CHAPTER 1: Your team

- Establish which consultant you are assigned to (especially if working on a team with many consultants).

- Find out what wards your patients are most commonly admitted to and introduce yourself to the staff there – nurses and ward clerks. Befriending the ward clerks is a very worthwhile exercise.

- Print out a list of that consultant's patients every morning early.

- Find out which days your consultant is on call (and what weekends) and come in early the following day and get cracking.

- Find out the role of each of the other members of the team. There is usually one SPR who is more senior than the others and usually one SHO per consultant. There may be research registrars or fellows who may have only a part time clinical role so find out who is the best person to go to for advice – ideally the SHO who is working for the same consultant as you.

- Write down the weekly schedule: days and times of consultant ward rounds and where they start, theatre days, outpatient days, multidisciplinary meeting and conference days and teaching days.

- The intern usually has to get radiology results and pathology reports for various meeting days (MDMs, radiology conferences etc.) so find out when they are and how to get the list of patients that will be discussed and what results are required.

- If you are a surgical intern ensure you know what days your team are in theatre and what theatre they work in. Figure out how to get into theatre, scrub and how to dial directly into the theatre they are in if you need to speak to them.

- Help out your fellow interns on the team if you are having a quiet day.
CHAPTER 2: The Ward Round

- Be prepared for the consultant led ward round.
- Get in early that morning and see where all the patients are located. If your team were on take, there may be still patients in the ED that you will have to go and see too.
- Make sure that if one of your patients was ill, transferred or died during the night that the team is made aware of this first thing.
- Print the patient list and write down on your own list:
  - The most recent blood results
  - Radiology results
  - Patient progress
- Have a note book and write the recommendations and investigations that the consultant requests for each patient. If there is more than one intern on the team, one might stay on the ward round and the other may begin ordering the requests and writing notes in the chart (on the computer, filling out forms etc.). However you should alternate this each ward round so that both interns get to know the patients.
- Ensure that you are happy that each patient’s vital signs are within the “normal” parameters. If there is a patient who has abnormal baseline vital signs, and the team are happy and aware of this (e.g. COPD patient with an O2 sat of 90%), ensure the registrar or consultant records this as a baseline parameter on the observations sheet (EWS sheet).
- If a patient is for discharge, find out when they are to come back for review and make sure the ward clerk books them an appointment.
- Complete notes EVERY DAY on all patients that are short stay, acute or who have a changing clinical picture. You can use the SOAP system for writing daily notes. For example:
  - S: Day 2 post acute admission with LRTI. Feeling better, tolerating nasal prongs.
  - O: PR 80, BP120/80, Apyrexic, RR 16, Sp02 nasal prongs 96%. WCC 14.6.
  - A: Improving on antibiotics, physiotherapy. and oxygen.
  - P: Check results of sputum and blood cultures. Repeat WCC mane. If apyrexic x 48 hours and WCC normalizing, consider IV to PO antibiotic switch.
- Write notes on stable patients and long stay patients AT LEAST twice a week.
- If blood tests are ordered on the ward round it is usually sufficient to request them for the following day – check with the team on the ward round, do any need to be done that day.
- Always remember to chart the warfarin dose and the insulin dose for all your patients at the end of the day (check their INR result and the trend. For insulin, check their daily glucometer readings and regular insulin doses – remember to always have a supplementary scale selected and signed for, in case a patient’s sugars become abnormal when you finish work).
- Always be thinking about the discharge plan for each patient – think: when are they going home, will they be able to go home or do I need to organize consults, home oxygen, rehabilitation, public health nurse etc? Get all of these processes organized early.
CHAPTER 3:
Requesting things

- Blood tests:
  - Complete the forms or request on the computer every evening and the phlebotomist will perform the tests the following day. Check if the patient needs to be fasting and inform the nurses. Complete the clinical data and the patient details, location and name of their consultant on the requests.

- Radiology:
  - Order on the computer or form and complete all clinical details. In the case of contrast or ultrasound studies ensure the patient is fasting. For contrast studies, check allergies and renal function and if patient requires an IV check what size cannula is required. In the case of MRI, complete the check list regarding metal implants and in the case of invasive tests, check coagulation screen and consent.

- Cardiac:
  - Order as early as possible – ECG, stress, ECHO etc. Completing clinical details is very important including symptoms, results of previous cardiac investigations and cardiac medications. You may visit the department if tests are required urgently.

- Vascular:
  - Complete the details and the indication for the test. Phone the vascular lab of you are not sure which is the best test – they will tell you if you just need ABIs or if you need more than that.

- Consults:
  - Computerised or paper requests. Always write something in the chart regardless – a SOAP note and all the results of the investigations. In the consult include the reason for admission and the reason for the consult and the results of the investigations ordered so far. CONTACT the team re consults FIRST (before sending it – have a discussion with the intern on the team and ask them who is seeing consults that week and address to that consultant. Ask what investigations they would like done.

