Clinical Haematology Ward and Service Orientation.

Junior Doctors April 2016
Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Introduction</strong></td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Orientation programme</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Post graduate education</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Clinical Haematology timetable</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Service information</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Message from the Consultants</td>
<td>8</td>
</tr>
<tr>
<td>1.</td>
<td>Clinical teams</td>
<td>9</td>
</tr>
<tr>
<td>2.</td>
<td>Service departments</td>
<td>9</td>
</tr>
<tr>
<td>3.</td>
<td>Infection control, Ward protective environment policy</td>
<td>9</td>
</tr>
<tr>
<td>4.</td>
<td>Central lines</td>
<td>13</td>
</tr>
<tr>
<td>5.</td>
<td>Chemotherapy and stem cell infusions</td>
<td>13</td>
</tr>
<tr>
<td>6.</td>
<td>Service documents and websites</td>
<td>13</td>
</tr>
<tr>
<td>7.</td>
<td>Department meetings</td>
<td>13</td>
</tr>
<tr>
<td>8.</td>
<td>ICU referral</td>
<td>13</td>
</tr>
<tr>
<td>9.</td>
<td>Managing febrile neutropenia</td>
<td>13</td>
</tr>
<tr>
<td>10.</td>
<td>Oxford Cancer and Haematology Triage assessment service</td>
<td>14</td>
</tr>
<tr>
<td>11.</td>
<td>Transfusion laboratory frequently asked questions</td>
<td>15</td>
</tr>
<tr>
<td>12.</td>
<td>Junior doctor handover guidelines</td>
<td>19</td>
</tr>
<tr>
<td>13.</td>
<td>A few top tips from a fellow junior doctor</td>
<td>20</td>
</tr>
<tr>
<td>14.</td>
<td>Clinical coding in haematology</td>
<td>22</td>
</tr>
<tr>
<td>15.</td>
<td>Endorsing results in EPR</td>
<td>25</td>
</tr>
<tr>
<td>16.</td>
<td>Feedback</td>
<td>26</td>
</tr>
</tbody>
</table>
Introduction

Welcome to Clinical Haematology ward, the purpose of this document is to ensure you are supported in your role whilst working with us. We aim to refresh your knowledge and skills in key areas to ensure you maintain your compliance with OUH Trust protocols, ward standards and patient safety. We will also orientate you to Clinical Haematology ward specific processes which will ensure a smooth coordinated approach to care.

The following programme is compulsory for you to attend and is supported by your SpR and Consultant colleagues who will provide ward cover during this session.

**Junior Doctor Induction Programme: Wednesday 6th April 2016**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Presenter(s)</th>
</tr>
</thead>
</table>
| 0900 - 0930 | Welcome to Haematology  
Medical management: VTE, Neutropenic sepsis policy and IV antibiotics, day to day working, service cover and leave planning, NSSG, clinical coding, documentation standards, team work, consent, educational opportunities and departmental meetings, M&M, EPR, handover sheets/work lists, endorsing results in EPR, bereavement office and death certification. | Dr Rob Danby                           |
| 0930 - 1020 | Specialist blood products  
The management of blood products; ordering and managing the blood product work load.  
Electronic requesting of blood products(EPR) | Simon Noel.                           |
| 1020: Coffee |  |  |
| 1020 - 1030 | Pharmacy  
EIDD, prescribing, drug protocols, introduction to chemotherapy including extravasation management. | Arti Shah, Ward Pharmacist |
| 1030 – 1045 | Pharmacy  
Managing the ARIA EPR interface, preventing errors and improving safety | Arti Shah |
| 1045 – 1100 | DNACPR project | Kirsty Crozier, Senior ANP |
| 1100 – 1115 | Triage service  
Febrile neutropenia pathway | Triage ANP |
| 1115 – 1130 | Infection control  
An overview of issues facing Haematology patients | Gemma Pill/Simon Wells, Infection Control Nurse |
| 1130 – 1145 | VTE assessment and prophylaxis | TBC |
### 1145-1200

A quick tour of the department and an introduction to Haematology Ward, its work and philosophy. To include:

- hand hygiene
- infection control
- timely EIDD and discharge planning
- team communication e.g. communication diary, end of round handovers
- patient confidentiality
- planning of patient care
- explanation of the use of relevant ward equipment, and in particular infusion pumps and the pneumatic system
- use of Central Lines and PICC
- housekeeping
- ward team working
- ANTT
- Track and trigger algorithm

**Rachel Miller, Ward Sister**

### 1200: Join ward medical teams

#### Other topics to be covered during your first week

Explanation of the use of the ward computer for obtaining laboratory results and writing discharge letters, TSSG website. Specific information on:

- EPR VTE assessments and review
- Antibiotic prescribing indication / duration
- Re-enforce blood product / electrolyte replacement thresholds
- Predicting discharge date (EDD) and timely prescription of EIDD.
- CMV/EBV/Ciclosporin level monitoring (correct blood tubes and days performed)
- Workstation on wheels(WOW)

**Ward Registrar**

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**Electronic patient record & EPMA prescribing modules**: We have been advised by the Trust that you have been notified and requested to complete these modules by e-learning prior to commencement on Wednesday 6th April. This is essential.

**ANTT assessment**: will be undertaken by one of the senior ward nurses within your first week in the department.
Postgraduate Education and Clinical Haematology Timetable

