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**Departement van Gesondheid
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Referral Guidelines

An open letter to all the communities, clinics, private practitioners, care facilities, and district hospital colleagues that have a referral relationship with George Hospital.

We are committed to delivering a high quality service to the communities and colleagues that we serve. However, in order to deliver an appropriate, effective, and efficient service, we need your help and close cooperation in terms of the referral pathways in our region.

Our aim is to consistently find the **shortest path to health for our patients.**

A brief background

George hospital is a busy 226-bed rural, regional referral hospital, serving a scattered population of about 500 000 people. The hospital serves as the referral centre for 5 outlying district hospitals [Knysna, Mossel Bay, Oudtshoorn, Beaufort West and Riversdal], 4 Provincially aided hospitals [Murraysburg, Ladysmith, Prince Albert and Uniondale], 8 local primary health care [PHC] clinics, a number of outlying district clinics [Herold – Great Brak River – Waboomskraal – Touwsrante – Plettenberg Bay], 3 frail care homes, the Correctional Services, Harry Comay TB hospital, Bethesda Centre, the private health care sector and the direct community of George.

The hospital has dedicated staff in all the mainline clinical disciplines, including medicine, surgery, paediatrics, orthopaedics, psychiatry, family medicine, anaesthetics, and obstetrics & gynaecology. A quick calculation will tell you that every main discipline, e.g. Internal Medicine, has about 30 in-patient beds to its disposal. This means that bed space is at a constant high premium, with lack of open beds in the wards often resulting in ill clients waiting in Casualty for up to 7 days for a ward bed. The average bed-occupancy rate in the hospital is 90% monthly.

Specialist outpatient clinics (OPD) manages about 4000 patients per month, with some clinics sometimes helping up to 60 patients per day.

The Emergency Centre attends to about 120 patients per 24-hour day, many of whom are red, orange or yellow coded clients, involving prolonged care for poly-pathology or advanced disease. There is a 6-bed High Care facility, which occupies the sickest of the sick, mostly patients who need mechanical ventilation. One of the challenges is the great distance [500 km] between George hospital and its referral hospital [Groote Schuur Hospital], which are often unable to accept those patients who need more specialised care in a tertiary hospital. Consequently our Intensive Care Unit is constantly full or (more often) over full.

There are 4 operating theatres, with 2 day theatres. The number of theatre cases averages 500 monthly.

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There is no 24-hour Community Health Care Centre in George, meaning that after hours [After 16h00 Mondays to Fridays, and the whole of Saturdays and Sundays.] all sick people in the George area who cannot afford private health care make use of George hospital, placing a huge after-hours burden on the hospital, which is predominantly run by junior skeleton staff with very limited access to laboratory and X-ray/sonar facilities after hours.

The George community is served by 3 ambulances of Emergency Medical Services (EMS), which often means delays in patient transfers or patient transport, especially Fridays and weekends.

With the above in mind, we need to all work together and constantly communicate our strengths and weaknesses to each other. We need to optimally utilize the total service.

Emergency Centre (EC)

Only clients who need emergency care should be referred here.

All clients must be telephonically discussed with either Dr L. Jenkins (Head of Family Medicine) or Dr R. Gibson, or one of the Emergency Centre doctors on duty, or obviously the specific departmental doctor (MO, Intern, Registrar) on call for the day.

A clear referral letter, indicating the referring doctor's or nurse's name, date, the receiving doctor's name (the doctor with whom the patient was discussed), and also the clinical department to whom the patient is being referred, should accompany the client.

Patients must ideally attend Casualty well before 17h00, in order to receive more optimal care. Failing to observe the above guidelines may well mean that the most optimal treatment for a specific client is delayed or protracted, causing client dissatisfaction and increased morbidity.

A worrying trend is the number of clients referred to Casualty with no acute illness, but with a specific problem for which they should attend one of the specialist OPD clinics. Such clients may spend a number of hours between opening a file at Reception and the EC, only to receive an appointment date at one of the specialist OPD clinics. These clients should not be referred to the EC at all, but be booked directly by the referring practitioner with the OPD secretary [8024408], or specialist on call.

Another inefficient practice is to send patients (often frail) who need a sonar or Doppler investigation from one of the Frail Care Homes, Harry Comay TB hospital or Bethesda Centre to Casualty for further arrangements. The referring doctor should book these patients directly with the specific clinical department, who should then arrange with the sonar department.

