



INTEGRATED EDUCATION

MEDICAL EDUCATION



FY1 Handbook



FY1 Survival Guide:

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Introduction

Hello new FY1s and welcome to East Sussex NHS Healthcare trust (ESHT)!

This is a small guide that the previous FY1s have put together with the aim of giving you some useful information about being an FY1 at ESHT.

This handbook is very general, however, most people in the trust are very helpful and understand that you are new, so please ask and people will point you in the right direction if you have any queries!

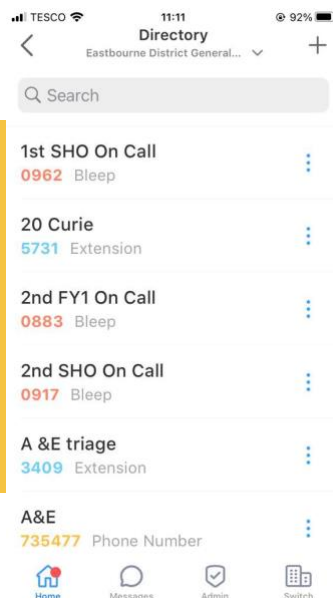
We want to wish you a happy and successful time at ESHT.

Where to find out information

NHS Computer System's at ESHT	
Software	What you can find on it
E- Searcher	Imaging results Blood results and requesting for blood tests Previous documentation such as discharge letters and clinic letters
Nerve Centre	Ward handover sheets Early warning scores (EWS)
Evolve	Historic records from previous admissions. Rarely used day-to-day.
Electronic prescribing	This is relatively new to ESHT. All drug charts are now online, and all prescribing is done through this platform
Medical notes	At present, all medical notes are paper. These are on the wards in locked cabinets

Trust Extranet
Has a staff directory where you can look up how to contact different team members

Induction App
A platform which has a comprehensive directory containing all bleep numbers. (can download from the app store free of charge)



How to bleep:
Dial 333
Dial their bleep number
Dial your phone extension

Return a bleep: Dial back the number which bleeped you

Dial '0' to speak to switch board

To dial external number dial 9 followed by the number

2222 calls – for MET/ SET calls and cardiac arrest calls. Outline your location and cardiac arrest or medical emergency

General advice

Day to day advice:

- Try to get familiar with the equipment and admin tasks during your shadowing period in your working area. For example, e-prescribing, venepuncture and cannulation, discharge letters and how to refer to different specialities. It is a lot to take in...! and you are likely to forget a lot of it! But don't worry, you can ask anyone in your team and very quickly you will get the hang of it.
- If you request a scan or test, make sure you review it or hand it over for review.

What to do prior to going home

- Put tomorrow's bloods out for phlebotomy round (you can book these on e-searcher). Try to space out the blood tests if you can so the phlebotomists do not become overwhelmed.

Top tips: don't forget to put out bloods for Monday on a Friday as well as weekend bloods (if needed).

- Remember if patients have a long line (for example, a PICC line) phlebotomy do not take these samples so you can print off the forms and hand this over to the nursing staff who will hand over to the nursing night team.
- Prior to leaving, check all blood results from the day and prescribe all the warfarin and IV fluids which are needed overnight to help your on-call colleagues. Remember to replace electrolytes (refeeding guidelines have a very helpful table on when to replace K⁺, Mg²⁺, PO₄³⁻ and how). If you are not sure what to do with certain blood test results, then discuss with a colleague.
- **Handover to the on-call team:** you can do this by finding them personally (especially if you are on a surgical rotation – this is likely to be your FY1 colleague) or bleeping them. You should handover any unwell patients or patients that require any jobs doing or chasing (for example, scans).

Prior to weekend

- Try and ensure that a clear plan is documented from the ward round. In certain departments, certain 'weekend forms' are used. Try and find out from your colleagues if your department uses these.
- Any patient who will need a review/ blood test or another test results chasing ensure that this is handed over to the weekend on call team. On medical jobs this is done on e-searcher on the weekend handover list. On a surgical job it is likely that you will be handing over to your FY1 colleague, remember to try and highlight who is day 1 post operation date as they will likely need to be reviewed and have post- op bloods. Try and be as specific as possible and provide as much information as you can to help your colleagues. For example, why they are in hospital, their PMH, why you are doing the investigation and what you would like your colleague to do based on the outcome of the result. Ask a senior colleague to help you if you are not sure.

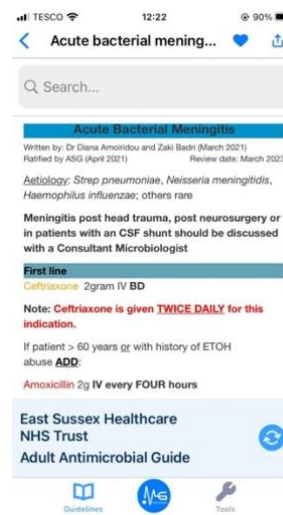
Ward rounds

- Prior to ward round try and print a patient list (doctors ward list from nerve centre for example) and write down the jobs as you go.
- Look at the latest bloods, observations and review the drug chart (for any antibiotics or ongoing therapy). Raise any concerns that you have on the ward round.
- Its good practice after the ward round to discuss with the nursing staff the plan for the patients in their bay (if they are not also on the ward round).
- If you are doing your own ward round – don't stress. Go through each patient logically, looking at the early warning score, recent blood and imaging tests, previous plan from the senior. Try and do an A-E approach and discuss patients/ their relatives about any worries they have. If there are any concerns escalate to a senior.
- Senior colleagues like to conduct ward rounds in different ways and will have different expectations from their juniors. Your team members will help guide you and this will quickly become apparent.

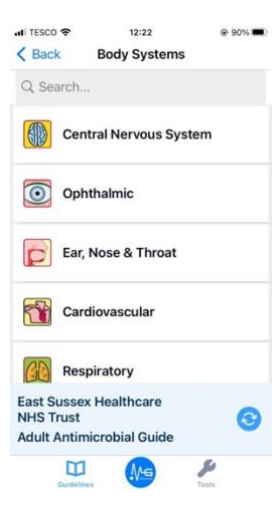
Micro guide App

Antimicrobial guide: outlines the key antibiotic guides for key conditions

Example screen shots:

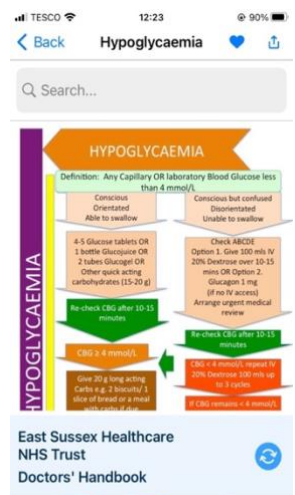
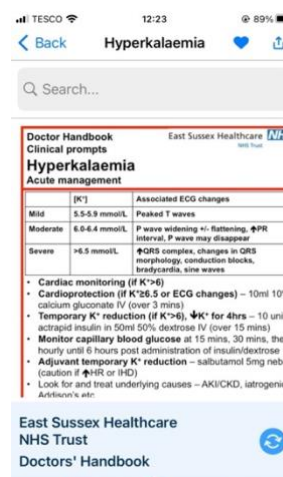


with



Doctors' handbook: outlines trust guidelines to manage common problems and presentations

Example screen shots:



Microguide can also be found on the extranet in addition to a free phone App.

Printer troubleshooting:

- Printer difficulties will occur and quite often the computer hasn't linked to the "RXC_secure" printer. This can be resolved by when clicking add printer in the search put "RXC_sec" this will bring up a shorter list to look through as opposed to searching through all the printers for the trust.
- Another issue is when the printer dialog box for inserting your username for printing doesn't show up. Go into file explorer and search the PC for "Uniflow" this will take a few minutes but will give you the client you need for the printing to be re-established.

Things that FY1 should not be doing:

- Discharge patients without senior authorisation
- Accept patient referrals from other teams

- Consent for procedures that you do not have sufficient knowledge about (for example, operations)
- Sign consent form 4 (for patients that do not have capacity)
- Prescribe certain medications (for example, methotrexate)
- FP10 prescriptions
- And generally, whenever you don't know/ feel uncomfortable - ask for senior help

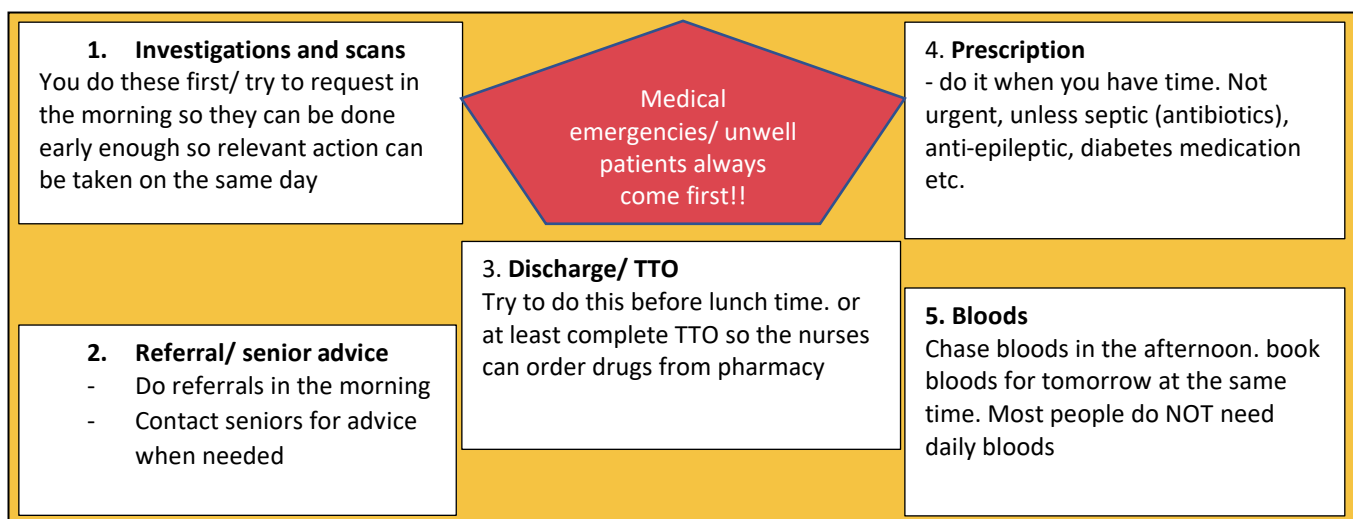
Prioritising Jobs:

It can be overwhelming to prioritise the jobs you need to complete, especially when you are on call and extremely busy. Typical F1 jobs that you will need to do include:

- Prescriptions and reviewing medications (Abx, oral electrolyte replacement etc.)
- Referrals to different specialities
- Ordering investigations (scans, blood tests etc.)
- Discharge summaries and TTOs
- Updating patients and their families
- Reviewing unwell patients and escalating any concerns

It is important to find a method for prioritising these that works for you. Here are a few useful suggestions that different senior colleagues have given us this year:

- **Four grid method** – split a sheet of paper in to four quadrants and group jobs into different categories, most important (do first), important but less urgent (do second), urgent but less important (do third), not urgent or important (do fourth).
- Prioritising based on type of job – generally completing 1) reviews of unwell patients, ordering investigations, and referrals, then 2) prescriptions and medication reviews and patient/family updates and lastly 3) discharge summaries and TTOs.
- Prioritising requesting investigations that are querying urgent diagnoses that need immediate treatment (e.g., CTPA for PE).
- It can be hard to leave discharge summaries and TTOs at the end of your jobs list, especially with external bed pressures. However, please remember that these patients are well enough to be discharged home and so you should prioritise jobs for more unwell patients first!
- If you have any additional time during the day, it is good practice to write discharge summaries as you go so you do not become overwhelmed just before the patient is discharged.



