

FY Handbook

Paediatric Surgery

**Royal Hospital for Children & Young
People
Edinburgh**



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Contents

General Advice.....	3
Weekly Meetings & Teaching.....	4
Practical Aspects of the Job.....	5
Discharge Letters.....	6
Prescribing Top Tips.....	7-8
General Surgery.....	9
Specialities	10-12
Crichton.....	13-14
On Call.....	15
Nights.....	16
Weekends.....	17
Backslashes.....	18
Key Contacts	19
Additional Prescribing Guidance.....	20-22
How to Add Cannulas to Trak.....	23

Note:

This Handbook should be updated regularly. If you notice something which is incorrect or out-of-date, or you have a suggestion for information to be included, please discuss with the registrars and update on shared drive. It is useful if someone updates it towards the end of a job and emails the new version to Jane McCrindle for the next set of FYs.

General Advice

Welcome to the Paediatric Surgical job! We hope this handbook should give you an introduction to the job as well as being a reference point throughout your 4 months in the job.

Wards

Dunvegan & Tantallon Wards - General Surgery + Specialties (3rd floor)

Crichton Ward- Day Case Unit (1st floor)

Paediatric Critical Care (1st floor)

Simpsons (Neonatal unit) - RIE

Daily Expectations of FY1s

There should be one FY allocated to each of:

- General surgery (on-call)
- Specialties (ENT, ortho, spinal, plastics)
- Crichton (day case unit)
- Extra Gen Surg "float" (if available)

Bleeps

The on-call FY should carry the 9107 bleep and respond to ED referrals, as well as bleeps from the ward.

Otherwise other FYs feel free to grab any other bleep and write it on the whiteboard in Dunvegan/Crichton with your name + role for the day so that the nurses know the best person to contact.

To bleep someone at RHCYP: dial 772, enter their bleep number followed by the extension number of the phone you're at and hang up. Listen to the whole message before hanging up!

To bleep someone at RIE: dial 110, enter their bleep number followed by the extension number.

Switchboard- 0

External number- dial 9 before you enter the number



Accurx app should have the contact details of most people. Otherwise the nursing team/ward clerks have lists of phone numbers/bleeps.

Printers

How to link a printer:

Start > Control Panel > Devices and Printers > Add a printer > Add a network printer > The printer that I want isn't listed > Find a printer in the directory based on location or feature > Enter search criteria > Find now

(Try "CYP Tantallon" and "CYP Dunvegan")

Food/coffee

Microwaves are in the staff room on level 3. There is canteen on the 4th floor with a balcony (ideal on a sunny day). There is a phone in the corner to answer bleeps! They serve breakfast (rolls until 11am) and lunch (until 2pm) as well as coffee. There is also a shop on the ground floor as well as M+S and canteen at the RIE.

Weekly Meetings and Teaching

Every day 8am:

General Surgical team ward round on Dunvegan & Tantallon at 8am

Specialties FY receive handover from night FY and then go on Ortho ward round at 8am (level 3 meeting room by staff room). Other specialities such as ENT or plastics will update nursing team/find you with an update

Crichton FY to go to Crichton at 8am and enquire re admissions/jobs for the day

Mondays:

12:45 Radiology meeting in radiology department (ground floor)

Paediatric Surgery Registrar (Who is on Day-shift over weekend) should ensure the radiology list is filled in and sent to radiology **before 10am** to loth.rhcypradiologists@nhs.scot and loth.rhcyimaging@nhs.scot (lists are in STAP folder on shared drive)

(There is a surgical FY laptop in Dunvegan office – bring to the meeting to scribe discussion points– the scribe should not be the on-call person as they are often bleeped away)

14:00 Grand Round at Sphere (3rd floor), followed by FY and registrar teaching presentation

Tuesdays:

12:30-1:30 FY1 Teaching (Bleep free) face to face in Postgraduate Education Centre, RIE

Monday Teaching:

Surgical Grand Round – The FY who worked the days over the weekend will present all of the surgical inpatients (including recent blood/imaging results) and facilitate group discussion about their management.

Teaching presentation – FYs take turns presenting a self-chosen topic/case/project, followed by a Higher Surgical Training or Surgical M&M or Journal Club. A rota will be made and circulated. Allocations can be swapped if unable to present on the allocated day.

The primary purpose of the presentation is to provide FYs with an opportunity to present and to stimulate discussion amongst the registrars and consultants. Aim to choose a topic relating to a recent interesting case and as far as possible try to avoid testicular pain and appendicitis, focusing on paediatric surgery specific conditions. Each presentation should aim to include at least 1 new piece of research or a guideline. Approach a registrar early for help and direction. Each presentation should last 10 minutes maximum and have a maximum of 7 slides. Short & sweet is the goal in order to leave plenty of time for discussion.

Thursdays:

12:30-1:30 FY2 Teaching (Bleep free) face to face in Postgraduate Education Centre, RIE

Practical Aspects of the Job

Radiology Requests

Be as detailed as you can and don't be afraid to ask the registrar/consultant for the indication if you are unsure. It is helpful to include a ? for example ?appendicitis, ?ovarian pathology, ?testicular torsion etc. When requesting AUSS, these must be discussed with the on call radiologist (50805/50120). Xrays should be discussed with the on call radiographer.

