1. Abnormal Bloods (Potassium raised)
2. Atrial Fibrillation – New Onset
3. Cellulitis – Red Leg
4. Chest Pain Assessment Unit
5. COPD
6. Diabetes
7. DVT
8. First Seizure
9. Painless Jaundice
10. Pneumonia or Lower Respiratory Tract Infection
11. Pulmonary Embolism – (HOSPITAL ONLY)
12. Severe Acute Headache without focal Neurology
13. Spontaneous Pneumothorax
14. SVT
15. Unilateral Pleural effusion
Pathway for Out of Hours High Potassium Results - (GP)

- A&E GP: Patient has bloods taken and sent to Pathology

  Potassium > 6.5 (OOH) OOH GP called by lab. Check list reviewed*

  OOH hrs GP contacts patient and arranges for patient to attend A&E** for repeat bloods

  A&E perform near patient testing for potassium level

  Potassium > 6.5

  YES
  - Refer to Medical team (OOH)
  - ECG Abnormal
    - Refer to A&E
  - ECG - Normal
    - Refer to Ambulatory Care

  NO
  - A&E discharge with note to GP

* Checklist attached
** Patient to be made aware attending for test, Not necessarily requires admission
Appendix 1.2 Factors supporting a real hyperkalaemia Checklist

Factors supporting a real hyperkalaemia, if any one of the factors below are present the potassium level should be repeated urgently:

- Potassium greater than 7.0 mmol/l
- Patient appears to be unwell
- Compromised renal function (raised creatinine and urea if measured)
- Hyperglycaemia
- ECG changes (tall T waves, prolonged PR interval, flat P waves, widening of QRS complex)
- Cardiac arrhythmias
- Acidosis (low bicarbonate if measured)
- Treatment with potassium supplements
- Treatment with potassium sparing diuretics
- Treatment with ACE inhibitors or angiotensin receptor blockers
- Possibility of digoxin toxicity
- Clinical features of weakness/myopathy
- Known hypoadrenalism
- Evidence of acute tissue damage

Factors which may cause artifactualy raised measured serum potassium, if any one of these factors are present and all the above are absent then factitious hyperkalaemia is more likely:

- Haemolysis (if present, should be reported as such by the laboratory)
- Potassium EDTA contamination of the sample (e.g. contamination by FBC sample, will also have a low measured calcium)
- Prolonged time before separation particularly when exposed to cold (e.g. transport in cold weather, sample left overnight prior to separation, sample stored in fridge—even for a short period of time, etc.)
- Thrombocytosis
- Leukocytosis (very high WBC counts only)
- Erythrocytosis
- Fragile cells (e.g. known familial pseudohyperkalaemia, hereditary spherocytosis etc.)
AMBULATORY CARE PATHWAY New Onset Atrial Fibrillation

Patient presents with suspected Atrial Fibrillation

- No Loss of consciousness
- ECG No ischaemia
- BP >100/60

12 Lead ECG & Bloods

- ECG confirms AF
  - Treat as per guidelines
  - NICE, ESC

- If HR <110 after 3hrs and clinically stable
  - Discharge, continue GP Care

- ECG not AF
  - Consider alternative diagnosis

Refer to Anticoagulation Clinic if CHADS 2 and above. Urgent anticoagulation within 48hrs if no contraindications

Refer to New Onset AF Clinic if new onset AF not requiring immediate assessment

Refer to and complete Pathfinder

Bloods- HB, U&E, Glucose, Lipids, TFT’s

Outpatient ECHO and 24HR Tape referral

ACUTE Patient Contact EMAS, Emergency transfer

Heart Rate <60
BP<100/60
Ischaemic changes on ECG
History of LOC

Contact Cardiac Team

ADMIT

NICE, ESC- European Society of Cardiology
Ambulatory Pathway- RED LEG

Possible Cellulitis
- Unilateral
- Acute
- Painful
- Usually smooth and shiny+/- blistering
- Patient often unwell
- Pyrexia /raised WCC