Employment and how you get paid:

- You are paid monthly on the same day of each month (often the 24th). Your payslip will be available via ESR portal which you will get access to before you start.
- Your pay will be broken down into the basic pay, additional hours, nights, and weekends. Refer to Fig.1.

ASSIGNMENT NUMBER EMPLOYEE/PAYROLL NO.		EMPLOYEE NAME		LOCATION			
2655 Junior Med		FY1 Geriatrics 011/F1/005		Eastbourne District General Ho			
DEPARTMENT		JOB TITLE		PAYROLL DESCRIPTION			
2655 Junior Med		FY1 Geriatrics 011/F1/005		Foundation Doctor Year 1			
SALVAGE		NIC DATE		PT SALVAGE			
29384.00				29384.00			
TAX OFFICE NAME		TAX OFFICE REF		TAX CODE			
West Kent Area		577/H3T1		1257L CUMUL			
PAY AND ALLOWANCES (P - MINUS AMOUNT)		DEDUCTIONS (D - INDICATES REFUND)					
DESCRIPTION	W/EARNED	PAYABLE	RATE	AMOUNT	DESCRIPTION	AMOUNT	BALANCE OF
Basic Pay	173.81	173.81	14.0882	2445.67	PAYE } These are both types of income tax	375.00	
Add Roster Hours NP	24.99	24.99	14.0882	352.00	N/A	308.52	
Night Duty 37%	28.11	14.47	14.0882	203.85	NHS Pension 9.3%	227.73	
Weekend <11st-11st				146.92	Student Loan	78.00	
					374 Don Miss Hasting	12.00	
<p><i>This is for the basic 40 hours per week. This represents the basic salary (£25,000) [2021-2022].</i></p> <p><i>The frequency of your night shifts will guide a percentage increase in your pay as a whole. [NB you do not get paid for these hours individually.]</i></p> <p><i>This includes 'normal' night shifts, or all hours of any shift between midnight and 4am. You will be paid at an increased rate of 37% for these hours.</i></p> <p><i>Any extra hours you work over 40 and up to 48 (or 56 if you have opted out of the working time regulations)</i></p> <p><i>These are all deducted from your raw salary.</i></p>							
Year To Date Balances (This Employment Only)				This Period Summary			
GROSS PAY	6338.63	TAXABLE PAY	5883.17	PENSIONABLE PAY	2448.67	TAXABLE PAY	2923.71
NI LETTER **	A	TAX PAID	757.20	TAX PERIOD	2	NON-TAXABLE PAY	8.00
NI PAY	6338.63	OTHER NI PAY		FREQUENCY	Monthly	TOTAL PAYMENTS	3151.44
NI CONTR	821.77	OTHER NI CONTR		PERIOD END DATE	31 MAY 2022	TOTAL DEDUCTIONS	1007.25
PENSIONABLE PAY	4897.34	PENSION CONTR	455.48	PAY DATE	24 MAY 2022	NET PAY	2150.19
ID REF NUMBER		EMPLOYEE NO.		PAY METHOD	BACS		
<p>MESSAGES FROM EMPLOYER - A PREVIOUS FY1</p> <p>* "1257L CUMUL" is the correct tax code. This refers to the allowance of your income that is not taxed - ie your 'personal allowance'. If this box reads anything different (e.g. 'D0 NONCUM', 'OT' or 'BR NONCUM') this indicates you may be being overtaxed - HMRC think you have >1 job.</p> <p>** National insurance. It is likely you will be in category "A" for this tax. Further information may be found at: www.gov.uk/national-insurance-rates-letters</p>							

Figure 1: Example pay slip with explanations.

- If you take locum shifts these will be represented on a separate payslip at the end of the month. They may also be subject to a different tax code.
- As an FY1 you are technically employed/ paid by the foundation school rather than the individual trust
- Whilst approximately the first £12 000 of any money you make during a year is not taxed, your earnings will be constantly reassessed, and predictions made by HMRC.

Hence you will start paying tax before you reach this marker. At the end of the year, you may or may not receive a rebate if they have overtaxed you.

- Your student loan will only start being deducted once you have reached the income threshold
- There are lots of websites that offer more help/ explanations such as: medics money, nhspayrollservices.co.uk, BMA pay and contracts

Exception Reporting and Guardian of Safe Working

Exception reporting is the process of reporting any extra hours you work.

Extra hours may be:

- leaving late
- arriving early
- missing teaching
- missing breaks (30 mins total on a normal ward day, or 1 hour on a 12-hour day)
- These are submitted on an online system called DRS4 (doctors rostering system). They will be automatically sent for approval to your clinical supervisor. Your educational supervisor will also be notified. You will get log in details for this when you start.
- The purpose of exception reporting is to indicate where more support is required in the hospital, for example, recruiting a doctors' assistant or discussing with the team how to make timings more manageable.
- Exception reporting is **NOT** a reflection on you as a doctor. Nor can it possibly be added to your record/ work against you, despite what some may believe. It simply protects you, highlights where extra help may be beneficial and ensures you are paid for your worked hours.
- If you receive resistance to your exception reports we would strongly advise escalating this for yourself, others, and the department.
- All exception reports, whether approved or declined, will be reviewed by the guardian of safe working hours - a local doctor who reviews and acts upon areas that may need further support.
- All exception reports should be submitted as soon as possible after the exception takes place. This should be done within a maximum of 14 days (or 7 days when making a claim for payment).
- There is an option on the exception report for you to highlight any immediate safety concerns. If there is a safety concern, it is advised that you talk to a consultant immediately.
- Exception reporting is a mechanism that ensures training is safeguarded and workloads are kept manageable.

Top tips: with exception reporting often, you will get additional pay for the time you have worked, or the time back in lieu. If you get the time back in lieu, make sure that you liaise with the rota coordinator so that you can take the time off. Also, if you get a payment make sure you check your pay slip to ensure that you are being paid for the additional time.

What rest breaks are we entitled to?

- Shift >5 hours – 30 minutes
- Shift >9 hours – 1 hour

- Shift >12 hours – 1.5 hours
- For longer shifts, it is likely you would need to take a couple of smaller breaks to get the rest time.

Rota:

You should receive your rota 6 weeks prior to the start of the rotation, and you are advised to request your annual leave as soon as possible.

Most departments at ESHT use Employee Online Health Roster to plan/ view the rota, this will tell you who else you are working with, and a platform to book annual leave. Some departments, such as orthopaedics will send you the rota each week via email, but you can email the rota coordinators to book leave and the rota will be predicted for the whole rotation and updated when necessary.

MD Medicine EDGH June — July 2022

WK	Mon	Tue	Wed	Thu	Fri	Sat	Sun
25	20 1st FY1 0830-2100	21 1st FY1 0830-2100	22 1st FY1 0830-2100	23 1st FY1 0830-2100	24 FY1 Zero	25 FY1 Zero	26 FY1 Zero
26	27 A/L	28 Ward Day	29 Ward Day	30 Ward Day	1 A/L	2 FY1 Zero	3 FY1 Zero
27	4 Ward Day	5 Ward Day	6 Ward Day	7 Ward Day	8 A/L	9 FY1 Zero	10 FY1 Zero
28	11 Ward Day	12 Ward Day	13 SDT 09:00 - 17:00	14 A/L	15 A/L	16 FY1 Zero	17 FY1 Zero

View and share your roster calendar on other devices

Figure 2: Example rota on Employee online Health Roster

You are entitled to 9 days of leave per rotation. There will be some days where you are working a bank holiday, when this happens you will receive a day off in return (day in lieu) after you worked the shift. You are not normally permitted to carry your leave onto another placement if you haven't taken it all, so make sure you use it or you may lose it!

Top tips: Being an FY1 is a big transition from being a student. Make sure that you look after yourself and take time for yourself. Ensure that you get lunch on time, can attend your teaching, and try to go home on time. If you cannot, make sure that you exception report. As with all hospitals, there are rota gaps and staffing problems. Do not feel pressured to pick up additional locum shifts. Make sure that you put your health and wellbeing first. East Sussex is a beautiful place to live – with some of the best weather and beaches around! Make sure that you manage to enjoy your time outside of work!

The Library

Kindly reproduced from the library's existing information booklet

Contact details: 0300 131 5221 (Internal Ext. 770493) and email address:

esht.libraryservices@nhs.net

The Rosewell Library and Eastbourne DGH library is situated in the Education Centre at Conquest Hospital and Eastbourne hospital respectively, it has 24/7 access with your ESHT ID badge. Please speak to the library team if you are unable to access the library with your card. It's staffed opening hours are Monday to Friday 8:30am to 5pm.

The resources available to you in the library include:

- **Books** – you can borrow up to 10 items for 4 weeks, books can be delivered to your workplace via the courier and there is an online catalogue at www.southeastlibrarysearch.nhs.uk where you can search for, renew or request books
- **NHS Knowledge and Library Hub** – you can find journal articles, e-books, and clinical information via <https://library.nhs.uk/knowledgehub/> – sign in via NHS OpenAthens
- **Journals** – print and online journals are available here and articles can be requested free of charge – <https://browzine.com/libraries/2730/subjects>
- **Literature searching** - you can request comprehensive literature searches that are tailored to your needs

The facilities available to you in the library include:

- Computer access with PCs available 24/7 with Trust logins, and printing
- Wi-Fi (NHS Wi-Fi)
- Photocopying and scanning
- Study room (quiet space available 24/7)

You can join the library if you are working for the NHS and if you are student on placement. You can also sign up for an NHS OpenAthens account to access different e-resources. Use the following link to do so: <https://openathens.nice.org.uk> – note that if you register on an NHS computer, you will get your username immediately. If not, you will be sent your username within a few days. To complete your registration, click on the link in the email you receive to set your OpenAthens password. You can then sign in to your OpenAthens account via my.openathens.net to view the resources you now have access to.