ECG/Echo requests

You will find the form via intranet- send via the attached email address, and bleep the technician (9263). There is a helpful guide on the intranet to help you interpret paediatric ECGs and the criteria for onward cardiology ECG reviews.

Referrals

There is a helpful "referrals guideline" collated by one of the FY1s on the K-drive (Paediatrics >> ARU >>Referral guides and forms >>Referral guide).

Bloods

You will have a teaching session during induction on venepuncture and capillary blood gases.

Tubes: Pink – Haem, Orange – Biochem, Yellow – Gluc/Lactate, Green – Coag.

It is helpful to print 2 sets of labels and click sample collected when ordering bloods so the labels print straight away – place one on tube and one on the request form.

"Numbing cream" – Ametop and Emla: Ametop is kept in the fridge, takes 45mins to take effect and vasodilates quite well. Emla takes 60mins to work. Both Ametop and Emla work for a few hours after they are removed from the skin surface. Both should technically be prescribed on HEPMA.

"Cold spray" – Ethyl chloride: Makes the skin feel numb before venepuncture, usually used in older children. Can often give the smaller kids a bigger fright than the needle so best to give a warning. Spray until the skin turns white.

Heel/finger pricks: All babies can be heel-pricked in preference to venepuncture, as it saves their veins for when they need cannulas replaced. Toddlers can be finger-pricked. Smear a small amount of paraffin/Vaseline on to help the blood flow out in "blebs". Note that heel/finger prick bloods are not 100% reliable as Na, K and lactate can be raised due to a "squeezed sample" – it is generally a good idea to obtain U+Es first, before FBC for this reason.

Capillary Blood Gases (CBGs): Use a heel/finger prick, fill a capillary tube (don't get any air bubbles in the straw or it will be rejected by the machine), take it to the blood gas machine in HDU or ED. Be careful carrying the glasses tube as it can leak and will not run if not completely filled, always carry it in a tray. You will need to ask a nurse for their log in for the blood gas machine.

Central lines/PICC lines: Patients may have a line which bleeds back and the nurses can take the bloods for you. It is helpful if you can print the labels for them!

Escalating: If you are struggling for bloods or a cannula, do not exceed 3 attempts without escalating. If another FY is confident, it may be appropriate for up to 2 FYs to try. Otherwise, during the day contact your surgical registrar, or overnight you should ask the medical registrar for help. Worst case scenario the on-call anaesthetist could be approached if IV access is urgent.

Labs:

Bloods/virology samples should be sent in a pod to RIE labs (555 is the number). The pod system tends to break a lot, in which case you can call porters on 33333 (then press option 3) and they will collect them.

Discharge Letters

Immediate Discharge Letters

This involves the written discharge letter and discharge prescription, to be completed on Trak, use \idlps (space bar to enter). There are some backslashes that will give you templates for certain common conditions e.g. appendicitis, circumcision and testicular exploration. There is a poster in Dunvegan MDT with the backslashes. Useful backslashes:

\idlps – generic \adeton - adenotonsillectomy \idlpsappendix – appendicitis
\idlpstesticle – testicles \idlpscirc – circumcision \idlpsspinal – spinal patients

For medications for discharge, this can be accessed by Hepma. Select the “discharge” tab and prescribe the medications including duration, whether GP is to continue and the number of days to supply. Then select the tab “discharge letter” and select your name from the drop-down menu. Finally, you need to select “complete discharge”. Next time you access the discharge letter on Trak, ensure medications source is selected to hepma, before printing and signing for pharmacy to dispense. Should you need to make any changes, you will need to select the tab “edit discharge”, before re-completing and printing via Trak.

Final Discharge Letters

Each FY2 will be allocated a couple of consultants for whom you should complete the discharge summaries for (list should be available in the Drs office). Read the IDL and update it as appropriate. Chase outstanding investigations and ensure follow-up has been arranged. Print the final IDL from Trak and take it to the secretaries’ offices (second floor clinical offices) along with the case notes. The registrars are also responsible for ensuring all of their named consultant’s letters are completed.

Overnight stays/Nurse Led Discharges

Certain patient groups will stay overnight following their surgery and most will be fit for discharge the following morning. It is important for the Crichton FY to have these discharge prescriptions prepared the day of their surgery so their medications can be prepared by pharmacy, and they can be discharged early the following morning.

1. ENT post-adenotonsillectomy patients- oral morphine solution (0.1mg/kg) in the morning on days 3, 4 & 5 post- op. These patients have a nurse-led discharge
2. Hypospadias repair patients- triple therapy (see below)

Prescribing Top Tips

There are lots of resources on the intranet and a red prescribing folder in the Dunvegan MDT office that will be your lifesaver on the job (includes paediatric fluids, analgesia etc). There are numerous nurse practitioners and a deputy charge nurse who are experienced prescribers and can help/give advice with any prescribing questions, especially during your first few weeks on the job.

Wards have specific drug round times- it is important to stick to these. Ask the nurses and they will keep you right. For example, for a regular QDS drug, prescribe this for 0600, 1200, 1800, 0000. The table below is a useful rough summary, but see the pages 20-22, or Hepma Paediatric Intranet, for more detailed guidance.