Patient presents to GP

OBVIOUS CELLULITIS

Does the patient have 1 of the following?
- WBC >14 or <4
- Severe lymphangitis, blistering or large affected area
- Immunosuppression
- Pregnant
- Poorly controlled diabetes
- Peripheral vascular disease
- Lives alone
- Have poor vision/hearing
- Psychological or alcohol/drug misuse issues that would make out patient attendance unsafe

NO and well

Consider Home with IV or Oral Antibiotics

YES

ADMIT for IV Antibiotics if 2 signs of systemic sepsis
- Temp > 38
- Pulse> 90
- Systolic BP<100
- RR > 20

Unsure Diagnosis

Consider DVT (see pathway)

Review above differential If doubt persists

Obvious Eczema

Remain at home
Topical emollients +/- Steroids (e.g. Betnovate RD ointment)

Patient Presents to A& E

Contact Dermatology Unit Medical Staff
Ext: 3319
Hours: 9-5

Possible Eczema
- Often Bilateral
- Chronic (or acute on chronic)
- Itchy
- Scaly +/- blistering
- May have rashes elsewhere
- Patient Well
  - Apyrexial
  - Normal WCC

- WBC >14 or <4
- Severe lymphangitis, blistering or large affected area
- Immunosuppression
- Pregnant
- Poorly controlled diabetes
- Peripheral vascular disease
- Lives alone
- Have poor vision/hearing
- Psychological or alcohol/drug misuse issues that would make out patient attendance unsafe
AMBULATORY CARE PATHWAY – Chest Pain Assessment Unit Access

PATIENTS WITH CHEST PAIN IN COMMUNITY

Is the Chest Pain History ATYPICAL?
  e.g. Pleuritic, Sharp, Positional

Patient to be transferred and assessed in A&E

Is the Chest Pain History CARDIAC sounding?

Perform 12 Lead ECG

ECG = Normal or changes not indicative of STEMI

Evidence of Haemodynamic Instability? i.e. SBP < 90mm Hg, Sats < 90%, HR >100

NO

Patient suitable for Chest Pain Unit Assessment - Inform of ECG findings, History, TIMI and Pain Score

Tel: 01536 491212 / 01536 491177

Calculate TIMI Score (1 point for each)

- Age > 65
- Aspirin use in last 7 days
- >2 episodes in <24 hours
- > 3 Risk factors for CAD*
- Diagnosis of CAD in past
- > 0.5mm ST changes on ECG

YES

ECG changes consistent with STEMI

Activate PPCI pathway through Cardiac Outreach Nurse at KGH

Patient to be assessed in Resus by on call Cardiology Team

BLEEP CARDIOLOGY REGISTRAR VIA KGH SWITCHBOARD
(01536 492000)

TIMI Risk Factors:
- Diabetes
- Smoking
- Raised Cholesterol
- Hypertension
- Family history = male first degree relative < 55yrs or female first degree <65yrs
Patient presents with Primary diagnosis COPD Exacerbation

- Treatment failure or those threatening admission
  - Refer to Ambulatory Unit
  - SPO2 >90% on air or usual oxygen
  - Stable co-morbidities
  - Reduced exercise tolerance compared to normal
  - Socially stable or supportable with ICT or other care agency

- Respiratory HOT Clinic (Within 2-3 days)
  - For patients who cannot wait for an urgent respiratory clinic appointment but not needing immediate specialist management
  - Respiratory Rate > 30, Systolic Blood Pressure < 100
  - SPO2 < 90% on Air or usual oxygen
  - Unable to cope
  - Unstable co-morbidities
  - Treat and Discharge Home accordingly

- Consider home management with Rocket support
  - Patient Stable
  - Patient socially supported
  - No confusion
  - No chest pain

- ACUTE Patient Contact EMAS, Emergency transfer to A&E
  - Respiration Rate > 30, Systolic Blood Pressure < 100
  - SPO2 < 90% on Air or usual oxygen
  - Unable to cope
  - Unstable co-morbidities
  - Admit Harrowden A or Clifford