The different e-resources available to you are:

- Clinical Key (journals and books) – with OpenAthens
- Kortext Online Books – with OpenAthens
- UpToDate (current information of a wide range of clinical topics)
- BMJ Best Practice – with OpenAthens
- AnatomyTV – with OpenAthens
- Royal Marsden Online – with OpenAthens

You can also register for KnowledgeShare by identifying clinical topics of interest. Whenever high impact documents in these fields are identified – you will be emailed and informed.

You can also let the library know which journals you are interested in, and they will send contents alert each time a new issue is published.

A range of library workshops are also available in a range of different topics including literature searching, Google Scholar, UpToDate, PubMed, ClinicalKey, reflective writing, critical appraisal writing.

Top tips: Out of hours when visiting the library at Conquest please don't try to access the atrium, as it will set off the alarm!

Specialty Referral pathways:

- Remember - to speak to switchboard call '0'
- If you are unsure of a bleep holder number or extension number, switchboard will have a complete list of numbers and can both advise you and out you through, including to external hospital switchboards.
- Calling '2222' in an emergency will take you to switchboard but faster! You can then request cardiac arrest team/ MET team/ SET team/ security/ an individual bleep holder via 'fast-bleep'
- Often the fastest/ most effective way to refer is to go to the specialty ward and talk in person to the registrar. (For surgical wards they may be in theatres.)
- Both hospitals have developed summaries of how to refer to certain specialities. It changes frequently and it differs slightly between Eastbourne and conquest. Often this information is on the walls of the wards and you should be given it during induction. Normally its via e-searcher. Sometimes it is found on my list/ my document, inpatient speciality referral.

Wellbeing Pastoral Fellows:

We have two pastoral fellows at ESHT who support the doctors of all grades and medical students. You will meet them as soon as you start. Jolie Wilkinson is based at Conquest hospital and Paul Gosling is at Eastbourne DGH. Paul and Jolie are mental health first aiders. They offer a variety of confidential support, wellbeing advice, provide a safe space with a listening ear and can signpost you appropriately to relevant mental health organisations where specialist support is required. Paul and Jolie are visible around the hospitals, they also host events including the FY1 "Freshers Week" and have offices in the Education centres.

Discharge Summaries

How to be good at writing an Effective Discharge letter

By Dr Saif Bhatti (SpR)

A discharge letter is like “story-telling”. It has to catch attention of the reader, as well as convey the message in a clear yet concise manner. The “perspective” of a discharge letter varies from the point of view it’s stated from.

To achieve its purpose, an effective discharge letter ideally needs to be clear, coherent, relevant and descriptive (yet in succinct manner), whilst incorporating the appropriate blend of patient-friendly language as well as medical terms/procedural details for the kind perusal of your fellow colleagues and GP.

Top tips: Each letter has patient identification information e-g hospital number, date of birth, address and duration of the clinical episode etc. In most hospital e-systems this is automatically generated. However, sometimes, the clinical episode is listed under a wrong specialty, or the admitting consultant name is incorrectly listed or the dates of admission are incorrect. In such a case, kindly request ward clerk to amend or create new clinical episode prior to drafting your discharge letter.

Main Contents of a discharge letter (and few pointers to aid you):

- ❖ **A title** or diagnosis (This can be multiple)
Often it is best to mention the significant background in diagnosis section. Even when there is no exacerbation/decompensation of that “significant background/co-morbidity”

For example:
Diagnosis: Urosepsis.
Background of bowel cancer. Cancer resected in & currently on chemotherapy.
- ❖ **Body** or clinical summary note (This would include details of the admission episode including the clinical assessment, diagnostic investigations and management offered).
 - i. One recommendation is to start with how the patient presented. List the presenting complaint along with circumstances in which patient came/or was brought in the hospital
 - ii. For example, did the patient attend ED him/herself? Or was he/she referred by the GP?
 - iii. Was the patient brought-in by ambulance?
 - iv. Was the patient found unconscious and if unconscious then found by who (neighbour/passers-by or family)?
 - v. What was the main presenting concern in ED and AMU and what was initial assessment?This will paint a realistic approach and provide a patient-centric context to the letter
- ❖ **Additional supporting information** like investigations/ diagnostic work up (this includes bloods, imaging etc)

❖ **A GP section:**

Post all your clinical handover & queries for GP here.

- Please note, GPs are extremely busy so kindly ensure that the clinical question is clearly elucidated, along with clinical rationale, and is “do-able” in primary care set up.
- If in doubt, please discuss with your consultant prior to assigning any “clinical tasks” to GP. For example, if you have spoken with a neurosurgical team and they have advised your team to send a formal referral, please do not ask GP to do so. It will remain responsibility of your team to send the referral.
- GPs can, however, follow up and/or repeat bloods in community for example.

❖ **Secondary follow up:**

This includes referral to other specialities.

- Please mention here if you are sending a copy of letter to that speciality (and ensure you print a separate copy and send it by internal post)
- This is also a space for mentioning if a certain speciality has reviewed the patient during in-hospital episode and provided some follow up plan (which may include clinic appointment, follow up outpatient investigations like echo or R test or an imaging)
- Kindly clearly mention who will be reviewing the outcome/report of that investigation.
- Kindly ensure the requested dates of these investigations are also clearly listed on the imaging request card (for example: 3 month CT chest request with respiratory follow up. In this case, you request the investigation clearly mentioning 3-months’ time duration on the request-card as well as document in the letter that the investigation has been requested. This is to ensure respiratory team as well anyone following up patient would know that the investigation was requested.
- Another example, a speciality has done a comprehensive work up in the past and this current admission relates to it. E-g Patient known to haematology team for workup of Myelodysplasia with anaemia requiring frequent iron & blood transfusions. And the patient is now admitted under c/o your team with anaemia. In this case, document in this section and send a copy of letter to haematology making them aware of this clinical episode. e-g we are sending a copy of this letter to haematology for their kind attention

❖ **Include the past medical history (PMH) details.**

Some helpful pointers!!

- Search clinical coding section in e-searcher and GP Summary care records to guide you about a PMH.
- Be aware though, that even if it is clearly listed in GP summary care records, often you will find that when discussed with patient, they would inform that although they were “investigated” for that disease nevertheless they never had that co-morbidity or illness. If in doubt, kindly mention the source next to the listed PMH (e-g as per GP SCR)
- In case patient denies taking any medication and/or does not recognise or recall a previous illness/comorbidity/procedure (and has capacity for this), kindly mention

this in GP section and request GP to kindly review the listed information in GP records.

- This also includes review of certain regular medication that whilst may have continued during this admission, however your consultant feels that it needs to be stopped as e-g there is no more clinical indication for it now.
- Please mention the antibiotic of choice for the duration of inpatient treatment.

❖ **Anticoagulation**

- It's a good practice to mention **CHA₂DS₂-VASc** Score, if new anticoagulant is commenced.
- Bonus point 😊 if you mention any adverse effects reported with previous use of anticoagulant/anticoagulation (and was the anti-coagulant changed?).
- Often people are intolerant of one of DOACs or warfarin and are switched to another
- In other cases, when some patients are already on dual or mono anti platelet therapy and if a new anticoagulant is started for e-g new AF, the anti-clotting profile is often adjusted in consultation with specialists like cardiology or haematology.

❖ **AKI**

- Please mention the largest stage of AKI
- Which nephrotoxic medications were withheld or discontinued?
- DO you plan to request any follow up renal function monitoring blood tests.

❖ **Respect form**

Top tips: if you can, mention who was involved in RESPECT discussion and what are the agreed "parameters" or ceiling of care along with DNACPR.

What are RESPECT forms? RESPECT forms have replaced the old DNAR forms and is an escalation plan rather than just a DNAR form. Therefore, it's so important to have these conversations early before the patient deteriorates wherever possible. RESPECT forms are often completed on admission during initial clerking where appropriate. Discuss with a senior prior to initiating these forms and always make sure they are countersigned.

❖ **Ending of discharge letter**

- Mention discharging date
- Discharge consultant's name
- Try to mention the destination correctly (e-g respite care, re-settled, back to home with increased or new POC etc)
- And person writing discharge letter

❖ **Discharge letter emergencies and how to tackle them:**

There are days when you are moved, for a day, to a new ward to assist the team there due to short staffing etc.

Scenario: You are attending the ward round with new team consultant and you are confronted with writing an “urgent discharge letter” within next hour as transport is already booked and the native ward team did not draft any discharge letter

In this scenario, the following approach may be found useful:

- First, politely mention to the consultant if you can be excused to document this urgent letter. Most seniors and consultants are very understanding and often allow you to proceed with it as it will otherwise delay patient discharge.
- If, however, consultant cannot interrupt ward round and you are the only doctor in the ward that necessitates for you to continue attending the round, then kindly ask the nurse In-charge to escalate this to bed manager. Also, immediately, contact the medical administrator seeking their guidance and explaining your predicament. They will often arrange a doctor assistant or someone to help you draft urgent discharge letters whilst you complete ward round
- If the consultant or senior agrees for you to proceed. Politely explain that you are new to the ward and have never met the patient or have not been part of their clinical care. Sometimes senior will, in this case, summarise the patient’s clinical episode to you and even aid you by advising what diagnosis should be listed on the letter
- Have the nurse in charge witness this and explain to nursing staff as well that you are assisting this team only on that day and you have whole list of medical jobs to complete. This will aid in developing understanding with your fellow healthcare team and they will escalate prioritised jobs for you.
- Start with TTO’s first so that the N staff can organise the medications for the patient whilst you prepare the rest of the discharge document.
- It is often a good practice to enquire both your senior/consultant as well nursing team what jobs they would like for you to prioritise first. It is often seen that some juniors remain silent (perceiving that they are being good team members by accepting clinical tasks). However, due to multifold factors including being new to the ward, they end up not finishing clinical tasks during work hours. This can result in errors, and delay of some urgent investigations etc.
- It is always sensible and professional to escalate clearly to your senior if you feel struggling to complete tasks in job hours. This will not only ensure patient safety, but also provide them time to either assist you themselves and/or arrange a help.

Different Types of Discharge letters (under care of various ward teams etc):

A discharge letter write-up can vary depending upon the speciality and/or patient’s type of clinical episode.

To mention few:

1. A **Surgical** ward discharge letter, for example, may necessitate inclusion of
 - a) indication for surgery with relevant imaging result.
 - b) Operation or procedural details
 - c) relevant details of post-op care provided
 - d) and follow-up care plan
2. A **SDEC** or short stay AMU letter may just have a short write up. For example:

Patient presented with 1-week history of cough and breathlessness. CXR showed evidence of Pneumonia.

Diagnosis: CAP. CURB65 score of 2

Treatment: Patient was commenced on 5-day course of oral antibiotics and discharged with follow up plan as follows...

