NHS Borders Induction

ID Badge Collection

HR Paperwork

Please take completed paperwork to HR then collect your ID badge

Welcome

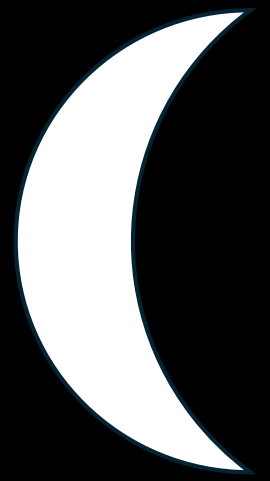
Dr Olive Herlihy
DME

Welcome From Medical Director

Dr Lynn McCallum

Hospital at Night (H@N)

Dr Andy Gale, Clinical Teaching Fellow

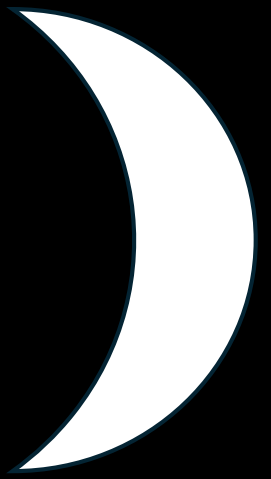


Hospital @ Night

HAN/H@N

Dr Andy Gale
Clinical Teaching Fellow

The Team



- F1 (6005)
  - Ward jobs
  - Clerking
- F2/SHO (6005) (6016 – gynae)
  - More complex ward jobs + surgical clerking)
  - Scrubs for theatre (obstetrics C-sections / general surgery)
    - (obviously supervised)
- H@N Team Lead – usually Med Reg or senior CDF (6006 & 1111)
- 2 x H@N ANPs – do the bulk of bloods/cannulas & keep track of jobs
  - All Referrals & new Jobs should go through coordinating ANP (6344)

Everyone Else

- ED – usually senior SHO/Clinical fellow/spec doc +/- junior
- ITU/Anaesthetics – registrar on site, consultant by phone
- Gen Surg Reg (6008)
  - Not always on site, but within short distance
  - Contact via switchboard usually
- Ortho Reg – who knows (6009)
- Obstetric Reg (6017)
  - 1630 – 0830 weekdays, 24 hr on call weekends
- Paediatrics – ANP/doctor staffing overnight.

Tricky H@N Jobs

- AWI forms – only F2 or SpR overnight
- Med SpR responsible for stroke calls +/- thrombolysis initiation
  - Needs discussion with on-call stroke consultant in Lothian
- All CTs overnight need vetting with Telemedicine (even ?stroke)
- PPCI is @ Royal Infirmary Edinburgh
  - If ?STEMI – email ECG to cardiolrie.as021411@nhslothian.scot.nhs.uk
  - Med SpR speaks to Cardio reg on call
- UGIB/Haemorrhage is cons – cons referral up to RIE.

DO NOT DRIVE TIRED - A68 is a FAST road

- Borders General Hospital provides on-call accommodation rooms
  - Bookable via bghaccommodation@borders.scot.nhs.uk
  - Better to have the room booked and not need it
- I tend to book the run of my nights
  - You can sleep post nights in the room after your last one
  - There are some nice runs along the River Tweed
  - 24h Budgens at the Petrol Station up near Tweedbank
  - Canteen is decent
    - (incredible curries)

Good Night Points

- On-call consultant always happy to be contacted
  - Needs discussion for admission to ITU (consultant-consultant)
  - UGIB protocol
- The Med Reg/H@N Leader is allowed to admit to surgery

- GO TO PMAV TRAINING
  - Learn how to protect yourself from aggressive patients!

Falling Head Over Heels – How to Falls review

Something that happens overnight a fair bit…

Falling Head Over Heels – How to Falls review

CABCDE first!

C – c-spine / catastrophic bleed

Alertness/airway

BCDE

Pre Fall

- What were they doing at the time?
- Any SOB/dizziness/chest pain/palpitations?

Falling Head Over Heels – How to Falls review

Fall

- Ask them what happened (mechanism – weak legs/ collapse/ tripped?)
  - If they can’t tell you – is this normal?
  - Establish the mechanism from any witnesses
- Any LOC?
- What did they hit? What made contact first? Did they hit their head?
- Signs of Seizure? (tongue biting, incontinence, jerking movements)

Falling Head Over Heels - How to Falls review

Post Fall

- Were they able to get themselves up?
- Any confusion, headaches, vomiting?
- Any pain or obvious injury?

Falling Head Over Heels – How to Falls review

Examination

- Cardio/resp/abdo exam
- Look for cuts/bruises/haematoma – especially on the head
- Palpate hips & femurs + over C-spine – pain or deformity?
- Examine painful joints
- Clearly document GCS & neuro exam
- Get Neuro obs + LSBP + BG
- Review drug chart
  - Contributing drugs? Sedatives, antihypertensives
  - Anticoagulated??

Falling Head Over Heels – How to Falls review

Plan

- ECG
- Bloods if concerned (FBC, U&Es, LFTs, Trops if ?cardiac, Bone profile)
  - Not every falls patient needs bloods, especially not overnight.
- CT Head (if significant head injury, atypical neurology, on anticoagulation)
  - Consider including C-spine if concerned.
  - Check NICE guidance
- Neuro obs for head injuries
- ?Hold anticoagulation
- Consider escalation to senior if concerned

Death Certification

Dr Stephen Ross

death certification

the medical certificate of cause of death (MCCD)

- statutory requirement to be registered within 2-7 days of a person's death (unless referred to the procurator fiscal)

- allows for the "Certificate of Registration of Death" to be issued (for burial/cremation, settling financial matters)

- can be randomly selected for review by the National Records of Scotland (NRS)

PART A - DETAILS OF DECEASED

Name of deceased	
Date of death *(dd/mm/yyyy)*	
Time of death *(24-hour clock – hh:mm)*	
Place of death	
Health Board area in which death occurred	
Community Health Index (CHI) number	
Date of birth *(dd/mm/yyyy)*	

PART B - DETAILS OF CERTIFYING DOCTOR

Name	
GMC number	
Business address	
Business contact telephone number	
For a death in hospital **Name of the consultant** responsible for the deceased	

I hereby certify that to the best of my knowledge and belief the information contained in this Medical Certificate of Cause of Death is correct.

Signature of certifying doctor	
Date	

PART C - CAUSE OF DEATH

PLEASE PRINT CLEARLY IN BLOCK CAPITALS AND DO NOT ABBREVIATE

	Approximate interval between onset and death		
	Years	Months	Days
I Disease or condition directly leading to death * **(a)**			
Antecedent causes – Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last			
due to (or as a consequence of) **(b)**			
due to (or as a consequence of) **(c)**			
due to (or as a consequence of) **(d)**			
II Other significant conditions contributing to the death, but not related to the disease or condition causing it			

* *This does not mean mode of dying, such as heart or respiratory failure; it means the disease, injury or complication that caused death.*

PART D - HAZARDS

To the best of your knowledge and belief;		Y	N
DH1	Does the body of the deceased pose a risk to public health: for example, did the deceased have a notifiable infectious disease or was their body "contaminated", immediately before death?		
DH2	Is there a cardiac pacemaker or any other potentially explosive device currently present in the deceased?		
DH3	Is there radioactive material or other hazardous implant currently present in the deceased?		

PART E – ADDITIONAL INFORMATION

Post mortem examination by a pathologist (*tick one*)		
PM1	Post mortem has been done and information is included above	
PM2	Post mortem information may be available later	
PM3	No post mortem	

Attendance on deceased *(tick one)*		
A1	I was in attendance upon the deceased during last illness	
A2	I was not in attendance upon the deceased during last illness: the doctor who was is unable to provide the certificate	
A3	No doctor was in attendance on the deceased	

Procurator Fiscal *(tick if applicable)*		
PF	This death has been reported to the procurator fiscal	

Extra information for statistical purposes *(tick if applicable)*		
X	I may be able to supply the Registrar General with additional information	

Maternal Deaths (*tick if applicable*)		
M1	Death during pregnancy or within 42 days of the pregnancy ending	
M2	Death between 43 days and 12 months after the end of pregnancy	

completing Part C

- Box I: the underlying cause and the events or results that then led to death

- Box II: any underlying conditions that made the person more vulnerable (but not directly related) to the underlying cause

- Specify as much as possible eg organism, histology, site of metastases, location of fall, medical interventions

- Avoid vague terms like cerebrovascular accident, organ failure alone, abbreviations

- Acceptable abbreviations are: HIVV, AIDS, COVID-19 disease, SARS-CoV-2, CREST, CARASIL, CADASIL, SCID, IgM, IgA, IgG

example 1

I		Approximate interval between onset and death		
		Years	Months	Days
Disease or condition directly leading to death	**(a) Intraperitoneal haemorrhage**			**1**
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	due to (or a consequence of) **(b) Ruptured metastatic deposit in liver**			**1**
	due to (or a consequence of) **(c) Metastases to liver**		**6**	
	due to (or a consequence of) **(d) Primary adenocarcinoma of ascending colon**	**2**		

II Other significant conditions contributing to the death, but not related to the disease or condition causing it	**Type 2 diabetes mellitus (mild obesity related)**	**20**		

example 2

I		Approximate interval between onset and death		
		Years	Months	Days
Disease or condition directly leading to death	**(a) Cerebral infarction**			**1**
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	due to (or a consequence of) **(b) Thrombosis of basilar artery**			**2**
	due to (or a consequence of) **(c) Cerebrovascular atherosclerosis**		**6**	
	due to (or a consequence of) **(d)**			

II Other significant conditions contributing to the death, but not related to the disease or condition causing it				

when to refer to the procurator fiscal (PF)
(and therefore cannot issue a MCCD)

- **Unnatural causes due to:**

- suspicious circumstances, accidents, suicide, drug-use

- **Natural causes where:**

- the cause of death is not identifiable (to the best of your knowledge)
- death is as a result of neglect or fault (including medical error)
- the deceased is a child
- there is a notifiable industrial/infectious disease
- the person is in custody

- If in doubt, always best to ask

What to do with the completed MCCD

• Phone the NOK to inform them the MCCD has been completed – offer to discuss the cause(s) of death with them.

• Advise NOK to contact the registrar to make an appointment to register the death.

The NOK do not need a copy of the MCCD and all the information on this will also be on the 'certificate of registration of death.'

•Scan a copy and email it to local registrar:
RegistrationService@scotborders.gov.uk

• Send the original in the post (usually the ward clerk will do this)

• Put a copy in the notes in case this needs to be discussed with the review service or the original goes missing.

Treatment Escalation Plans

Dr Gemma Alcorn

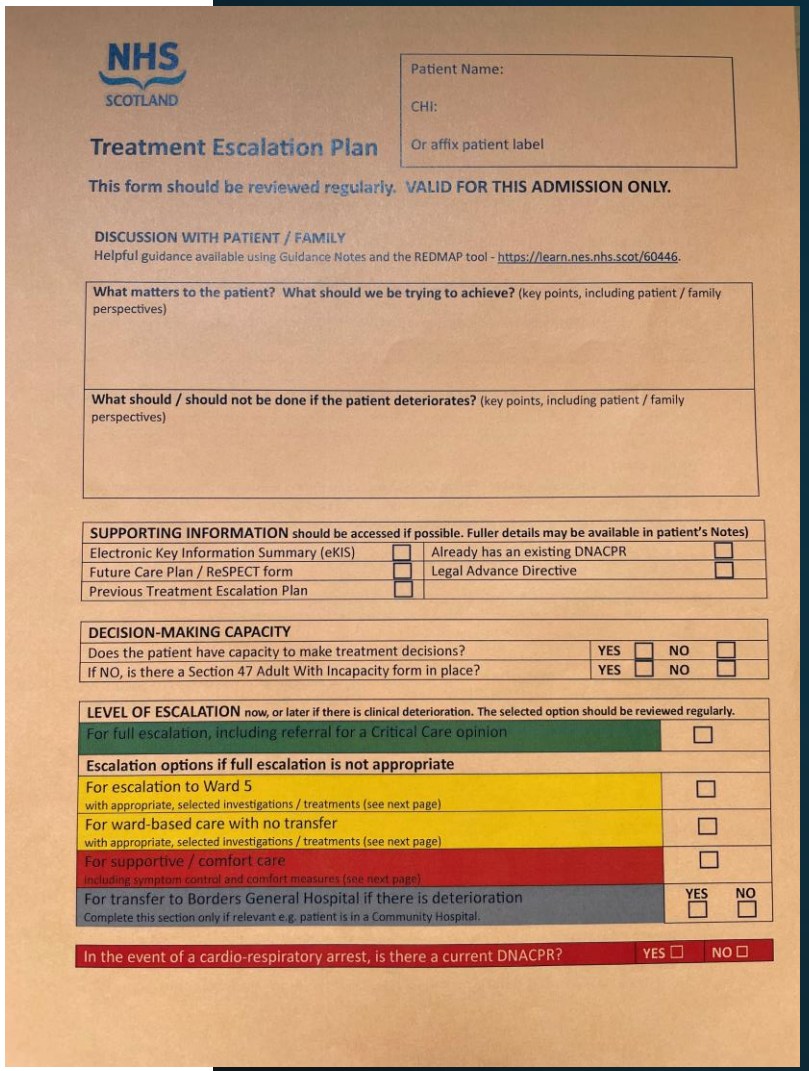
Treatment Escalation Plans NHS Borders

Trainee induction August 2025

Dr Gemma Alcorn

What is a TEP

- Summary document, detailing patient wishes and decisions made regarding what to do if the patient deteriorates



NHS SCOTLAND

Patient Name:

CHI:

Or affix patient label

Treatment Escalation Plan

This form should be reviewed regularly. VALID FOR THIS ADMISSION ONLY.

DISCUSSION WITH PATIENT / FAMILY

Helpful guidance available using Guidance Notes and the REDMAP tool - https://learn.nes.nhs.scot/60446.

What matters to the patient? What should we be trying to achieve? (key points, including patient / family perspectives)

What should / should not be done if the patient deteriorates? (key points, including patient / family perspectives)

SUPPORTING INFORMATION should be accessed if possible. Fuller details may be available in patient's Notes)

Electronic Key Information Summary (eKIS)	☐	Already has an existing DNACPR	☐
Future Care Plan / ReSPECT form	☐	Legal Advance Directive	☐
Previous Treatment Escalation Plan	☐		

DECISION-MAKING CAPACITY

Does the patient have capacity to make treatment decisions?	YES ☐	NO ☐
If NO, is there a Section 47 Adult With Incapacity form in place?	YES ☐	NO ☐

LEVEL OF ESCALATION now, or later if there is clinical deterioration. The selected option should be reviewed regularly.

For full escalation, including referral for a Critical Care opinion	☐
Escalation options if full escalation is not appropriate	
For escalation to Ward 5 with appropriate, selected investigations / treatments (see next page)	☐
For ward-based care with no transfer with appropriate, selected investigations / treatments (see next page)	☐
For supportive / comfort care including symptom control and comfort measures (see next page)	☐
For transfer to Borders General Hospital if there is deterioration Complete this section only if relevant e.g. patient is in a Community Hospital.	YES ☐ NO ☐

In the event of a cardio-respiratory arrest, is there a current DNACPR? YES ☐ NO ☐

In which patients should we consider a TEP?

The current national Guidelines suggest:

- TEPs are strongly recommended for patients whose **condition is unstable**, or who are at **risk of deterioration.**

- **TEPs should be considered for the following groups:**

1. NEWS score of **5** or more.
2. Frailty Score of **5** or more.
3. Progressive organ failure; progressive incurable disease e.g. dementia, MND; cancer currently being treated – irrespective of the prognosis.
4. Patients deemed to require a DNACPR: “no DNACPR without a TEP”.
5. Patients in community hospitals.
6. At request of patient / welfare attorney or guardian / nearest relative.

Who should undertake a TEP discussion?

Any member of team with sufficient training

Must be endorsed by responsible consultant/clinician at earliest possible time.

NHS SCOTLAND

Patient Name:

CHI:

Or affix patient label

reatment Escalation Plan

is form should be reviewed regularly. VALID FOR THIS ADMISSION ONLY.