- Contact to be made with Community Team
AMBULATORY CARE PATHWAY - Diabetes

Patient presents with abnormal blood glucose levels

Ketoacidosis
- Blood Glucose >14
- +ve Ketones in Blood or Urine
- ph ↓
- Bicarb ↓

ACUTE Patient Contact EMAS, Emergency transfer

Hyper Osmolar Non Ketotic
- BM>14
- Dehydrated
- Osmolarity High
- Drowsy

ACUTE Patient Contact EMAS, Emergency transfer to A&E
ADMIT MAU/Clifford

Patient presents to A&E
BM increased but patient otherwise well

Contact Community Diabetes MDT
Mon-Fri 9-5
Each Locality

Ambulatory Pathway-
Tel: 01536 491678
A&E and MAU

DVT DIAGNOSIS PATHWAY

Patient presenting to the Department or referred from primary care with suspected DVT

Out of Hours

Monday to Friday 0900 - 1600

Refer to the ambulatory DVT service (Bleep 331)
If patient is not ambulatory consider medical admission

Clinical feature (circle as appropriate) | Points
--- | ---
Active cancer (treatment on-going, within 6 months, or palliative) | 1
Paralysis, paresis or recent plaster immobilisation of the lower extremities | 1
Recently bedridden for 3 days or more or major surgery within 12 weeks requiring general or regional anaesthesia | 1
Localised tenderness along the distribution of the deep venous system | 1
Entire leg swollen | 1
Calf swelling at least 3 cm larger than asymptomatic side | 1
Pitting oedema confined to the symptomatic leg | 1
Collateral superficial veins (non-varicose) | 1
Previously documented DVT | 1
An alternative diagnosis is at least as likely as DVT | −2

Clinical probability simplified score

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>DVT likely</td>
<td>≥ 2</td>
</tr>
<tr>
<td>DVT unlikely</td>
<td>&lt;2</td>
</tr>
</tbody>
</table>

Calculated Score
**Likely Wells ≥ 2**

Check FBC, U&E, LFT, Clotting screen and D-dimer*

Assess suitability for ambulatory care and home treatment with therapeutic LMWH (appendix 1 & 2)

- If no contraindications to ambulatory care or therapeutic LMWH then commence therapeutic Enoxaparin (see dose banding chart)

  Refer to Ambulatory DVT service (appendix 3)

**Unlikely Wells < 2**

Check FBC, U&E, LFT, Clotting screen and D-dimer*

- Negative D-dimer‡
  - Take into consideration alternative diagnosis. Advise patient that it is unlikely that they have a DVT

  *In 3rd trimester of pregnancy the D-dimer is unlikely to be negative, therefore only do D-dimer if <26/40. Otherwise proceed to objective testing i.e. Ultrasound Scan

  ‡A negative D-dimer does not exclude acute thrombus if the patient is taking an anticoagulant

All pregnant women either found to have DVT or referred to Ambulatory DVT service must be discussed with Haematology StR or Consultant at time of referral
Appendix 1

Contraindications to ambulatory care/ indications for admission

- Pregnant women who are more than 34 weeks gestation (admit for medical/haematology and obstetric review)*
- Patient already on anticoagulation i.e. warfarin, sinthrome, phenindione, dabigatran, rivaroxaban, apixaban, therapeutic LMWH*
- Requirement for thrombolysis (ileofemoral DVT)*
- Acute massive venous thrombosis and obstruction of the venous drainage of an extremity – ischaemic form of venous occlusion - **phlegmasia cerulea dolens** – painful blue inflammation*
- Milk leg – **phlegmasia alba dolens**. Painful ‘white’ inflammation caused by massive ileofemoral venous thrombosis with associated arterial spasm. The affected limb is often pale with poor or absent pulses, petechiae and distended superficial veins*
- Bleeding risks* (see appendix 2)
- Signs or symptoms of pulmonary embolus
- Visual/cognitive impairment such that unable to understand/carry out treatment instructions
- Unable to weight bear/transfer chair to couch, not able to attend hospital for outpatient treatment

* Discuss with haematology StR /Consultant

Appendix 2

Assessment for home LMWH (if ‘yes’ to any of the following discuss with Haematology StR/Cons)