Standard prescribing times: OD- 0700 or 2000 BD- 0700, 2000 TDS- 0600 1400 2200 QDS- 0600 1200 1800 0000
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Ideal Body Weight:

Be mindful of children's weight when prescribing drugs like paracetamol and morphine sulphate. If a child is over expected weight, base their dose on upper limit of expected weight for their age as below.

Age Range	Expected Weight
3-12 months	5-10kg
1-3 years	10-16kg
4-6 years	17-22kg
7-9 years	23-29kg
10-12 years	30-39kg
13-14 years	40-50kg
Over 15 years	Above 50kg

Common Inpatient Prescribing Protocols

Appendicitis:

- IV antibiotics:
 - Metronidazole (7.5mg/kg) 8hrly- max 500mg per dose.
 - Cefotaxime (50mg/kg) 8hrly – max 3g per dose.
- IVOST choice is usually co-amox (dosing as per BNFC) for 5-7 days

Hypospadias repair “triple therapy”:

- Trimethoprim: 2mg/kg at night
- Lactulose: as per BNFC, start with lowest dose
- Oxybutynin: as per BNFC
 - Children under 2 are prescribed 1.25mg twice daily (tablets can be halved and crushed)
 - Prescribe tablets and not solution
- Triple therapy should continue until urinary catheter is removed (this will be stated in the op note). Will often continue until review in clinic the following week and will therefore need these meds for discharge. Add an order note to the prescription to appear on discharge letter “until catheter removal - [date]”

Fluids

You should have teaching on IV fluids at induction and nursing staff are great at keeping you right on IV fluid prescriptions.

Bolus

Fluid choice: 0.9% NaCl

Volume: 10ml/kg

Rate: STAT

Repeat a 2nd bolus of 10ml/kg if needed. If still no response, escalate.

Maintenance Fluids

Fluid choice: ** In Aug 25 the first-choice IV fluid for surgical patients is changing to: Plasmalyte or Plasmalyte + Glucose 5%. If not available can use 0.9% sodium chloride + 5% dextrose with or without 10mmol KCl

Volume: 500ml

Rate calculation:

First 10kg: 100ml/kg/day

Second 10kg: 50ml/kg/day

For remaining kg: 20ml/kg/day

For example in a 32kg patient:

First 10kg: $100 \times 10 = 1000ml$

Second 10kg: $50 \times 10 = 500ml$

Remaining kg: $20 \times 12 = 240ml$

24h volume= 1740ml

Rate= $1740/24 = 72.5 = 73ml/hr$

As per guidance, those on maintenance need daily electrolyte check, but the ward round will guide this.

General Surgery

Ward Rounds

Morning Ward Round: 8am at Dunvegan MDT office

Afternoon Ward Round: ~5pm with registrar on call

Typical Day Timeline:

- Meet at 8am in Dunvegan MDT office
- “Huddle” - Night shift FY takes morning team through the list of patients, explaining their diagnosis and current management as well as any issues from overnight
- Ward round on Dunvegan. It is helpful to take two computers on wheels (COWS) and swap who is scribing between patients if there is an on call and “float” FY
- The general surgical team will “debrief” in the Dunvegan MDT office and quickly run through the jobs for each patient. This is your chance to double check anything you are unclear about
- The ward round continues to see surgical patients on other wards, as well as critical care and Simpsons (neonatal unit). The on call FY should technically follow this ward round (mostly for educational purposes) whilst the other FYs peel off to start jobs
- Afternoon ward round usually happens around 5pm where the on call reg +/- consultant will review the patients on the ward for a second time, usually with the on call FY.

Handover List

This is found in the shared drive (Paediatrics>Surgery Theatre Anaesthetics Perioperative > LISTS). To be printed every morning by the nights FY.

Update the list every morning and evening with the following format (example used):

Location	Patient	C o n s	Date	Diagnosis	Situation	Results	Plan	Jobs
1	Joe Bloggs	EJ B	02/0 1/23	D1 post- lap appendice ctomy	Lap appendectomy 1/1/23. Inflamed appendix. No perforation	Bloods 1/1/23- CRP 60, WCC 18	IV ABx (5 days) IVF E+D	Chase urine culture

Jobs Book

There is a navy hard back diary which can be helpful to record jobs – for the ward or to be chased later.

Excel Jobs sheet

This is in the shared drive in the LISTS folder and is for following up jobs/results when patients are discharged. When discharging a patient make sure you add any outstanding results and allocate someone to chase and action them. All FYs should check, action and sign these off when free.

Specialities

Spinal

Generic info:

- The Spinal team write in a “spinal pathway” in paper notes, unless readmitted with post-op complications in which case they will write on trak. Spinal pathway is very lengthy but has lots of useful information.
- Specialty FY should attend the “post-op handover” for the spinal patients (meet in Theatre recovery area). The anaesthetist will go through their management plan and give threshold BP/heart rate/urine output values for fluid bolus requirement criteria – double check at this time whether there are any specific parameters for day one post-op bloods (e.g. if intra op Hb >100, no day 1 bloods).
- You will need to change the pain medications as per the spinal pain pathway/the pain team in the notes.