- Allied health professionals:
  - Computerised or paper request forms – make sure the paper requests are left in whatever area the AHP picks them up from (there is usually a box or a tray for physiotherapy, dietetics, OT etc). You are required to complete the clinical details and if the patient is an infection risk. Other details like date of admission and planned discharge dates are useful. In the case of social work, be specific about what you require. In the case of physiotherapy and OT, they will decide the type of treatment once you have a clear and accurate diagnosis.

- Care nurses:
  - Some specialties have care nurses that work very closely with them and are a fountain of knowledge and excellent for giving advice and can be very helpful. Think about requesting their help for the following areas: GI surgery - stoma care nurse; breast surgery – breast care nurses; plastics/vascular – tissue viability nurses; diabetes – diabetic/tissue viability nurse; oncology – cancer care nurse etc.

- Discharge planner/coordinator:
  - These exist for medicine and surgery and are really helpful and you should contact them early if you detect that a patient may be difficult to get home or will need a lot of support or if you are having difficulty getting investigations organized that lead to
a delay in discharge. Very useful in orthopaedics and medicine for the elderly.

CHAPTER 4:  
Handovers

- Formal handovers are done face to face, in the evenings when the nighttime intern is coming to work and in the mornings of the weekends.
- Informal handovers are done weekday mornings via phone call or bleep. The night intern should bleep the interns looking after any patient who had a problem of concern over night.
- Problems of concern are:
  - A patient death.
  - A patient who has been transferred to another hospital or ward.
  - A patient who has been unstable and requires regular monitoring.
  - An outstanding result or investigation that has not yet returned and needs to be reviewed.
- In order to cut out waffle and in all conversations concerning a patient use the SBAR system of communication:
  - S: Situation:
    - What is the problem and why you are concerned
  - B: Background summary:
    - Post operative, laboratory results, medication, relevant history
  - A: Assessment of the situation:
    - Current EWS and vitals and anything you found on examination
  - R: Recommendations:
    - What you would like to be done – advice, further tests, urgently see the patient etc.
CHAPTER 5:
The Early Warning Score (Track and Trigger System):

- This is a track and trigger system that scores patients according to how “abnormal” their vital signs are (outside a defined range of normality).

- If a patient has vital signs outside the “normal” ranges, but the patient is stable, always ensure that the registrar daily resets the parameters. For example – a COPD patient may have a persistently low O2 sats but that is ok for him. This will decrease the number of calls about that patient after 5pm.

- When called to see a patient with an EWS score of 3 or more, ask for the breakdown of the parameters (pulse rate, blood pressure, respiratory rate, saturations). Get the nurse to communicate the information to you using the SBAR system (see Chapter 4).

- Ask the nurse what does she think the problems is and issue some instructions:
  - Repeat another set of observations
  - Have the chart and kardex ready for you when you arrive
  - If relevant ask for an ECG to be performed
  - Management instruction as appropriate e.g. sit the patient upright

- Tell the nurse that you are on your way and while en route think of differential diagnoses.

- Go to see the patient and request a fresh set of observations. Examine the pattern of vital signs to get an idea of the trend. Sit the patient up and get a history and examine them thoroughly. You must manage them AND investigate them at the same time AND constantly review any treatment that you commence.

- Dyspnoea:
  - Think of possible causes (pulmonary embolism, congestive cardiac failure, Lower respiratory tract infection, respiratory failure, myocardial infarction).
  - Management: Consider oxygen, put in IV cannula and start fluids if not in failure.
  - Investigations: FBC, troponins, renal, lactate, glucose, ABG, ECG, CXR.
  - Remember to examine the legs for DVT and do Well’s score.

- Chest pain:
  - Think of causes (myocardial infarction, lower respiratory tract infection, pulmonary embolism, peptic ulcer disease, non specific chest pain).
  - Management: Consider oxygen and morphine and nitrates and aspirin. Put in a cannula and start fluids.
  - Investigations: FBC, troponins, renal, lactate, glucose & ECG.
  - Remember to examine legs for DVT and do Well’s score.

- Pyrexia:
  - Think of causes (lower respiratory tract infection, urinary tract infection, soft tissue, intra abdominal, dehiscence).
  - Management: Consider oxygen. Put in 2 cannulae and start fluids (1000mls normal saline stat a good start). Consult antimicrobial guidelines for selecting an IV antibiotic (GAPP app or book). If fluid resuscitation is required insert a urinary catheter (ensure urinary out put is between 0.5 - 1ml/kg/hr ).
  - Investigations: FBC, renal and liver profile, coagulation screen, lactate, glucose, blood cultures, other body fluid cultures (sputum, wound etc.)
And always remember, if in doubt: **CALL FOR HELP EARLY!**