- Active bleeding or inherited or acquired bleeding disorder Yes / No
- Strong family history of bleeding Yes / No
- Active peptic ulcer disease Yes / No
- Uncontrolled hypertension (> 180/100 mmHg) Yes / No
- Bacterial endocarditis Yes / No
- Recent intracerebral bleed/CVA (within 1 month) Yes / No
- Recent trauma/surgery (within 1 month) Yes / No
- Recent spinal / epidural / lumbar puncture (within 24 hours) Yes / No
- Chronic liver disease (PT > 2 seconds above normal range) Yes / No
- Thrombocytopenia (platelets < 100 x 10^9/l) Yes / No
- Chronic renal disease (on dialysis or GFR < 30mls/min) Yes / No
- Allergy to heparin or history of HIT Yes / No
- Body weight < 35 Kg Yes / No
- Current drug or alcohol abuse Yes / No
  - Alcohol units per week __________
- Currently taking investigation drug Yes / No
- Already receiving formal anticoagulation Yes / No
  - Warfarin, sinthrome, phenindione, dabigatran, rivaroxaban, apixaban, therapeutic LMWH
Appendix 3

Out of hours ambulatory DVT service referral

1. Suspected _________ leg DVT (calf circumference L _______ cm, R _______ cm)
2. No contraindication to Ambulatory care
3. No concerns, or after discussion with Haematology StR/Consultant, deemed suitable for home treatment with LMWH
4. Body weight _________ Kg
5. LMWH (Enoxaparin) given (see dose banding information)
   a. Dose ___________________________
   b. Date and Time ___________________________
6. Registered with a GP
7. Able to attend DVT clinic (next working day)
8. Aware that DVT nurse will phone (next working day)
9. If Friday evening / weekend / Public holiday, the patient has been shown how to self-administer LMWH (or alternative plan for administration arranged), and given sufficient LMWH and a sharps bin (clinic attendance next working day)
10. Counsellingled
   a. What to do if experiencing worsening pain, leg swelling or discoulouration or develops dyspnoea, chest pain or haemoptysis
   b. Side effects of anti-coagulation (bleeding, bruising)
11. Referral made to the ambulatory DVT service

Assessment carried out by:
Name __________________________________________
Signature __________________________________________
Position __________________________________________
Date __________________________
Time __________________________

Management and referral completed by:
Name __________________________________________
Signature __________________________________________
Position __________________________________________
Date __________________________
Time __________________________
AMBULATORY CARE PATHWAY FIRST SEIZURE

True seizure?:
Document eyewitness account in notes (☐ Unresponsive, ☐ Tongue biting, ☐ Incontinence, ☐ Injuries, ☐ Post ictal confusion Neuro examination: Focal signs, e.g., Limb Weakness, Dysphasia

Yes

No

2nd plus seizure /known epilepsy

Check drug compliance
Refer to Neurology Clinic

CT Normal?

Yes

No

Signs of infection?

Yes

No

Consider MRI

Non Specific

Tumour/Abcess

Admit

Refer Oxford Neurosurgery

Acute Patient Contact EMAS, Emergency transfer to A&E

Acute Patient GCS < 15, Focal, Sudden onset Headache, Signs of Meningitis. Headache with seizures

Discharge Home

Driving Advice

Discharge Home

Abnormal

Antibiotics & Acyclovir

Admit Clifford Ward

CSF Examination

Normal

Arrange EEG & Neuro OPD

General Safety Advice & Driving

Discharge Home
Patient shows signs of jaundice without pain

- Full list of current and past medications, past medical conditions
- Clinical questionnaire completed
- Clinical observations completed
- FBC, Coagulation screen, LFT, GGT, U&E, CRP and store blood in 2 yellow top and 1 red top and 1 purple top Vacutainer® for liver screen in case required

Abdominal ultrasound to assess for any dilated ducts, ascites, Portal vein and Hepatic Vein Flow

Ultrasound result

- Normal bile ducts and gall bladder
- Normal portal vein and hepatic vein blood flow