<table>
<thead>
<tr>
<th>Day/Time</th>
<th>Event</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0830</td>
<td>Consultant ward round</td>
<td>Ward</td>
</tr>
<tr>
<td>1200</td>
<td>BMT MDT, 2(^{nd}) &amp; 4(^{th}) weeks</td>
<td>Seminar room</td>
</tr>
<tr>
<td>1330</td>
<td>Ward MDT</td>
<td>Seminar room</td>
</tr>
<tr>
<td>Tuesday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0815</td>
<td>Lymphoma teaching (Optional)</td>
<td>Haem Onc meeting room, level 2</td>
</tr>
<tr>
<td>0900</td>
<td>Myeloma chemotherapy clinic</td>
<td>Level 0</td>
</tr>
<tr>
<td>1500</td>
<td>Service Operational and Governance meeting 1(^{st}) Tuesday of the month</td>
<td>Meeting room 3, level 2</td>
</tr>
<tr>
<td>1345</td>
<td>Outpatient clinic: General Haematology.</td>
<td>Level 0</td>
</tr>
<tr>
<td></td>
<td>Attendance essential (TL)</td>
<td></td>
</tr>
<tr>
<td>Wednesday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0815</td>
<td>Teaching (SpR)</td>
<td>Ward</td>
</tr>
<tr>
<td>0900</td>
<td>Outpatient clinic: BMT</td>
<td>Level 0</td>
</tr>
<tr>
<td>1300</td>
<td>Lymphoma MDT</td>
<td>Path seminar room, JR</td>
</tr>
<tr>
<td>1330</td>
<td>Outpatient clinic: Myeloma</td>
<td>Level 0</td>
</tr>
<tr>
<td>Thursday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0830</td>
<td>Consultant ward round</td>
<td>Ward</td>
</tr>
<tr>
<td>1100</td>
<td>Myeloma MDT or Myeloid MDT alternate week</td>
<td>Meeting room 2, Level 2</td>
</tr>
<tr>
<td>1100</td>
<td>Trephine meeting</td>
<td>Haem lab, Level 4, JR</td>
</tr>
<tr>
<td>1330</td>
<td>Outpatient clinic: Lymphoma, CLL</td>
<td>Level 0</td>
</tr>
<tr>
<td>1330</td>
<td>Outpatient clinic: Myeloid</td>
<td>Level 0</td>
</tr>
<tr>
<td>Friday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0815</td>
<td>Journal club (Optional)</td>
<td>Meeting room 3, Level 2</td>
</tr>
<tr>
<td>0930</td>
<td>Outpatient clinic: Haemoglobinopathy or ITP, alternate week</td>
<td>Level 0</td>
</tr>
<tr>
<td>1130</td>
<td>Microscope teaching: Dr Littlewood</td>
<td>Meeting room 3</td>
</tr>
<tr>
<td>1300</td>
<td>Outpatient clinic: Myeloma</td>
<td>Level 0</td>
</tr>
<tr>
<td>1330</td>
<td>New patient clinic and BMT follow up</td>
<td>Level 0</td>
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Meetings
- Hospital Grand Round (during term) 13.00, Thursday afternoon.
- Service Operational and Governance Meeting: see Dr Peniket or Dr Rob Danby. Your attendance at this meeting is encouraged and is a great learning opportunity.

Outpatient Clinics (OP)
These are very important for your learning.
One person should attend the Lymphoma clinic on Thursday afternoon each week.
One person **every week must** attend Tim Littlewoods Tuesday afternoon clinic (1345) as patients are booked in to be seen by you. Please coordinate this between you. In addition, you should attend either the Wednesday or Friday afternoon myeloma clinic or the Thursday afternoon myeloid clinic at least once during your time in Haematology.

During the 4 months you should also attend at least one Haemoglobinopathy clinic on a Friday morning.

**Educational Targets** (Covered mainly through SpR teaching)

1. Anaemia; investigation and treatment
2. Management of fever in an immunocompromised person
3. Safe blood transfusion
4. Haemophilia care and the DVT service
5. Lymphadenopathy; causes and investigation
6. Anticoagulation
7. Leukaemia; different types and treatments
8. Lymphoma; different types and treatments

**Syllabus**

**General**

Investigation and management of anaemia:

- Microcytic, hypochromic
- Normocytic, normochromic
- Macrocytic

Examination of the abdomen

Differential diagnosis and investigation of lymphadenopathy

Examination of cervical lymphadenopathy

Differential diagnosis and investigation of hepato-splenomegaly

Communication with patients with malignant disease

**Coagulation**

- Coagulation screening tests
- Anti-coagulant therapy
- Acquired bleeding disorders
Inherited bleeding disorders
Thrombosis

**Common haematological malignant disease**
E.g. Myeloma
CLL
Other

**Haemolytic anaemia**
E.g. Auto-immune
Haemoglobinopathy

**Blood transfusion**
- Risks of blood transfusion
- Administration of blood products
- Compatibility testing

**Programme feedback**
We are always trying to improve this programme. Please feedback any suggested changes to Dr Danby.
Service Information

The following information provides a brief overview of the service.

Message from the consultants:

‘We appreciate that Haematology is a busy job and it can be emotionally very tiring. Please do feel able to talk with seniors in your team at any point if you feel you’re struggling. We would much rather know sooner rather than later. You are invaluable part of the team so please do look after yourselves! Please do take your lunch breaks and your annual leave although we would ask that you coordinate your leave so that AT LEAST 2 junior doctors (preferably 3) are on the ward at any one time. We are aware that 2 days of the week we ask you to start at 08.30 (Monday and Thursday). We would therefore expect you to leave half an hour early on those days, or a different day. Again you may want to stagger this, so please do arrange it among yourselves.’

1. Clinical teams
The Lymphoid consultant attending cycle is 1 month, Myeloid 2 months.

<table>
<thead>
<tr>
<th>Lymphoid team attending Consultants</th>
<th>Myeloid team attending Consultants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Graham Collins</td>
<td>Dr Andy Peniket</td>
</tr>
<tr>
<td>Dr Jaimal Kothari</td>
<td>Dr Robert Danby</td>
</tr>
<tr>
<td>Dr Karthik Ramasamy</td>
<td>Prof. Paresh Vyas</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Registrar cover</th>
<th>Registrar cover</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Ward SpR</td>
<td>1 Ward SpR</td>
</tr>
<tr>
<td>1 DTU SpR</td>
<td>1 DTU SpR</td>
</tr>
<tr>
<td>1 Research SpR</td>
<td>1 Myeloma SpR</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient groups</th>
<th>Patient groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lymphoma</td>
<td>ALL</td>
</tr>
<tr>
<td>CLL</td>
<td>AML/APML</td>
</tr>
<tr>
<td>Autologous transplants</td>
<td>MDS</td>
</tr>
<tr>
<td>Myeloma</td>
<td>Myelofibrosis</td>
</tr>
<tr>
<td>Haemoglobinopathy</td>
<td>Autologous/Allogeneic transplants</td>
</tr>
<tr>
<td>Clotting</td>
<td></td>
</tr>
<tr>
<td>Autoimmune Haematology(ITP, AIHA etc)</td>
<td></td>
</tr>
<tr>
<td>TTP</td>
<td></td>
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<tr>
<td>Haemophilia (covered by Haemostasis SpR)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Nurse practitioners</th>
<th>Nurse practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lymphoma:</strong> Tracy Mitchell Floyd, Anya Aspinall</td>
<td><strong>Myeloid:</strong> Kirsty Crozier</td>
</tr>
<tr>
<td>CLL: Leanne Palmer</td>
<td>Allograft coordinators: Mandy Ellis, Denis Wareham</td>
</tr>
<tr>
<td><strong>Myeloma:</strong> Lisa Fergusson</td>
<td>Allograft NP: Lara Rowley, Daja Barton</td>
</tr>
<tr>
<td>Haemoglobinopathy: Sandy Hayes from May 2016.</td>
<td>Administrator for Disease specific NP’s: Rosanna Wells(35284)</td>
</tr>
<tr>
<td><strong>Autograft Coordinators:</strong> Sue Moore,</td>
<td>Administrator for BMT NP’s:</td>
</tr>
</tbody>
</table>
2. **Service departments**

*Haematology Day Treatment Unit (DTU)*, located on level 1. This service is open Monday to Saturday, and sees patients requiring supportive care such as: transfusion, antibiotics, electrolyte replacement, bisphosphonate therapy; and chemotherapy. There is a SpR for each team based here.