3. **Referral based.** 76 years of Mrs XYZ was referred by GP for incidental finding of Hb = 5.5g/dl. She was investigated as part of workup of anaemia. ..
4. A neurosurgical patient was **repatriated** from ABC University hospital, for rehabilitation, following operation for ICH etc,
5. For patient with **multiple admissions**. Please try to mention recent admissions. For example.

Mr ABC presented with acute breathlessness and leg swelling.

Recent prolonged admission (in dates .. to ..) wherein he was admitted with .. and treated for CAP and leg cellulitis.

Patient was due for an outpatient e-g OGD.

Now, he is presenting with ...

6. Similarly, **for geriatric patients with frailty**, it is worthwhile mentioning Rockwood score and/or for example number of falls or when the last polypharmacy review was completed.
7. Some discharge letters are required to narrate **complex social input** during clinical episodes. Caution is advised, however, when reporting and documenting such episodes. Discharge letter is a professional document, so while we encourage enlisting anything and everything relevant to the patient, in terms of their current & future healthcare/social care needs, it's advised to be professionally judicious (and therefore avoid) mentioning any personal family conflicts/disagreements, that is outside the scope of clinical care of the patient.
8. A **medical ward** discharge letter may have **multiple diagnosis** and outcomes of multidisciplinary team inputs in diagnosis section.
In such instances, its often useful to enlist all clinical issues and their short outcomes within **Diagnosis section**; including enlisting **different multi-speciality inputs** with their respective recommendations during the clinical episode. This way it gives a quick and easy access to any reader to elucidate the in-depth outcome of a complex medical clinical episode in concise and succinct manner. This is especially useful for your urgent-care colleagues, when/if the same patient presents unconscious in Resus in a state of medical emergency and every moment is vital.
9. Another example of a descriptive "diagnosis section" can be for patients who undergo "**Best interest meeting**" with multidisciplinary outcome of input & advice from medical, nursing and social care teams as well as incorporating wishes &

expectations of NOK/family members. A clear outcome and agreed best-interest plan highlighted clearly in discharge letter (preferably in diagnosis section at the start of letter) would enable the future health care providers in providing & adopting a patient-specific agreed management approach. Whilst every new clinical episode needs to be considered & explored independently on its own “clinical” merits. A holistically investigated and discussed/best-interest-meeting agreed-outcome would greatly aid in guiding the management as well as it will provide a framework in formulating clinical decision making in discharge plan.

If you notice, all of the abovementioned discharge letters start differently, because the nature of clinical episode and/or clinical management & procedures are patient-episode specific. Hence a custom-tailored patient-centric approach is often necessitated.

DO'S AND DON'TS OF WRITING AN EFFECTIVE DISCHARGE LETTER

Common pitfalls & mistakes & things to avoid in discharge letters:

1. Often doctors mention certain presenting complaints in the start of the letter, however there is no follow up explanation of it in the body of the letter. Kindly **mention only relevant presenting complaint** and/or enlist outcome of/investigation for each and every presenting complaint that you mention in the letter
2. It is useful to **group together each symptom with relevant investigation & diagnosis** based on that symptom **and the treatment offered** for it during clinical episode. This way you provide reader with a nice “flow” and coherence in the letter and also less chances of missing any diagnostic workup.

You can, thus, group together in paragraphs various treatments offered during clinical episode with their relevant investigations, whilst also mentioning the outcome & patients’ response to each of these treatments offered. This can also include future management plans/any imaging planned for each of these listed treatments.

3. Whilst mentioning investigation outcome, like that of imaging report; **mention only the relevant outcome of the investigation** and not the detailed imaging report. For example, if a patient presented with breathlessness, tachycardia and pleurisy and then underwent CTPA. Mention PE ruled out or there was evidence of PE. It’s often not necessary or relevant to mention about e-g old atelectatic changes, old rib fractures etc in clinical summary body (unless relevant e-g in trauma). However, this information and detailed investigation report can be copied in investigation section of discharge letter.
4. **Do not forget medication changes**, any medication that was withheld or discontinued during the clinical episode and do not forget to mention the duration of (with dates) any short-term antibiotic course offered for the patient.
5. **Please ensure the language and contents of the discharge letter are professional**, respectful and not accusatory/demeaning or discriminatory. For example, a patient with

alcohol dependence presenting with intoxication. Or a patient with epilepsy with poor medication compliance. Recommendation in such instances is to have a clear and open discussion with patient and NOK and let them summarise back the clinical episode.

If you can shift the focus away from patient (in this instance) and shift the discussion to the harmful effects of any drug/substance or intoxication on the body, it would yield stronger patient-clinician bond-of-trust as well greatly aid in developing a professional rapport with the patient. You can then respectfully share the printed draft version of your document with the patient, prior to discharge, so that they can review it and agree with the description of their clinical episode prior to its submission in the electronic system.

6. **Ensure the question to the GP is clearly elaborated** with clinical rationale and not simply stating “GP to follow up”.
7. It’s often helpful to “speak up” and **discuss with your senior**, summarising your understanding of clinical presentation/diagnosis and management offered for the patient. This way they can either endorse your understanding *OR* rectify it by providing further clarification of clinical rationale during the ward rounds. This would avoid the last minute “panic attack” in drafting the discharge letter “with transport already booked”
8. **Spend time with pharmacists**. They are excellent resource of learning regarding medications including their correct prescription, drug interactions and medication review.
9. Some consultants are very specific about the write-up of clinical summary for their patients. It’s useful, in those instances, then, to **get the discharge draft** (especially the diagnosis section) **reviewed by the consultant** and get it vetted by them prior to printing the completed version.
10. **Predict/plan ahead**. If you expect patient to be discharged by Friday (which is one of the busiest clinical days of the week); please start drafting discharge letter few days in advance. If you are extremely busy, try to do the TTOs first and give a copy of TTO list to nursing staff and pharmacist for review.

Horus portfolio

Throughout your foundation training you will use HORUS to log your achievements and activities throughout the year. It is worth logging onto this in the first few weeks to become familiar with how to use it.

Educational and clinical supervisor:

During your time as an FY1 at ESHT you will be given an educational supervisor for the year in addition to a clinical supervisor for your three different rotations. Often at ESHT, your educational supervisor will also be your clinical supervisor for the first rotation.

Once you have a named supervisor it's a good to arrange a meeting as soon as possible and find out how you can contact them if you need to. You are advised to meet your clinical supervisor within the first 2 weeks of the rotation and your educational supervisor at the end of each rotation.

Mapping curriculum evidence:

There is a list of 13 curriculum areas that need to have evidence mapped to them throughout FY1. It's good to look at these curriculum areas in advance so you can think about how you can get the relevant evidence to show you have achieved it. Evidence from reflections, teaching sessions, courses/ training days/ additional achievements, or if you are struggling you can complete relevant e-learning (which can be viewed on Horus and accessed through e-learning for health). Additionally, Mini Clinical Experiences (Mini CEXs) and Case based discussions (CBDs) can be used.

*Requirements (based on 2022) *may change, always check with the education team/ ARCP for the most up to date information*

Rotation 1	<ul style="list-style-type: none"> - Mini CEX 2-3 - CBD x 2 - DOP x 1 - Personal development plan - Satisfactory educational supervisor end of placement report - Satisfactory clinical supervisor end of placement report 	<ul style="list-style-type: none"> - Satisfactory team of assessment behaviour (TAB) – normally rotation 1 - At least one placement of supervision group report during the year (this will be started by your clinical supervisor you may need to remind them to do this) - Personal learning log of core/ non-core teaching and other learning - Reflection including summary narrative - Passed the PSA - Involvement with quality improvement project/ audit
Rotation 2	<ul style="list-style-type: none"> - Mini CEX 2-3 - CBD x 2 - DOP x 1 - Personal development plan - Satisfactory educational supervisor end of placement report - Satisfactory clinical supervisor end of placement report 	
Rotation 3	<ul style="list-style-type: none"> - Mini CEX 2-3 - CBD x 2 	

	<ul style="list-style-type: none"> - DOP x 1 - Personal development plan - Satisfactory clinical supervisor end of placement report - Satisfactory end of placement report (educational supervisor) 	<ul style="list-style-type: none"> - Complete SCRIPT modules - ILS - Attend one simulation session
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Quality improvement/ audit project:

Before you start a quality improvement or audit project you need to get permission prior to starting the project in addition to a clinical supervisor.

You need to register the project with the clinical effectiveness audit team. You can get advice about projects in addition to more information about existing programmes of work you can be involved in by emailing the QI team esht.improvements@nhs.net.

Teaching:

We have an hour teaching a week. Tuesdays at Eastbourne and Wednesday at Conquest normally between 1pm- 2pm. This can be logged as core hours. There is also grand round and departmental teaching that you are encouraged to attend. There is also Grand Round organised by the hospital, in addition to departmental teaching for many departments across the trust. Make sure you ask what teaching there is in your working areas when you start your rotations!

Often there are medical students on the ward, both from Brighton and Sussex Medical School and Kings Medical school. This is a great opportunity to teach. There are also opportunities for more formal teaching as well. If you are keen on teaching, then always ask the Educational Fellows at the trust who will be happy to get you involved!

Portfolio tips:

- Spend some time getting used to the HORUS portfolio when you get your log in, so you are aware of how to use it. If you are not sure, ask a friendly FY2 to show you.
- Look over the curriculum, if you click on 'descriptors' then you read what behaviours/ skills you will need to map by the end of the year. This will help your Mini-CEXs, CBDs and reflections etc be more geared to the curriculum aims.
- Try and do portfolio activities little and often. A good place to start to get two things completed/ signed off a week.
- Log teaching hours as you go to ensure that it is all recorded as it's easy to forget!
- Try and arrange your supervisor meetings well in advance. If they are difficult to get hold of then talk to their secretaries – they are often very helpful!
- Sometimes it is helpful to do reflections with other FY1 colleagues/ seniors.

Conquest Hospital

Welcome to CQ!