Consultants:

Mr Tsirikos – operates on Tuesday

Mr Roberts

Mr Garrido – operates on Friday

Spinal liaison nurse = Hilary Sharp and Caroline Hanley

Post-op:

Depending on extent of procedure + patient’s co-morbidities they may either go to PICU or the ward post-operatively.

If going to the ward:

- Take handover in recovery from surgeon + anaesthetist
- Prescribe fluids when on ward based on anaesthetist plan. This is usually Hartmann’s for the first bag but should be changed to 0.9% NaCl + 5% dextrose with supplemental potassium following this.
- Spinal patients follow a specific analgesia pathway and are reviewed by pain team daily
- Some patients may require day 1 bloods post-op (coag, FBC, U&Es)
- Some patients will also need day 3 bloods– check the pathway/ask the spinal nurses whether these are needed
- Spinal patients are typically constipated post-op, they will be on sodium picosulfate and lactulose, and sometimes require enemas – should be prescribed 8am day 1 post-op. Stop sodium picosulfate once bowels moving.

Discharge:

Script should be completed and in pharmacy by day 3, the patients' analgesia shouldn't change from then and the ward likes to have meds ready.

Discharge Analgesia

Discharge analgesia for spinal patients is as follows:

- Paracetamol + ibuprofen as per discharge analgesia guideline
- Oramorph/Sevredol/Tramadol dose as per day 3 of the analgesia pathway 4-6 hrly max QDS
- Lactulose BD – while taking opioid analgesia

NB:

- Patients on gabapentin should go home on current dose with pain team follow up
- Don't discharge on clonidine or sodium picosulphate unless specifically told to
- Iron replacement – if started to continue for 3 months following discharge. Ask GP on discharge letter to repeat FBC in 3 months to see if they need further iron replacement.

SPINAL DISCHARGE FOLLOW UPS

Spinal Nurses will usually call all patients 2 to 7 days after discharge
Wound check in 5 days with practice nurse.

They will then be followed up as follows:

Mr Tsirikos – outpatient clinic in **3 weeks** AT RIE (if live further away they will be seen locally in 3 weeks the back to Edinburgh at 4 months)

Mr Garrido – outpatient clinic at RHCYP or Yorkhill in **3 months**

Ortho

- Ward round: 8am at the "lobster pot"- next to the level 3 break room beside Kildrummy Unit
- Registrars and consultants available via bleep or switchboard

ENT

Post tonsillectomy bleeds

This is one of the ENT emergencies you should be aware of. Do a full ABCDE assessment, ensure they have IV access and call the ENT reg as soon as possible. They will require BTS samples, coag and a FBC. Make sure all post-tonsillectomy patients have IV access – this should only be removed at discharge.

Obstructive Sleep Apnoea (OSA)

These patients should be on O2 monitoring overnight and may still desaturate whilst asleep even post-op. This usually self-resolves with repositioning. There is a guideline in the doctor's office above the printer which guides you on how long and to what level of desaturation you should tolerate before escalating these patients to the ENT reg +/- HDU level care.

Plastics

- Often you will not attend the plastics ward round as it occurs at the same time as general surgery and ortho ward rounds. A nurse will attend and update you with any jobs for the plastics patients. You can also get in touch with the on call reg via bleep numbers if required. Consultants will have their own phone/bleep numbers available from switchboard.
- A plan should also be made by the plastics team in the morning on TRAK.
- If a patient has a haemangioma and requires propranolol treatment – you will need to get a ECG pre treatment. This is requested via a paper form that can be found on the ward. You then ring the cardiology nurses to carry out the ECG. The ECG needs to be read by a consultant – often the ARU consultant. These patients also require medical photography, which has its own form.
- Inpatient Burns: chloramphenicol eye ointment 1% topical- 1 application – BD-TDS

Crichton (Day Case Unit)

Typical Duties

- Touch base with the Crichton team at 8am to get an idea of jobs for the day. All the patients who are due to come in will be on the board in the office. Write your bleep number and name on the board so the nurses know who to contact
- Some patients will have been identified as requiring an FY “top to toe examination”. These are usually patients who have a complex medical background or are going for a complex procedure.
- Clerk in and take bloods from spinal pre-admission patients (see spinal section of handbook)
- Write scripts for day-case patients requiring medications on discharge
- Review patients for whom the nurses have concerns and escalate to the surgeon/anaesthetist responsible for them.

Top to Toes

This generally involves examining ENT, cardio, respiratory, abdo and neuro systems and documenting this in the history and examination part of clerking on Trak. You should also complete a med-rec.