*Clinical Haematology Ward (CHW)*. This 25 bed inpatient ward, has 15 single rooms, 10 with positive pressure and hepa filtration (for allogeneic transplantation) and 5 twin bed bays; all rooms are en-suite. There is a patient prioritisation system for acute and planned admissions.

*Oncology ward and outlying patients*. Haematology patients are outlied to Oncology ward as a first preference. All outliers, are cared for by the specific clinical team and should be reviewed on a daily basis and included on the patient sheet. Excellent communication with the nursing teams on the outlying ward is imperative, especially if you have prescribed new drugs/fluids etc. Also remember that as these teams are not familiar with Haematology care, so please educate them and if you need something done for the patient please ask directly, don’t assume.

*Outpatients department*, located on level 1. This outpatient area is used by Oncology, Haematology and Surgery. Appointments are booked via the ward clerk or team secretary.

*Haematology secretariat*, located on level 2. All consultants, NP’s, and secretaries are housed in the same area on level 2 admin.

3. **Infection control**

*Hand hygiene*: All patients on Haematology ward are vulnerable to infection therefore scrupulous hand hygiene is essential. Hands are to be cleaned by **everyone** entering and leaving a patient space, regardless of whether you intend to or have touched the patient. Hand hygiene audits are a regular practice on the ward.

*Specific infection control measures*: Allograft patients should be examined wearing an apron. Where there are specific patient issues, there will be a sign on the door.

*ANTT*: is to be practiced on all occasions procedures and specifically where cannula are inserted or blood taken.

All possible line related bacteraemia are fully investigated, including any MRSA/MSSA.

*C-diff*: if C-diff is suspected then the patient should be isolated and treatment commenced, as per Trust policy.

Gemma Pill is the infection control nurse and can be contacted via bleep for advice.

On the next page is copied the Protective environment protocol, it is important that you are very familiar with this in order to protect yourself and the patients.
Protocol for the management of protective environment for Haematology and Bone Marrow Transplant patients (B.6, V5.0, Oct 2014)

Environment for patients

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Standard ALLO, MUD</th>
<th>RIC ALLO/ MUD</th>
<th>Autograft incl. TBI auto</th>
<th>Aplastic Anaemia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Room Allocation</strong></td>
<td>Filtered side room, ideally from admission</td>
<td>Filtered side room ideally from admission but from Day 0 as minimum</td>
<td>Single room or 2 bedded bay</td>
<td>Filtered side room</td>
</tr>
<tr>
<td><strong>Room Pressure Requirements</strong></td>
<td>Positive pressure Day 0 until discharge</td>
<td>Positive pressure Day 0 until discharge</td>
<td>N/A</td>
<td>Duration of treatment</td>
</tr>
<tr>
<td><strong>Windows and Doors</strong></td>
<td>Closed from Day 0</td>
<td>Closed from Day 0</td>
<td>No restrictions</td>
<td>Closed</td>
</tr>
<tr>
<td><strong>Able to come out of room</strong></td>
<td>Yes at quiet times for exercise</td>
<td>Yes at quiet times for exercise</td>
<td>Yes</td>
<td>Yes at quiet times and exercise</td>
</tr>
<tr>
<td><strong>Infection Control e.g. D&amp;V, MRSA, C. diff, VRE, CPE</strong></td>
<td>Positive pressure to neutral</td>
<td>Positive pressure to neutral</td>
<td>Isolate to side room if infection identified</td>
<td>Positive pressure to neutral</td>
</tr>
<tr>
<td><strong>Zoster, RSV, Influenza</strong></td>
<td>Positive pressure to negative (Room 10, 11)</td>
<td>Positive pressure to negative</td>
<td>Positive pressure to negative</td>
<td>Positive pressure to negative</td>
</tr>
</tbody>
</table>

Notes:

**Negative pressure:** (Room 10, 11) should not be used unless directed by BMT consultant, Infection Control consultant or ward sister. Room air pressurisation stickers should also be used and completed on each shift. Patients with identified transmissible infection (e.g. MRSA, C. Diff, VRE, CPE) should have room pressurisation switched to neutral as positive pressure (which blows room air into the corridor) would pose a significant risk to the other immunocompromised patients on the ward.

G4S are responsible for the maintenance of the pressure system and should be contacted on Ex 35353 in case of any problems.

**Room sharing:**

When transplant patients are temporarily housed in a 2 bedded bay please consider which other patient they are sharing with, e.g. those coughing, and arrange bed moves if necessary.

1.0 Hand hygiene:
1.1 Scrupulous hand hygiene with either hand gel or soap and water must be carried out before and after contact with patients.
1.2 If a patient is positive for C Diff, soap and water must be used.
1.3 Disposable paper towels should be used to dry hands thoroughly.
1.4 Gelled hands must be allowed to dry prior to contact with patients.
1.5 All staff should adhere to trust hand washing policy.

2.0 Gloves: single use disposable gloves must be worn when:
   2.1 Handling any IV access or undertaking cannulation and phlebotomy, ensuring ANTT guidelines are adhered to at all times.
   2.2 Dealing with blood, body fluids or soiled linen.
   2.3 When in direct contact with patient with an identified transmissible infection that is being barrier nursed, to reduce risk of micro-organism transmission.
   2.4 Sterile gloves should only be worn when carrying out aseptic procedures.
   2.5 Gloves need to be changed after each procedure.
   2.6 Hands should be decontaminated before and after all glove use.

3.0 Plastic aprons: should be worn when:
   3.1 Bed making
   3.2 Bathing patients or giving personal care
   3.3 Dealing with body fluids
   3.4 When in direct contact with patient with an identified transmissible infection that is being barrier nursed, to reduce risk of micro-organism transmission.
   3.5 When serving food.

4.0 Patient hygiene:
   4.1 Daily assessment and care of CVC with VIP scoring, please ensure use of VIP scoring stickers on medication chart.
   4.2 Patients should be encouraged to shower/bathe daily and be educated to pay particular attention to axilla, groin and perineum.
   4.3 Flannels or bars of soap should not be used. Patients should use disposable cloths used once only with liquid soap preparation.
   4.4 Patients towels and bed linen should be changed daily.
   4.5 Patients should use single use disposable was bowls, which must be disposed of immediately after use.
   4.6 Encourage patients to wash their hands after toileting and prior to eating.
       Ensure hand wipes are provided at bedside.