Date of Admission:

CUSSION WITH PATIENT / FAMILY

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What matters to the patient? What should we be trying to achieve? (key points, including patient / family perspectives)
What should / should not be done if the patient deteriorates? (key points, including patient / family perspectives)

LEVEL OF ESCALATION now, or later if there is clinical deterioration. The selected option should be reviewed regularly.	
For full escalation, including referral for a Critical Care opinion	☐
Escalation options if full escalation is not appropriate	
For escalation to Ward 5 with appropriate, selected investigations / treatments (see next page)	☐
For ward-based care with no transfer with appropriate, selected investigations / treatments (see next page)	☐
For supportive / comfort care including symptom control and comfort measures (see next page)	☐
For transfer to Borders General Hospital if there is deterioration Complete this section only if relevant e.g. patient is in a Community Hospital.	**YES** ☐ **NO** ☐

Is there a current DNACPR?	**YES** ☐	**NO** ☐

OTHER INVESTIGATIONS AND TREATMENTS TO BE CONSIDERED					
	Appropriate	Inappropriate		Appropriate	Inappropriate
Arterial blood gas	☐	☐	IV antibiotics	☐	☐
Blood sampling	☐	☐	Oral antibiotics	☐	☐
IV access	☐	☐	Blood transfusion	☐	☐
IV fluids	☐	☐	Imaging	☐	☐
Subcut. fluids	☐	☐	Nasogastric tube	☐	☐
Blood glucose measurement	☐	☐	NEWS scoring	☐	☐
Oxygen	☐	☐			

Other specific investigations/treatments that are APPROPRIATE; e.g. endoscopy/ pleural aspiration/ eating and drinking with acknowledged risk

……

Other specific investigations/treatments that are INAPPROPRIATE; e.g. endoscopy / pleural aspiration/ prolonged nil by mouth

……

DISCUSSION

Communication about the patient's condition, prognosis and their priorities for their treatment is an essential part of good patient care. Where a complex discussion has taken place, it may be necessary to document this more fully in the patient's notes, in addition to commenting here.

Have the contents of this TEP been discussed with the patient? Yes ☐ No ☐

If necessary, comment briefly about the patient's understanding of their illness and management plan?

e.g. The patient in agreement about what should/should not be done if there is deterioration.

……

The TEP has been discussed with:

Family / carers / POA Yes ☐ No ☐

ITU team Yes ☐ No ☐ N/A ☐

Name of family member (and relationship) with whom TEP was discussed:

……

If discussion was not possible for any reason, and/or is planned in the future, this should be recorded:

……

Healthcare professional initiating and role Print:	**Responsible Senior Clinician** Print:
Sign: Date:	Sign: Date:

What if the clinical situation/decisions change?

1. Discuss with senior/consultant responsible
2. Score through form and date
3. Complete new TEP
4. File previous TEP at front of notes in plastic polypocket

Quality of TEPs

- Patient and family involvement
- Responsible senior clinician involvement and endorsement
- Only valid for current admission
- Must be reviewed on a regular basis and updated as the clinical situation evolves
- New TEP written if situation or plan changes

What is a TEP not?

Does not replace a DNACPR document or AWI document

Not legally binding – can act outwith/change if good clinical reason to do so, always with senior support.

Role of trainees

FLAG UP TO SENIORS IN TEAM IF TEP FELT TO BE NEEDED BUT NOT IN PLACE

BE INVOLVED IN DISCUSSIONS WITH PATIENT/NOK WITH SENIOR SUPPORT

INITIATE TEP CONVERSATIONS WITH PATIENTS/NOK

FLAG UP ON CONSULTANT WARD ROUNDS IF TEP NEEDS SIGNED

REFER TO TEP WHEN REVIEWING A PATIENT

CONSIDER BEING INVOLVED IN QIP

Training opportunities

Teaching sessions

Simulated conversation practice sessions

"It's ok to ask" session

Learn pro sign up

Opportunities for supervised/supported conversations

Questions

Gemma.Alcorn@nhs.scot

Chief Residents

Dr Stephen Ross

CHIEF RESIDENTS

2024-2025

ROLES OF CHIEF RESIDENTS

- Liaison between Junior Doctors and Consultants / Managers
- Organise JDF
- Organise social events

WHO ARE THE CHIEF RESIDENTS?

chief.residents@borders.scot.nhs.uk

DR MAX JEFFREY

Chief Resident

EM Fellow

DR FELICITY BAINES

Chief Resident

Medical Registrar

DR STEPHEN ROSS

Chief Resident

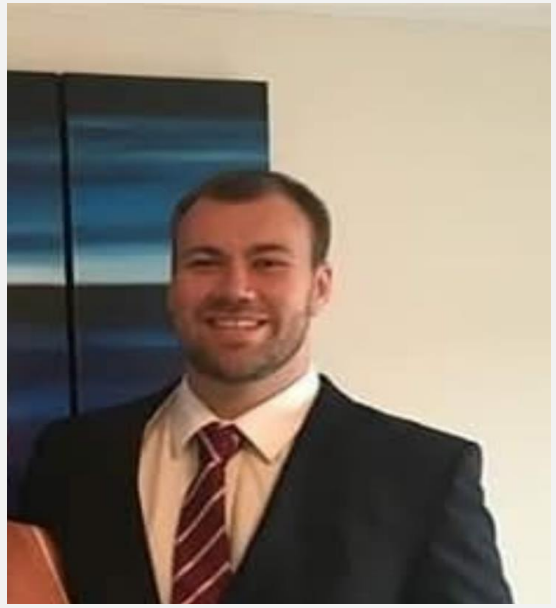
ACCS 4

MR PRASH RAMARAJ

Chief Resident

ST3 General Surgery

DR ANGUS WALLACE



Deputy Chief Resident

IMT 3

Critical Care Outreach

Ronnie Dornan - CCOT

Let’s have a break

Unit induction for Psychiatry, Paediatric and Obs & Gynae Trainees

Medical Education Introduction

Kath Liddington – Medical Education Manager

Medical Education

Induction – 6th August 2025

Medical Education Team

Dr Lynn McCallum
Medical Director

Dr Olive Herlihy
DME

Dr Mat Topping
ADME

Dr Effie Dearden
FPD s03

Dr Jennifer Lonnen
FPD S17

Jill Rose
SIM Nurse

Rod McIntosh
SIMTech

Dr Andy Gale
CTF

Chief Residents

CDFs

Medical Education Team

Kath Liddington
MedEd Manager

Peter Tennant
Deputy MedEd Manager

Debbie Dear
MedEd Administrator

Abraham George
MedEd Quality Officer

Bob Salmond
Medical Staffing Manager

Victoria Roy
Medical Staffing Advisor

Moira Mitchell
Clinical Librarian

Role of the Medical Education Team

Our job is to support
you to do your job

Your wellbeing

* Educational / Clinical Supervisor
* Chief Residents
* FPD / DME / ADME
* Work & Wellbeing (Occupational Health)
* HR medical staffing

* Medical Education
  - Medical.Education@borders.scot.nhs.uk
* Focus Groups

Induction eLearning

Please complete NHS Lothian eLearning
for FYs on
Turas Learn

If you have a concern

Adverse Event Recording

- Intranet - Jump to an application – Adverse Event Recording (InPhase)
- Guidance (intranet)
- Support - Lettie Pringle, Risk Co-Ordinator, 01896 828250
- Follow up
  - Risk Owners / Approvers in your Dept (Risk microsite)
  - Clinical Supervisor
  - Improvements

Other concerns

* TOPdesk (jump to an application)
* On call rooms
* Public WiFi / Govroam / BT WiFi in Library / BYOD / Residences WiFi / Teams teaching
* Please report issues with WiFi in residences to the Library
* Please report issues with on-site accommodation to Medical Education
* Please don't add your mobile number to the telephone directory
* Please don’t adjust HICK / PICC lines

Concerns

* Educational / Clinical Supervisor
* Chief Residents
* FPD / DME / ADME
* Work & Wellbeing (Occupational Health)
* HR medical staffing

* Medical Education
  - Medical.Education@borders.scot.nhs.uk
* Focus Groups

NHS Borders Clinical Guidelines app

The Right Decision Service

Digital Health & Care Innovation Centre

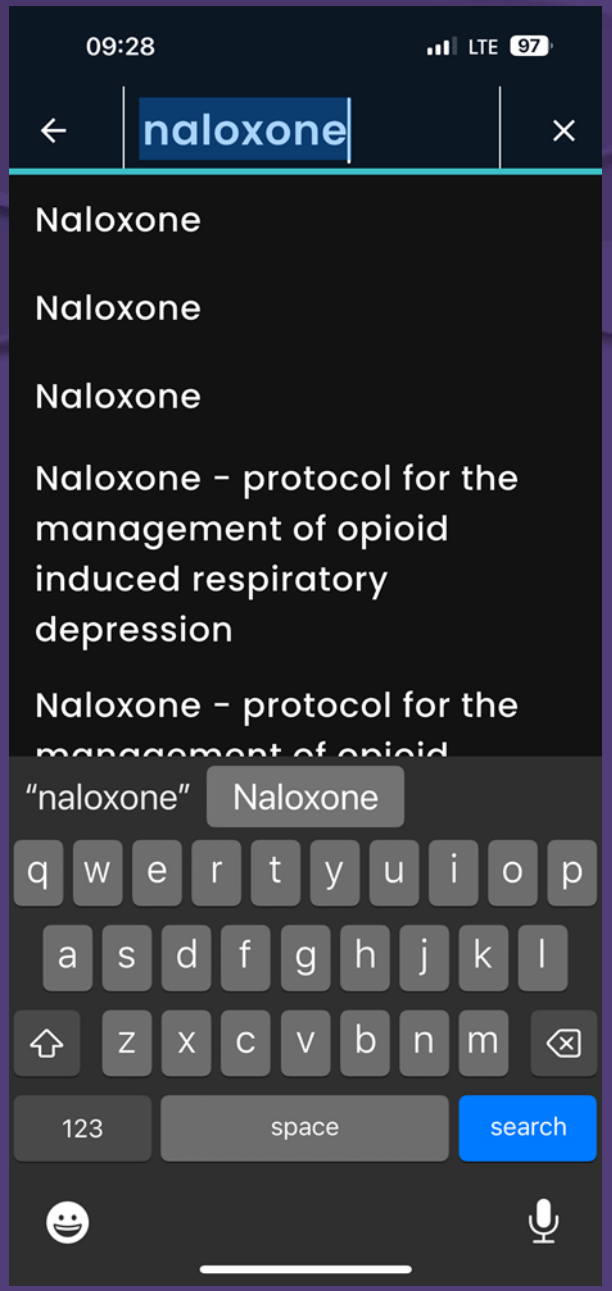
NHS Borders

https://rightdecisions.scot.nhs.uk/nhs-borders-clinical-guidelines

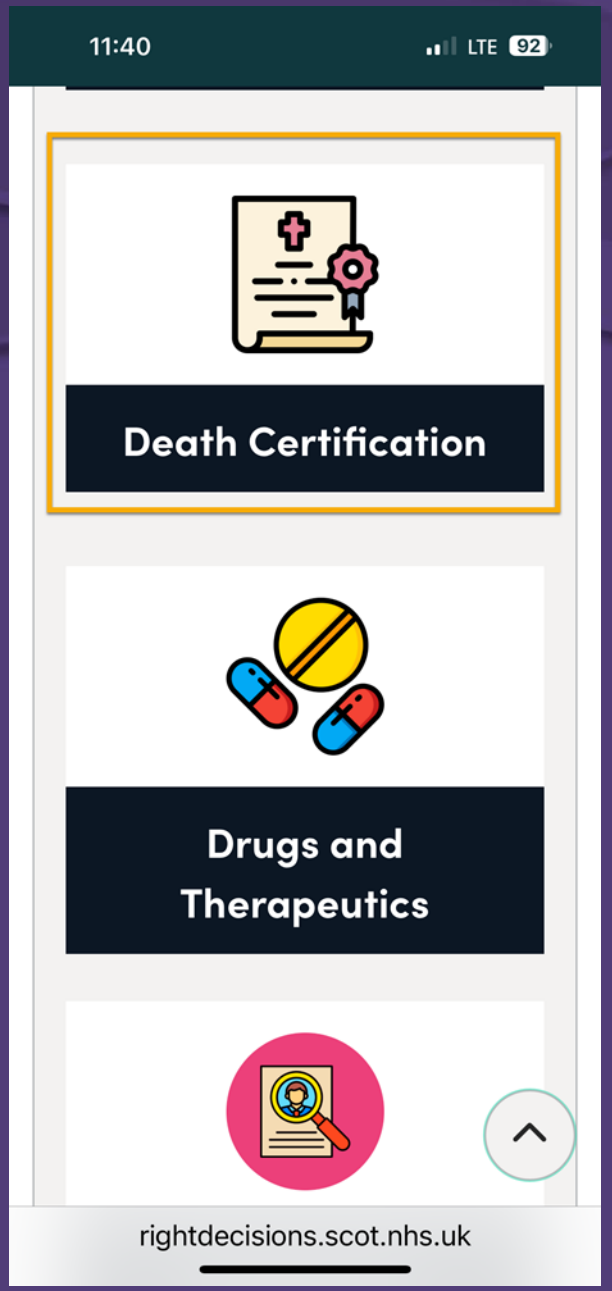
NHS Borders Clinical Guidelines app

Why?