- Make urgent appointment with gastro clinic
- Inform lab to process liver screen tests
- Give patient safety information
- Give forms for repeat blood tests to be done alternate days till seen in clinic
- Inform GP of plan of follow up
- Fax assessment paperwork to 2296

- Dilated bile ducts
- With signs of infection

- Make urgent appointment with surgeons/ specialist surgeon
- Give information on ERCP
- Give patient safety information
- Inform GP of plan of follow up
- Fax paperwork to 2777

- Inflamed gall bladder

ADMIT UNDER SURGEONS

ACUTE Patient Contact
EMAS, Emergency transfer

Pregnant
Abnormal clotting or renal function
Bilirubin > 150
Recent significant alcohol use
Fever or significant anorexia or repeated vomiting
Confusion or drowsiness
Sepsis

ADMIT
Patient presents with suspected Pneumonia

ACUTE Patient
Contact EMAS, Emergency transfer to A&E
Respiration Rate > 30,
Systolic Blood Pressure < 100
SPO2 < 92% on Air

CXR confirms Pneumonia

CXR no evidence of Pneumonia

CURB 65 Score 2
Co-morbidities
Yes
No

Curb 65 Score 0-1
Check Procalcitonin Levels and Start Antibiotics

Procalcitonin levels >0.25
Start Antibiotics
Discharge Home

Procalcitonin levels Normal
Consider other diagnosis

No systemic signs of sepsis
Respiration Rate < 30
SPO2 > 92% on air
BP >100 systolic

Refer to Ambulatory Unit

ADMIT
Clifford or Harr A

Hot Clinic with repeat Procalcitonin levels to guide therapy

Ambulatory Pathway
Tel: 01536 491678
HOSPITAL ALGORITHM FOR SUSPECTED PULMONARY EMBOLISM

Pulmonary Embolism is suspected in the context of breathlessness, tachycardia, tachypnoea, unexplained hypoxia, pleuritic chest pain, haemoptysis and/or collapse.

Mandatory investigations:
- FBC, U&E, CRP, LFT, clotting screen/INR
- ECG
- CXR
- ABG

Assess clinical probability:
- High probability >4
- Low probability ≤4

Give LMWH while waiting for CTPA if High probability or raised D-dimer

High probability: (D-Dimer not required)
Refer to medics

CTPA
Consider outpatient investigation through Ambulatory Care

Low probability:
Check D-Dimer

Raised D-dimers:
Refer to medics

Re-consider diagnosis
Consider discharge if clinically well, no unexplained abnormal test results and no other diagnosis needing treatment

Anticoagulation
- Consider early discharge
- LMWH for at least 5 days
- Contact Anticoagulation team

Modified Wells Score for clinical probability of PE

<table>
<thead>
<tr>
<th>Clinical sign</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical signs of DVT (objective swelling and pain)</td>
<td>3</td>
</tr>
<tr>
<td>Heart rate &gt;100</td>
<td>1.5</td>
</tr>
<tr>
<td>Immobilisation &gt;3 days or surgery &lt;4 weeks</td>
<td>1.5</td>
</tr>
<tr>
<td>Previous objective diagnosis of PE or DVT</td>
<td>1.5</td>
</tr>
<tr>
<td>Haemoptysis</td>
<td>1</td>
</tr>
<tr>
<td>Malignancy (treatment in &lt;6 months or palliative)</td>
<td>1</td>
</tr>
<tr>
<td>PE more likely than any other diagnosis</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>

Remember D-Dimers can be raised in sepsis, pneumonia, pregnancy and other conditions.
**ASSESSMENT**

In a patient presenting with features of PE such as breathlessness, tachycardia, tachypnoea, unexplained hypoxia, pleuritic chest pain, haemoptysis and/or collapse, the algorithm on page 5 should be used. A thorough medical history, physical examination and relevant investigations including FBC, U&E, CRP, LFT, clotting screen/INR, ECG, CXR and ABG should be recorded on the Universal Emergency Assessment Document. The Pulmonary Embolism Ambulatory Care Pathway (Appendix 3) should be used to assess for suitability of and guide outpatient/home management. The respiratory team will be available to provide input where required.