5.0 Patient monitoring:
   5.1 Clinically stable patients may leave the ward for necessary radiological investigations. Liaise with radiographer and porters to ensure prompt investigation and return to the ward.
   5.2 Portable X-Rays are permitted.
   5.3 Critically ill/unstable patients may have their doors opened to ensure close observation, however infection control issues must always be considered. If necessary, patient should be moved to a bed close to the nurse’s station.

6.0 Cleaning:
   6.1 Ensure appropriate infection control sign is on patient’s room door where there is an identified organism or diarrhoea.
6.2 Rooms should be cleaned thoroughly on a daily basis as per service level agreement and trust policy.
6.3 Ward staff are required to ensure surfaces and rooms are clutter free to facilitate daily cleaning.
6.4 All equipment must be cleaned between patients and labelled with date.
6.5 Patients fridges must be cleaned on discharge or more frequently if admission a long period.
6.6 Following discharge of a patient, rooms must have a full discharge clean.
6.7 If a patient has a transmissible infection ensure appropriate infection control sign is on the patient’s door.

7.0 Visitors:
7.1 The Ward has policy of open visiting but avoid overcrowding in patients rooms.
7.2 Visitors should remove coats and wash/gel their hands before entering and on leaving the room.
7.3 Flowers and plants are not allowed onto the ward.
7.4 Visitors should not attend the ward if they have had recent exposure to or had:
   - Diarrhoea and vomiting
   - Flu-like symptoms
   - Chicken pox or shingles
   - Viral-like illness
   - Upper respiratory tract infection.

8.0 Diet:
8.1 Patients should be referred to dietician prior to or during admission
8.2 Guidelines on safe eating should be followed.
8.3 When appropriate food should be ordered from the neutropenic menu, liaise with senior house keeper and CSW.
8.4 A good standard of food hygiene is essential; particularly hand washing and ensuring a clean food preparation area.

9.0 Uniform
9.1 Nurses should adhere to trust uniform policy.
9.2 Medical and other staff should adhere to the trusts bare below the elbow policy.
9.3 All clothes should be freshly laundered at 60°C.
9.4 Hair should be tied back and off the collar.
9.5 Wrist watches should not be worn and jewellery should be limited to wedding bands only.
9.6 Nails must be kept short.

10.0 Patients who have Shingles or Chicken Pox
10.1 Patient’s with active Shingles or Chicken Pox should be housed on the John Warin Ward and preferably nursed in an en-suite room.
10.2 Patients should not be nursed on the Haematology Ward unless it is clinically indicated and directed by the patient’s consultant.
10.3 An Airborne precautions isolation sign should be clearly visible on the patients door
10.4 Patients should be nursed only by staff who are immune to VZV.
10.5 All health care staff should have their VZV status recorded in their personal information folder. Those staff who are not immune should be offered immunisation by the Occupational Health team.

4. **Central lines**
These are generally inserted electively by the line insertion team. Management of central lines is a nursing responsibility.

5. **Chemotherapy and stem cell infusion**
Chemotherapy is prescribed by SpR’s/Consultants on the ARIA electronic system. It is important that supportive treatment, such as antiemetic’s and IV fluids, are prescribed in EPR. All protocols are available on the NSSG website for your information. BMT patients will have a copy of the conditioning regime in the patient notes. Chemotherapy and stem cell infusions are managed by the nursing staff. Intrathecal chemotherapy is given only by trained SpR’s.

6. **Service documents and websites**
All documents produced for use/reference within the Clinical Haematology department are subject to a quality control system. All documents are available on the NSSG website and we advise you to ensure you have a short cut to this your desk top. Here is the link: [http://nssg.oxford-haematology.org.uk/](http://nssg.oxford-haematology.org.uk/)
The departments’ external website is [http://www.ouh.nhs.uk/haematology/](http://www.ouh.nhs.uk/haematology/)

7. **Departmental meeting:**
You will receive agenda and are very welcome to attend the following meeting:
- Service Operational and Governance meeting: 1st Tuesday of the month (Meeting room 3), this is an operational meeting and a place to bring any ideas that may benefit the service, and/or issues you have not been able to resolve; audit, safety issues, Datix, and Morbidity and Mortality reviews are discussed

8. **ICU referral:**
The referral pathway for patients needing ICU admission is ‘Consultant to Consultant’. Please escalate all serious clinical concerns to the team SpR, if they are not available for whatever reason, please bleep or phone your team consultant.

9. **Management of febrile neutropenia**
Febrile neutropenia or Neutropenic sepsis (they get used interchangeably) is a Haematological emergency and must be managed promptly. National guidance requires that antibiotics are prescribed and given within an hour of the patient spiking (new temperature not on antibiotics) on the ward or arriving in the ward (including outliers) or Triage service. The hospital policy is available on the NSSG website or the pharmacy page of the Trust website.
Key points to note: patients who have received chemotherapy (including those on high dose steroids) or are severely immune compromised because of their disease, may not always develop a normal immune response and therefore may not present febrile. Monitoring patient hydration, urine output and vital signs are imperative. Notify a senior early if the patient is unwell.

10. **Oxford Cancer and Haematology Triage Assessment Service**

**Hours of Operation:**
Monday – Friday 8am-8pm
Monday – Wednesday 8pm – 8am
Saturday and Sunday 8am-8pm

**Team:**  
Advanced Nurse Practitioners  
Specialist Nurse Practitioners  
Triage nurses  
Clerical Officer

**Location:**  
Located on Level One of the Cancer & Haematology Centre at the Churchill Hospital. The Oxford Cancer & Haematology Triage Assessment Area consists of 5 bed spaces (1 side room). This gives a maximum capacity of 4-5 patients according to patient acuity and dependency. The Triage side room provides an opportunity to isolate patients with suspected infections or those patients who are facing end of life issues.

