to-doctor discussion and not via message from nursing staff or other means.

8pm - 8am
Nursing team monitors admitted patients and contacts EDcare Doctor where necessary (see below for indicative protocols). At any time, nursing team can ask the EDcare Doctor to attend a deteriorating patient on behalf of the Admitting GP and FFS will be claimed and retained by EDcare.

Where any Admitting GP has failed to undertake minimal expectations (clinical care plan, drug charts, IV orders and standing drug orders) during the day and not handed over to EDcare, then the patient will remain the responsibility of the Admitting GP.

The EDcare Doctor will respond to nursing staff requests overnight whenever possible, however the hospital will follow-up with the Admitting GP to address matters of concern.

It is anticipated that Clear Care Plans (including weekends and public holidays), checklists and communication of Practice after hours/weekend ward cover arrangements to the hospital would be valuable in mitigating unnecessary call outs to the GPs. On the assumption that this model is applied in a mutually respectful manner, then we would envisage this will create some goodwill/flex in the system to benefit all for those odd outliers for which no protocol exists.

The intention will be that a revised model is developed within the first three months that GPs can consider and respond to. It will also give Summit Health the opportunity to engage with the new Regional Board that comes into effect on 1 July and ensure it understands the local issues. During this period we feel it is unlikely that there will be any significant increase in hospital activity that would significantly alter current workload levels for admitting GPs.

Protocols

Background

We are keen to work with the membership to develop a sustainable management plan for non-urgent after hours inpatient requests that:

1. Avoids an AH call to the GP responsible for the patient and
2. Avoids adding additional avoidable workload to AH A&E staff

This will help us all better manage patient care given the likely increase in A&E workload and higher acuity that will (at least on some occasions) make it unfeasible for the MO to leave the ED to deal with non-urgent ward issues.

We are proposing the following checklist and protocol to standardise the approach for notifying GPs of AH issues and managing overnight issues and invite your input:

Checklist for GPs reviewing / admitting inpatients

1. Check IV orders are written for the next 24 hours (or next planned patient review)
2. Check drug charts document the patient's drug orders for the next 24 hours (or next planned patient review)
3. Write up Standing Drug Orders for the patient in anticipation of AH issues including:
    - analgesia (e.g. use of paracetamol, panadeine forte or oxycodone)
    - sedation (e.g. oxazepam, risoperidone or olanzepine or haloperidol)
    - sleeping tablets (e.g. temazepam)
    - laxatives (e.g. coloxyl)
    - antiemetics (e.g. ondansetron)
    - +/- additional drugs based on the patient's PMH such as GTN, salbutamol, antacids, proton pump inhibitors etc.

Protocol for inpatient issues between 8pm and 8am

Problem 1: Patient needs continuing IV orders

Nursing Assessment

- Check the medical case notes for any GP advice on this issue (e.g. cease IV after next bag of normal saline)
- Perform a set of observations to assess the patient meets criteria for deterioration (MET call)
- Leave IV cannula in place.

Nurse to contact ED Care MO

If patient stable: IV orders may be written up the following day.

Nursing staff to notify GP at 8am of need for IV fluid orders.

Problem 2: Patient needs continuing drug orders
Nursing Assessment:

- Check the medical case notes for any GP advice on this issue
- Perform a set of observations to assess the patient meets criteria for deterioration (MET call)

Nurse to contact ED Care MO

If patient stable: Drug orders may be written up the following day. The patient's prescribed drugs will be held pending the written orders.

Nursing staff to notify GP at 8am of need for continuing drug orders.

Problem 3: Patient's IV tissues
Nursing Assessment:

- Check the medical case notes for any GP advice on this issue (e.g. if drinking normally IV cannula can be removed)
- Perform a set of observations to assess the patient meets criteria for deterioration (MET call)
- Hold IV drugs.

Nurse to contact ED Care MO

If patient stable: IV cannula to be reinserted if required the following day.

Nursing staff to notify GP at 8am of need for IV reinsertion.

Problem 4: Patient reports Mild - Moderate Pain

Nursing Assessment:

- Check the medical case notes for any GP advice on this issue
- Perform a set of observations to assess the patient meets criteria for deterioration (MET call)

Nurse to contact ED Care MO

If patient stable: ED Care MO to direct nurse to administer Paracetamol or Panadeine forte or Oxycodone from standing orders.

Nursing staff to notify GP at 8am of need for AH analgesia.

Problem 5: Mild / Mod Agitation
Nursing assessment:

- Check the case notes for GP advice on this issue (e.g. specific sedation orders)
- Perform a set of observations to assess the patient meets criteria for deterioration (MET call)

Nurse to contact ED Care MO

If patient stable: ED Care MO to direct nurse to administer Oxazepam +/- Risperidone (or other sedation as per standing orders).
Nursing staff to notify GP at 8am of need for AH sedation.

Problem 6: Clinical Deterioration

Nursing assessment:

- Check the medical case notes for any GP modification of Deterioration parameters
- Perform a set of observations to assess the patient for deterioration (MET call)

Nurse to contact ED Care MO

If patient stable: Continue close observation of the patient.
Nursing staff to notify GP at 8am of the clinical issue.

Where nursing staff request the EDcare Doctor to attend an in-patient (excluding Code Blues and METs) then fee for service will be claimed by EDcare.

Where admitting GPs have not met the above expectations and there has been no doctor to doctor conversation then it is *not* the EDcare doctors' obligation to play catch-up.

Nursing staff will be expected to contact the admitting GP to address protocols.