The diagnostic process is facilitated by validated clinical probability scores and second generation D-dimer assays. After carrying out a clinical assessment and the above investigations to exclude other causes, use the two-level PE Wells score (see table 1) to estimate the clinical probability of PE.

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<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
</tr>
<tr>
<td><strong>PE Likely (High Probability)</strong></td>
<td>&gt; 4 points</td>
</tr>
<tr>
<td><strong>PE Unlikely (Low Probability)</strong></td>
<td>≤ 4 points</td>
</tr>
</tbody>
</table>

Table 1: Two-level PE Wells score

Patients with a ‘likely’ two-level PE Wells score should have:

A computed tomography pulmonary angiogram (CTPA) and consider a proximal ultrasound scan if the CTPA is negative and DVT is suspected.

Offer patients with an ‘unlikely’ two-level PE Wells score, a D-dimer test and a CTPA if the D-dimer test is positive.
Offer parenteral anticoagulant therapy (LMWH) to patients with suspected PE who are having imaging and in whom PE cannot be excluded within 4 Hours.

Consider a ventilation/perfusion single photon emission computed tomography (V/Q SPECT) scan as an alternative to CTPA for patients with suspected PE who have:

- an allergy to contrast media or
- renal impairment (eGFR <60).

Take into consideration the patient’s age and history of cancer, and the increased risk of exposing dividing cells to radiation.

Diagnose PE and start treatment in patients with a positive CTPA or in whom PE is identified with a perfusion V/Q scan.

Take into consideration alternative diagnoses in patients with:

- an ‘unlikely’ modified two-level PE Wells score and
  - a negative D-dimer test or
  - a positive D-dimer test and a negative CTPA.

- a ‘likely’ modified two-level PE Wells score and
  - a negative CTPA and
  - no suspected DVT.

Advise these patients that it is not likely they have PE and discuss with them the signs and symptoms of PE, and when and where to seek further medical help.

**Patients with signs or symptoms of both DVT and PE**

If a patient presents with signs or symptoms of both DVT (for example a swollen and/or painful leg) and PE (for example chest pain, shortness of breath or haemoptysis), carry out diagnostic investigations for either DVT or PE, basing the choice of diagnostic investigations on clinical judgement.
Ambulatory Pathway

Tel: 01536 491678

Ambulatory Care Pathway Acute Headache without Focal Neurology

SEVERE ACUTE HEADACHE WITHOUT FOCAL NEUROLOGY

Possible SAH (Subarachnoid Haemorrhage)

☐ Sudden onset ☐ Worst ever headache ☐ Photophobia ☐ Neck stiffness

YES

TO A&E FOR CT BRAIN

Normal

MAU

NSAID, pain relief

Other brain lesion e.g. Tumour

SAH confirmed

Nimodipine

LP after 10 hours of onset

MAU

Normal

Abnormal Protein – cells +

Xanthochromia

Analgesics

Admit to Clifford Ward

Refer to Neurology

Refer to Oxford Neurosurgery

Discharge Home +/- neurology review as outpatient for headache

Analgesics

Acute onset Headache

Photophobia

Neck stiffness

GCS<15

Signs of Meningitis

Signs and symptoms of raised Intracranial pressure

Postural Headache

FH of SAH

New Focal Neurology

ACUTE Patient Contact EMAS, Emergency transfer to A&E
Ambulatory Care – Primary Spontaneous Pneumothorax

Spontaneous Primary Pneumothorax

< 2cm in Size and no breathlessness

- Discharge

>2cm in size*

- Aspirate or drain (refer BTS guidelines)
  - Improved
    - Discharge and review in HOT Clinic within 1 week
  - Not improved
    - Insert Chest Drain
      - Attach Ambulatory Bag
        - Observe for 6hrs on Ambulatory unit/Clifford ward
          - Patient able to cope at home
            - Discharge with review in HOT Clinic within 2 working days
          - Patient unable to cope at home
            - ADMIT

Stable incidental Pneumothorax on CXR

- Discuss with Respiratory Physician on Call for Ambulatory Management via switchboard