**Role:**  
- Provides a designated area/service that tends to all emergency calls and admissions within Cancer services (Oncology, Haematology and Radiotherapy). This service is carried out by a specialist nursing and medical team skilled and competent in Haematology and Oncology Triage  
- Provides telephone triage to patients who are currently receiving oral/intravenous chemotherapy, anti-cancer biological agents, radiotherapy or those waiting to start treatment following diagnosis  
- Provides telephone triage to those patients on supportive treatment and those patients with a non-malignant haematological disease including sickle cell anaemia and thrombocytopenia  
- Provides an area to assess and monitor patients prior to the decision of allocating an Oncology/Haematology bed. Allows for the efficient use of beds in combination with patients being appropriately placed according to their clinical need

**Common source of referral:**  
1) Patient contacts the Cancer and Haematology Triage assessment helpline and assessed using the UKONS assessment tool. There are various outcomes:  
   a) Advice and direction given to patient with toxicities that do not require hospital assessment. Patients may be referred to their GP or Macmillan service. Patients may be invited back for earlier outpatient review  
   b) Patient discussed with Specialist Registrar or Consultant and patient accepted for assessment in the Cancer and Haematology Centre or their local hospital  
   c) Patient advised to contact 999 for emergency assessment with further discussion with the Cancer and Haematology Triage assessment team  
2) Patient referred to Specialist Registrar by local specialist team or GP within community. Patient accepted for assessment on the Cancer and Haematology Triage assessment area  
3) Patient becomes unwell within our Day treatment, Outpatient or Radiotherapy areas and referred to the Cancer and Haematology Triage assessment team
Team responsibilities:
Following the patient’s arrival within the Cancer and Haematology Triage assessment area:

- Patients will receive an initial vital sign assessment, cannulation, phlebotomy and any appropriate investigations such as ECGs, urinalysis and sepsis screens
- Responsible junior doctor will be contacted and asked to review patient within a clinically appropriate timeframe. Patients with suspected neutropenic sepsis will require urgent assessment and treatment
- Following assessment, the junior doctor will present their findings and plan to the appropriate specialist registrar. Further decisions regarding treatment and admission/discharge can then take place
- Triage assessment team will continue to monitor, treat and care for patient until they are discharged or transferred to an inpatient bed

Common presentations:
- Suspected Neutropenic sepsis
- Suspected Metastatic Spinal cord compression
- Chemotherapy and Radiotherapy induced emesis, diarrhoea and dehydration
- Acute pain issues due to disease and associated treatment
- Suspected pulmonary embolism or upper limb DVTs
- General deterioration due to treatment or consequence of cancer

Any patients with suspected cardiac problems, acute cerebral neurological problems or those patients deemed to require immediate resuscitation or theatre within 2 hours will be referred directly to the nearest Emergency Department.

Out of hours telephone Triage management:
- The telephone triage service is currently covered by the inpatient nursing team during the Out of hours period (8pm-8am Monday- Friday and 6pm-8am Saturday & Sunday)
- All calls will be discussed with the On-call registrar and Junior doctors will be notified if any emergency admissions are expected on the Churchill site
- Please discuss all emergency admissions with the on-call registrar once you have completed your assessment and treatment plan

If you have any queries or concerns regarding the Cancer and Haematology Triage assessment service, please discuss with the Triage team or the Oncology and Haematology Matron

11. Transfusion Laboratory: Frequently asked questions (Haematology) (H.91, V.1.0)

How do I contact the JR Transfusion Laboratory?
- During routine hours (08.30-17.00 M-F) phone 20339 or 20340
- Outside these times bleep 1719

How do I contact the Horton Transfusion Laboratory?
- Phone 29236 at any time

How should I label a transfusion sample?
- Transfusion samples MUST only be labelled using the Tx system at the patient’s bedside
• Samples not labelled in this way WILL be discarded

**How long does a group and save sample last?**

• For patients how have received blood products within the last 3 months a group and save sample is only valid for 72 hours. This means that a sample taken at 10pm will be valid only until 10pm 72 hours later
• For patients not transfused in the last 3 months – group and save samples are valid for a maximum of 3 months. If the patient is transfused within those 3 months the validity then reverts to 72 hours from the start of the transfusion
• It is good practice of regularly group and save all Haematology inpatients. If samples are taken on Monday and Thursday mornings then patients will maintain a valid sample except for on Sundays

**How do I know if my patient has a valid group and save?**

• The quickest way to check if a patient has a valid sample is to use BloodTrack ward enquiry which is available on all virtual desktops
• The results of all transfusion samples are also visible on the patient flowchart in EPR – this will allow you to check when the last group and save was sent. If this is not within the last 72 hours then for haematology patients is it unlikely that they have a valid sample

**How do I place a transfusion request?**

• All transfusion requests (except for requests for emergency stock) must be placed on EPR
• During EPR downtime it is acceptable to use paper request cards

**How long does it take to do a group and save?**

• A routine group and save usually takes between 1 and 4 hours to complete after the laboratory have received the sample. The time is variable and depends on time of day, staffing levels, what else the laboratory is already processing and other variables such as analyser maintenance.
• If you require a group and save processed urgently phone the laboratory to alert them to this so that we can prioritise it. Please don’t ask for all your group and saves to be treated as urgent because it is not possible for us to prioritise every sample we receive and the use of the term urgent becomes meaningless if it is abused.

**What is the difference between a group and save and a crossmatch?**

• A group and save is the sample processing
• It consists of a blood group and an antibody screen to determine the patients group and whether or not they have atypical red cell antibodies in their blood. If atypical antibodies are present the laboratory will do additional work to identify them
• A crossmatch is when the laboratory actually provides red cells products for the patient. It is not possible for the laboratory to provide crossmatched blood without having processed a group and save sample first.

**How do I get a sample to the transfusion lab?**

• Routine working hours – either pod or use a porter to take the sample to laboratory medicine at the Churchill. From there the sample will go on one of the routine hourly transport runs to the JR for processing
• Outside routine hours, either pod or use a porter to take the sample to the porters lodge. There is an hourly routine transport run from the porters lodge.
• Urgent samples should always be transported directly to the JR laboratory using the CitySprint urgent transport runs. Instructions are available on every ward