Discharge Scripts – to be done by Crichton FY as early as possible

- **ENT scripts**
 - Patients attending for tonsillectomy/adenotonsillectomy are admitted to Dunvegan post-op for observation and have a nurse-led discharge the next morning once eating and drinking
 - Their IDL should therefore be prepped the day of their admission so that they can be discharged first thing
 - The backslash is \adeton and all patients get paracetamol, ibuprofen and oral morphine for days 3,4,5 post-op (0.1mg/kg using ideal body weight if overweight, to be taken once daily on the mornings of day 3,4,5 post-op). No paracetamol or ibuprofen.
- **Orchidopexy**
 - Under 2 years:
 - Oral morphine solution- 0.1mg/kg (max 10mg/dose), 3 doses, 4hrly PRN over the first 24h post-op
 - Over 2 years:
 - Oral morphine solution- 0.1mg/kg (max 10mg/dose), 3 doses, 4hrly PRN over the first 24h post-op
- **Circumcision, prepucioplasty, ingrown toenail surgery or complex oral surgery:**
 - <2 years: no opioid analgesia, paracetamol and ibuprofen only (only prescribe in exceptional circumstances, encourage families to purchase it OTC)
 - 2 years or over:
 - Oral morphine solution- 0.2mg/kg (max 10mg/dose), 3 doses, 4 hrly PRN over first 24h following surgery
- **Ophthalmology/ENT patients**
 - Sometimes require drops e.g. chloramphenicol- check the pink op note for details

If patient is on a daycase booklet and needs meds for discharge, this is done on trak rather than hepma. Select “order” tab (same for scan, bloods) and pick pharmacy as the category before entering the medications. To print, ensure the medication source on the d/c letter is TRAK before printing, signing and dispensing.

NB: There are no pharmacists in Crichton so once you print the scripts you should dispense them with the nursing team in Crichton who will keep you right. If the medicines aren't in stock, bring the script to the ward and leave in the pharmacy tray.

Spinal Pre-Op Assessment

Spinal patients will attend Crichton pre-op for a "pre-admission day". This is an intense full day of investigations and consultations, including appointments with anaesthetics, OT, physio and the spinal consultant, X-rays, clinical photography, and sometimes CPET (cardio-pulmonary exercise tests). The patient will then go home and return on the morning of their operation.

1. Bloods

- a. "Preadmission spinal" order set on trak + BTS samples (x2 pink, orange, green, yellow, x2 blue), you can call BTS (27501) before to see if they have a historical sample and therefore only need to send 1 blue
- b. Need to check results before sending home and write in spinal pathway, so do these first so you know if there's any issues/they need repeated. Crichton will phone you to check if bloods are back as you need to write these in the spinal pathway book – this job is important and should be prioritised.
- c. If abnormal may need to discuss with anaesthetics/spinal team

2. BTS

- a. x2 samples should be taken 15 minutes apart, unless BTS have historic samples (in which case you will only need to send one- call blood bank to check)
- b. Adult sample tube unless <10kg
- c. Crossmatch- as a general rule request the number of units below unless specified:
 - Anterior spinal fusion- 1 unit red cells
 - Posterior spinal fusion- 1 unit red cells
 - Anterior and posterior fusion- as per anaesthetics
 - Insertion of growth rods- 1 unit red cells
 - Neuromuscular patients having spinal fusion- 4 units red cells
- d. Call BTS before the patient leaves (27501) to ensure samples are accepted and processed

3. Clerk

Patient should be clerked following the template in the spinal pathway booklet not Trak

On Call

Carry the 9107 bleep from 8am to 8pm (long day)

Duties

- Morning ward round
- Referrals from ED, GP and SJH (referrals from other hospitals should be through the reg)
- Review and clerk patients in ED
- Clerk speciality patients arriving in out-of- hours (in hours this is the specialties person)
- Evening ward round ~5pm with the on call reg +/- consultant
- Update handover lists and print copies for night FY and reg
- Handover to night FY 8pm

General Tips for ED referrals

- Take patient details first from the referrer- name and CHI followed by the history
- GP referrals should have a referral letter
- For abdo pain ensure a urine dip has been taken to rule out UTI and including bHCG in girls of menstrual age. Ensure to check genitalia in males to exclude testicular torsion.
- For ?appendicitis ED are helpful and will insert a cannula and take bloods if you ask nicely
- It is helpful to be at a computer when you take the referral so you can review the patient's history on Trak including previous attendances, outpatient appointments etc
- Don't be afraid to be firm if you don't believe a referral is appropriate- this becomes easier as you get further on in the job.
- FY1s cannot discharge from ED, FY2s can. In most cases the surgical reg should review
- Ensure patients have been appropriately worked up before they are referred i.e. had a urine dip and bloods etc.
- ED referrals are challenging especially as an FY but it is important to try your best to have a good rapport with ED staff- ultimately they are just doing their job and have targets to meet e.g. patients not breaching etc. It makes your life much easier if you form a good working relationship with the ED staff.
- **ANY** testicular/scrotal pain referral needs to be discussed with the on call registrar.

What you are expected to review in ED:

- GP/ GP OOH referrals:
 - Suspected appendicitis, scrotal pain, or suspected acute (<7 days) complication of a surgical procedure*
 - These patients should be identified at triage and the surgical FY should assess the patient (without review from an ED doctor).
- Referrals from ED
 - Head injuries
 - >2 years old= surgeons
 - <2 years old= medics
 - Skull fracture= neuro (Borthwick)
 - If patients need to be admitted under the surgeons for observation, assess them in A&E and consider whether a CT head is indicated prior to transfer to the ward (guidelines are on the intranet). If there is any uncertainty, discuss with the surgical reg (day or night).
 - Abdominal pain
 - ?appendicitis
 - ?obstruction
 - Pyloric stenosis with abnormal capillary blood gas= surgeons
 - These patients should have an NG tube and IV access
 - Foreign bodies
 - Above clavicle= ENT
 - Between clavicle and diaphragm= surgeons
 - Below diaphragm= GI