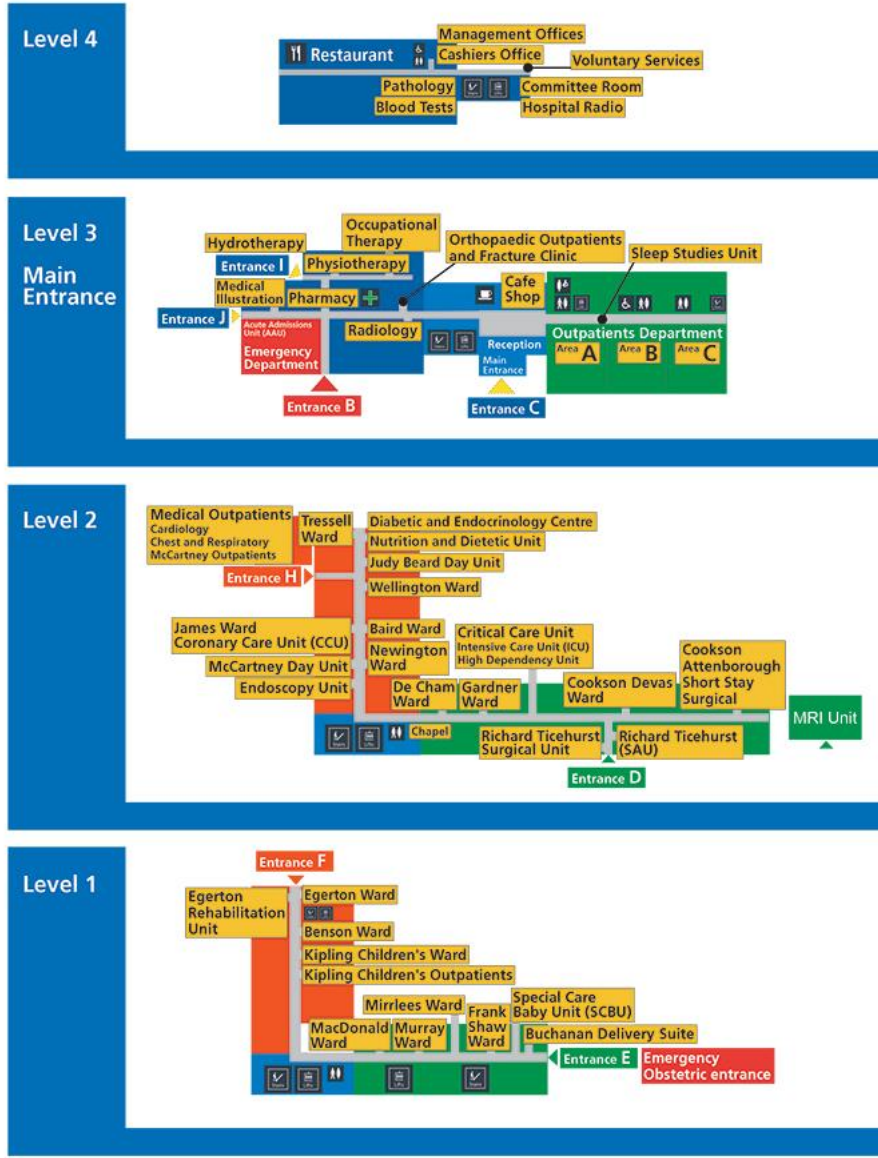
It is a district general hospital located within a 15-minute drive from the beautiful Hastings Beach and Pier. The hospital is small but provides many services in General Medicine, General Surgery, Trauma and Orthopaedics, ITU, Paediatrics and Obstetrics and Gynaecology. It also has a bustling A+E department. The small hospital has many FY1s working within it, which provides a friendly and enjoyable working environment. There are multiple opportunities for learning and development within your everyday work.



There is an active mess at Conquest, providing a variety of events to suit everyone – from water sports Wednesdays to dinner nights and pub quizzes. There is also a canteen with a wide selection of hot and cold meals, drinks, and snacks. There is a small gift shop and the popular 1066 café shop, which provides delicious drinks, and sweet and savoury treats. We also have a large pond that works well as a peaceful outdoor lunch spot in the summer. The library and education centre provide useful and educational resources for use. The wonderful Jolie (Pastoral Fellow) is also on hand for any support/advice/questions that you may have.

Hastings Beach and Pier come to life in the summer, with a beautiful sea that is perfect for swimming and paddle boarding. The old town provides a unique shopping experience and a wide variety of delicious cuisines – there is certainly something for everyone! Alexandra Park, Fairlight and East and West Hill are perfect for scenic and peaceful walks or runs. We are also within commutable distance to London and Brighton for days when you miss the bustle of the cities.

Conquest Hospital Map



The Conquest Mess

The Mess is located on the 2nd floor, Orange Zone (next to Baird Ward). There is currently a password needed to enter it, which is provided to those who sign up to the Doctor's Mess. It currently costs £12 per month, and you will be given the option to sign up for this during your induction week. If you forget and later want to sign up, there are sign-up sheets within the mess that you can fill in.

Once you join, you will be added to a Mess WhatsApp group chat. Here, the Mess Presidents and Jolie will promote any Mess events so that you can sign up. There is usually a discount for Mess members for all Mess affiliated events. Examples of events that have happened this year include pub quizzes, water sports Wednesdays, pay day pizza parties etc., There is really something for everyone and you can always plan events yourselves if you are keen on doing something a bit different!

The Mess also has a range of snacks (sweet and savoury), coffee/tea, milk and a coffee machine, kettle, fridges, and cutlery available for use. It makes a perfect lunch spot for socialising with colleagues and meeting other doctors. There's also a pool table, TV, board games for those who have more free time. A selection of sofa beds is available for doctors working night shifts and there are usually blankets and pillows available in the mess too.



You will have the opportunity to run for Mess President in your FY1 year and be involved in planning events and using the budget for weekly shops for the Mess. This is an exciting opportunity and looks good on portfolios for speciality applications later!

Canteen

The canteen is located on 4th floor and provides a variety of hot and cold meals. There is usually fish and chips on Fridays, which is the most popular lunch menu but there is something for everyone! They also do a Christmas dinner menu to help make work feel more festive!

Out of hours, vending machines provide drinks and snacks to keep you going through on calls/night shifts. Coffees/teas and ice creams are also available at the canteen to keep everyone energised and refreshed!

Rotation at Conquest Hospital:

General Medicine and medical specialities

- A **ward day** starts at 8:30am every day. When you arrive, you are expected to start preparing ward round notes and attend the ward round with your senior colleagues.
- Most consultants do a ward round twice a week and other days another senior member will often do a ward round.
- If you are on an on-call day, the cardiac arrest meeting huddle is at 8:45am in fracture clinic. Here, you will be allocated roles and will meet the team.

Ward round entry example

DATE + TIME patient reviewed

WR by Dr. XXXX (most senior to junior)

Admitted on DATE

Admitted due to/ problem list:

e.g.

1. *Pneumonia as seen on CXR*

2. *Decompensated heart failure – BNP 3000*

(Try to justify diagnose if possible with supportive evidence such as clinical findings, blood results or scan findings)

Observations (NEWS score)

Recent blood results

Recent scans

O/E:

e.g.

patient alert and talkative, orientated (AMT 4/4), comfortable lying in bed during ward round

Examination finding: no pitting oedema. Well perfused. Chest clear, abdomen soft and non tender

No urinary symptoms, last opened bowels yesterday evening type 6.

Plan:

- 1) *continue antibiotics until day 7, and regular saline nebulisers.*
- 2) *encourage sitting out in chair*
- 3) *encourage oral fluids (aim for at least 2 litres a day)*

Top tips: if consultant is leaving the ward, ask what the best way is to contact them. They sometimes will give you the phone number/ let you know where to find them. They are very approachable!

- After the ward round complete outstanding jobs. Try to prioritize your jobs as outlined in the general advice section.

Your day will finish at 5pm.

Prior to going home, handover any outstanding jobs that are urgent and need attention overnight or during the evening.

Examples: recheck hyperkalaemia post treatment, chase scans result (CXR, CT head)

On-call 5-9

- Receive bleeps from wards from other doctors who finish at 5 and need you to do any outstanding jobs.

Top tips: On a blank piece of paper, write down all the information you need. Remember to ask about which ward, which bed, patient x number. Issues, and plan for the patient. Other than jobs, other doctors may also handover patient that are unwell and may deteriorate who they would like you to review. Tick off the jobs as you go so you can keep track of it.

- Nurses will bleep you if a patient becomes unwell/ and if they have any queries or concerns. You are there to troubleshoot all issues. If you have any questions, remember to bleep on call SHO, medical registrar/ outreach team
- Handover at 8:30pm on 4th floor - Handover urgent jobs/ unwell and deteriorating patients

Top tips: Generally, routine relative updates should be done by the patient's primary team who know them best, however, if a patient becomes unwell during your on call shift you should call their next of kin to ensure they are updated.

Weekend ward day

Handover in AAU at 8:30. After handover you will go to your allocated wards:

- You will be allocated 2-4 wards during the weekend (depending on staffing levels).
- You will have the FY1 bleep. Before 7pm, no one should bleep you as there are other SHOs covering the other medical wards.
- New patients will require post-taking. If they are in your ward, remember to prepare the notes for these patients first, and medical consultant will come for the post take ward round.
- Nurses sometimes will write you a list of jobs
- On e-searcher- my documents- conquest weekend handover list- do the jobs on your wards
- there is a ward on-call medical consultant/ on call take consultant, if you have any questions, you can always ask them during the ward round
- any acute issues- bleep the on call SHO /medical registrar for help

After 7 pm:

- same as normal ward cover during the weekday
- will be bleeped for acute issues by nurses

Almost home time - 8: 30pm handover on 4th floor (where the canteen is), management corridor

- If there is nothing to handover/ night team is here before the on-call team, you can usually handover and leave first
- Handover acutely unwell / deteriorating patients
- Handover outstanding urgent jobs

Acute assessment unit

Working in the Acute Assessment Unit (AAU) is very interesting, but it can be challenging given the long and many out-of-hours shifts, and the more acutely unwell patients. Here is some general information about how AAU works that may make the shifts easier:

- Patients will be referred from A+E/GPs/clinics etc. to the medical on call team (usually composed of a registrar, two SHOs, a twilight doctor – either F1/SHO +/- a twilight registrar in the day, and a registrar, SHO and a night AAU doctor – F1/SHO) with a medical on call Consultant with overriding responsibility for the patients. Note that there are also AAU Consultants (usually two) that review patients on AAU.
- If the medical on call team accept the referral, the patient will be added to a list on Esearcher titled 'AAU Conquest – Acute Admissions' with the patient's details and location, a brief presenting history and often the urgency of the clinical review needed (routine, urgent, ward round etc.)
- The patient's location will usually be either: TCI (to come in), NCI (not coming in), ED (split into different departments e.g., resus, RAT – rapid assessment triage, WR – waiting room), SDEC (same day emergency care) or AAU
- Different doctors will then add their name by each patient before going to clerk them in
- Clerking involves completing an inpatient admissions booklet and prescribing all routine medications on EMPA (unless in SDEC/CDU/ED where the EMPA system isn't live as of writing this yet)
- Patient's being referred from ED usually have a CAS card with admitting details, a provisional drug chart and any ECG or blood gas results that have been performed in ED
- The ED clerking and ambulance records can be accessed from NerveCentre by clicking on the admission details and then selecting 'ED Summary' from the drop-down menu – this information can help you check the patient's observations taken by the paramedics on initial assessment, and check what management the patient has received in ED already
- The patient is then usually admitted and a Consultant (either the medical Consultant on call or another AAU Consultant) will review the patient as part of a post take ward round and plan ongoing management. The post take ward is filled out in a separate double page spread in the inpatient admissions booklet.
- Patients are usually then transferred from AAU to the ward or discharged home once more stable
- Board round normally happens at 11am where you go through all the patients and their plan.