HOT CLINIC

Ambulatory Care

ACUTE Patient Contact
EMAS, Emergency transfer to A&E

If in extremis or struggling to breathe – divert to resus in A&E for immediate drainage by A&E Staff
Patient presents with suspected SVT

History of pre syncope / syncope
BP<100
Ischaemic changes on ECG

ECG confirms SVT (not AF)
Contact Cardiac On Call Registrar & Cardiac Outreach Nurse to attend
Treat as per guidelines ESC
Monitor, if returns to or remains in Sinus Rhythm for 1hr, Consider Oral Preventative Medications (Consult Cardiologist if unsure)
Discharge & FU in Cardiology Clinic

No Loss of consciousness
ECG No ischemia
BP >100 systolic
12 Lead ECG & Bloods

ECG not SVT
Consider alternative diagnosis

ACUTE Patient Contact EMAS, Emergency transfer
Bleep Cardiology registrar via KGH switchboard 01536 492000

ADMIT VIA A&E RESUS

Patient presents with suspected SVT

No Loss of consciousness
ECG No ischemia
BP >100 systolic
12 Lead ECG & Bloods

ECG not SVT
Consider alternative diagnosis

ESC- European Society of Cardiology
Ambulatory Care Pathway – Unilateral Pleural Effusion

Patient presents with Shortness of Breath suggestive of Pleural Effusion

Symptomatic and cannot wait for CXR as an outpatient

- SpO2 < 90%
- Respiration Rate > 25
- High Temperature

ACUTE Patient:
- Contact EMAS, Emergency transfer to

- SpO2 > 90%
- Respiration Rate < 25
- Temperature - Normal

Suitable for Ambulatory Care Pathway (No Age limit)

FBC, U&E, CRP, LFT, Coagulation Screen

Relieve symptoms (Ultrasound Guided Diagnostic Therapeutic Tap)

No relief of symptoms

Consider admission

CXR as an outpatient if symptoms

Unexplained Pleural Effusion

2 week Cancer Clinic

Patient cannot wait for 2 weeks due to symptoms

Symptoms relieved

Review in Respiratory HOT Clinic.

SpO2 > 90%

Respiration Rate < 25

Temperature - Normal

SpO2 < 90%

Respiration Rate > 25

High Temperature

Recommended for Ambulatory Care Pathway
No Age limit

Cancer Clinic

SpO2 > 90%

Respiration Rate < 25

Temperature - Normal

Suitable for Ambulatory Care Pathway (No Age limit)

FBC, U&E, CRP, LFT, Coagulation Screen

Relieve symptoms (Ultrasound Guided Diagnostic Therapeutic Tap)

No relief of symptoms

Consider admission

CXR as an outpatient if symptoms

Unexplained Pleural Effusion

2 week Cancer Clinic

Patient cannot wait for 2 weeks due to symptoms

Symptoms relieved

Review in Respiratory HOT Clinic.

SpO2 > 90%

Respiration Rate < 25

Temperature - Normal

Suitable for Ambulatory Care Pathway (No Age limit)

FBC, U&E, CRP, LFT, Coagulation Screen

Relieve symptoms (Ultrasound Guided Diagnostic Therapeutic Tap)

No relief of symptoms

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FBC, U&E, CRP, LFT, Coagulation Screen

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FBC, U&E, CRP, LFT, Coagulation Screen

Relieve symptoms (Ultrasound Guided Diagnostic Therapeutic Tap)

No relief of symptoms

Consider admission

CXR as an outpatient if symptoms

Unexplained Pleural Effusion

2 week Cancer Clinic

Patient cannot wait for 2 weeks due to symptoms

Symptoms relieved

Review in Respiratory HOT Clinic.

SpO2 > 90%

Respiration Rate < 25

Temperature - Normal

Suitable for Ambulatory Care Pathway (No Age limit)

FBC, U&E, CRP, LFT, Coagulation Screen

Relieve symptoms (Ultrasound Guided Diagnostic Therapeutic Tap)

No relief of symptoms

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