After a patient has opened a file, he or she is **triaged** according to standard criteria:

Acutely ill patients (red, orange and yellow codes) are attended to first. Only once all red, orange and yellow coded clients have been attended to, will green coded clients receive attention. It is not a first come first help service.

So-called green coded patients (stable, non-life threatening observations) may therefore have to wait more than 4 hours before they are attended to. After hours, especially weekends, this may be much longer. Green coded patients are therefore strongly encouraged to rather attend their local primary health care clinic.

Family Medicine

Urology

For a family medicine level urology consult, please phone Dr Jenkins or Gibson, who will discuss a Family Medicine OPD appointment for patients on an individual basis. Family Medicine clinic runs every Monday & Tuesday afternoons.

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There are perhaps 10 beds available for Family Medicine patients for the region, which is shared with Ophthalmology, Maxillo-Facial, and ENT patients. Orthopaedics also often utilize these beds.

All PHC clinics and district hospitals should please take a careful history and thorough examination, including a rectal examination (where appropriate) of the client.

A urine dipstix and (where indicated) a urine MCS (e.g. recurrent haematuria, recurrent UTI symptoms), PSA (men over 45 years of age), and Cr should also be taken.

District hospitals must please arrange a sonar or IVP where indicated.

For urethra stricture, an ascending and descending MCUG is necessary.

We offer our clients the 10 basic surgical procedures in Urology at George hospital.

Clients for cystoscopy, vasectomy, hydroselectomy, circumcision, or orchidectomy are booked onto our Monday morning theatre list via the day theatre secretary [8024338]. Cases must first be discussed with Dr Jenkins or Dr Gibson. All other urology cases cannot be catered for.

Emergency procedures like suprapubic catheters, El Ghorap shunting, torsion testis or reduction of paraphimosis are dealt with as they present.

Prostate biopsies are done in the Day Theatre by Dr Jenkins or one of the Family Medicine doctors. These patients (raised PSA or prostate nodule on PR examination) must be booked at the Family Medicine clinics (044-8024408).

Children with undescended testes [1-2 years] or hydrocoeles [2-3 years] must receive a SOPD booking [8024408]. Children with hypospadias must be discussed directly with the Urologist on call at Red Cross Children's hospital and receive a booking date.

Women with symptoms of urinary stress incontinence must receive a booking date at the Gyne OPD [8024408]. Similarly, women with unexplained haematuria can be booked for cystoscopy at Gyne OPD.

Patients who need surgery for urinary stones or urethral obstruction must be discussed with GSH by the attending doctor. No such service exists in the Eden-Karoo subdistricts.

Mandible Fractures

Patients with mandible fractures must be booked for a bed in George hospital directly with the Main Theatre secretary 802 4343.

The patient will receive a date to be admitted to Ward B1 on a Sunday afternoon.

Dr J. Viljoen will assess the patients the Monday morning, and select those for the theatre list for the Monday afternoon. All other maxillo-facial surgery is managed by GSH.

ENT (Ear, Nose, & Throat)

Patients who need a specialist ENT opinion are booked directly with the OPD secretary [8024408] for a Monday morning appointment with Dr M. Young in Knysna.

Patients who need an ENT opinion but not necessarily a specialist opinion, or who may need a tonsillectomy/adenoidectomy/grommets can be discussed telephonically with either Dr Jenkins or Dr Gibson, where-after a Family Medicine Clinic appointment in OPD on a Monday or Tuesday afternoon can be made at 8024408. Selected cases will be referred from here to a local sessional ENT specialist.

ENT patients from the Karoo, who may need a specialist opinion, or e.g. direct laryngoscopy, must be booked on a Tuesday afternoon FM OPD, in order to be sent for opinion to the local ENT specialist in George (same day), before returning to the Karoo in the late afternoon.

Dermatology

We have a good teledermatology referral system in place with the Dermatology Department at GSH. You are welcome to discuss any Dermatology clients with Dr Jenkins, who will advise you further.

The 5 easy steps to most Dermatology challenges include: Take a history, take blood for VDRL and HIV (+/- FBC, Cr, ALT, IgE), take a skin scraping for fungi or scabies, take a skin biopsy (punch), and take a photo.