How quickly can blood be made available?
• The answer to this question is complex and depends on a number of factors
• Emergency stock is always available for patients – at the Churchill this is either from the Theatre fridge or the porters lodge. Emergency stock should be used to ensure no patients life is put at risk because of a lack of blood. It should not however be used as a substitute for cross matched blood in routine situations as it is not without risk.
• The critical factors as to how long it will take to provide red cells are
  i. Does the patient have a valid group and save sample?
  ii. Does the patient have any red cell antibodies?
• For a patient with no red cells antibodies, who has a valid group and save sample red cells are routinely issued within 15 mins for the request being received in the lab. Urgent requests can be prioritised and you should alert the laboratory is your request is urgent
• For a patient with no history of red cells antibodies but for whom there is no valid sample.
  i. Take a sample for group and save from the patient
  ii. Ensure the sample is quickly sent to the laboratory – we can’t begin to process a sample until it arrives in the laboratory
  iii. Once in the laboratory, the sample is processed on one of the analysers – this takes approximately 1 hour
  iv. If the antibody screen is negative, the lab can then almost immediately issue red cells
  v. If the antibody screen is positive – see information on patients with red cells antibodies
  vi. Don’t assume that a patient will be able to have red cells within 1 hour of sending a sample – it does depend on the results of the testing
• For patients with an history of atypical antibodies
  i. Ensure the laboratory has a valid sample
  ii. Request blood as SOON as you suspect it may be needed – this will allow the laboratory time to order red cells is required
  iii. Note patients with historical red cell antibodies are at risk of developing new antibodies with every transfusion and so need samples as per patients with no antibodies
  iv. The lab will need to undertake additional work to identify the antibody. It is impossible to guarantee how long this may take as it varies with the complexity of the antibody(ies). We may need to ask for additional samples and refer the sample to a reference laboratory.
  v. Once the lab has identified the antibody(ies), we may not have red cells which are suitable for the patient in stock and may need to order these from NHSBT, this may take considerable time to arrive.
  vi. If a patient develops an antibodies and blood is required urgently, it may be necessary to give products before work is completed, however this should not be done without discussion with a Haematology SpR or consultant as there may be considerable risk to the patient.

How quickly can platelets be made available?
Department of Clinical Haematology

- The laboratories endeavour to keep a stock of platelets although there may be times when they are awaiting additional supplies due to recent demand.
- Routine requests are usually issued within 1 hour of the request being received by the laboratory.
- Platelets for patients who require group identical or apheresis platelets may not be available from stock and may need to be specifically ordered from NHSBT.
- All the platelets ordered into the Trust are irradiated, this is help with stock management.

**How quickly can FFP be made available?**
- The laboratory at the JR site keeps 1 adult dose of FFP which is suitable for 80% of patients thawed in the laboratory, for suitable patients this can be made available within 10 mins of a appropriate request being made to the lab.
- For other patients, the FFP will be thawed upon receipt of the request – this makes approximately 30 mins.

**I want HLA matched platelets for my patient – what do I do?**
- Firstly ensure HLA matched platelets are appropriate for your patient.
- Ensure that a sample has been sent to NHSBT for an HLA type and antibody screen.
- Medical staff directly order HLA matched platelets from NHSBT in Filton.
- Note: because the Churchill laboratory is not open out of routine hours, HLA matched platelets are always delivered to the JR site for issue and labelling by the laboratory before being transported to Churchill.

**How do I know if my patient requires irradiated blood products?**
- There is a comprehensive list of type of patients that require irradiated blood within the Clinical Haematology guidelines.
- This is available here: link to Transfusion intranet.
- The O drive which is accessible from the ward and DTU-H has a patient list which is updated weekly showing which patients are currently receiving irradiated products.
- Remember if you prescribe a new purine analogue or other drug which means the patient requires irradiated blood – it is essential that you inform the laboratory of this new requirement.

**Author:** Julie Staves, Blood Bank manager

12. **Foundation Doctor 2 / Core Medical Trainee Handover Guidelines (H.41a,V.1.0)**

Handover is a clinical governance issue. Good quality handovers are essential to good patient care. Please ensure you are aware of how to dispose of your printed handover sheets.

**Weekday Handover**
- It is the responsibility of the on call foundation doctor (FT) or core medical trainee (CMT) to contact the ward teams to ensure adequate handover takes place. This should include...
handover of patients of concern and expected/”to come in” patients. Equally, the ward junior doctors should also see it as their responsibility to contact the on call doctor if there is concern about a particular patient, and whenever possible, treatment plans should be clearly documented in the notes for patients identified to be at risk in case they become more unwell overnight. Patients of concern that may need to be seen by the hospital at night team should be handed over to the hospital at night team during their scheduled handover meeting at 9pm.

• The day teams on the ward should ensure that there are brief problem lists in the notes, updated on every consultant ward-round, to make patient reviews that occur out of hours easier for the on call team
• If there is a concern that a particular patient may need intensive care input over night, then the day team Consultant/registrar has to ensure that ICU is informed during daytime working hours and a plan for overnight management is put in the notes.

**Weekend Handover**

• Every Haematology patient who is an inpatient on either the JR site or the Churchill site has to be formally handed over by the ward teams to the weekend on call team. The ward teams must ensure that an up to date ward list is available for the on call registrar.
• Clear weekend summaries for every patient should be documented in the patient notes on the Friday morning ward-round to facilitate care over the weekend.
• If there is a concern that a particular patient may need intensive care input over the weekend, the responsible team (usually led by the consultant) should take appropriate steps to alert the ICU team before the weekend so that a management plan can be agreed upon.
• Admissions expected over the weekend and their management plans should be discussed. This requires a review of “to come in” patients listed on the board and in the ward diary.
• Wherever possible, the ward teams must aim to have completed discharge documentation and put in place follow-up arrangements for patients expected to be discharged over the weekend. It is generally not possible to arrange DTU follow-up over the weekend, so this has to be done “in hours”.

**Handing patients back**

• The outgoing on call junior doctor must ensure that patients with new or active problems over night are handed back over to the day/weekend teams.

**Author:** Graham Collins, Consultant Haematologist

**13. A few top tips from a fellow Junior Doctor!**

**Ciclosporin levels: Getting it right**
To allow ciclosporin levels to be taken reliably and processed on the day, please consider the following:

- Unless otherwise specified, ciclosporin levels need to be sent every Monday and Thursday prior to morning dose (i.e. blood taken at approximately 0600)
- If the line is in use, the on call SHO needs to be bleeped to take the blood peripherally
- Samples must go across promptly to meet the JR deadline of 11am
- If ciclosporin being given IV, samples should be taken from the red lumen, and ciclosporin given down the white lumen
- The lab will process ciclosporin levels Monday-Friday at approx. 11am, and Sundays on request
- The lab would like a list of patients requiring ciclosporin levels to be faxed on a weekly basis

**Blood product prescribing: Reducing delays to transfusion**

In order to help reduce delays, please consider the following:

- Order routine cross-match for all patients Monday / Thursday & on admission
- Chase blood results & order blood products early in day (ideally prior to ward round!)
- Prior to requesting blood product, check Blood Tracker to ensure valid cross-match
- If no valid cross-match, this will need requesting on EPR and a cross-match collected using the SafeTx system (either bleed patient peripherally yourself or (if early!) try asking phlebotomists. If patient has a line, nursing staff will do if asked nicely!)
- Remember to postpone start time on EPR blood product orders by 2-3 hours
- Update Nurse In Charge after ward round & specifically mention who requires transfusion (& whether urgent vs routine)
- Nurses are able to request Group & Screens too
- To be aware: Blood product requests can only be processed under separate order numbers (!) which means that if you want to request a G&S, platelets and red cells, you must not do so simultaneously on the same order – i.e. do one at the time, or else requests are cancelled