The different shifts that you can be working are:

- **AAU Ward Day**
 - Attend handover from the night team at 08:30 (note that it may be useful to print off a ward list from NerveCentre before this so that you can note which patients are new admissions and jobs as you go – the ED Summary view is especially useful as there is a blank box to write down jobs next to each patient's details)

- Split the ward based on how many doctors there are covering AAU that day (there is usually 2-3 doctors on AAU in the day and they are a mix of F1s, CT1s, IMTs 1-2)
 - Join ward round with the Consultant and compile a list of jobs
 - Work your way through your jobs, ensuring to take a lunch break
 - Aim to complete the majority if not all your jobs before the end of shift at 5:30pm
 - Clearly handover any jobs to the twilight doctor +/- adding jobs to be completed on to the handover on Esearcher
- **AAU Twilight**
 - Start shift at 3pm by identifying the on call and AAU ward teams and introducing yourself
 - Your job is largely to clerk new patients on the 'Conquest – General Medicine – Acute Admissions' Esearcher list in (see above for full guidance about how to do this). However, you may also be asked to support the AAU ward team and handed over jobs when these doctors leave at 5:30pm
 - The on-call team will attend handover at 8:30pm upstairs (4th floor, control room) and you will usually stay in AAU as there always needs to be a doctor on the ward, and you can usually hand over your patients to the night team later in your shift
 - For the remaining of your shift, you will oversee reviewing any unwell patients on AAU, completing any jobs previously handed over from the AAU ward team, answering any queries from the nursing team, and clerking new patients
 - Before you leave at 11pm, hand over (verbally and written on the Esearcher list) your patients to the night team with any jobs that you would like completed overnight
- **AAU Night:**
 - Start shift at 8:30pm by attending handover upstairs (4th floor, control room), making note of any important information and any outstanding jobs to be completed on the printed handover list
 - Your job is to clerk new patients in, review any unwell patients on AAU, complete any outstanding jobs handed over by the day team/twilight doctor
 - Be sure to take break(s) and have something to eat and drink – note that you won't be carrying a bleep at night so be sure to set alarms if you want to have a quick nap
 - The mess is available for use at night and provides hot and cold drinks, snacks, couches, pillows, and blankets – note that it can get quite cold in the hospital at night so it may be worth bringing a hoodie/jumper that you can put on when you're not in a clinical area
 - Before the end of your shift at 8:30am, print off and staple the handover lists together (the 'Conquest – General Medicine – Acute Admissions' on Esearcher for that date) – you usually need 9-10 copies for the morning team
 - It is also worth keeping a note of each patient's key history and examination findings, investigation results and your proposed management plan when clerking – you will be presenting the patients that you have clerked and handing over any outstanding jobs so it's important that you remember the key points

- Handover usually starts at 8:30am in a designated room in AAU (further along the corridor past SR1) – if this room is locked, ask the Sister/Nurse in Charge for the key

Top tips: FY1 should not accept patients from A+E. Ask them to bleep the on call SHO or registrar

- **AAU Weekend (on the Friday):**
 - Shift starts at 8:30am by attending the handover in AAU and the day is largely the same as a normal AAU ward day until 5:30pm
 - At 5:30pm, the doctors on a normal ward day will leave work and handover any jobs for the rest of the evening or the weekend to you
 - For the remainder of your shift, you will be completing any jobs handed over to you, reviewing any unwell patients in AAU, answering any queries from the nursing team, and supporting the on-call team (you can help clerk patients if you are free)
 - Attend handover at 8:30pm and handover any AAU ward patients to the night team
- **AAU Weekend (on the Saturday and Sunday):**
 - Start shift at 8:30am by attending the handover in AAU – note that on weekends, the entire medical team working that weekend (AAU weekend consultant, consultant on call, on call team, ward cover doctors and FY1 on call) attends handover
 - You will be the only doctor covering AAU ward that weekend, which means that you will be very busy with many jobs – make sure to ask your seniors for help/advice if needed
 - It may be helpful to print out an AAU ward list from NerveCentre so that you can make note of which patients are new and require a post take ward round. This will also help you write a jobs list as you go along as patients will often get moved to different wards during the day. This can become confusing as you will need to handover the jobs to the weekend ward doctor covering that ward, which will be difficult if you don't remember the patient's details
 - Identify the AAU weekend consultant and complete a ward round with them, adding to your jobs list as you go
 - All patients in AAU will usually be seen by the AAU weekend consultant on the Saturday and Sunday
 - You will be spending your shift completing your jobs, reviewing any unwell patients, answering any queries from the nursing team, and supporting the on-call team (you can help clerk patients if you are free)
 - Attend handover at 8:30pm and handover AAU ward patients to the night team

SDEC

Same Day Emergency Care (SDEC) is a day unit and there is one in both Conquest and Eastbourne. Patients can be referred here from A+E, clinics, or any of the wards on discharge. Commonly, patients present for bloods and a clinical review, IV electrolyte replacement/medication delivery, CT/USS scans and review etc. SDEC is designed to be a place to follow up patients when they are less acutely unwell. SDEC at Conquest is next to

AAU and sometimes, patients referred to the on-call team (usually after 9am) will be admitted to a chair on SDEC. These patients will usually be less acutely unwell and seen by the on-call team instead of the SDEC team. On SDEC's board of patients, there is a color-coding system to help you identify which patients are to be seen by the SDEC or on call teams. However, if SDEC is quieter than usual, SDEC doctors can help see these patients for the on-call team. If it is likely a patient will be admitted, it is better to clerk the patient in on the inpatient admissions booklet instead of the ambulatory care booklet.

There is usually between 2-3 doctors on SDEC, with one being an SDEC late doctor who starts at 11am. One of these will be a registrar and there are also usually 1 or 2 consultants attached to SDEC. These consultants are on hand to review/post take any patients, and give any senior advice needed. They can be found either in AAU or the A+E/AAU consultants office (near A+E and Radiology – it may be easier to ask one of the AAU doctors).

The different shifts that can be worked in SDEC are the following:

- **SDEC day:**
 - Start shift at 8:30am by printing off the 'Conquest – AAU – Same Day Emergency Care' list on Esearcher – it can be helpful to sort the patients by alphabetical order before printing the list
 - Attend handover with all SDEC doctors and nurses in SDEC
 - Clerk patients in on the Ambulatory Care booklets, request any scans needed (CTPA, USS etc.), prescribe any medications required
 - Be sure to put your name by the patient you are seeing on the Esearcher list – note that you may not have authority to edit the Esearcher list so you may have to ask the nurses to help you do this until you are able to request access
 - Handover any outstanding jobs to the SDEC late/on-call team as appropriate before leaving at 5:30pm
- **SDEC late:**
 - Start shift at 11am by printing off the 'Conquest – AAU – Same Day Emergency Care' list on Esearcher – it can be helpful to sort the patients by alphabetical order before printing the list
 - Introduce yourself to the other SDEC doctors and then start clerking patients in as described above, making sure to put your name by any patient that you are seeing
 - Handover any outstanding jobs to the on-call team before leaving at 7pm

Top tips: there are many opportunities to do procedures or observe procedures in SDEC. For example, lumbar punctures, chest drains, and ascitic taps/drains. Prior to starting the rotation, let the nurse in charge know if you are interested in observing them/ performing them under direct supervision with a senior. You can also always ask the on call team.

General Surgery

Ward day

- Ward day starts at 8am. Normally you divide the team amongst yourselves and cover Gardener and Cookson Devas ward. To start with you prepare all the ward round notes for the ward round and discuss with the nursing staff about any concerns they have had overnight. The senior team members will then come to the ward for the ward round.

Example of how to prepare ward round entry/ things to consider in general surgery:

- WR by Ms/ Mr XXX
- Admission date and reason for admission (presenting complaint)
Diagnosis: e.g. acute appendicitis
- Operation date: (including post op day 1) and any post operative complications they developed
E.g. On day 2 tazocin for hospital acquired pneumonia
- Blood test: always put the most recent blood test result, in addition to the one before in order to look at the trend of the blood test.
E.g. CRP 190 (230), WCC 12.4 (15.4)
- NEWS score
- Any nursing concerns
- Bowels open: yes/ no
- Eating and drinking: yes/ no
- Abdomen pain: yes/ no
- Stoma
- Drain in situ? Output from the drain
- O/E and assessment during WR
- Plan

Top tips: Questions to ask during the ward round

- If patient on antibiotics, for how long
- If they want a CTAP: what are we looking for? Need exact indication or the scan can be rejected
- Drains: when can they be removed
- If patient is for discharge, do they need outpatient clinic follow up?

Top tips: For two week wait referral and outpatient (OP) urgent scans- a blue dot for outpatient is to mark possible malignancy/cancer.

- After the ward round it will be jobs time! The jobs you will be doing would have been largely outlined in the ward round. Example jobs will be organising scans, updating relatives, discharge letters and reviewing unwell patients.
- You will need to request blood tests for the following day on Esearcher. Don't forget you need to print out blood tests if the patient has a PICC line and let the nurses know (normally they keep them in a folder).

- Your day will finish at 5pm. Remember to hand over any outstanding jobs to the on-call ward surgical cover. Normally this would be your fellow FY1 colleagues.

Top tips: when reviewing the bloods in general surgery electrolyte disturbances are very common, especially with patients who have stomas. The trust refeeding guidelines on the intranet outline how to replace certain electrolytes and what therapies to use at certain levels!

Weekday ward cover

- Starts at 5pm
- Outstanding jobs from the ward (you will cover Gardener ward and Cookson Devas in addition to helping the SAU team if needed).
- Urgent issue: faecal vomiting, acute bowel obstruction, HAP, aspiration pneumonia (very common)- especially if they are vomiting. If you need any senior support, then you can find seniors normally in the SAU. Alternatively, you can ring outreach or do a MET/SET call.
- Handover in coffee room in SAU 8pm

Top tips: if you are keen on surgery, you will get opportunities during this rotation to go to theatre! Let your team know and make sure that your fellow FY1s are happy on the ward before you go.

Weekend ward cover

- Starts at 8am. You attend handover in surgical handover room in the surgical corridor near endoscopy.
- Many consultants do attend the wards for a ward round. If they don't do a formal ward round, they should still be available to troubleshoot for any acute or urgent issues. You will also have a SHO and Registrar on the weekend team who can offer support and advice.

