

# Specialty guidance

## Part 1: Major impact medical specialties

### Acute and general (internal) medicine

#### A Impact of a pandemic on emergency departments and medical admissions units

- ▶ Early in a pandemic (Phase 6, alert levels 1 or 2; see Table 1, p2), in the interests of infection control and efficiency of patient flows, trusts will need to separate individual emergency cases immediately into influenza and non-influenza cases as far as practicable.
- ▶ Further into a pandemic (Phase 6, alert levels 3 or 4) separation and isolation of individual patients in the assessment and admission pathways will not be possible. Instead trusts will need to manage the large numbers of patients presenting, by cohorting influenza and non-influenza management streams in order to minimise cross-infection.
- ▶ Bed demand will increase substantially during a pandemic. Trusts will need to plan for up to a fourfold increase in emergency admissions. Planning measures will include a substantial reduction in elective activity and transfer out into the community of all patients who do not need active medical treatment in hospital.
- ▶ Constraints of staffing and specialist equipment (eg ventilators) are very likely to adversely affect the number of available inpatient beds.
- ▶ In the peak of a pandemic (weeks 6–8) up to 50% of certain staff groups (eg nursing) may not be working because of a combination of personal illness, the requirement to care for ill family members, transport disruption and child care demands due to school closure.

#### B Acute physician activity and duties during a pandemic

##### Emergency departments and medical admissions units

- ▶ Acute physicians will have a major role in the assessment and initial management of patients presenting as an emergency with and without symptoms of influenza.
- ▶ Acute trusts are likely to designate medical admissions units (MAUs) as a cohort area for the assessment and admission of patients presenting as an emergency with influenza symptoms.
- ▶ MAUs designated as flu cohort areas are likely to be managed primarily by the acute medical team in conjunction with respiratory and G(I)M physicians and, where available, infectious disease (ID) physicians. It is anticipated that acute physicians will take the lead in triaging patients and coordinating the available workforce.

- ▶ Central to acute trusts' contingency planning is the designation of pandemic influenza cohort wards. Where the MAU is the designated flu assessment area, designated flu wards are likely to be those wards nearest the MAU in the interests of infection control within the hospital.

- ▶ A likely sequence of designated flu wards identified is:

MAU and/or ID wards (where available) > respiratory wards > other medical wards.

Patients located on these wards are likely to be cared for primarily by the medical teams linked to the wards, supplemented by medical and nursing staff released from other clinical areas (eg elective surgery medical and nursing staff). Inpatients at high risk of death from pandemic influenza (eg immunosuppressed patients) should be segregated and managed in designated 'non-flu' ward areas.

- ▶ It is anticipated that EDs will maintain a separate stream for assessment and admission of medical emergencies who do not have influenza symptoms. Acute physicians and geriatricians have an important contribution to the staffing of this 'non-flu' stream – with particular emphasis on identifying medical patients who do not require admission. Where admission is required this will be to 'non-flu' wards geographically separated from the influenza cohort wards.

## Outpatient services

- ▶ Specialty medicine outpatient services are likely to cease or be substantially reduced during the 16-week wave of pandemic influenza. This will be because of prioritisation of alternative duties for staff (and the clinic area), staff absence and a reluctance of patients to attend hospital during a pandemic for any reason other than an emergency.
- ▶ Without careful planning, cancellation of specialty medicine clinics is likely to generate additional GP referrals (and self-referrals) to the ED. Medical specialty teams should address this by operating virtual clinics providing specialist advice by telephone and email to primary care staff and patients, backed up by arrangements to review the patient in a clinic or domiciliary setting.
- ▶ Acute physicians should have the opportunity to set up virtual clinics to:
  - receive and advise remotely on patient management issues arising from referrals by telephone or email by GPs
  - provide remote follow-up and support to medical patients assessed in the ED who were not admitted
  - receive patient self-referrals by phone or email with medical problems as an alternative to them otherwise attending the ED; this service could be provided by a senior nurse in an acute medicine team with consultant support. This service is likely to be most effective where virtual GP surgeries are also in place, receiving initial patient self-referrals and providing advice to patients when referral (or self-referral) to secondary care is required.

- ▶ The layout and facilities of a large outpatient department mean that the area may well have a specific designated function during a pandemic; for example:
  - assessment and admission area for either flu or non-flu patients where alternative areas for these distinct clinical pathways cannot be found in the trust
  - area for the administration of antiviral agents to staff (prophylactic or therapeutic) and/or for the administration of flu vaccine (once available).

## C GIM physician activity and duties during a pandemic

### Emergency departments, medical admissions units and medical wards

- ▶ There will be three distinct roles for GIM physicians:
  - working in conjunction with acute physicians (see above) in the assessment and management of the early admission of patients with suspected pandemic influenza
  - continuing care of influenza patients on flu cohort wards, intensive care units (ITUs) and high dependency units (HDUs)
  - caring for inpatients admitted as medical emergencies who do not have influenza symptoms.

### Outpatient services

- ▶ Any GIM clinic activity occurring in the trust is likely to cease altogether. This activity will either be managed in primary care or referred to specialty medicine.
- ▶ GIM physicians should have the opportunity to develop virtual clinics as for acute physicians. The specific aims of these remote-access clinics would be to:
  - prevent a patient otherwise presenting to the ED
  - provide follow-up support to those patients discharged either direct from the ED or following an inpatient stay.

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