**A few pointers...**

1. FBCs and electrolytes change very quickly and require daily attention for most patients

2. Blood requesting is a time-consuming daily process!
   a. If a patient has a PICC or Hickman line: request blood to be taken as “Routine” at 23.00
   b. If a patient is peripherally bled, request blood as “Planned” at 0600 the following day
   c. In general, request...
      i. Daily FBC/U&E/LFT/Mg/PO4/CRP
      ii. Group & Save Mon + Thursday – note that this means that cross-match is not valid for Sun – if it looks they will need transfusing on Sun need repeat Xmatch then
      iii. Clotting Monday and Thursday
      iv. Allograft patients on ciclosporin: Ciclosporin Mon/Thurs pre morning dose
      v. Allograft patients: EBV/CMV levels once weekly on Monday (lab runs these routinely Tuesday and Thursday if required)
      vi. Tumour lysis risk: U&E/Mg/PO4/Urate/LDH
      vii. Any new Acute leukaemia/Lymphoma/Myeloma: Check NSSG website for blood tests required.
   d. On Friday afternoon, the above will need doing for Sat/Sun/Mon.
3. There is a phlebotomy service Mon-Thurs and Sat. Friday and Sunday the SHOs take bloods – it is helpful to indicate ahead of the weekend who you think will need bloods on Sunday.

4. Electrolyte replacement:
   See Department or Trust guidance

5. At the beginning of your block, work out which 2 SHOs are on which team, and go through the rota to
   a. Ensure teams are covered with minimum 1 SHO despite nights/annual leave
   b. Divide up clinics equally
   c. Put teaching/study leave on the rota
   d. Highlight days in advance on which cross-cover across teams may be required

6. On nights, you cover Haem/Onc/Sobell house and (surgical) gynae onc – the latter tend not to give you any handover, so don’t be too surprised when Jane Ashley ward phones you to ask for a post-op/ITU step-down review. There is generally no SpR for gynae onc, so if any problems contact the gynae onc surgical consultant.
   a. In the evening, cover for Sobell is negotiable between haem and onc SHOs – but usually falls to haem!
   b. The internal door to Sobell is locked, but you can get the code from Sobell by phoning or garden to the front door – call ahead on 25873 to get them to open the internal door for you!

7. If in doubt, always give antibiotics (generally tazocin and gentamycin 5mg/kg, unless penicillin allergic)
   a. Even if not neutropenic - consider dysplasia? recent steroid exposure
   b. Remember to send viral throat swabs (request under “Respiratory mol detection” on EPR) if suspicion
   c. Blood cultures (line and peripheral) should be sent (at minimum) every 48 hours in patients with persistent fevers

8. The clinical nurse specialists are brilliant and very helpful.
9. Triage has a (very expensive and amazingly useful) UV vein finder!
10. Posaconazole prophylaxis and treatment doses are the same BUT liquid and tablet doses are different – beware! See the policy on the NSSG

Author: Dr Charlotte Brierley, Dec 2014, amended Nov 2015

14. Clinical Coding in Haematology

Clinical Coding is the translation of medical terminology describing the reason for a patient’s encounter; such as a patient’s presenting complaint, problem, diagnosis, treatment or other reason for medical attention; into statistical codes to support both statistical and clinical uses.

Clinical coders depend on clear, concise accurate clinical documentation in order to capture a true reflection of the patient’s episode of care. Clinical Coding is directly related to your directorate’s
income via Payment by Results so by helping the Coding Department achieve thorough and accurate coding you are also helping to maximise income within the ‘Haematology CSU’.

Key Points

- Coders are able to extract the following clinical documentation recorded within the medical records:
  - Working Diagnosis
  - Treat As
  - Presumed
  - Probable

  It is critical that clinicians clearly document one of the above terms to ensure an accurate diagnosis is assigned.

  E.g.: Patient presents with fever.
  ? Sepsis
  ? Neutropenia
  ? Specified site

  Clinically documented as:
  Treat as ‘Lower Respiratory Tract Infection’ (LRTI)
  Primary diagnosis will be assigned to LRTI.

- Patients administered antibiotics for presenting symptoms of ‘neutropenic fever’ - source of infection not identified - must be documented within the Medical Records, Discharge Summary and Triage Log Sheet as ‘treat as neutropenic sepsis’.

- Clinical documentation of ‘diarrhoea’ must be documented within the medical records as ‘non infective diarrhoea’ ‘toxic diarrhoea’ or ‘diarrhoea due to chemotherapy or antibiotics’

  Clinical documentation of ‘diarrhoea’ will be coded as ‘infective diarrhoea’ adhering to Clinical Coding National Guidelines.

- Clinical staff must ensure all relevant co-morbidities are clearly documented within the medical records. These can make a difference to the HRG/Tariff and will improve the depth of co-morbidities within the’ Haematology Directorate’ for the purpose of Hospital Standardised Mortality Ratio (HSMR) & Dr Foster.

- Follicular Lymphomas must be clinical documented according to their ‘grades’

- Chemotherapy Trials must be clinical documented relating to:
  - Early
  - Late

- Clinical documentation of ‘lymphomas’ must be consistent and clear stating that there is a ‘transformation’ of the disease.

- Discharge Summaries must be completed with an accurate ‘Diagnosis’ and reflect a true review of the patient’s episode of care.
Impact of accurate clinical coding

• Patient coded only as 
  J22.X Unspecified acute lower respiratory infection 
  HRG: DZ22C Unspecified Acute Lower Respiratory Infection without CC 
  Tariff £525

• The addition of a CC (complication or co-morbidity) 
  I10.X Essential (primary) hypertension 
  HRG: DZ22B Unspecified Acute Lower Respiratory Infection with CC 
  Tariff £2059

• If coded more specifically to 
  J18.1 Pneumonia due to Pseudomonas 
  I10.X Essential (primary) hypertension 
  HRG: DZ21B Lobar, Atypical or Viral Pneumonia with CC 
  Tariff £2457
Top ten tips for coding – a guide for clinical staff

Clinical coding is the process whereby information written in the patient notes is translated into coded data and entered onto hospital information systems. Coding usually occurs after the patient has been discharged from hospital, and must be completed to strict deadlines in order for hospitals to receive payment for their activity.

Clinical coding staff are entirely dependent on clear, accurate information about all diagnoses and procedures in order to produce a true picture of hospital activity. The coded data are vitally important, and are used for:

- Monitoring the provision of health services across the UK
- Research and the monitoring of health trends and variations
- NHS financial planning and Payment by Results
- Local and national clinical audit and case-mix analysis
- Clinical governance.