Internal Medicine

The department of Internal Medicine now requires that all patient referrals to George Hospital be discussed telephonically. The reasons for this are as follows:

- **To ensure appropriate triage of patients.** In the past ill patients requiring immediate attention waited weeks/months for Medical Out-patient (MOPD) appointments.
- **To ensure appropriate arrangements can be made to accommodate the patient, ie: where to send patient and doctor to see patient.** Patients with non-urgent pathology that simply arrive at MOPD or casualty without an appointment will be referred back to the doctor of origin.

We believe this will improve the quality of care our patients receive.

Our permanent medical officers will accept telephonic referrals between **08h00 and 16h00, Monday to Friday (URGENT and NON-URGENT referrals)**. George Hospital switchboard will forward your call to the permanent medical officer on call for referrals that morning. **Urgent referrals after 16h00** must be discussed with the medical officer on call in the emergency centre.

Paediatrics (Child Health)

Please send a letter along with patient with relevant history, clinical findings and if available, special investigations like X-rays and laboratory results.

All urgent referrals: Please phone Paediatrician on call via Switchboard.

All cold referrals: Please book at Clark at 8024424 and specify for SPECIALIST booking.

Please do not refer patients for circumcisions or tonsillectomies to Department of Paediatrics. (Discuss with Family Medicine),

Head injuries, inguinal hernias and undescended testis must be referred to Department of Surgery.

Gynaecology and Obstetrics

Abnormal Pap smears

Refer to Colposcopy Clinic Monday afternoons, with copy of most recent Pap report.

General Gynaecology

Gynaecology OPD is Wednesday morning.

All other gynaecologic problems, either new or follow-up are seen here.

We have an ultrasound machine at the clinic.

Please note that there are not facilities or budget to handle Infertility cases.

Do not send non-emergencies to the Trauma unit unless you have spoken to the consultant on call – they will just receive an appointment and have to come on the correct day at the correct time anyway.

Gynaecologic ultrasound requests are generally abused and not requested intelligently – if there is nothing to indicate a pregnancy, and no masses are felt in the pelvis, there is seldom any benefit in scanning a woman with abnormal bleeding.

If ectopic pregnancy is suspected, e. g. a positive pregnancy test and signs of peritonism, there is little sense in referring the patient for scanning – the diagnosis is fairly obvious and we often find unstable patients referred from ultrasound, as they are too sick to send back to the hospital of referral – this is ridiculous – they should be treated on the CLINICAL diagnosis.

In the case of pregnant women with threatened miscarriage, if the cervix is closed and the uterus size corresponds to dates, there is very little justification for a scan, unless the cervix starts dilating and the uterus does not correspond to dates. Generally, these patients should be treated CLINICALLY, not referred here for ultrasound.

If you are in doubt whether an ultrasound examination is indicated, or whether it will have any effect on the management of the patient, rather discuss the matter with the consultant on call before requesting a scan. These are expensive examinations and transport is also expensive, so rather get an opinion first if in any doubt.

Gynaecologic emergencies

Contact the consultant on call and discuss the case with him/her – do not send unstable patients – e.g. ectopics – until resuscitated and/or stabilized.
Arrange further management in consultation with the consultant on call.

Antenatal

High Risk Antenatal

If the patient is considered a High Risk Antenatal case, according to the protocol for referral to the High Risk ANC, refer them on a Tuesday morning, with all relevant notes and results. As a rule, patients should first book at their nearest clinic and get a green card before they are referred to H/R ANC. We have an ultrasound machine at the clinic.

Antenatal Emergencies

Contact the consultant on call and discuss the case with him/her.
Do not send patients who are unstable – e.g. APH, PET – until they have been resuscitated and/or stabilized. Send such patients, after consultation with the consultant on call, to Labour Ward (Ward B4) not to the Trauma Unit.
Severe hypertensives should be transferred under cover of a Magnesium Sulphate infusion – see relevant protocol.

If referring preterm patients, as a rule they should receive the first dose of Betamethazone (Celestone-Soluspan) for fetal lung maturity before they are sent to us.
DO NOT do a vaginal examination on women with pre-term labour Rupture of Membranes – the only acceptable examination is a sterile speculum examination.

Psychiatry

Emergency Psychiatry:

- Aggressive patients.
- Suicidal patients.