*As of October 2022 all patients presenting from a GP with ?appendicitis, scrotal pain or suspected acute (<7 days) complication of a surgical procedure come **straight to the on-call surgical FY1 without A&E seeing them first.**

Nights

8am to 8pm

Duties

- Handover from the on-call FY in Dunvegan office. Make note of jobs to be completed and any unwell patients to be aware of.
- Evening ward round if the afternoon ward round has not happened.
- Most ward duties are similar to being on-call during the day time- you may be asked to review unwell patients, take ED referrals, amend prescriptions or prescribe IV fluids.
- Other duties include prepping IDLs for the next day (very different expectations to adult medicine). This is due to quick turnover of paediatric patients and pharmacy pressures.
- Update general surgery and specialty handover lists for the morning ward round.
- If you have time on night shift it is really helpful to prep the ward round notes for the following morning. Pop *DRAFT* at the top following by /pswr. It is helpful to put the observations and fluid balance in so that they are there for the team to quickly read on ward round in the morning. (Your morning colleagues will love you for this ☺)
- You may need to assist the reg in theatre overnight e.g. scrotal explorations.
- You will usually be holding the SpR and FY bleeps as the registrars are non-resident
- Referrals from other hospitals should go to the registrar via switchboard
- Calls from NICU or PICU should go to the registrar via switchboard

ED Referrals Overnight

- Overnight you can admit patients without a reg review if they are straightforward e.g. abdominal pain. You should admit for observation, give analgesia and fluids if they are fluid deplete. Ensure they are fasted for the morning ward round.
- If you have any concerns please do not hesitate to contact the registrar

Escalation Overnight

- The regs are non-resident overnight – make sure you have their mobile number!
- Presentations the surgical reg should be informed about overnight:
 1. Testicular pain
 2. Bilious vomiting/ ?pyloric stenosis with abnormal gas
 3. Trauma
 4. Any patient who is clinically unwell that you are worried about

If in any doubt about calling the surgical reg - you are always best to give them a call. You would rather regret calling them than to regret not calling them!

If you need urgent assistance from a senior who is in the building, you should bleep the paedics med reg on 9424.

If you feel the need for PET call, call 2222.

If you are struggling for bloods or IV access overnight, the first point of call is the medical ST1/2 (9102) or the med reg (9424).

Weekends

General surgical reg: 51241 / switchboard

Orthopaedic reg: 9284

ENT reg: switchboard

Plastics reg: 9143, often doesn't carry bleep, available on mobile via switch

Spinal consultants: via switchboard

General Weekend Tips:

- The team will consist of one FY, one reg and one consultant. The ward round sometimes starts later in the morning, so you should receive handover from the nights FY and let them head home.
- Your duties at the weekend are very similar to a normal on-call day but you will cover general surgery, specialities and ED. Crichton (day case unit) is closed at the weekends.
- You may have to scrub in to assist the registrar in theatre depending on consultant and registrar availability. Let the nurses know if this is the case as you may not be as readily available to answer bleeps. Set your bleep on the work benches in theatre so that the scrub nurses can take messages for you.
- Spinal consultants always do full ward rounds on the weekends

Back Slashes

WARD ROUND

/pswrd: PAEDS SURGERY WARD ROUND

/paedsmedrec: PAEDS MED REC

/traumatertiarypaeds: TRAUMA TERTIARY EXAM

/aruwb: WELL BABY

/aruwc: WELL CHILD

DISCHARGES

/adeton: ADENOTONSILLECTOMY

/idlps: PAEDIATRIC SURGERY

/idlpsappendix: APPENDICECTOMY

/idlpstesticle: TESTICULAR EXPLORATION

/idlpscirc: CIRCUMCISION

/idlspinal: SPINAL

Key Contacts

Paging System 772
Switchboard 0

On-call surgical FY 9107 General Surgical
Registrar 51241
Surgical Nurse Practitioners 9105

Ortho Reg 9284 (via switchboard at weekends and evenings)
ENT FY2 9145
ENT Reg via switchboard
Plastics Reg 9143

Radiology Cons 50805/50120

Anaesthetics Registrar 9152
Theatre Coordinator 9260

Nursing Clinical Coordinator 9278
Medical registrar 9424
Medical junior 9109

Phlebotomy (outpatients) 9266
ECG/echo technicians 9263

Biochem/Haematology lab RIE 20407
Microbiology lab RIE 26021
Microbiologist on-call 26066
Blood bank RIE 27501/27502
Pathology lab 27145
Tissue/bone bank 0131 314 5535

Dalhousie 51330
Lochranza 51334
Dunvegan 51332
Direlton (PIU) 51515
Castle Mey 50090 (Doctor's office 50098)
Borthwick 51333 PICU 51131/2/3/4
Crichton (SAU) 50970
ED 50007/8
OPD 50200/50201