Top tips: on Friday on Gardener and Cookson Devas ward there is a weekend handover sheet that we will in for the weekend.

SAU day

- Starts at 8am and attend surgical handover
- Take a handover sheet and write down all outstanding jobs during the meeting
- Ward round with on-call consultants
 - It is normally very quick! And you need to make sure you write down the important things and try and get the SHO/ helpful medical students to help!
 - Things that you need to write down are examination findings, investigation required, diagnosis and plan, and discharge planning/ outstanding tasks prior to discharge.
- Jobs- as outlined on the ward round. Often on SAU there are lots of discharge letters. If they have only been in the hospital for a couple of days you do not normally need to include all their routine medications, only new medications/ medications started during their SAU stay.

- Update the SAU list on Esearcher- include scan findings, most updated blood results and discussion with other specialty and plan (summary) from the medical notes).

Top tips: the nurses are usually very knowledgeable in general surgery, and also very good at teaching juniors and helping us with clinical skills, for example bloods, cannulas and NG tubes. You can learn a lot from them!

NIGHT shift

- Handover in coffee room at 8pm in SAU
- Identify urgent jobs that need doing from the day team
 - What is not an urgent job: discharge letters and specialty referral
 - Urgent job: scans, abnormal electrolytes
 - You cannot accept patient referrals
 - You do not need to go to trauma calls, but you can join the registrar if you are interested
- Depending on the registrar, you may have to clerk in the patients who are being admitted into SAU, but always ask them what the plan is.
- You will need to update the SAU Esearcher list during the night and print it out for the handover in the morning

Top tips: Prior to starting the night, ask the registrar how they like to work and what jobs they want you to do (for example, do they want you to clerk or just cover the wards).

Top tips: remember after 5pm you will need to discuss all scan requests with the on-call radiologist for out of hour approval, even if it has been approved earlier in the day it will need to be rediscussed at 5pm if it were to be done out of hours.

Top tips: at night time/ out of hours if an urgent CT with contrast needs to be performed you will have to go with the patient encase they have an anaphylactic reaction to the contrast. Do not worry – this is very rare. It is good to locate where the emergency drugs are if needed and if this happens remember to call 2222.

Orthopaedics/ orthogeriatrics:

Orthopaedics is a busy but friendly department. As an FY1 on orthopaedics/ orthogeriatric medicine you will be ward based. There are three orthopaedic wards at Conquest Hospital – the two trauma wards (Benson and Egerton) and the elective ward (Cookson Attenborough). There are also sometimes outliers in Gardener ward and SAU.

A normal day starts at 8am and ends at 5pm

- Try to attend the trauma meeting, here they will talk about the referrals that have been made to the department in addition to all the new admission. It is where the surgeons, anaesthetic team and other members discuss management plans and look at imaging.
- Ward round normally starts first on Egerton and then goes on to Benson ward and following this the elective wards and outliers. On Mondays and Fridays there is normally a full consultant ward round where all patients are seen. On other days, the consultant on call will see the day 1 post op patients, and new admission. They also see any patients that you are concerned about (for example, if you are concerned about a surgical wound) so make sure you consider these patients prior to the ward round. As FY1s we stay in our allocated ward.
- There is also normally a geriatric ward round to see the unwell patients and to review all new admissions. The orthogeriatric team normally run through every patient on the ward every day. The orthogeriatric team are incredibly friendly, helpful and knowledgeable and you learn a lot from them! The orthogeriatric ward round is where most of the teaching happens.
- Following this, you complete the jobs outlined to you during the rounds, complete discharge letters and review any unwell patients.
- At the end of the shift, remember to hand anything outstanding/ urgent to the on call orthopaedic FY1.
- Once a week there is geriatric journal club! Here, people discuss interesting cases - also often there is also a free lunch!

Top tips: the doctors assistants are incredibly helpful, and some have worked in the department for a long time! They often help with admin tasks such as discharge letters, preparing ward round stickers (in orthopaedics we write onto a sticker and then stick it in the notes as often the round is quite fast!) and updating handovers.

The ward has physiotherapists based on the ward who are also incredibly helpful and often review the patients daily post op, they often voice any concerns so make sure you listen to them!

During on calls you stay on after your shift until 8pm.

- You do any jobs handed over to you, and you respond to the bleep with any issues on the orthopaedic wards.

During the weekends

- During the weekends you cover the 3 orthopaedic wards. You have an SHO who is available to help you on the ward (they will also be clerking new admissions), in addition

to an operating consultant and registrar who you can talk to if you have any orthopaedic concerns. If you have any medical concerns do not forget you can contact the medical registrar, often they are very helpful and appreciate that orthogeriatric patients are often very complex.

- During the weekend ward rounds, the consultant will see day 1 post operation patients in addition to the new admissions overnight.
- You will have a bleep and respond to all ward issues. Often the wards have a clipboard where they record all jobs for you rather than bleeping you continuously, so make sure you make your way around the wards.

Top tips: The orthogeriatric team are fantastic and incredibly approachable! You will learn a lot from them, and they will help you with any patient concerns/ issues

Conquest Hospital - ITU rotation

by Dr S. Bolitho and Dr A. Eggink

Typical ICU Day

- 8:00 Doctor's handover
- 8:30 Nursing and outreach huddle
- 8:45 Check emergency drug boxes
- 9:00 Ward round
- 12:00 Microbiology round
- 13:00 Jobs/lines/transfers/new admissions
- 16:30 Update handover sheet
- 17:00 Handover to evening team

This is a summary of a more comprehensive guide they developed which will be available to you if you do this rotation

“ICU in my opinion was a fantastic rotation to have as an FY1 as you got a lot of senior presence with plenty of teaching options, be it through Wednesday lunch time teaching and sometimes the possibility of joining the core trainees for their teaching, to getting experience of trying to do complex vascular access and help manage very complex and critical patients. During your rotation there will be plenty of opportunities to observe, assist and with some procedures and attempt them yourself.”

- A typical day consists of handover from the night team in the morning. This is followed by a nursing huddle to ensure that the unit is safe to run, and to make everyone aware of any new changes or proposed interruptions (such as transfers or potential new admissions) that may affect the day-to-day running.
- The first job of a junior member of the team (normally the FY1 or SHO) is to check the emergency drugs in the fridges for both HDU and ICU. The nurses will have access to Omnicell (pharmacy dispensing unit) to which the list of contents of each box are labelled on the front. Ensure that the medications are in date and they have all relevant drugs in there, as after an arrest or emergency intubation they don't always get restocked. This is also a good way to understand the more commonly used drugs in emergency situations.
- The next part of the day will be the ward round. This is consultant dependent – some will prefer the team to see the patients on their own to then be discussed with them, or they'll make their own entry in the consultant box of ICCA; others will go around with a team to review the patients. Initially it would be good idea to join one of the more senior members of the team to understand how an ICU ward round differs to that of the wards.
- Following the ward round, you may have time to start doing jobs before the Microbiology ward round which happens at 12:00 every day. This is a mini board round with a microbiology consultant discussing the treatment of those on antibiotics. Again, a junior member of the team will be responsible to update the relevant section of the ICCA ward round with what is discussed.
- The afternoon normally consists of getting on with any jobs, writing discharge to ward summaries and completing any referrals/requests. This is also the time where procedures such as tracheostomy and inserting lines would occur.

- Finally, the last task of the day is to update the handover list. This is located on the ICU shared drive and should be available from any consoles in the department. Handover to the evening team begins at 17:00.

Using ICCA

- ICCA is ICU's own electronic system in which you can find all the information you need regarding a patient. This is where daily ward rounds are entered, along with if visiting teams entries (which you may need to confirm using your login) and progress notes. You'll also find all the observations, organ support information, blood results and the drug. When you first start you should receive an induction to the system and there is a test system to have a practice on.
- ICCA is also where you'll need to write the discharge summary to the wards, so that they know what happened to the patient during their ICU stay. With all documents on ICCA, they have specific boxes which tell you what information they want.
- Additionally, ICCA also has tab which links to Microguide and the ICU protocols/guidance of specific conditions, which are very useful to read through if you get some spare time.

Requesting investigations

Tests and scans are generally requested in the same way as the rest of the hospital.

Some tips:

- ICU blood profile: unless instructed otherwise, the nursing staff will send off the entire ICU blood profile for every patient every morning. If you need any other blood tests, often you can simply send up the request form to add on that specific test from the morning bloods.
- X-rays: fill out the white x-ray form and bleep 2613 with patient details; they will arrive with an x-ray machine within 30 minutes (no need for transfer!).
- CT scans: CT have two ICU slots at 12:15 and 16:15 – it is worth requesting CT scans in advance of these times to ensure these slots are confirmed and the nursing staff is able to prepare the patient for transfer.
- Echocardiograms: if required urgently, speak to one of the echo technicians and explain the indication, otherwise the request may end up at the bottom of a long inpatient list.
- Neurosurgery: referapatient.org (Hurstwood Park in Brighton)
- EEG: Hurstwood Park centre - will need to call to get a referral form, or a colleague may have access to a blank copy.

Out of hours

- CT scan: call switch to see if there is an in-house radiologist or to be put through to Medica.
- MRI scans won't happen over the weekend so if urgent it will need discussion with Neurology in Brighton.
- Inpatient speciality referrals will also not be seen out of hours so if urgent contact the team directly.

Lines/experiences/theatre time

Feedback from previous FY1s – how to make the most of your ICU placement:

Top tips: with anaesthetists being required at emergency call outs (MET/SET/Cardiac arrest calls) I would recommend if the unit is safe to do so attempting to join in order to observe and gain an appreciation of those situations as you'll hopefully have more exposure here than when you are on the wards. It may also provide a teaching opportunity or discussion after regarding the case.

Top tips: organise some time spent in theatres in order to fully appreciate the role of an anaesthetist. Here you will get the opportunity to practise cannula's, how to support the airway, the use of different airway adjuncts and depending on the cases you may get the opportunity to intubate under supervision. Which was an amazing experience."

Eastbourne District General Hospital

Welcome to EDGH!

It is located on the outskirts of Eastbourne town centre – also known as the sunshine coast! The hospital itself has numerous medical wards and some surgical wards. It also has some specialist services, including the stroke and haematology services for the area. Elective operations are also carried out at EDGH. Additionally, the ENT and urology service for the trust is based here. Eastbourne also has a busy A+E department and an intensive care unit.



As FY1 doctors at EDGH we have a friendly doctor's mess which you will be welcomed to! There is also a canteen, league of friend's shop, and a coffee shop! We can also benefit from the facilities in the library and education centre.