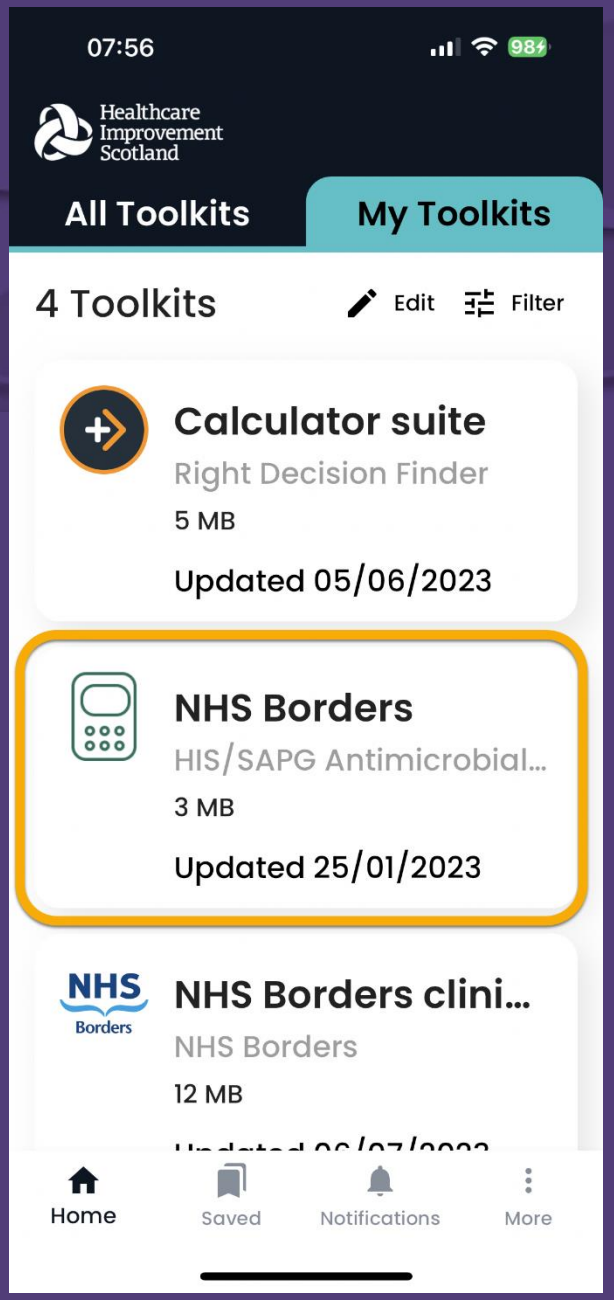
NHS Borders toolkit



NHS Borders toolkit



NHS Borders toolkit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Healthcare Improvement Scotland
All Toolkits
My Toolkits
4 Toolkits
Edit
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Updated 05/06/2023
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Notifications
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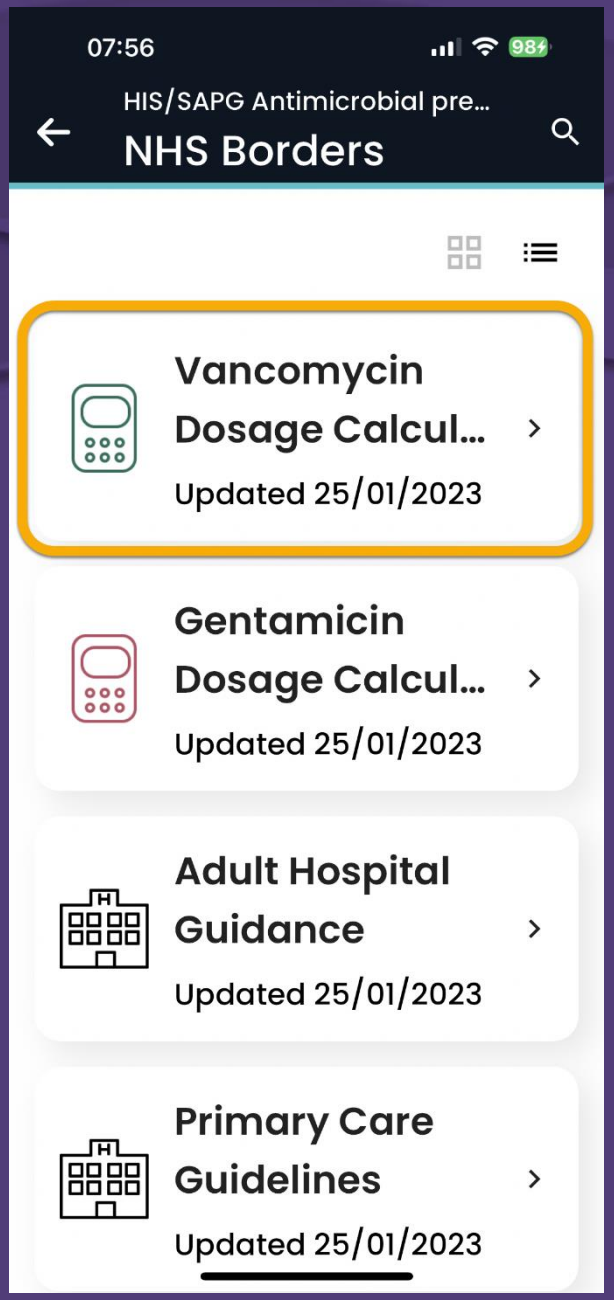
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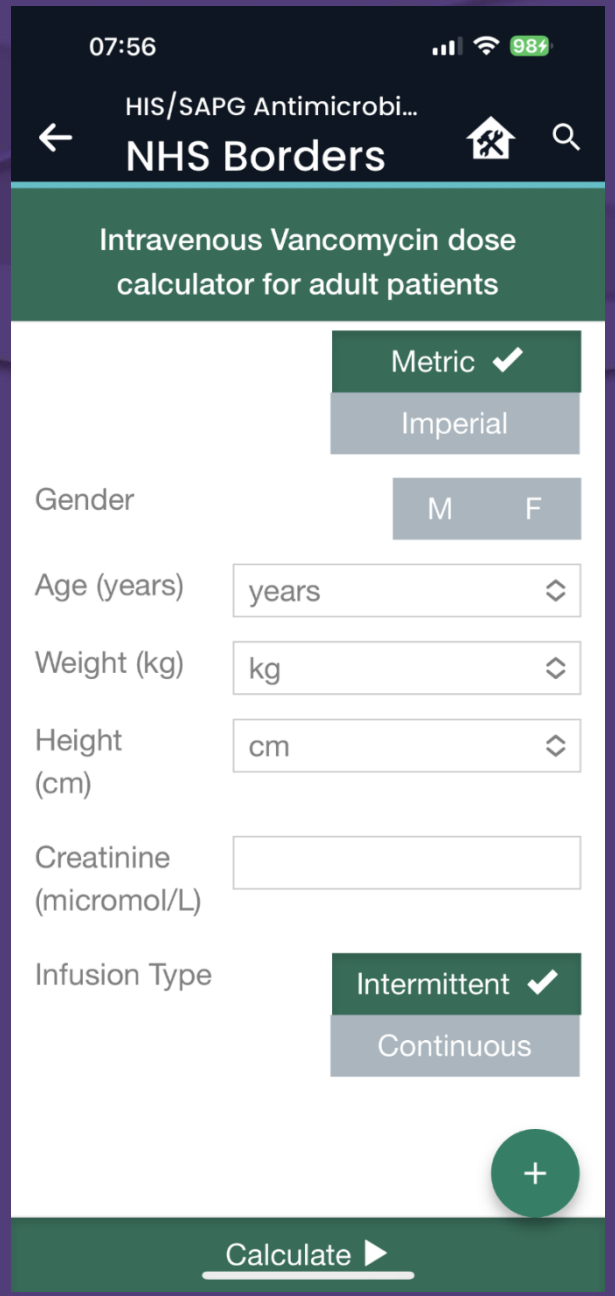
Vancomycin Dosage Calcul...
Updated 25/01/2023
Gentamicin Dosage Calcul...
Updated 25/01/2023
Adult Hospital Guidance
Updated 25/01/2023
Primary Care Guidelines
Updated 25/01/2023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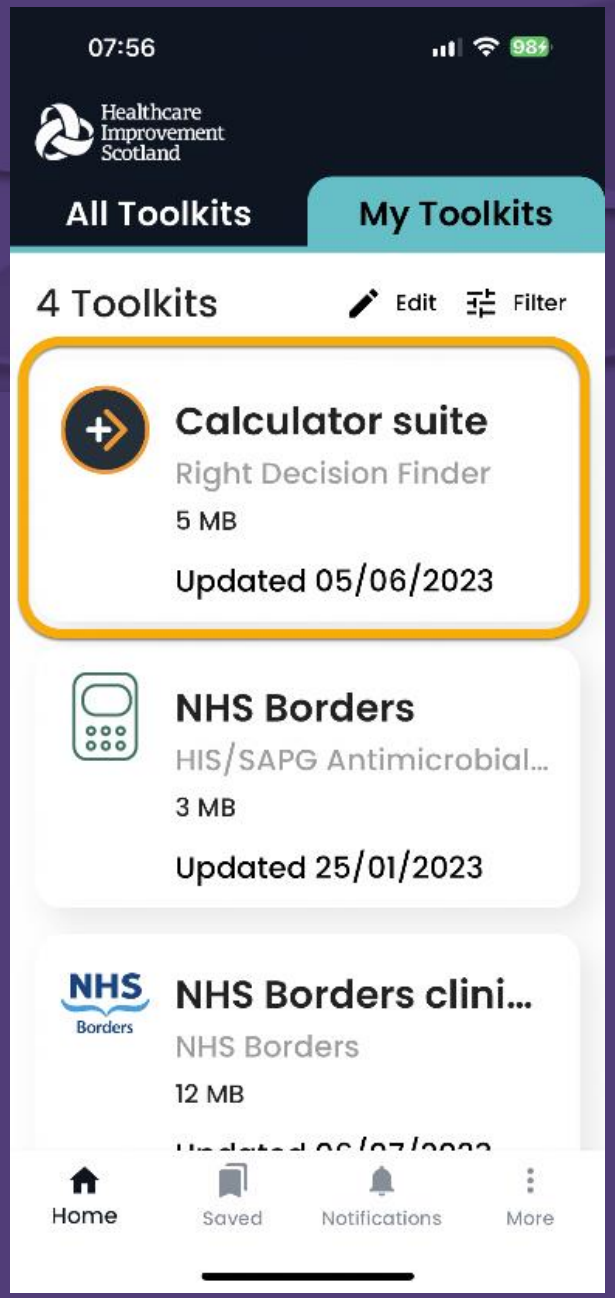
Intravenous Vancomycin dose calculator for adult patients
Metric
Imperial
Gender
M
F
Age (years)
years
Weight (kg)
kg
Height (cm)
cm
Creatinine (micromol/L)
Infusion Type
Intermittent
Continuous
Calculate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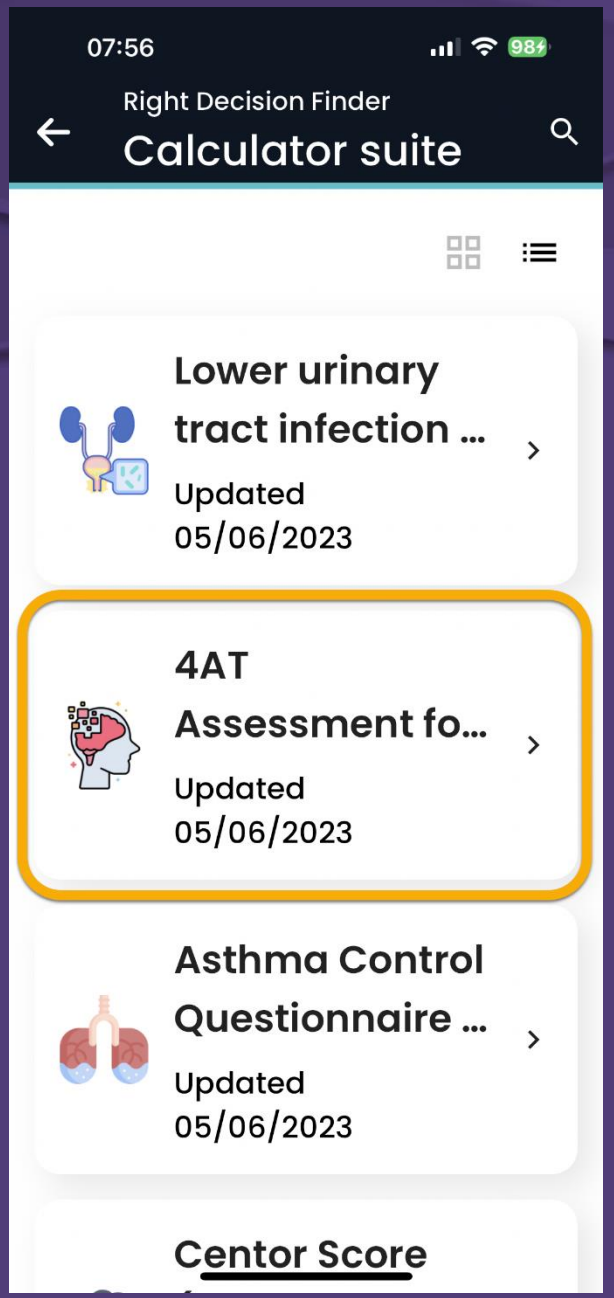
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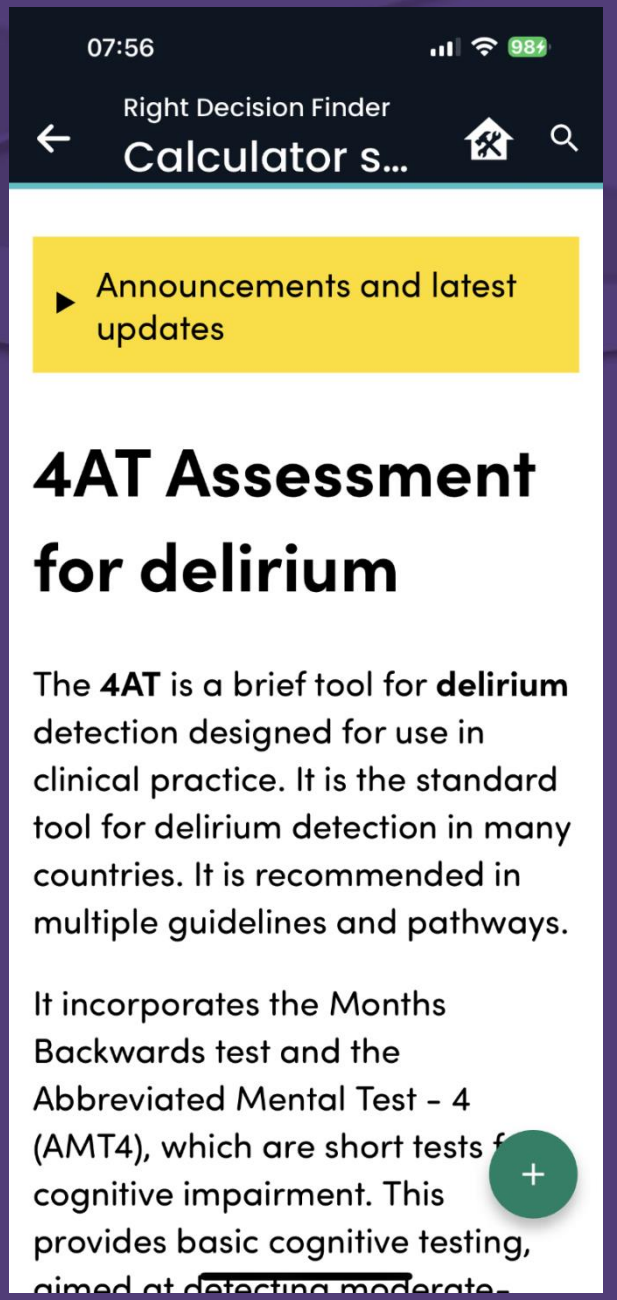
Right Decision Finder
Calculator suite
Lower urinary tract infection ...
Updated 05/06/2023
4AT Assessment fo...
Updated 05/06/2023
Asthma Control Questionnaire ...
Updated 05/06/2023
Centor Score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Right Decision Finder
Calculator s...
Announcements and latest updates
4AT Assessment for delirium
The 4AT is a brief tool for delirium detection designed for use in clinical practice. It is the standard tool for delirium detection in many countries. It is recommended in multiple guidelines and pathways.
It incorporates the Months Backwards test and the Abbreviated Mental Test - 4 (AMT4), which are short tests f
cognitive impairment. This provides basic cognitive testing,

Over to you!

Welcome

NHS Borders Clinical Guidelines app

https://rightdecisions.scot.nhs.uk/nhs-borders-clinical-guidelines

Resuscitation Overview

Ange Hislop

Resuscitation Equipment & Procedure Overview

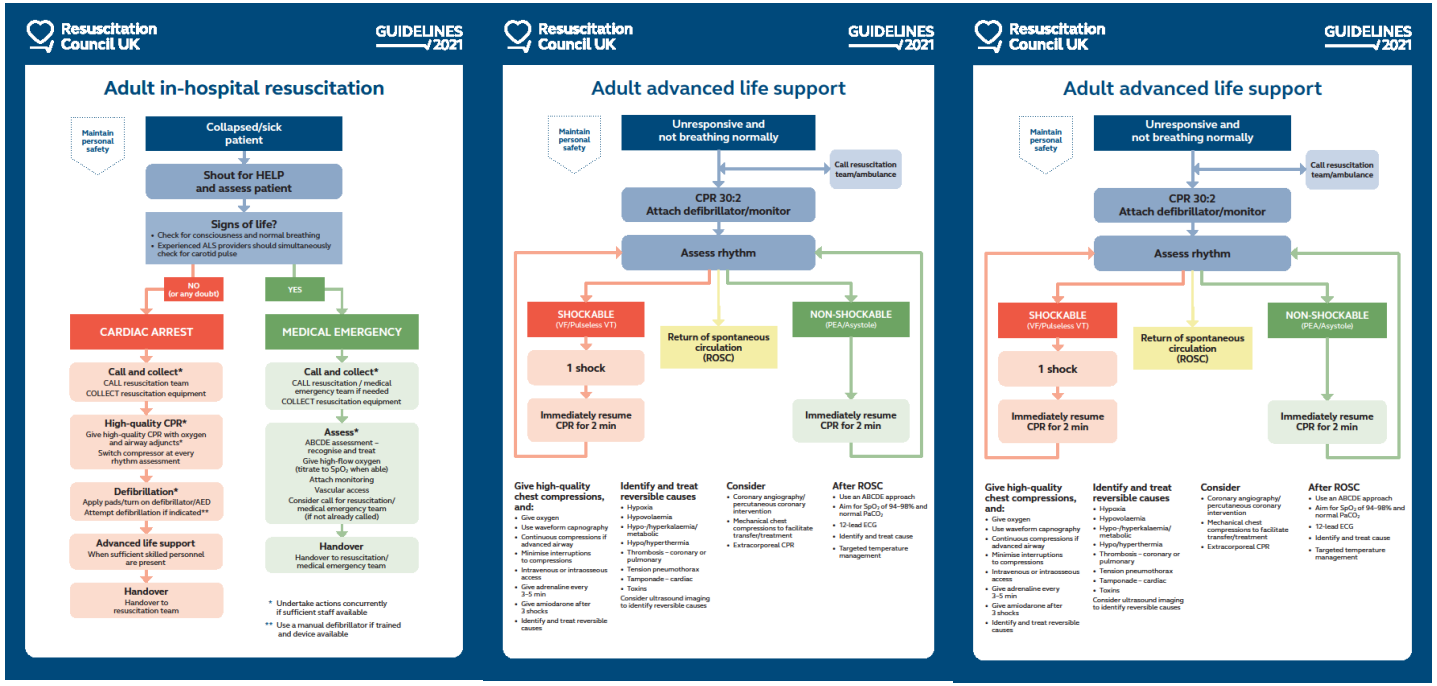
Borders General Hospital

Doctors Induction

Deteriorating Patient – Reducing In-Hospital Cardiac Arrests

- **Careful assessment using the A to E approach should be developed. Early recognition of deterioration**
- **Use / understanding of NEWS2**
- **Knowing the right Escalation pathways (Outreach / HaN ect)**
- **DNACPR/RESPECT**