Codes For Doors

Dunvegan store C0458
Dunvegan doctors' room C2379
Dunvegan staff toilet C5719

Additional Prescribing Guidance

HEPMA – TOP TIPS FOR CHOOSING CORRECT MEDICATION FORMULATIONS – DUNVEGAN

Regular analgesia prescribing times

Paracetamol QDS= 6/12/18/24

Ibuprofen TDS = 6/14/22, QDS = 6/12/18/24

Drug name	Patient groups/notes	Correct formulation to choose on HEPMA
Paracetamol Suspension	All in-patients – Please prescribe this for all inpatients as this is what the nurses will use to administer the dose. When preparing the discharge please change to age appropriate preparation as below.	Paracetamol 250mg/5mL oral suspension sugar free
Paracetamol Suspension	For discharge - birth to 5 years *Remember dosing as per discharge analgesia guidelines*	Paracetamol 120mg/5mL oral suspension paediatric SF
Paracetamol Suspension	For discharge - 6 years and over *Remember dosing as per discharge analgesia guidelines*	Paracetamol 250mg/5mL oral suspension sugar free
Morphine Sulphate oral solution	For doses less than 200micrograms	Morphine sulphate (ULM) 100micrograms in 1ml oral liquid
Morphine Sulphate oral solution	For doses 200micrograms-1000micrograms	Morphine sulphate 10mg/5ml oral solution (200 – 1000microgram dose)
Morphine Sulphate oral solution	For doses greater than 1mg	Morphine sulphate 10mg/5ml oral solution
Clindamycin Suspension or Capsules	The suspension has an unpleasant taste so if choosing to give a proportion of a capsule instead, ensure that the dose can be easily measured e.g. contents of 150mg capsule dispersed in 10mL of water will give 15mg/mL concentration. Please add information for dispersing capsules as a 'Note to appear in discharge letter' on HEPMA	Clindamycin 75mg/5mL oral suspension or Clindamycin 75mg capsules or Clindamycin 150mg capsules
Omeprazole	For patients who cannot swallow capsules. For doses <10mg please note 5mg is the smallest measurable dose.	Omeprazole xxmg dispersible gastro resistant tablets
Sodium Ferredetate	Always prescribe dose in ml	

*For all **ANTIBIOTIC SUSPENSIONS** please select the **SUGAR FREE** version on HEPMA*

For **ALL** drugs with a **SPECIFIC COURSE LENGTH** please enter the '**days to supply**' as the amount of days remaining of the course e.g. a 7 day course of antibiotics with only 4 days remaining should have 4 days entered in the days to supply box.

If the antibiotic course has been prescribed in hospital add a note to appear in discharge letter with "last dose due..."

RYCYP wards (Non PCCU) MEDICATION ADMINISTRATION TIMES

IV MEDICATIONS

-Some medication frequencies are available from the drop down menu on HEPMA. If not available, they need to be entered as 'other frequency' with set times. The guide below shows whether the frequencies are available on HEPMA as a drop down, and what the relevant short code for the frequency is (can type this in frequency box to go to that section in the drop down list), or whether they need to be entered as 'other frequency'.

-In general, prescribe for standard IV drug round times 06, 12, 14, 18, 22, 24

-AVOID IVs at 08, 10, 20 (see exception – Dunvegan 1000)

-If outwith these times discuss with nurses, may need to prescribe as a 'STAT and regular' order to fit subsequent doses with standard IV times (see general notes section for examples).

Frequency	Drop down or 'other frequency'	Times	Code on HEPMA	Comments
OD	Drop down	0600	D1 06	Eg ceftriaxone
	Dropdown 1000 not avail, use 'every 24 hours' frequency	1000 ONLY Dunvegan non PN patients, see comments	XH 24 Set time as 1000	AVOID IVs at: 0800, 1000, 2000 EXCEPT Dunvegan – Once daily for patient not on PN – 1000 is preferred time eg for methylprednisolone, esomeprazole.
	Drop down	1200 Ambisome on Lochranza 1200 or 1400	D1 12	OD IV antibiotics can be at any of the standard IV drug times, unless on PN, use 1800.
	Drop down	1400 Ambisome on Lochranza 1200 or 1400	D1 14	Lochranza: Ambisome – Choose 1200 or 1400
	Drop down	1800 Preferred time for PN patients	D1 18	Patient on parenteral nutrition – 1800 preferred time as line broken to hang PN.
	Drop down	2200	D1 22	
	Dropdown 2400 not avail, use 'every 24 hours'	2400	XH 24 Set time as 2400	
BD	Drop down – but 06/18 not avail - use 'every 12 hours'	0600, 1800	XH12 Set times 0600, 1800	Eg Teicoplanin (first 3 doses) Set time of first dose to 0600 or 1800 as appropriate, HEPMA then sets the next dose to 12 hours later.
	Drop down	1200, 2400	D2 12/24	Set time of first dose to 1200 or 2400 as appropriate, HEPMA then sets the next dose to 12 hours later.
TDS	Drop down	0600, 1400, 2200	D3 06/14/22	Eg Co-amoxiclav
QDS	Drop down	0600, 1200, 1800, 2400	D4 ALT 2	Eg Tazocin, Benzylpenicillin

OTHER MEDICATIONS – ENTERAL, INHALERS ETC

DUNVEGAN

-Some medication frequencies are available from the drop down menu on HEPMA. If not available, they need to be entered as 'other frequency' with set times. The guide below shows whether the frequencies are available on HEPMA as a drop down, and what the relevant short code for the frequency is (can type this in frequency box to go to that section in the drop down list), or whether they need to be entered as 'other frequency'.