Refer to the EC for assessment according to protocols.

Admission to Acute Psychiatric In-Patient Unit:

- Psychiatric emergencies from Casualty Unit.
- Patients admitted under the Mental Health Care Act (72 assessments, Involuntary- & Assisted Mental Health Care Users).
- Patients with acute and serious deterioration from their baseline functioning to the extent that behavior is so disordered that it would be unsafe for the patient to be treated at a lesser level of care.

All admissions must first be discussed with and psychiatrist on call.

authorized by the psychiatric medical officer or

Out-Patient Service:

- Users who have a medical aid or where medical aid is temporarily exhausted. *(NB. Need proof from the medical aid that fund is exhausted.)*
- Child & Adolescent Psychiatry. *(NB. Need a) report from school re academic & social functioning; b) report from social worker if there is already one involved)*
 - NB. It is inappropriate to refer C & A's where the identified problem is longstanding poor school performance due to straightforward educational problems, to this service. Such referral should be directed via the teacher to the school psychologist.

Appointments must be arranged with the secretary at Ward A1 (044 802 4451).

All other Mental Health Care Users qualifying for out-patient services should be referred to the Community Mental Health Nurse at the closest Community Health Centre.

All users referred to Hospital or Community Mental Health Services must be accompanied by:

- A complete comprehensive referral letter documenting psychiatric-, medical- and substance history, examination findings, results from special investigations done and all treatment already administered.
- All documents as required by MHCA.
- All other reports specifically stated.

Surgery

All emergencies must be discussed with either the medical officer or intern on call for surgery, or the consultant on call. The call list for office-hours as well as during after-hours is available at the exchange. Patients must then be send to the EC with a complete referral letter. Cold cases can be booked directly at SOPD, tel 802 4408. Doubtful cases must also be discussed with the doctor on call for surgery. Please refrain from just sending patients to the EC.

Orthopaedic Department

The main differentiation is between acute and urgent referrals or chronic and long-standing problems to the department.

The following problems are regarded as urgent or Orthopaedic emergencies:

- Open factures.
- Compartment syndrome of the limbs.
- Complicated injuries such as dislocations or fractures that will most likely require surgical intervention Orthopaedically. E.g. acute femur neck fracture.
- Acute injuries of the limbs e.g. sharp trauma to the forearm with possible tendon and nerve injuries.
- Spinal injuries.
- Any malignant-looking musculo-skeletal tumour e.g. osteosarcoma
- Septic arthritis.
- Multi-trauma patients with injuries of musculo-skeletal involved. E.g patient in MVA with head trauma, a pneumothorax and a compound tib fib fracture. These patients require quick decision-making and all the parties involved should be contacted directly. The General surgeons specifically should also be contacted before transferring these patients.

Each case should be assessed in its own merit, but the cases that require transfer to George Provincial Hospital (I.e. Patients seen in the George area) should be discussed with the Orthopod on call. Cases that

are to be referred to our outlying hospitals (Oudtshoorn, Mossel Bay, Knysna, Beaufort West) should be organized with that local trauma unit. Cases that we feel can be managed by our outlying hospitals include:

- Simple reduction of fractures or dislocations.
- Initial debridement of open or compound fractures.
- Repair of simple tendon injuries e.g. repair of forearm extensors.

Chronic problems are to be treated in a different manner. Cases that we think fit this category include:

- Chronic mechanical backache
- Neglected dislocations of more than 6 weeks.
- Non-unions
- Chronic musculoskeletal infections.
- Chronic osteoarthritis

If you feel the patient requires referral, the patient should be first sent to their local outpatient clinic for the initial workup and possible to initiate conservative treatment. Of course if you think the patient must be seen more urgently than this and should be sent directly to the specialist Orthopaedic clinic, the case should be discussed with one of the Orthopaedic team. Our outpatient clinics run on Monday from 10h00, Wednesday and Thursday from 08h00. We can be contacted there directly at: 044 802 4408 or 044 802 4433. In this instance we may be limited by the patient load of the clinic or even of theatre list backlog. We do however try to accommodate if possible.

Our cell numbers can be used if we are unobtainable through the hospital switchboard.

Tom Barrett: 082 468 0744

Wayne Le Grange: 083 9861 8719

Renier Greyling: 082 554 2776



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