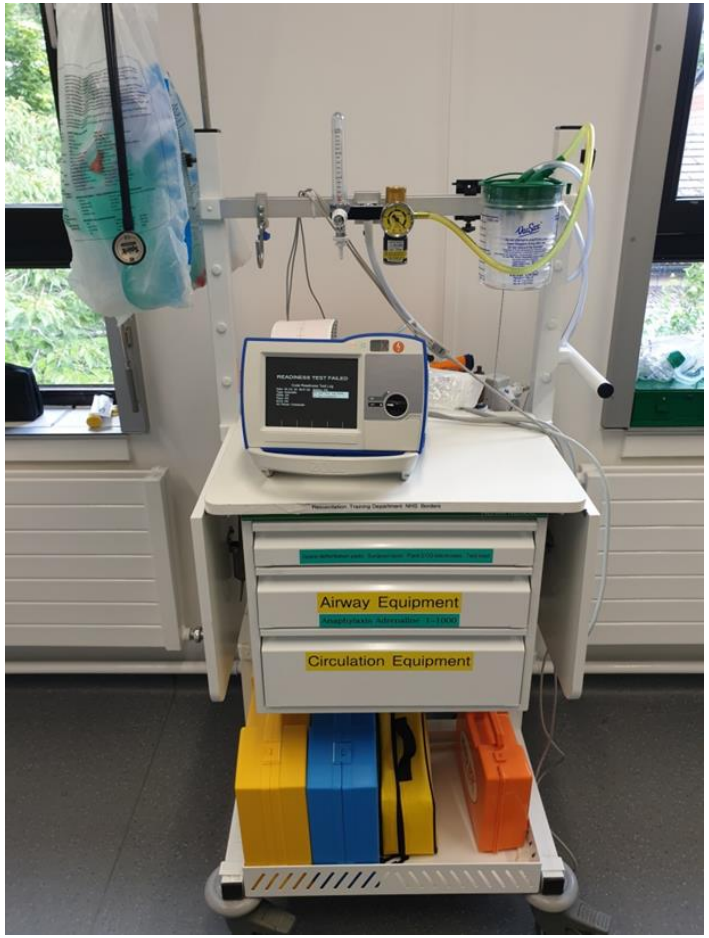
Know the Resus Guidelines & know how to access them



Please note there are several version of the emergency call system active in the BGH

Emergency CPR – Pull flattens chest section of bed

Standard BGH Trolley

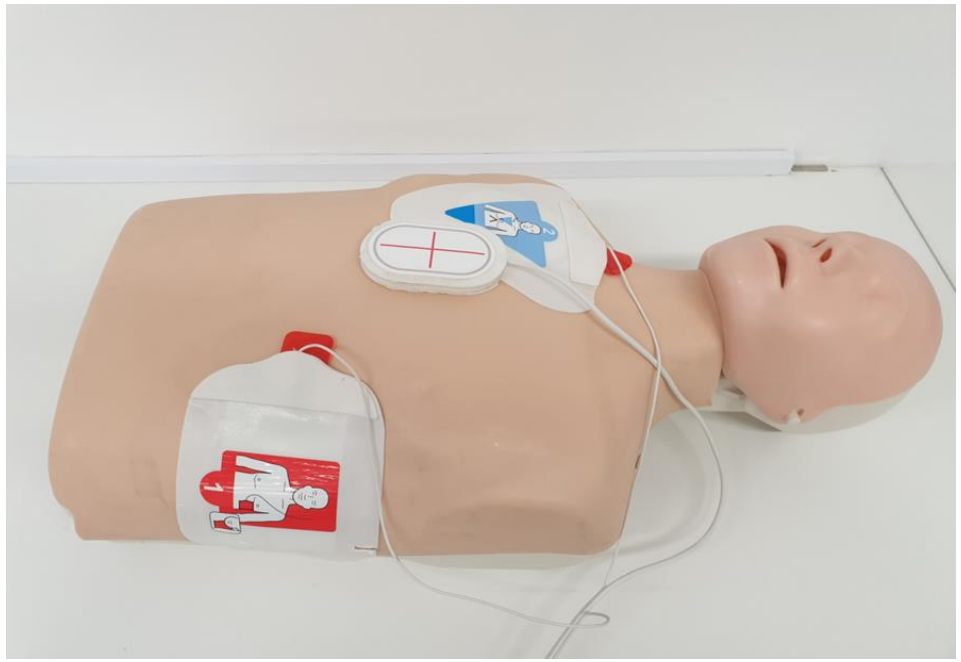


Zoll R series plus

Zoll AED Pro

Switch ON Defib & apply pads

Follow the voice prompts



Zoll AED Pro

AED Mode

1. Press On Button.
2. Attach electrodes to patients chest.
3. AED will auto-analyse. if shock advised, AED will auto charge. Clear patient, then press shock button.
4. Follow voice prompts

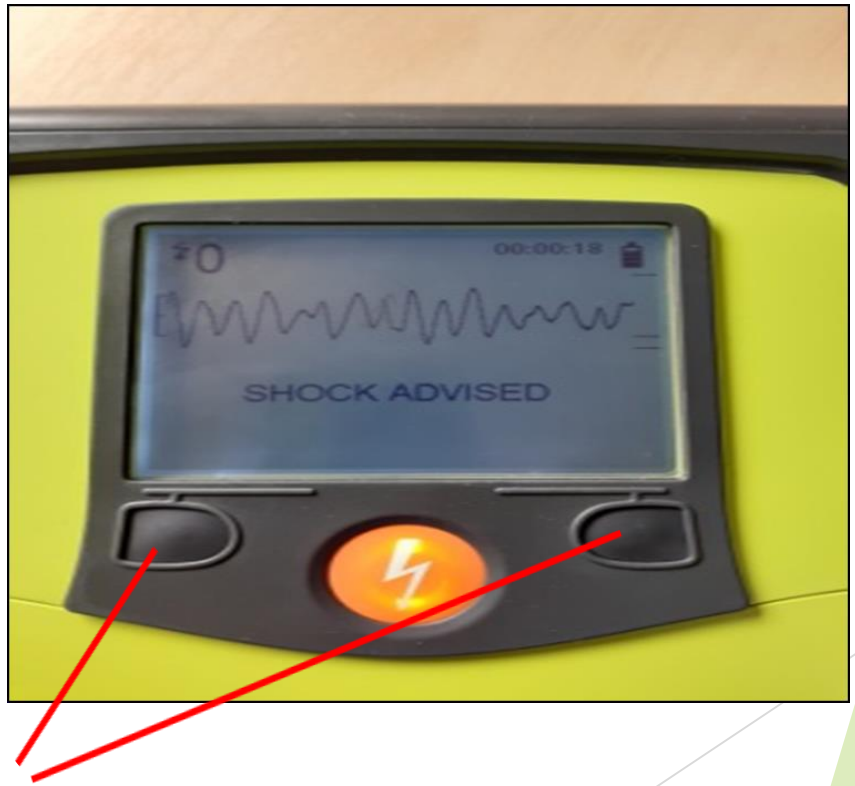
Zoll AED Pro Defibrillation - Manual Mode

1. Switch to manual mode by holding down the 2 lack buttons at the same time for 5 seconds

2. Charge will appear on bottom left on screen

3. Press charge

4. When defib charged clear patient then press shock



Manual mode buttons

Zoll R Series

AED Mode

1. Attach electrodes to patient.
2. Turn dial to ON.
3. Defib will auto-analyze; if shock advised, defib will auto-charge. Clear patient, then press SHOCK button.
4. Follow voice prompts.

Zoll R Series Defibrillation - Manual Mode

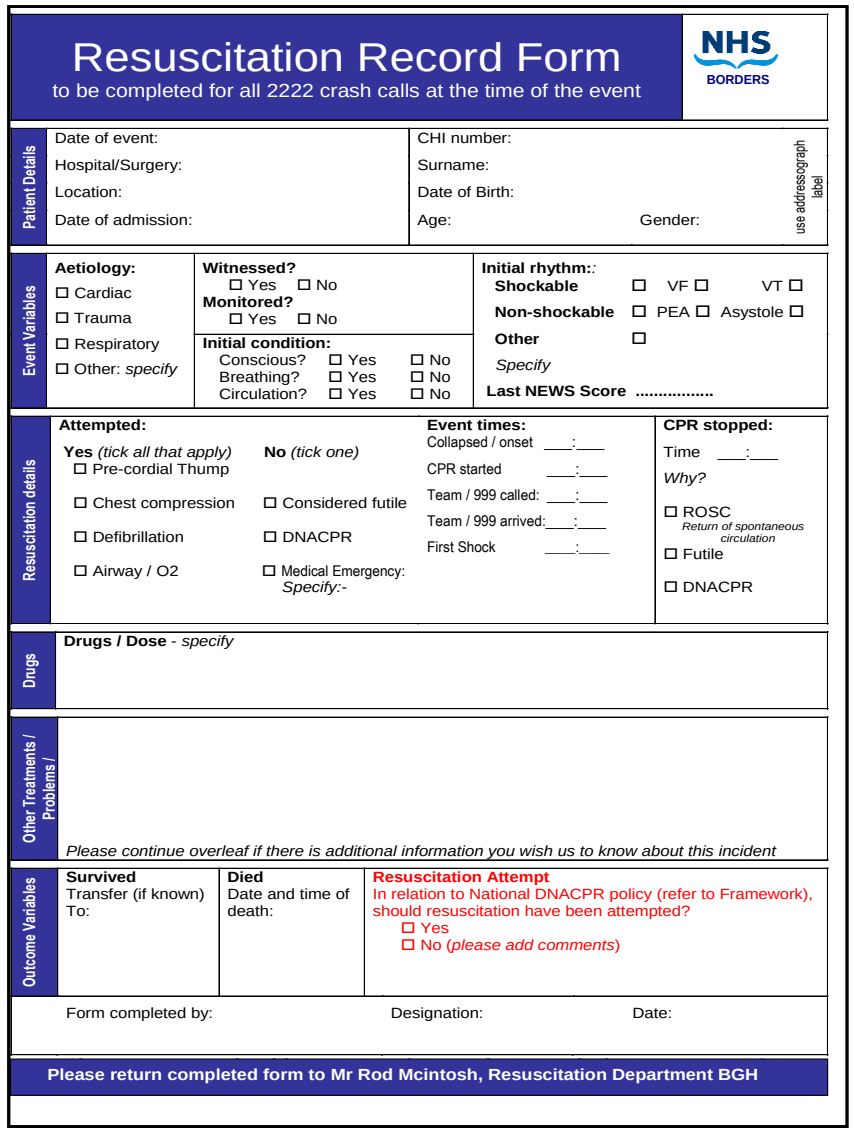
New Presentation of Adrenaline 1:10000

Existing Adrenaline 1:10000

Composition of NHS Borders Cardiac Arrest Team

Job title	Bleep number
Medical Registrar	6006
Medical FY2	6005
Anaesthetist	3933
Hospital at Night Practitioner	6344/6355
Critical Care Nurse	6321
General Service Supervisor	6059

Resuscitation Record Form



Resuscitation Record Form

to be completed for all 2222 crash calls at the time of the event

NHS BORDERS

Patient Details

Date of event:
Hospital/Surgery:
Location:
Date of admission:

CHI number:
Surname:
Date of Birth:
Age: Gender:

use addressograph label

Event Variables

Aetiology:
☐ Cardiac
☐ Trauma
☐ Respiratory
☐ Other: *specify*

Witnessed?
☐ Yes ☐ No
Monitored?
☐ Yes ☐ No

Initial condition:
Conscious? ☐ Yes ☐ No
Breathing? ☐ Yes ☐ No
Circulation? ☐ Yes ☐ No

Initial rhythm:
Shockable ☐ VF ☐ VT ☐
Non-shockable ☐ PEA ☐ Asystole ☐
Other ☐
Specify
Last NEWS Score .....

Resuscitation details

Attempted:

Yes *(tick all that apply)*
☐ Pre-cordial Thump
☐ Chest compression
☐ Defibrillation
☐ Airway / O2

No *(tick one)*
☐ Considered futile
☐ DNACPR
☐ Medical Emergency: *Specify:-*

Event times:
Collapsed / onset ___:___
CPR started ___:___
Team / 999 called: ___:___
Team / 999 arrived:___:___
First Shock ___:___

CPR stopped:
Time ___:___
Why?
☐ ROSC *Return of spontaneous circulation*
☐ Futile
☐ DNACPR

Drugs

Drugs / Dose - *specify*

Other Treatments / Problems /

Please continue overleaf if there is additional information you wish us to know about this incident

Outcome Variables

Survived
Transfer (if known)
To:

Died
Date and time of death:

Resuscitation Attempt
In relation to National DNACPR policy (refer to Framework), should resuscitation have been attempted?
☐ Yes
☐ No (*please add comments*)

Form completed by: Designation: Date:

Please return completed form to Mr Rod Mcintosh, Resuscitation Department BGH

This form should be filled out following any incident where cardiopulmonary resuscitation is undertaken, OR where a cardiac arrest team is called (i.e. including Acute Medical Emergencies and false alarms)

Key learning points

- Good quality chest compressions, with minimal interruptions are key
- Know your equipment /location:
  - Resuscitation trolley
  - Defib
  - Suction
- Risk assess and treat all cardiac arrests appropriately
- Be aware of the Resuscitation Record Form - DNACPR

Medicine Reconciliation

Emma Beaton

Medicines Reconciliation

Emma Beaton

Clinical Pharmacist

Medicine Reconciliation

WHAT IS IT?

WHAT IS THE GOLD STANDARD?

WHY IS IT IMPORTANT?

What Is Med Rec?

Collation of what medications people are taking

Prescribed

Non prescribed

Topical/inhalers

Doses/tablets/frequency

Consideration for noncompliance

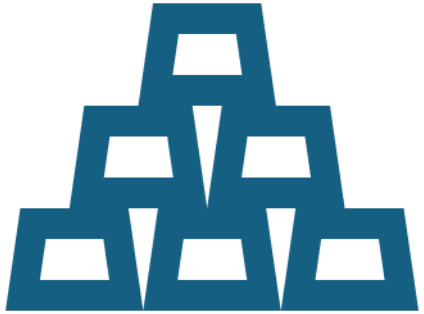
Important as you want to ensure current medications will not affect current illness and patients do not miss crucial medications they take at home

Adverse drug reactions account for ~ 17% of hospital admissions

Accurate meds rec may provide differential diagnosis

The Gold Standard

- **Minimum** 2 sources
  - ECS
  - Patient/family member
  - Patient own drugs
  - IDL/clinic letter
  - Community pharmacy
- Complete within 24 hours
- Document decision to continue, withhold, stop – plus rationale
- Correct prescription on Kardex
- Pharmacy can help check/clarify if unable to find 2 sources
  - Highlight med rec may be incomplete
- Accurate admission med rec = easier discharge med rec



A Good Med Rec

Step 1: Collect — the information about a patient's medication

Step 2: Confirm — that the information is accurate by comparing it with at least one other reliable source

Step 3: Communicate — this accurate list to all other healthcare professionals who may be involved in the patient's care

Collecting Info From ECS

- Ensure full ECS is displayed

						Date
In Practice	Nitrofurantoin	100 mg M/R capsules	ONE TO BE TAKEN EVERY 12 HOURS WITH FOOD		18-Jun-2024	18-Jun-2024

Repeat Medication Medicines Reconciliation Report

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Dispensed Date	Cancel Date
In Practice	Citalopram Hydrobromide	10 mg Tablets	ONE TO BE TAKEN EACH MORNING		09-Feb-2024	12-Jul-2024		
In Practice	Furosemide	20 mg Tablets	ONE TO BE TAKEN EACH MORNING		09-Feb-2024	12-Jul-2024		
In Practice	Clopidogrel	75 mg Tablets	ONE TO BE TAKEN EACH MORNING		25-Aug-2023	01-Jul-2024		
In Practice	Adcal-D3	750 mg + 5 micrograms (200 units) Caplets	TAKE TWO CAPLETS MORNING AND EVENING		09-Feb-2024	01-Jul-2024		
In Practice	Dihydrocodeine	30 mg Tablets	ONE TO BE TAKEN UP TO QDS FOR PAIN		09-Feb-2024	01-Jul-2024		
In Practice	Atorvastatin	10 mg Tablets	ONE TO BE TAKEN EACH MORNING		04-May-2011	01-Jul-2024		
In Practice	Lansoprazole	30 mg Capsules (Gastro-Resistant)	ONE TO BE TAKEN EACH MORNING		04-May-2011	01-Jul-2024		
In Practice	Allopurinol	100 mg Tablets	ONE TO BE TAKEN EACH MORNING		16-Mar-2017	01-Jul-2024		
In Practice	Mirtazapine	45 mg Tablets	ONE TO BE TAKEN AT NIGHT		18-Sep-2018	01-Jul-2024		
In Practice	Paracetamol	500 mg Tablets	TWO TO BE TAKEN FOUR TIMES A DAY PRN		10-Dec-2019	01-Jul-2024		
In Practice	Ibuprofen	5 % Gel	APPLY UP TO THREE TIMES DAILY WHEN REQUIRED		20-Jun-2024	20-Jun-2024		
In Practice	Doublebase Dayleve	Gel	APPLY TWICE DAILY IF REQUIRED		18-Aug-2020	28-May-2024		
In Practice	Macrogol	NPF Sugar Free Compound Oral Powder (sachets)	TAKE ONE TO TWO SACHETS DAILY PRN		28-May-2021	28-May-2024		
In Practice	Senna	7.5 mg Tablets	ONE OR TWO TO BE TAKEN AT NIGHT		09-Feb-2024	01-Apr-2024		

☐ Patient does not want their GP to know about this access.