There are many ways in which clinicians can assist the process of clinical coding: 10 of the most important are summarised below. Each is based on the basic principles:

1. Write clearly and legibly in the notes and on discharge documentation, using black ink only. Make sure the patient is identified on every sheet of paper used in the notes.
2. Sign, date and time every entry in the notes. Print your name and position at the end of every entry.
3. Never remove notes from the hospital. If you need to take notes away from the ward or clinic for an audit or a meeting, always let administrative staff know, and return them immediately afterwards.
4. Always communicate any transfers of care to ward administrative staff. This includes when patients go for an investigation or a procedure performed by another clinical team.
5. Clearly record details of all the diagnoses (including co-morbidities) and procedures (including those done on the ward) in the notes. Write the main diagnosis first. Best practice is to summarise all of these as the last (discharge) entry in the notes – this will make your discharge summaries easier too. For injuries, note the cause; for overdoses, note the drug; and for infections, note the organism.
6. Ask a senior member of the medical staff to confirm or validate these diagnoses and procedures. This can be done when writing in the notes on the discharge ward round.
7. Include details of all diagnoses and procedures on discharge summaries and TTOs (preliminary discharge summaries). Don’t let your discharge summaries pile up on a shelf for weeks on end, awaiting dictation – coding staff have strict deadlines to meet and delays cause huge problems.
8. If a clear diagnosis has not been reached, make sure you detail the main symptoms in the notes or discharge summary. Any 'query' diagnoses, or diagnoses preceded by a '?' cannot be coded by clinical coding staff. If histology is awaited for a definitive diagnosis, note this down.
9. Avoid the use of new or ambiguous abbreviations (eg ‘M.S.’ could mean multiple sclerosis or mitral stenosis). Remember: clinical coding staff are not allowed to make any clinical inferences.
10. If your hospital has a standard proforma for admissions or discharge, use it! Fill in all the details it asks for.

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15. Endorsing results in EPR:
Result endorsement is an important daily function. There are 3 simple ways to view and endorse results on EPR:

INBOX:
- If you have requested bloods or other tests the results will appear in your EPR message centre inbox for you to review and endorse from there by clicking on Endorse. Just viewing results does not endorse them. The same results will also appear in the lead clinician’s inbox. Once endorsed they disappear from all inboxes.
- You can forward results to other clinicians to endorse or if you won’t be on duty to see the results, set up proxies or pools so others can view them. (See Hitch Hikers Guide to EPR – link below)

FLOWSHEET:
- In the patient’s record, click on Flowsheet for latest results – change your date range if you prefer to view more than just 48hrs, then use the EXIT button to save before going to the next patient
- Once you have reviewed the results scroll to the bottom to find the Endorse Results button and click to endorse. If the button is greyed out, there may be a result containing some text eg. Microbiology or Blood Type results. Open these results and close again, then the Endorse Results button will allow you to click it.

ENDORSE RESULTS ICON:
- When reviewing results in the patient record, click the Endorse Results icon on the toolbar to bring up results that need endorsing
  - If the Endorse Results icon isn’t visible on your toolbar, you can bring it into view by right clicking on the toolbar, selecting “customise” and dragging the button to a position of choice on your toolbar. It may be in a drop down menu at the right of the toolbar – click on small arrow to find it. After making any changes save by using the EXIT button rather than the X to close

See this guide for endorsing results

Or for more details on results and endorsing, go to the hitch hikers guide to EPR – section 6, page 19:

Feedback:
If you have any suggestions on how this information package or the orientation morning could be improved, please speak to Dr Rob Danby

Original Author: Dr Tim Littlewood

Review

<table>
<thead>
<tr>
<th>Name</th>
<th>Revision</th>
<th>Date</th>
<th>Version</th>
<th>Review date</th>
</tr>
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<tbody>
<tr>
<td>Sandy Hayes, Quality manager</td>
<td>Details</td>
<td>March 2011</td>
<td>V1.1</td>
<td>March 2013</td>
</tr>
<tr>
<td>Sandy Hayes, Quality manager</td>
<td>Session timetable</td>
<td>July 2011</td>
<td>V1.2</td>
<td>July 2013</td>
</tr>
<tr>
<td>Author</td>
<td>Task</td>
<td>Date</td>
<td>Version</td>
<td>Date</td>
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<td>General review</td>
<td>November 2011</td>
<td>V1.3</td>
<td>November 2012</td>
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<tr>
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<td>Dates and review</td>
<td>March 2012</td>
<td>V1.4</td>
<td>September 2012</td>
</tr>
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<td>V1.5</td>
<td>November 2012</td>
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<td>Process review</td>
<td>Oct 2012</td>
<td>V1.6</td>
<td>March 2013</td>
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<td>V1.7</td>
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<td>V1.8</td>
<td>July 2013</td>
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<td>July 2013</td>
<td>V1.9</td>
<td>July 2013</td>
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<td>V2.1</td>
<td>March 2014</td>
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<td>Dates</td>
<td>March 2014</td>
<td>V2.2</td>
<td>July 2014</td>
</tr>
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<td>March 2014</td>
<td>V2.3</td>
<td>July 2014</td>
</tr>
<tr>
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<td>Dates and update</td>
<td>July 2014</td>
<td>V2.4</td>
<td>November 2014</td>
</tr>
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<td>Dates and content review</td>
<td>November 2014</td>
<td>V2.5</td>
<td>March 2015</td>
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<td>Dates and content review,</td>
<td>March 2015</td>
<td>V3.0</td>
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<td>Sandy Hayes, QM</td>
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<td>Sandy Hayes, QM</td>
<td>Dates, coding, content</td>
<td>July 2015</td>
<td>V4.0</td>
<td>November 2015</td>
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<tr>
<td>Rob Danby, Consultant</td>
<td>Dates, Protective environment, meetings</td>
<td>Nov 2015</td>
<td>V5.0</td>
<td>January 2016</td>
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<tr>
<td>Sandy Hayes, QM</td>
<td>Finalise programme</td>
<td>Nov 2015</td>
<td>V5.1</td>
<td>January 2016</td>
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<tr>
<td>Sandy Hayes, QM</td>
<td>Programme update, endorsing results in EPR, Pharmacy slot re ARIA/EPR interface</td>
<td>Jan 2016</td>
<td>V6.0</td>
<td>March 2016</td>
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<tr>
<td>Sandy Hayes, QM</td>
<td>Update and finalise programme</td>
<td>March 2016</td>
<td>V6.1</td>
<td>August 2016</td>
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*This is a controlled document and therefore must not be changed*