Drug round times: 06, 08 (07 on HEPMA), (10), 12, 14, (16), 18, 20, 22, 24, (02 – IVs if needed)

(Brackets – less commonly used standard drug round times)

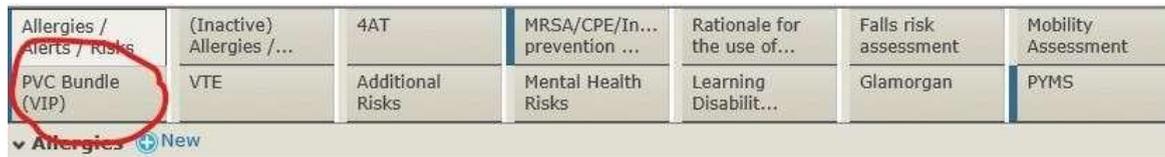
Frequency	Drop down or other frequency	Times	HEPMA Code	Comments
OD	Drop down	0700	D1 07	Eg omeprazole, abidec, prednisolone. Can prescribe specific 0600 or 0800 meds, eg if interactions with other meds, feeds etc. Avoid 1600 for OD orals
	Drop down	1200	D1 12	Eg omeprazole, abidec
	Drop down	1800	D1 18	Eg monteleukast, trimethoprim prophylaxis
	Drop down – but time not available – use 'every 24 hours'	2000	XH 24	Set time of first dose to 2000
BD	Drop down	0700, 2000	D2 07/20	Eg lactulose
TDS Regular antiemetics	Drop down	0600, 1400, 2200	D3 06/14/22	Eg regular ondansetron, regular ibuprofen TDS
TDS Spinal patients – clonidine	Other freq	0800, 1600, 2400	Other freq	These times often fit with doses given in theatre, then continue 8 hourly post op.
TDS	Other frequency	0700, 1400, 2000	Other freq	Eg co-amoxiclav, amoxicillin
QDS	Other frequency	0700, 1200, 1600, 2000	Other freq	Eg pen V, salbutamol (once on QDS)
QDS Reg analgesia	Drop down	0600, 1200, 1800, 2400	D4 ALT 2	Regular analgesia eg paracetamol QDS – evenly spaced times to cover full 24hr period.
X5/day	Other frequency	0600, 1000, 1400, 1800, 2200	Other freq	Eg Aciclovir The x5/day set frequency times on HEPMA (code D5) are not appropriate as not evenly spaced, so use 'other frequency'

How to add a cannula on Trak

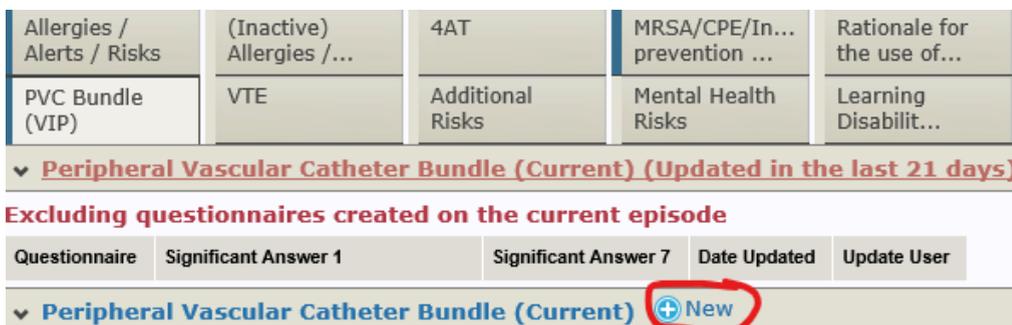
Step 1: Click on Allergies / Alerts / Risks



Step 2: Click on PVC Bundle on the top bar



Step 3: Click on 'new' beside Peripheral Vascular Catheter Bundle



Step 4: Click on 'Peripheral vascular catheter'

Code	Description	Document	Score	Used Flag
PVC	Peripheral vascular catheter			Y

Step 5: Complete Peripheral Vascular Catheter questionnaire and save

PERIPHERAL VASCULAR CATHETER

Best practice statement

- Hand hygiene must be performed before and after manipulation of the PVC
- Review clinical indication for PVC daily to ensure prompt removal when no longer required
- Assess the PVC site using the Visual Infusion Phlebitis score (VIP) and ensure the dressing is clean and intact daily

Insertion Bundle

Date of insertion	<input type="text" value="18/07/2023"/>		Date of removal	<input type="text"/>	
Time of insertion	<input type="text"/>		Time of removal	<input type="text"/>	
			Number of hours	<input type="text"/>	
Site	<input type="text"/>		Reasons for removal	<input type="text"/>	
Colour	<input type="text"/>		Plan for removal	<input type="text"/>	
Clinical Indication	<input type="text"/>				
Aseptic insertion	<input type="text"/>		If questionnaire created in error or no longer relevant, enter reason for excluding here		
Dressing dated / timed	<input type="text"/>		Reason Excluded	<input type="text"/>	
			User	<input type="text"/>	
			Password	<input type="text"/>	
Review date	<input type="text" value="18/07/2023"/>		<input type="button" value="Update"/>		
			Edit History		

Maintenance Bundle