Show All Medication Information

Collecting Info From ECS

- Check allergies
- Last prescription dates

Allergy

Description	Date Recorded	Comments

Acute Medication (within 30 days) Medicines Reconciliation Report

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date
In Practice	Naseptin	Nasal Cream	APPLY FOUR TIMES A DAY FOR 10 DAYS		03-May-2024	03-May-2024
In Practice	Xaqua	5 mg Tablets	ONE TAB ALTERNATE DAYS		20-Dec-2023	22-Apr-2024
In Practice	Spironolactone	100 mg Tablets	TAKE THREE TABLETS IN THE MORNING		05-Jan-2022	22-Apr-2024
In Practice	Shortec	20 mg Capsules	TAKE ONE CAPS 2 HOURLY AS REQUIRED - MAXIMUM FOUR DOSES IN 24 HOURS		28-Jan-2019	18-Apr-2024
In Practice	Oxypro	80 mg M/R tablets	TAKE ONE TABLET TWICE DAILY		11-Mar-2024	18-Apr-2024
In Practice	Oxypro	10 mg M/R tablets	1 TAB 8 HRLY		11-Mar-2024	18-Apr-2024

Repeat Medication Medicines Reconciliation Report

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Dispensed Date	Cancel Date
In Practice	Oxypro	60 mg M/R tablets	1 TAB 8 HRLY		30-Apr-2024	30-Apr-2024		
In Practice	Oxypro	10 mg M/R tablets	ONE TAB EVERY 8HRS		30-Apr-2024	30-Apr-2024		
In Practice	Mirtazapine	15 mg Tablets	ONE TO BE TAKEN AT NIGHT		29-Apr-2024	29-Apr-2024		
In Practice	Terbinafine Hydrochloride	250 mg Tablets	ONE TO BE TAKEN ON ALTERNATE DAYS		29-May-2023	25-Apr-2024		
In Practice	Dapagliflozin	10 mg Tablets	TAKE ONE IN THE MORNING		06-Aug-2023	22-Apr-2024		
In Practice	Fexofenadine Hydrochloride	180 mg Tablets	ONE TO BE TAKEN EACH DAY		03-May-2022	22-Apr-2024		

How To Print ECS

Allergy

Description	Date Recorded	Comments

Acute Medication (within 30 days) Medicines Reconciliation Report

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date
In Practice	Naseptin	Nasal Cream	APPLY FOUR TIMES A DAY FOR 10 DAYS		03-May-2024	03-May-2024
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In Practice	Spironolactone	100 mg Tablets	TAKE THREE TABLETS IN THE MORNING		05-Jan-2022	22-Apr-2024
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Repeat Medication Medicines Reconciliation Report

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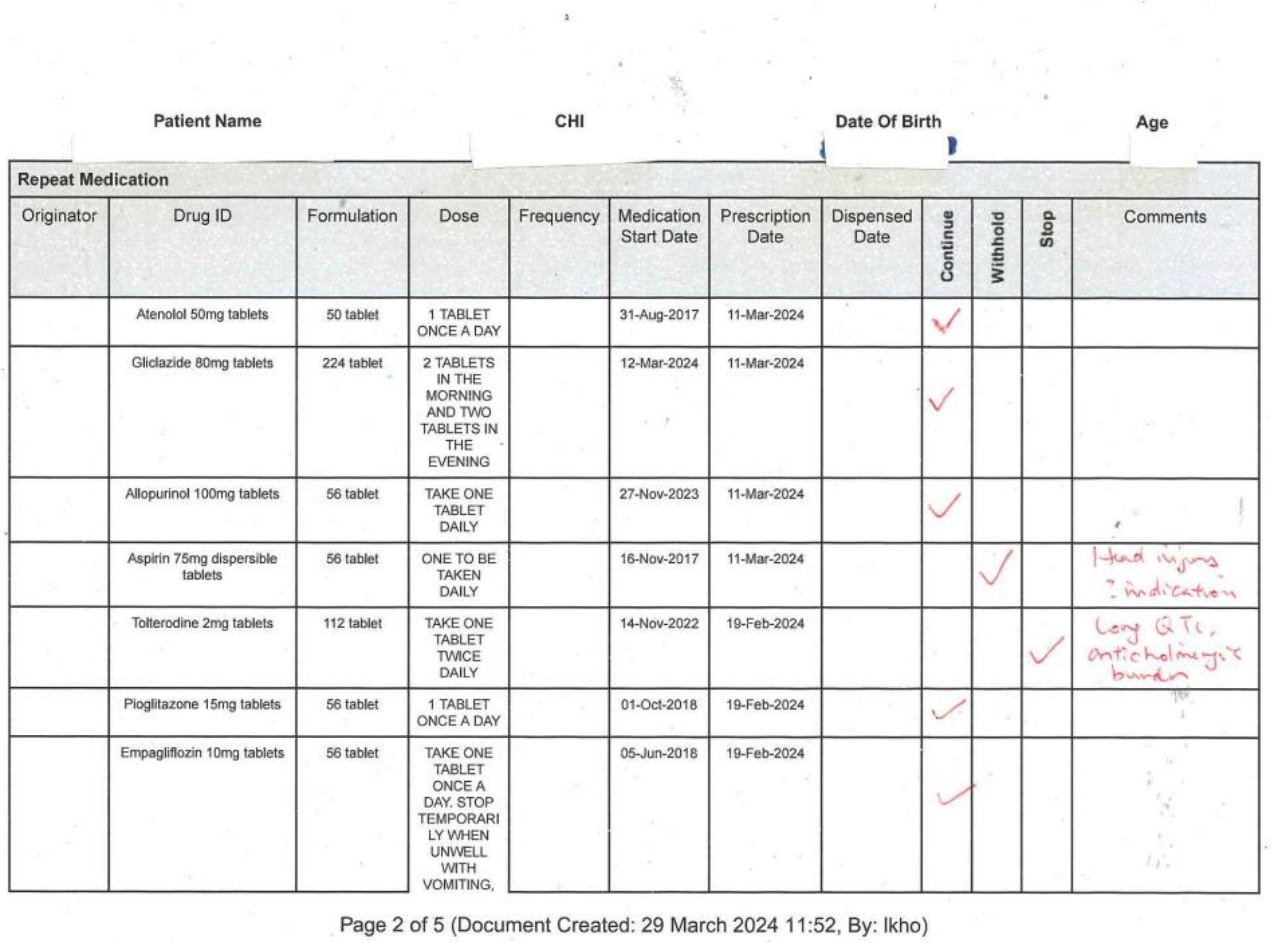
In Practice	Oxypro	60 mg M/R tablets	1 TAB 8 HRLY		30-Apr-2024	30-Apr-2024		
In Practice	Oxypro	10 mg M/R tablets	ONE TAB EVERY 8HRS		30-Apr-2024	30-Apr-2024		
In Practice	Mirtazapine	15 mg Tablets	ONE TO BE TAKEN AT NIGHT		29-Apr-2024	29-Apr-2024		
In Practice	Terbinafine Hydrochloride	250 mg Tablets	ONE TO BE TAKEN ON ALTERNATE DAYS		29-May-2023	25-Apr-2024		
In Practice	Dapagliflozin	10 mg Tablets	TAKE ONE IN THE MORNING		06-Aug-2023	22-Apr-2024		
In Practice	Fexofenadine Hydrochloride	180 mg Tablets	ONE TO BE TAKEN EACH DAY		03-May-2022	22-Apr-2024		

How To Print ECS

Make sure you log out every time (cannot just close page), 3 log ins active at once and your ECS account will be locked.

Then you will have to call IT to unlock it :(



Patient Name | CHI | Date Of Birth | Age

Repeat Medication

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Dispensed Date	Continue	Withhold	Stop	Comments
	Atenolol 50mg tablets	50 tablet	1 TABLET ONCE A DAY		31-Aug-2017	11-Mar-2024		✓			
	Gliclazide 80mg tablets	224 tablet	2 TABLETS IN THE MORNING AND TWO TABLETS IN THE EVENING		12-Mar-2024	11-Mar-2024		✓			
	Allopurinol 100mg tablets	56 tablet	TAKE ONE TABLET DAILY		27-Nov-2023	11-Mar-2024		✓			
	Aspirin 75mg dispersible tablets	56 tablet	ONE TO BE TAKEN DAILY		16-Nov-2017	11-Mar-2024			✓		Hx of stroke ? indication
	Tolterodine 2mg tablets	112 tablet	TAKE ONE TABLET TWICE DAILY		14-Nov-2022	19-Feb-2024				✓	Long QTc, anticholinergic burden
	Pioglitazone 15mg tablets	56 tablet	1 TABLET ONCE A DAY		01-Oct-2018	19-Feb-2024		✓			
	Empagliflozin 10mg tablets	56 tablet	TAKE ONE TABLET ONCE A DAY, STOP TEMPORARILY WHEN UNWELL WITH VOMITING,		05-Jun-2018	19-Feb-2024		✓			

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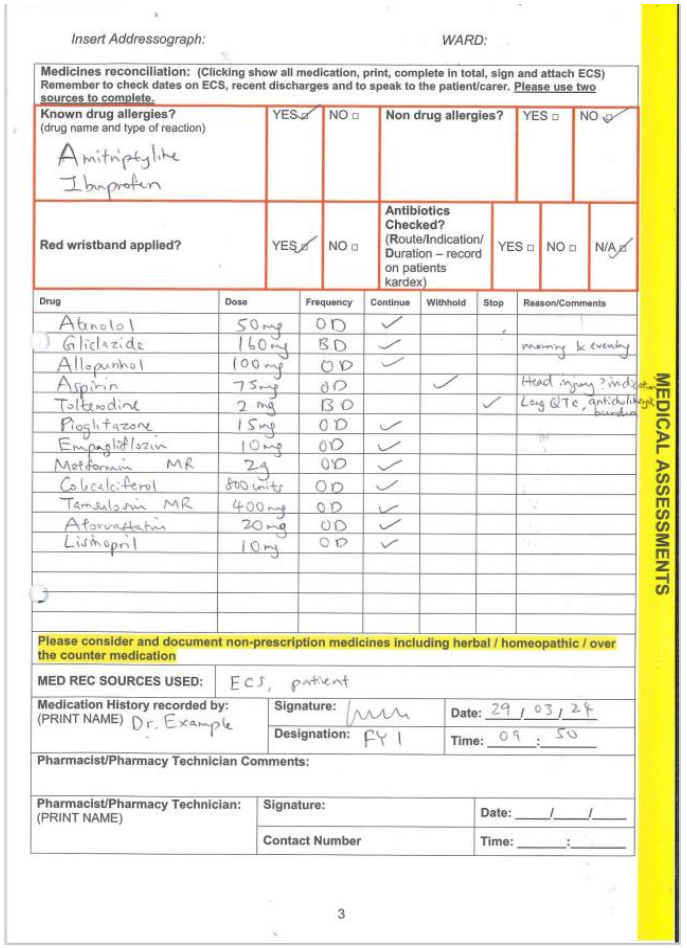
What Not To Miss

- Insulin – ask about usual regimen
- Anti-epileptics – brand and formulation (chrono, GR, dispersible etc)
- Parkinson's medicines – ask for times of administration + formulation
- Meds which may not be on ECS
  - Opioid substitution therapy
  - Cancer medications
  - Clozapine
  - Biologics
  - Over the counter medicines

Other Important Considerations

- Administration day for weekly meds
- Due date of non-frequent meds (B12 inj, biologics etc)
  - Can be given inpatient if appointment during stay
- Warfarin dose
- Clarify ‘as directed’ meds
- Formulation – should be specified in prescription
- Inhalers – prescribe by brand

Step 3: Communicate



Insert Addressograph: WARD:

Medicines reconciliation: (Clicking show all medication, print, complete in total, sign and attach ECS) Remember to check dates on ECS, recent discharges and to speak to the patient/carer. Please use two sources to complete.

Known drug allergies? (drug name and type of reaction) Amitriptyline, Ibuprofen	YES ☑	NO ☐	**Non drug allergies?**	YES ☐	NO ☑
Red wristband applied?	YES ☑	NO ☐	**Antibiotics Checked?** (Route/Indication/ Duration – record on patients kardex)	YES ☐ NO ☐	N/A ☑

Drug	Dose	Frequency	Continue	Withhold	Stop	Reason/Comments
Atenolol	50mg	OD	✓			
Gliclazide	160mg	BD	✓			morning & evening
Allopurinol	100mg	OD	✓			
Aspirin	75mg	OD		✓		Head injury ? indication
Tolterodine	2mg	BD			✓	Long QTc, anticholinergic burden
Pioglitazone	15mg	OD	✓			
Empagliflozin	10mg	OD	✓			
Metformin MR	2g	OD	✓			
Colecalciferol	800 units	OD	✓			
Tamsulosin MR	400mg	OD	✓			
Atorvastatin	20mg	OD	✓			
Lisinopril	10mg	OD	✓			

MEDICAL ASSESSMENTS

Please consider and document non-prescription medicines including herbal / homeopathic / over the counter medication

MED REC SOURCES USED: ECS, patient

Medication History recorded by: (PRINT NAME) Dr. Example | Signature: | Date: 29/03/24 | Designation: FY1 | Time: 09:50

Pharmacist/Pharmacy Technician Comments:

Pharmacist/Pharmacy Technician: (PRINT NAME) | Signature: | Date: ___/___/___ | Contact Number | Time: ___:___

3

Or

Patient Name **CHI** **Date Of Birth** **Age**

Repeat Medication

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Dispensed Date	Continue	Withhold	Stop	Comments
	Atenolol 50mg tablets	50 tablet	1 TABLET ONCE A DAY		31-Aug-2017	11-Mar-2024		✓			
	Gliclazide 80mg tablets	224 tablet	2 TABLETS IN THE MORNING AND TWO TABLETS IN THE EVENING		12-Mar-2024	11-Mar-2024		✓			
	Allopurinol 100mg tablets	56 tablet	TAKE ONE TABLET DAILY		27-Nov-2023	11-Mar-2024		✓			
	Aspirin 75mg dispersible tablets	56 tablet	ONE TO BE TAKEN DAILY		16-Nov-2017	11-Mar-2024			✓		Head injury ? indication
	Tolterodine 2mg tablets	112 tablet	TAKE ONE TABLET TWICE DAILY		14-Nov-2022	19-Feb-2024				✓	Long QTc, anticholinergic burden
	Pioglitazone 15mg tablets	56 tablet	1 TABLET ONCE A DAY		01-Oct-2018	19-Feb-2024		✓			
	Empagliflozin 10mg tablets	56 tablet	TAKE ONE TABLET ONCE A DAY. STOP TEMPORARILY WHEN UNWELL WITH VOMITING,		05-Jun-2018	19-Feb-2024		✓			

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Summary

- 2 sources
  - Collect then confirm with second source
- Be aware of the pitfalls of ECS
  - Dates on ECS – is the patient actually taking?
- Extra questions – especially for high-risk drugs
  - Timings, days, formulation etc
- Document plan for medicines on clerking book
- Make sure you have all the info on Kardex prescription
  - Drug/strength/dose/formulation/frequency

Any Questions?

Feedback

Please scan the QR code to provide feedback. Paper copies also available

Lunch Break

11:30-12:00

Head to unit inductions

UNIT/WARD INDUCTION		
12:00 (unless stated otherwise)		
SPECIALTY	REPORT TO	LOCATION
ANAESTHETICS	Marie Dodds	Anaesthetic Seminar Room, Second Floor, just before **BLUE ZONE**
GENERAL SURGERY	Martin Berlansky	Surgical Seminar Room, Second Floor, **YELLOW ZONE**
OBS & GYNAE	Kate Darlow	Labour Ward, Second Floor, **PINK ZONE**
ORTHOPAEDICS	Paul Middleton	Orthopaedic Seminar Room, Ground Floor, **YELLOW ZONE**

Medicine & DME Unit Inductions

Presentation by Dr Rachel Williamson

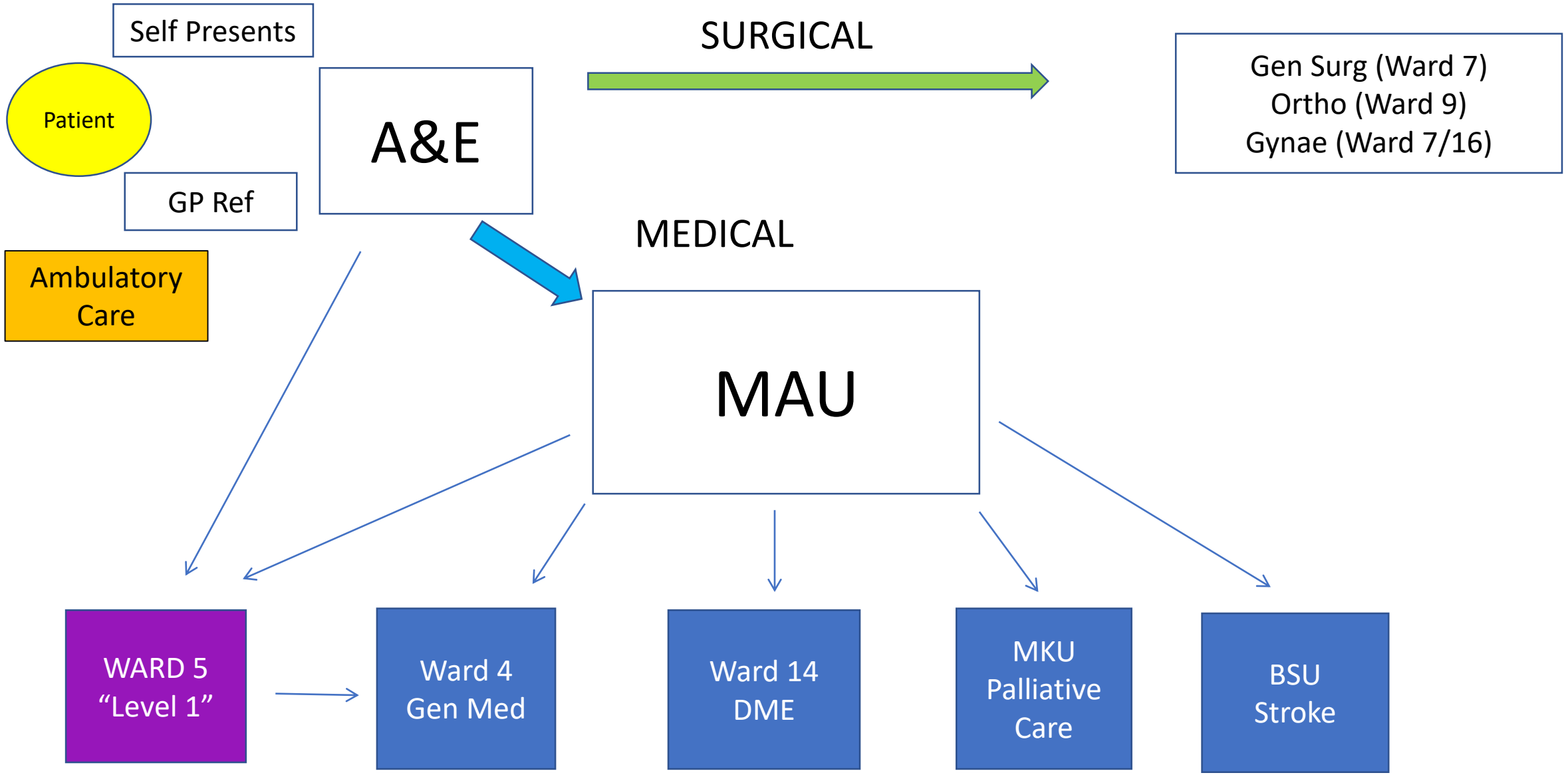
BGH Medicine & DME Induction

August 2025

Dr Rebecca Woolcock (GIM/ DME)

Aim to cover:

- Hospital flow & wards
- Handovers
- Shift patterns
- Ward structure & meetings
- HAN
- Weekends- staffing & handovers
- Investigations/ referrals
- Community hospitals & H@H
- Miscellaneous



THE MEDICAL WARDS

Morning Handover (Mon-Fri)

WEEKEND: **ALL** HANDOVERS AT 09:00 in TRYST

		1) Hospital Handover	2) MAU	3) ARREST TEAM
WHO	FROM	HAN Team	HAN	HAN
	TO	HANDOVER FY1	POST TAKE TEAM	TAKE TEAM FY1 MAU LONG
WHERE		Tryst	MAU	Ambulatory Care
WHEN		08:00	08:30	09:00
WHAT		Unwell patients from Wards (not MAU/ take)	Overnight take patients Unwell patients MAU	Handover bleeps
BLEEPS		Handover FY1 pick up 6644		6006 (Reg) 6005 (MG) 6004 (FY1)
				Arrest Team Huddle

HANDOVER FY1 will handover ward doctors (4, 5, 14, BSU, MKU) in Mess prior to 9am.

Evening Handover

	WARDS (4, 14, BSU, MKU)	WARD 5 (& Borderview)
WHO	Ward Drs → WARD LONG FY1	Ward 5 MG → LONG DAY MG
WHERE	Mess/ Bleep 6644	Ward 5
WHEN	17:00	17:00
WHAT	Ward tasks/ HAN reviews	Ward 5
BLEEP	6644	6621

Night Handover: 9pm

- EVERYBODY to HAN
- In the Tryst
- Handover arrest bleeps
- 6621- Leave in Ward 5
- 6644- Leave in Tryst

FY1 SHIFTS

	HANDOVER	WARD DAY	WARD LONG	MAU	MAU LONG	WE WARD	WE MAU
START	08:00	09:00	09:00	09:00	09:00	09:00	09:00
FINISH	16:00	17:00	21:30	17:00	21:30	21:30	21:30
ROLE	-Take handover for Medical Wards - Collect 6644 from Tryst -At 9am in person handover to Ward Drs -Give 6644 to MKU FY2	- Ward tasks on Base Ward	-At 5pm collect 6644 from MKU F2. -Take evening handovers -Ward tasks/ reviews 5-9pm -Handover to HAN (Wards BSU, 14, 4, MKU) -Leave bleep in Tryst	-Post take WR and tasks	-Arrest Team huddle 09:00 Amb Care -MAU tasks -Take MAU handover 5pm -Reviews & jobs until 9pm -Handover MAU jobs to HAN	**Go to Tryst for Handover**	**Go to Tryst for Handover**
BLEEP	6644 until 9am	Bleep for ward	6644 from 5pm-9pm		**6004**	6644	**6004**

BLEEP 6644: (Mon-Fri)

0800-0900:

- Picked up by HANDOVER FY1 in TRYST at 8am
- Held by HANDOVER FY1 until 9am
- At 9am HANDOVER FY1 goes to Mess to handover HAN information to ward doctors and then gives bleep to MKU FY2.

0900-1700:

- Held by MKU FY2

1700-2100:

- WARD LATE FY1 takes bleep from MKU FY2
- Ward doctors contact WARD LATE FY1 with handover for evening & HAN in person or via bleep
- WARD LATE FY1 does ward tasks and reviews until handover
- Leave bleep in Tryst at 2100

MIDDLE GRADE SHIFTS

SHIFT:	TAKE	BACK SHIFT	POST TAKE	WARD 5	NORMAL DAY	WARD LONG DAY	W/E TAKE	W/E WARD LONG DAY	W/E WARD SHORT DAY
START	09:00	13:30	08:30	09:00	09:00	09:00	09:00	09:00	09:00
FINISH	21:30	21:30	16:00	17:00	17:00	21:30	21:30	21:30	17:00
ROLE	Admissions Get bleep from HAN MG in Ambulatory Care 09:00	Admissions	MAU	Ward 5	Ward cover/ clinics	Ward & Ward 5 cover from 5pm.	MAU & admissions	Wards (mainly 5)	Wards (mainly 4)
BLEEP	**6005**			6621		6621	**6005**	6621	

REGISTRAR SHIFTS

SHIFT:	TAKE	POST TAKE	NORMAL DAY	W/E LONG	W/E SHORT
START	09:00	08:30	09:00	09:00	09:00
FINISH	21:30	16:00	17:00	21:30	17:00
ROLE	Admissions Arrest team leader	MAU Med referrals from other specialties	Ward cover/ clinic	MAU & take Ward support	Ward reviews/ MAU
BLEEPS	**Bleep 6006** Bleep 1111 (Acute Med Cons will also hold during day) Meet HAN Reg in Ambulatory Care for arrest bleep	**Bleep 7006**	Individual bleep	Bleep 6006 & 1111 Collect from HAN Reg at handover	Bleep 7006

Evening cover (wards- Mon-Fri)

- **FY1- 6644**
  - Ward 4, DME, BSU, MKU
- **FY2+ - 6621**
  - Ward 5 based but support FY1

Escalation

- Med Reg- 6006
- On call Cons

MAU:

08:30: HAN handover overnight patients

3 Ward round teams:

- Post take Consultant (+ PT Reg)
- Frailty Consultant (7019) (+PT MG)
- Acute Medicine Consultant (usually 2) (+/- FY1)

11:00: Board round & Floor plans

15:00: Huddle

Pharmacy closes at 4pm!!

Frailty= CFS >5- you will be asked!

ESCALATION:

POST TAKE REG
(7006)

CONSULTANT:
ACUTE MED/ FRAILTY

AFTER 4pm:
Med Reg (6006)
On Call Cons

Acute Med Junior

- High numbers of patients in ED for several hours
- Start 09:00 in ED
- Bleep 6622
- Liaise with PT Cons/ Acute Cons re jobs for patients
- Attend ED huddle 11am & 4pm to update ED team
- Attend 3pm in MAU to handover jobs
- IDLs (use \MAU in ED letter)
- If OP Ix- ensure ordered under requesting Med Cons

- Finish 17:00. Handover any reviews/ jobs to Take Team if still in ED. If moving to MAU handover to MAU Long FY1

WARD 5: Level 1

Cardiac Monitoring (NSTEMI, Heart block, Unstable AF, large PEs); NIV, Sick sepsis/ ODs; post thrombolysis, unstable GI bleed

START: 09:00

09:00: Huddle (treatment room)

- Daily Cons W/R:
  - Cardiology (+FY1)
  - Medical Cons (+MG)
- Post take Cons **

- Evening Handover: 17:00- In person Handover Ward Late MG

ESCALATION:

MIDDLE GRADE: 6621

CONSULTANT FOR PATIENT (or on call Cons post 5pm)

Check with Cons re PM availability and how to contact/ alternates

Ward 4: Gen Med

- **09:00** Start
  - Safety huddle- sick, new, d/c (~10mins)

- Consultant Ward Round- 3x/week**
  - Patients under Specialty (Haem, Cardio, GI)
  - Respiratory Cons (~10 pts)
  - DME Cons (or GIM) (~20 pts)

- **12:00:** Huddle
  - Run through all patients with MDT
  - Identify discharges for next 48hrs
  - Clarify plans
  - Review telemetry
  - Identify suitable medical boarders
  - Aim <30mins

ESCALATION:

WARD SHO

WARD REG

CONSULTANT FOR PATIENT

Check with Cons re PM availability and how to contact/ alternates

Medical Boarders:

- Boarders Doctor: Usually CDF/ Reg

- Carry bleep 6014 (kept in Ward 4) (6014 MUST BE CARRIED- if no rota'd Boarders Doctor- carried by most senior in Ward 4 (on loop))

- Generate boarders list:
  - "Tools"
  - "Reports"-> "Inpatient" -> "Inpatient Boarders"
  - Hospital= BGH
  - Specialty = Gen Med, Geriatric Medicine, Resp, Diabetes, GI

- Boarders from Ward 4 stay under Ward 4 Cons
- Boarders from MAU/ other go under Ward 5 GIM Cons

- Macmillan Centre (BMC) may bleep for review/ prescription

Borders Stroke Unit

- 14 Bed specialist stroke unit
- Staffing: 1 x middle grade doctor (FY2+)
- 3x weekly Cons WR (may not be AM as NVC clinics)
- MDT Tuesday 9.30am

- Medical boarders in BSU are seen by stroke team

- No FY1 so MG must take & give handover to Handover FY1 on 6644 in Mess at 9am & 5pm

- Escalation: Stroke Consultant (if not available 7006 post take reg)

DME

- Ward 14
- Start 09:00- may have a morning huddle
- 3x Weekly Cons WR
- Weekly MDT (Tuesday)
- Escalation:
  - DME Reg
  - Consultant for patient
  - Frailty Cons

ORTHOGERIES

- Ward 9
- Start 09:00- morning huddle
- Patients split between you & ortho junior
- Handover from Ortho Junior
- DME Cons WR- ~ 3x/week **
- Daily Cons r/w New #NOF
- Escalation:
  - OG Cons
  - Frailty Cons

DME contact details

- DME consultant – 7019 (Mon to Fri 8 – 4)
- DME registrar – 6110 (Mon to Fri 9 – 5 if not on nights/ AL/ SL)

HAN

- MED REG- 6006
  - HAN TEAM LEADER, MEDICAL REFERRALS, ADMISSIONS
- MIDDLE GRADE HAN
  - SURGICAL & GYNAE REFERRALS
  - ASSISTS WITH CAESAREAN SECTIONS
- MIDDLE GRADE ED
  - HELPS IN ED
- FY1
- 2x ANP- One coordinator

SURGICAL REG & O&G REG
24 HOUR ON CALL:
ON SITE BUT ASLEEP

WEEKEND TEAM- Everyone starts 09:00 in Tryst

TAKE/ MAU

- MED REG (6006)

- MIDDLE GRADE (TAKE) (6005)

Assist with MAU in morning and take in afternoon

- MAU FY1 (6004)

Assist with ward round and MAU jobs

WARDS

- REG- SHORT DAY

Sick/ complex ward patients & MAU

- MIDDLE GRADE- LONG DAY (6621)

09:00-21:30. Ward 5 based

- MIDDLE GRADE- SHORT DAY

09:00- 17:00. Ward 4 based

- FY1 (6644)

09:00-21:30: Mainly DME, BSU, MKU & W4 post 5pm

Weekend Handover:

- Floor plan notes for every patient
  - EPR → FLOORPLAN NOTES → NEW
  - *“WE 13-14/3: No review”*
  - *“WE 13-14/3: FY1 review, comfort review”*
  - *“WE 13-14/3: Senior review- Daily review, bloods Sun ?IVOS. SBAR….”*

- Email details of reviews to HAW email address (hospitalat.weekend@borders.scot.nhs.uk)

- If patient moved to downstream ward over weekend please check if any review required/ bloods requested.

Investigations/ Referrals

INVESTIGATIONS

- RADIOLOGY: Request via Trak, phone to discuss if OOH or urgent. TMC after 7pm,=.
  Phone Radiographer for portable CXR.
- ECHO/ ECG/ PFTS/ 24 Hr TAPE: Via Trak
- SCOPES: Paper referrals- take to department
- **ABG- PHONE LAB TO MAKE AWARE**
  - (ABG machine in Ward 5 but must be trained prior to using)

REFERRALS:

- **EMAIL**: Stroke, Neuro, Resp, Urology, Psych, Palliative Care, DME, Rheum, Derm, Endocrine/ Diabetes. GI
- **PAPER**: Cardio
- **PHONE**: Surgical, Ortho, Gynae, Micro
- **Renal: phone secretary for covering Cons email. If urgent/ OOH d/w RIE

COPY IN CONSULTANT TO ALL REFERRAL EMAILS

Trak codes & Backslashes

- Medical IDL (MAU & Ward 4):
  - \mau
  - \vte (PE &DVT)

- DME IDL
  - \DME

- Stroke
  - \strokeidl
  - \tiaidl

- PE/ DVT
  - \vte

- **Death certificate- discuss all death cert with consultant. Do not issue out of hours**
  - \deathcert

Community hospitals

- **Haylodge Hospital (HLH)** (Peebles) – need to phone GP to accept patient. Once accepted phone ward
- **Hawick Community Hospital** (HCH) – need to phone GP to accept patient, check which practice (Mairches or Teviot). Once accepted phone ward.
- **The Knoll** (Duns) – DME Consultants responsible. Phone ANP at KCH to refer patient.
- **Kelso Community Hospital** (KCH) – DME Consultants responsible. Phone ANP at KCH to refer patient.
- All patients should have valid TEP with completed if? for transfer back to BGH in event of deterioration

Intermediate care beds

- Garden View (Tweedbank)
- Upper Deanfield (Hawick)

- Local GPs provide medical input
- SW ownership of beds
- Some AHP input
- All need IDLs and MAR charts
- BV need 4 weeks of medications provided

Hospital at Home

- Providing care in patient's own homes
- Medical input only- not carers or rehab
- O2, IV abx (1-2x/day), IV diuretics etc.

- Mainly central borders area but discuss on case by case basis

- Direct GP referrals and supported discharge

Staff Sickness:

- Mon- Fri:
  - Phone hospital management first thing (8am)
    - Name, where meant to be, how many days off, any OOH commitments

- Sat & Sun
  - Phone Medical Cons on call
  - If still off Monday- must phone hospital management Monday morning & send message on Loop.

Documentation:

- Paper notes
  - ECO- yellow booklet. Agitated patients
  - CREOL- purple booklet. End of life care

- Kardexes
  - Ask for help if unsure

Other bits and pieces….

- Whatsapp groups
- On call rooms
- Teaching-
  - Grand Round : Tuesday 1pm
  - IMT/ Registrar Teaching: Wednesday 1pm
- Mess/ canteen- Close 2pm and 7pm
- Protocols
  - Right decision service
- Closing books/ signing off results
- Do not ask GPs to chase results
  - eg follow up CXRs
- Staff marriages
- Educational supervisors

QI

- DME: Contact Dr Lonnen with which project you are interested in/ ideas for a new project
- Jennifer.Lonnen@borders.scot.nhs.uk
- TEP: Dr Gemma Alcorn
- MAU: Dr Megan Hume
- QI Lead: Jonathan.antrobus@nhs.scot
- QI symposium in July with prizes

QUESTIONS?

Rebecca.woolcock@borders.scot.nhs.uk
Bleep 6653

Acute Medicine

Presentation by Dr Megan Hume

Acute Medicine at the BGH

Setup

MAU

- Currently 13 cubicles and 4 bays
- All medical admissions come to MAU unless needing higher dependency

AAU

- Same day care
- Variable number of patients
- PA / ANP led with input from take team
- Staffing model currently changing

Acute admissions via ED

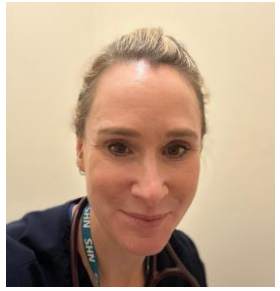
- Sicker patients / needing monitoring
- ED referrals

The Consultant Team

Dr Eva Palik

Consultant Physician

Dr Chris Evans, Consultant Physician



Dr Megan Hume

Locum Consultant Physician

Dr James Taylor, Consultant Physician

Dr Lynn McCallum, Consultant Acute Medicine

Dr Anna Kolb

MAU – the post take team

1 Registrar (7006), 1 Middle grader, 2-3 FY1 (Lates: 1 FY1)

Acute Medical Junior to cover ED bedded

8:30 Handover from night team (Reg, MG)

Divide patients based on frailty

Ward round (post take, acute, frailty)

11:00 Board round / MDT

15:00 Afternoon focused board round DDDD

(Discharges, delays, deteriorating, dying)

All meetings are in MAU Doctors' office

At least one doctor to be on the ward

During board round

- No notes in room
- MDT: Doctors, nurses, RAD / AHP, SW, Discharge support, Site and capacity
- Update Floorplan notes on Trak
  - Which team
  - SBAR format (\sbar)
- Job list – paper
- Consultant updates whiteboard
- TEP, CFS

Discharge letters – Discharge Dr?

Canned text: \mau

Short and focused

Medication changes (reason, length)

What does the GP need to do

Any follow up planned by secondary care team

Any discussion with the patient

Acute Med Junior

- Covering bedded patients in ED
- Holds Bleep 6022
- ED huddles: 12 pm and 4pm
- MAU afternoon huddle 3pm
- If very busy may ask for help from the take team
- If less busy can help the take or the MAU team

The Take

1 x reg 9am - 9:30pm
1 x Middle Grade 9-9:30pm
Backshift Middle Grade from 13:30
ANP and PA 9-5 in AAU, occasional long day ANP*
Acute Med Junior may help
Acute physician presence 12-4:30 pm
Frailty front door #7019 until 4pm
Oncall consultant from 2pm
Covers acute admissions via ED and AAU
9am: Handover and Resus huddle (AAU)
12 pm and 4pm ED board round
9pm Hospital wide handover Tryst

The Med Reg
(the busiest person in the hospital)

Carries 6006 bleep for in hospital referrals and crash calls

Carries 1111 bleep for GP referrals – may be the acute physician 12 – 4pm (ish).

Accepted patients to TCI list (ideally straightaway)

- Currently WA list format on Trak (MedReg TCI list)
- Patients recorded at the timeslot they were referred
- Marked "arrived" when in hospital
- Ideally mark who has seen (in comments)

Physical TCI list on board in MAU – if needed (night shift)

Monitor ED floorplan

Support trainees on wards OOH

Seeing patients in ED
Ask if unsure

Change Trak to Emergency Medicine (right upper corner), the ED floorplan is Homescreen

Allocate yourself as Responsible Clinician when picking up a patient

Plans: let ED staff know and / or put in Floorplan notes

Book a bed if patient passed admission treshold

Utilise waiting room and AAU for mobile patients. Minors can be used just update Trak

12 pm and 4pm **ED meeting: plans for medical patients**

Patients discharged from ED need ED discharge letter

Sign off results as you go!
No open books

Trays in office for referrals / amb care

AAU

Same day emergency care (medical)

PA / ANP led with the help of the take team

GP referrals who are likely to go home, mobile and no monitoring need

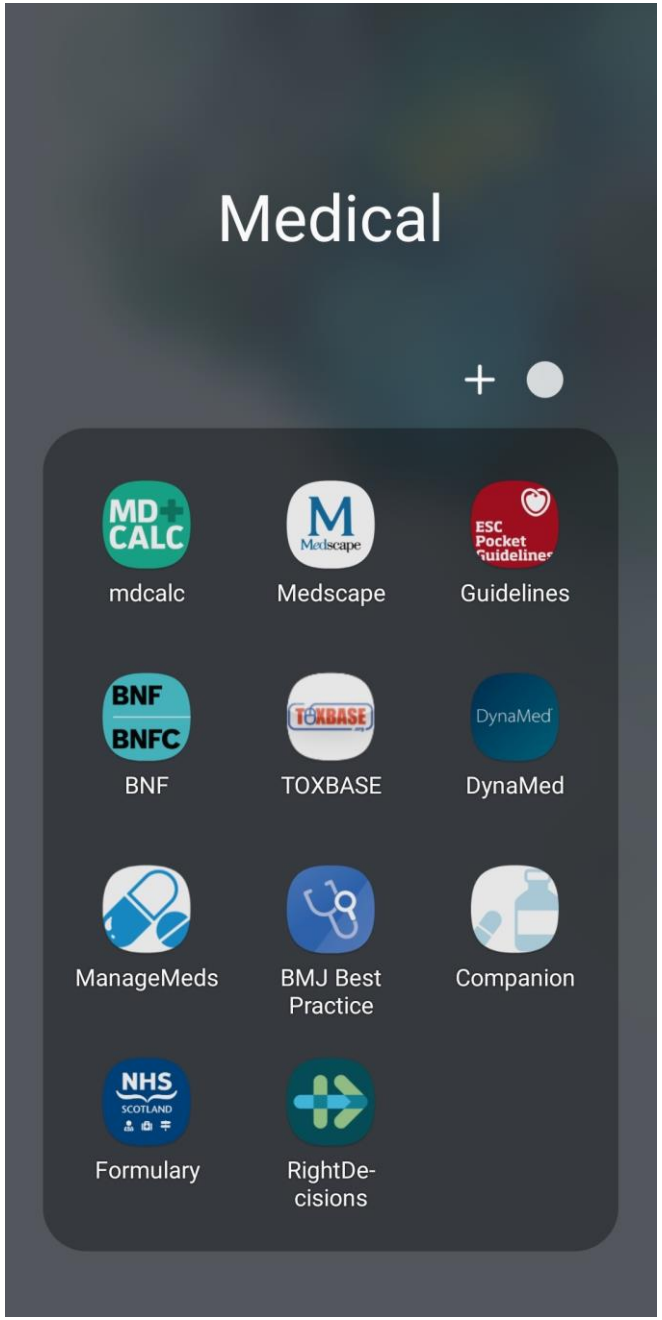
Patient has to be able to transfer with Ax1

Suitable patients can be pulled from ED

Currently changing

DVT / VTE at the front door

- \vte canned text with prompts for investigations / provoking factors
  - Suitable for those where the primary presentation is VTE
- AAU has Apixaban packs with leaflets
- DVT: follow up in 3 – 6 months in PA led clinic – let AAU staff know
- Exceptions:
  - Oncology, haematology (and some other) patients go to their own team
  - Pregnant patients to be seen by obstetrics
- PE: follow up in 3-6 months by respiratory team, will need OP echo



Useful apps

- Because no one has all the answers (not even the med reg!)
- Library website for suggestions / logins

QI projects

- DVT follow up clinic development
- AAU protocol uptdate and development
- Antimicrobial audits (Anne Duguid, Pharmacy)
- Safe discharge
- And many more

Seek us out in person or email

Questions?

Eva.palik@nhs.scot, megan.hume@nhs.scot James.taylor2@nhs.scot, Lynn.mccallum@nhs.scot

Rota

Presentation by Gemma Butterfield

Medical & DME Rotas
Borders General Hospital

Leave

- Leave Requests- should be made 6 weeks in advance and the request should be made via the Loop App under the relevant category
- Urgent Leave- requests should be emailed to bor.medicalrotaenquiries@borders.scot.nhs.uk
- Maternity & Paternity Leave- requests require the appropriate HR forms to be completed in advance- please refer to HR Intranet Microsite for full policies

Leave Continued

Leave Requests- if you are scheduled to work evenings/nights/ weekends on days you wish to take leave you will need to arrange a swap amongst appropriate colleagues in the first instance. If a swap is arranged, please email the full details to the rota inbox and the rota will then be updated. Please ensure that the person who is swapping has agreed via email prior and provide a copy of this confirmation when emailing.

Swaps in General- it is understood there will be occasions when you need to swap shifts with colleagues, if this is the case, please email the

Sickness Absence

Monday to Friday

All medical staff will telephone 01896 825535 to report their sickness absence- please note this telephone line is manned between the hours of 8.30am to 4.30pm by the Hospital Management PA/ Admin Team, no calls should be made prior to 8.30am.

Saturday & Sunday

All medical staff should contact the On Call Consultant (9am to 9pm) or HAN Team Leader (9pm to 9am) via the BGH Switchboard on 01896 826000 to report their sickness absence

Short Notice Sickness

All Short notice sickness absence (up to 48 hours) is required to be **covered contractually** within the training group:

- FY1
- Middle Grade
- Registrar

There is a short notice sickness absence list that has been created by the Chief Residents. This lists all Drs in each training group. If no one comes forward to cover a short notice gap, we move to the list.

Time back will be given to those covering gaps.

Clinics

- Clinics are arranged with Speciality, Medical Secretaries and the Rota Team
- There is usually a requirement for a sit in prior unless you have previous experience
- Clinics must be covered in instances of short notice sickness as patients cannot be cancelled. The rota team will support these conversations.

Shift Start/ Finish Times

- Handover - 8am to 9am – if you are on ‘handover’ at 8am, you can finish at 4pm
- am - 9am to 1pm (MAU is 08:30 for MG/SPR)
- pm - 1pm to 5pm
- eve - 5pm to 9:30pm
- nights - 9pm to 9:30am

App Contact Loop & WhatsApp

WhatsApp
https://chat.whatsapp.com/J9QD64pfLMyBP9fBA

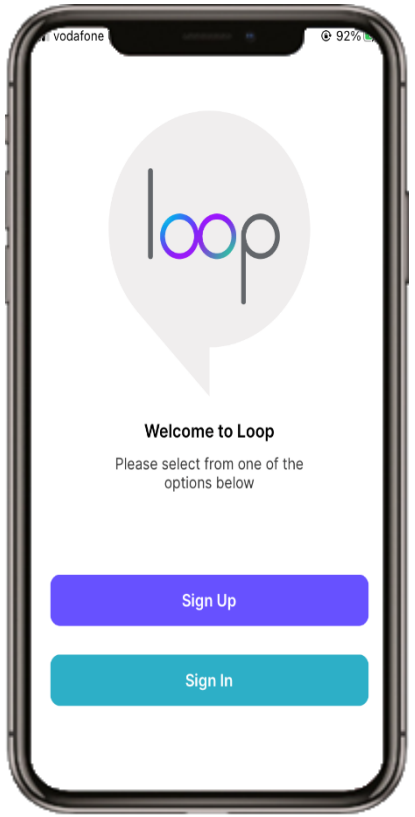
Loop App

The rota application Loop has a message function this allows people and the rota team to posts messages to the entire group or to individuals dependent on the message being sent. This will primarily be used by the rota team to update the group on urgent issues such as the need to cover short notice sickness or service updates

Loop – Creating your loop Account

1

Download the **Loop app** from the appropriate smartphone store. The landing page screen will appear. Select **Sign Up** or **Sign In**

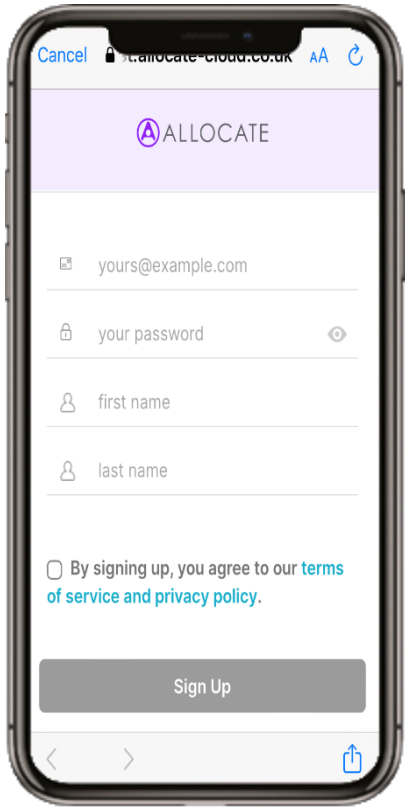


2

Make sure you have your **personal email address** and **mobile number** to hand and select **Continue**

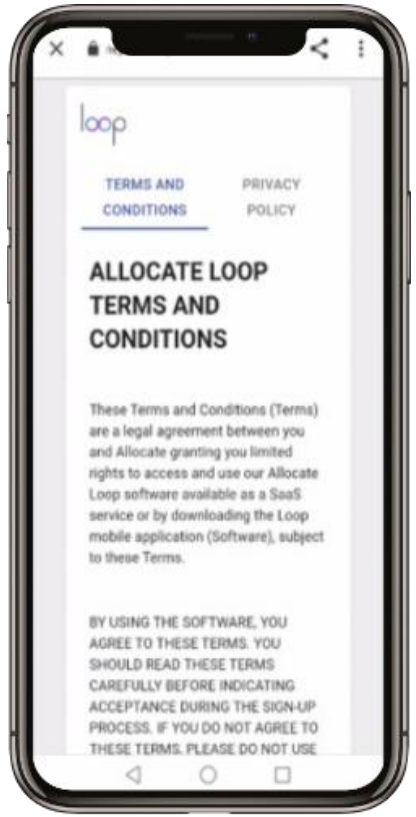
3

Enter your **Email, Password, First Name, Last Name and Phone Number.** Tap the **terms of service and privacy policy** to view and read. Tick the box to agree. The Sign Up button will be greyed out until you agree.



4

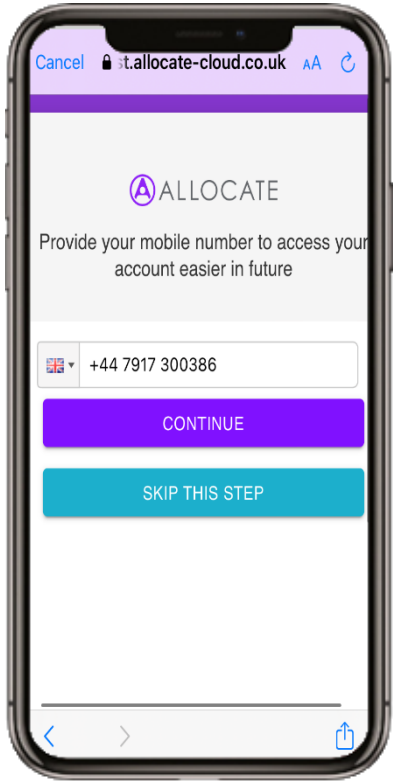
Read the Allocate Loop Terms and Conditions



Loop – Creating your loop Account

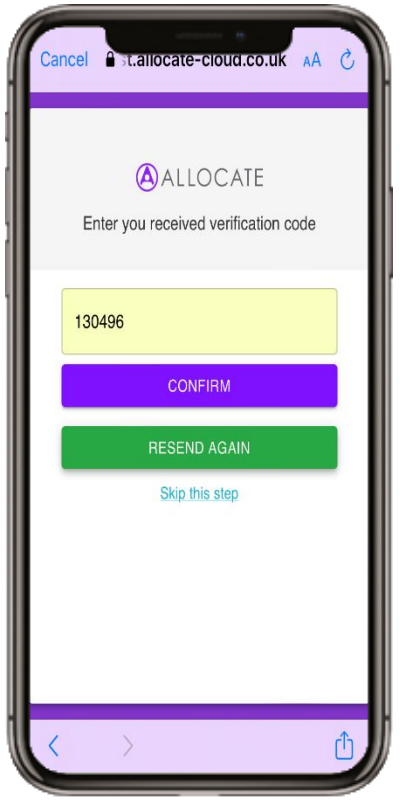
5

Once you have agreed to the Terms and Conditions, you have the option to add a **phone number** for another **Sign In** option. Enter your phone number and press **Continue** or press **Skip This Step**



6

If entered correctly, you will get a notification with a verification code. Enter the code and press **Confirm,** or **Resend Again** if the code has not been delivered.



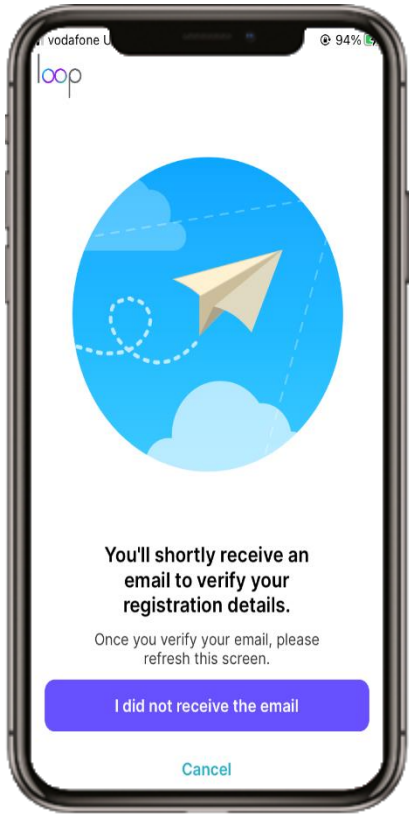
Loop – Creating your Loop Account

7

Once you have agreed to the terms, and (optionally) added a phone number, select to **Sign Up**

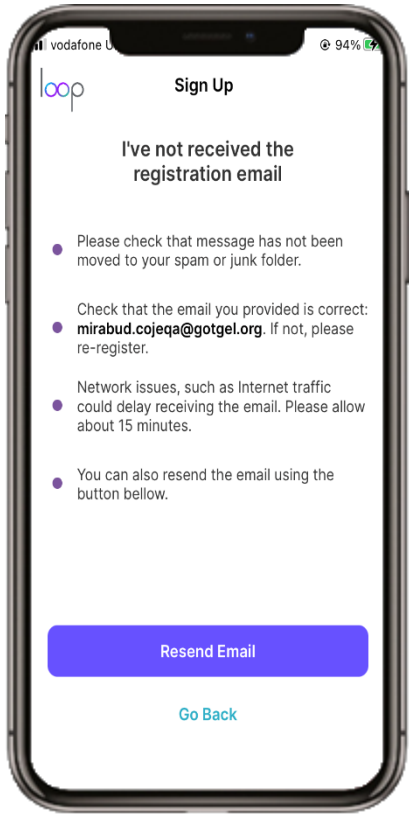
8

Check your email/Text message. Click the **link** in the email/text message to **verify your account**.
If you haven't received the email, select the **I did not receive the email** link at the bottom of the screen.



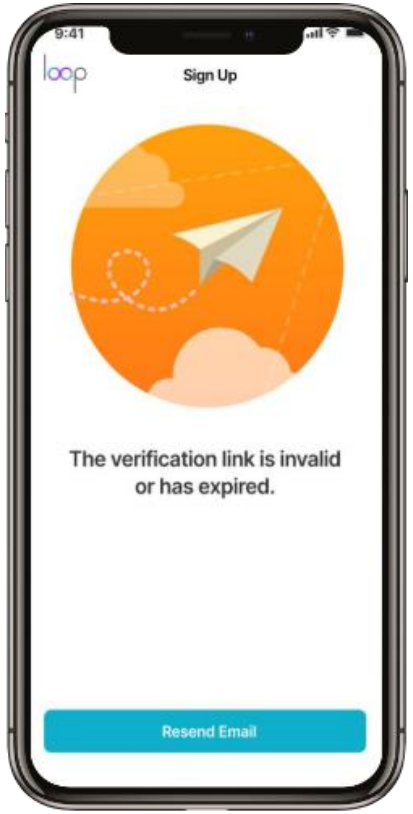
9

If you have followed all of the instructions and still not received the email, select **Resend Email** or if it has come through, select **Go Back**



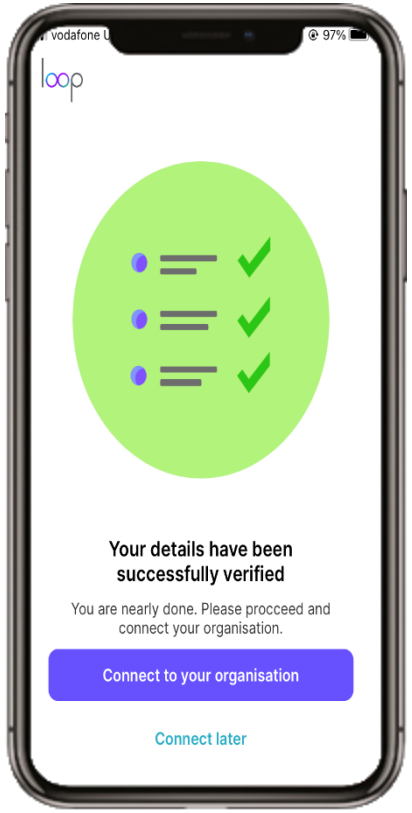
10

If the **verification link** has expired, then you will get the following message. Select **Resend Email**

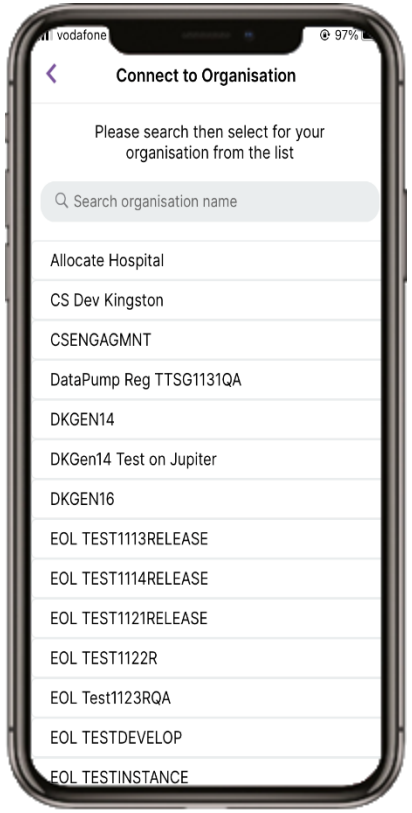


Loop – Creating your Loop Account

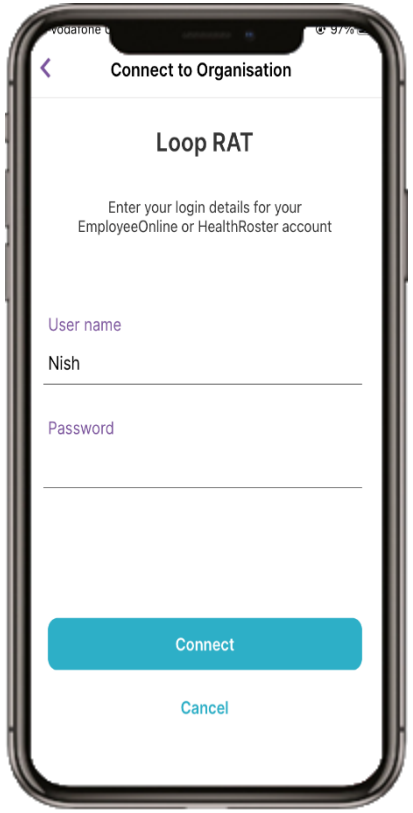
11
Once the email is verified, select **Connect to your organisation**



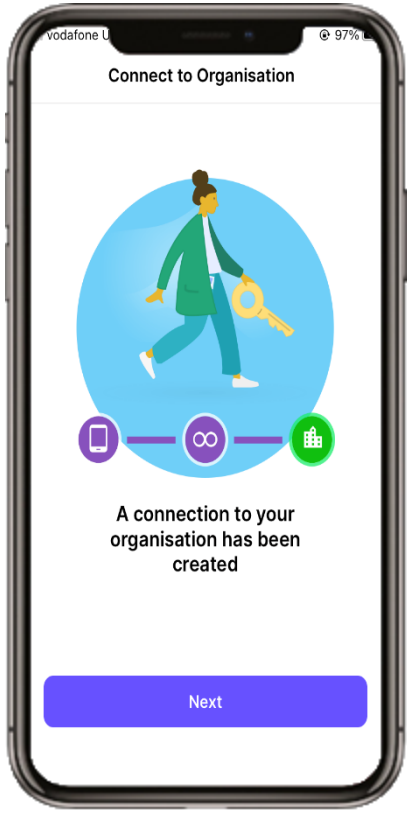
12
Type the name of your **organisation** in the **search** field and then select it.



13
Enter your **User name** and **Password** for **EmployeeOnLine** (EOL)
Select **Connect** or **Cancel**

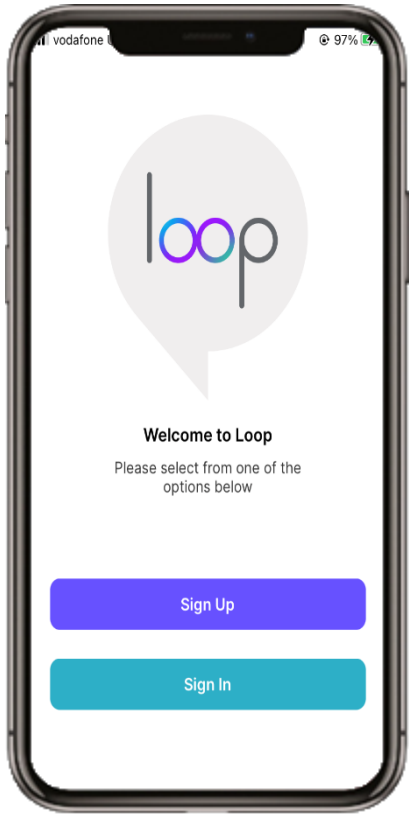


14
You are now connected to your organisation. Select **Next**

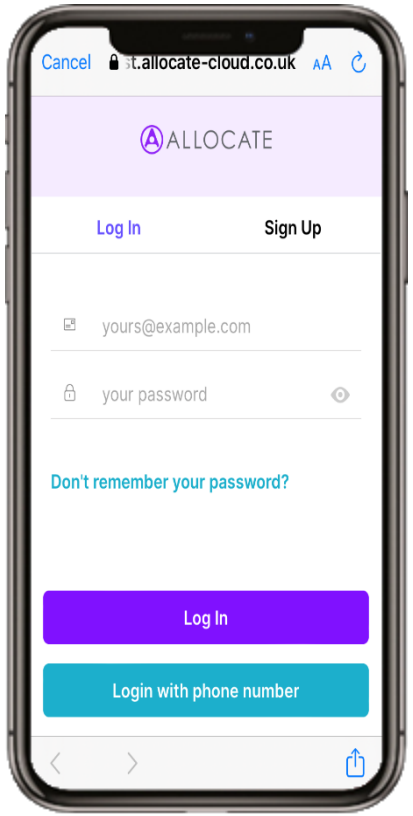


Loop – Sign In

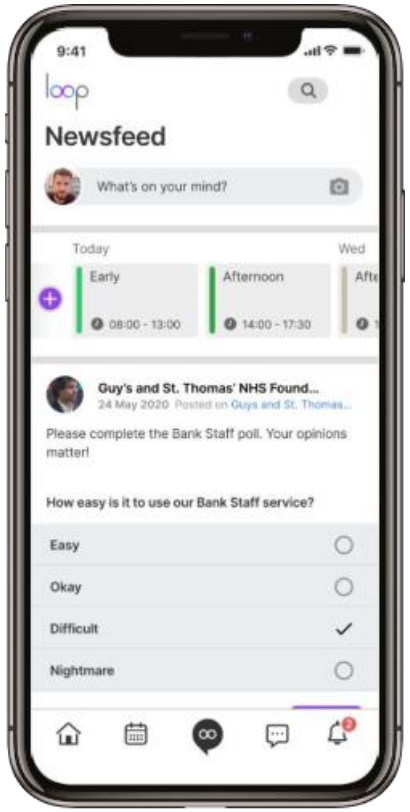
1
Select **Sign In** from the landing page



2
Enter you **Email** address that you used to sign up and enter your **Password**.
If you prefer to log on with your mobile number then select **Sign in with Phone Number**

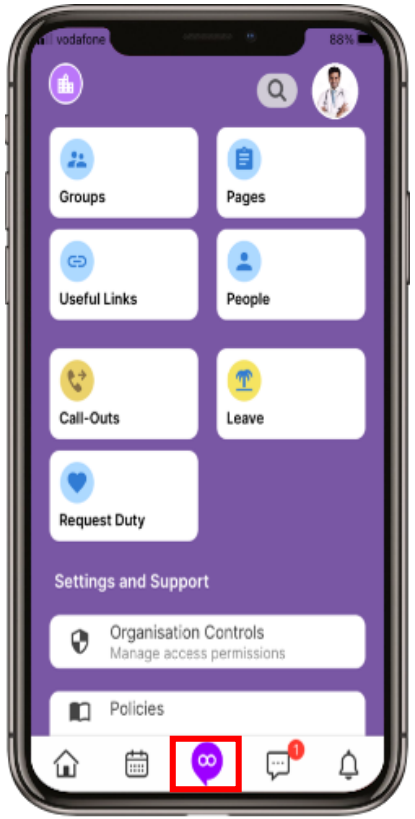


3
Once you have logged in successfully, you will land on the **Home** page and your **Newsfeed**.

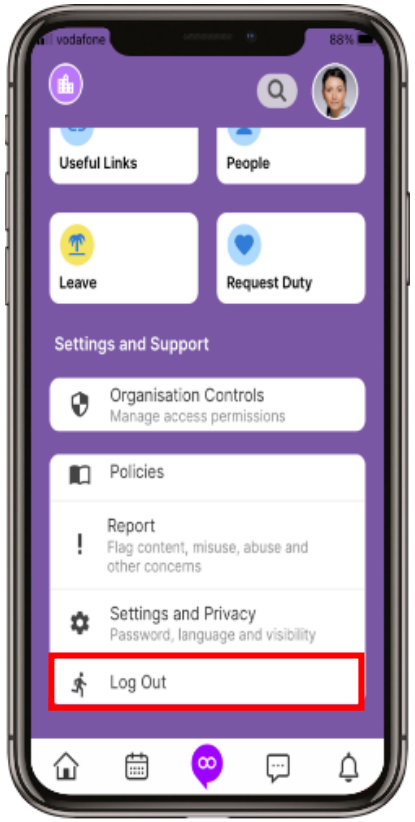


Loop – Log Out

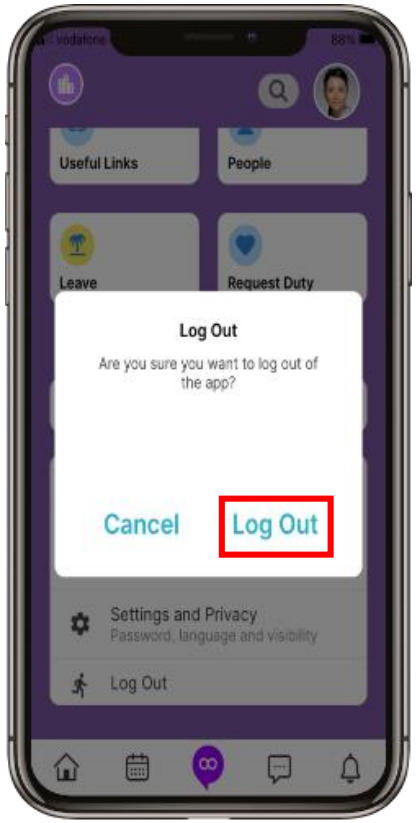
1
Select the **Loop Logo** at the bottom of the screen



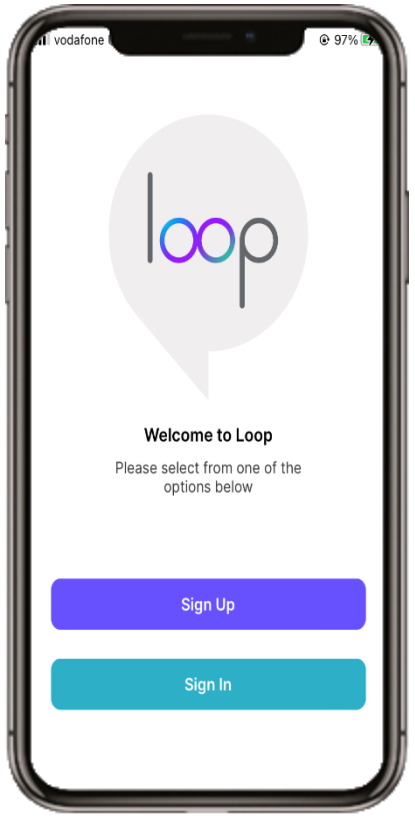
2
Scroll down to **Log Out.** Select the **Log Out** button



3
Confirm you want to **Log Out**



4
You will return to the **Sign In** screen



Contact Information

All rota related queries should be emailed in the first instance to bor.medicalrotaenquiries@borders.scot.nhs.uk

If you wish to speak to somebody following this, please contact:

Gemma Butterfield
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Gemma.Butterfield@borders.scot.nhs.uk