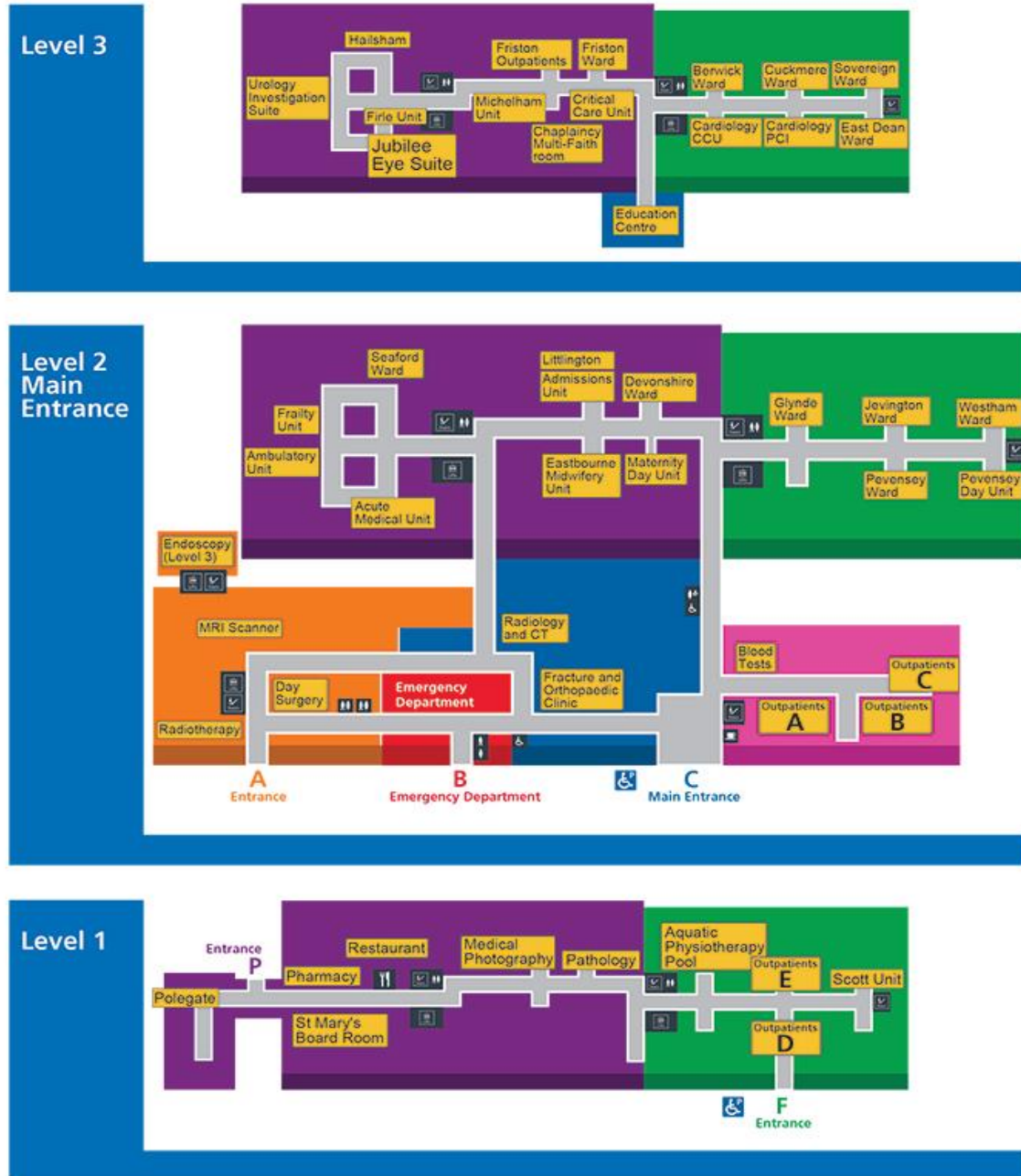
Foundation Doctors



'I think the best thing about Eastbourne hospital is the people. Being surrounded by friendly, approachable people makes every day a little bit easier and brings some fun to what can be a pretty tough job. On horrific night shifts running from ward to ward, it's the little moments that keep you going. The ward clerk popping a chocolate in your pocket, the nurses singing you happy birthday or the more serious moments after an arrest call when the resus officer brings you a cup of tea and checks everyone's ok. These moments of kindness I will always be grateful for and they've massively helped me get through my foundation years.'

Emma Pickering
Foundation Year 2 Trainee

Eastbourne DGH Map



The doctor's mess:

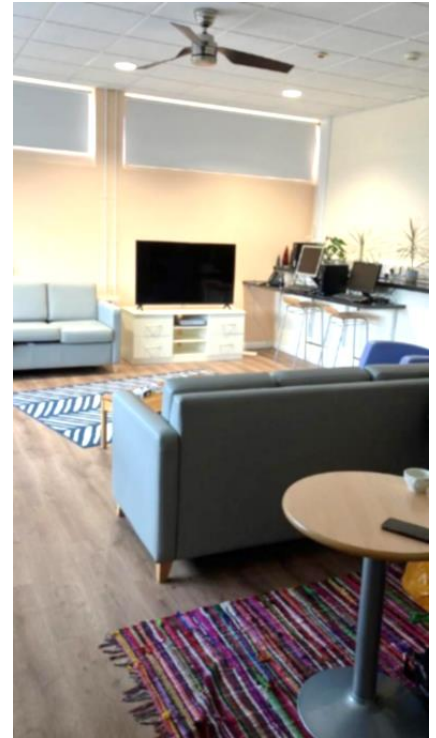
- It costs £12 month – it comes out of your salary automatically if you sign up (if you go to CQ for some rotations you can use their mess using this money)
- Food – fortnightly shops to stock up food and drinks in mess including hot drinks. You can also attend mess socials and access to the room to have lunch/when on calls. The mess room includes computers, phone, xbox and tv.

Food

- **53.3 Degrees Café located main entrance** – nice coffee and sandwiches / bakery bits – can get a loyalty card and get free 10th coffee
- **Canteen** located basement (floor one) purple zone – during the day they serve hot and cold food
- Around the corner from the canteen there is a ready meal vending machine for at night if you need food and there is also vending machines of crisps and chocolate located between A+E and Radiology
- **Fruit and Vegetable stall every Thursday** basement (floor one) purple zone (take cash and card)

Library

- Located in the education centre (third floor) blue zone
- Access to computers, and the staff can help you find books/access to journals etc (see earlier entry on the library and the facilities offered).



Rotations at Eastbourne Hospital

Medicine at Eastbourne

1st FY1 oncall

- Clerking new patients
- Meet in AMU handover room (first door on the right after the main desk in AMU). Morning handover starts 8:30/8:45 and evening handover starts 20:30. This is where the clerking team will briefly handover patients seen during the shift and alert the next team to do the outstanding jobs.
- Daytime and Night shift 1st FY1 is clerking – there is a pink list on the computers in AMU which the registrar will add names of patients who they have accepted and you will need to clerk them using the IPD and drug chart

Top tips: on eSEARCHER you can use old discharge letters on patient documents / SCR (can be accessed by typing into intranet search bar top right corner) to access patients most recent medications and comorbidities. You can get most recent observations from nervecentre (accessed on esearcher by opening patient observations / opening nervecentre separately). You can also access ambulance notes/A+E clerking through drop down menu left hand corner of nervecentre and selecting ED summary. Not as scary as first seems, can chat with senior before/after about what you should be doing for this presentation and A+E initiate the start of the management

Top tips: Sometimes when it is busy patients won't be allocated a space in resus/majors/CDU so you will need to ask A+E sister where you can review patients – sometimes patients will already be moved to AMU by the time you clerk them so check on nervecentre their location before

2nd FY1 oncall

- Ward cover and attending cardiac arrests **BUT NOT** MET calls
- Meeting 08:30 near resus/ helipad/ Day Surgery – the bleep you carry will alert you to the exact location at 08:15. Bleeps are located in the AMU handover office and all labelled.
- The morning resus meeting will decide roles of each member in the cardiac arrest (F1 tends to do access/scribe – if unsure how to document just check with the resus officers before day starts after meeting).
- Weekdays you go to your ward and do normal ward jobs and if called you will attend cardiac arrest calls for the wards, so after resus meeting you can go to your ward and start preparing for ward round as usual.
- After 5pm on weekday you will be covering the wards whilst still carrying the same bleep and attending cardiac arrests. Make a list of the X number, patient name, location and brief summary of what you need to do and prioritise your jobs. There will be an SHO who also covers the wards with you so you can always ask them for help. The medical registrar will be split between the clerking and ward cover team, dealing with complex patients, MET calls etc
- Weekends you will be doing ward cover all day – there is a list of jobs created on eSEARCHER called 'weekend handover'. The Friday day team of all wards will add

patients who need job doing/reviewing over the weekend. On the weekend, you will attend the resus meeting as usual and then go to AMU handover room and split the wards with your SHO(s). Normally, you will look after 4-5 wards. On top of this list, you will also receive bleeps from the nurses on the wards. If you are getting a lot of bleeps from a ward, you are not covering you can try and direct the nurses to contact the other bleep/ contact the SHO covering that area yourself but if they are too busy/it's an urgent job you might need to go to their area to support.

- On the weekend you will also be attending cardiac arrests for wards when called, but you do not attend MET calls.

Top tips: Weekend ward cover is one of the most challenging jobs - everyone is aware, and they know you are new so will know it's very overwhelming. If you feel like you are struggling to prioritise or unsure what to do contact your SHOs/Med Reg for support. They may not be able to help you straight away if they are very busy but often someone will be around to help you out. Remember the nurses can do a lot, if you have lots to do and nursing staff are asking you to review patients, get them to take bloods/VBGs/ECGs before you arrive. Some nurses can do blood cultures, and if they can't, get them to find you all the stuff before you go. Nurses (especially sisters and matrons) are very good at helping you, they will often know how to prescribe saline nebulisers for example so if unsure, ask them for help. If you have a poorly patient and you have contacted the medical registrar, but they can't get there straight away, you can also contact the outreach nurses to come and support. You will find that they are monitoring everyone in the hospital and will appear if someone is scoring high on the NEWS score. If in doubt or you feel out of your depth, you can put out a MET call.

Top tips: It will feel like you cannot catch up with your jobs list at times, and you may have a lot of stuff to handover. That is okay. See all the urgent problems, handover anyone who has been poorly that you are worried about/want to review again. Overtime you will get a feel of what jobs are non-urgent and can wait.

Top tips: Take your breaks, you are not paid for them. If you do not take them, exception report. You should only miss breaks if people are really poorly. Everything else can wait. You will make mistakes if you are hungry or tired.

Top tips: Some nurses and site managers can also verify deaths, again if you are struggling for time, you can ask these people to help you out.

Ward Day

Most wards will run similarly in terms of what you do day-to-day. You will have a board round at some point weekly, if not daily. Find out when your board rounds happen.

Find out if there is departmental teaching/when it happens

Ward rounds: you will need to prepare the notes for when a senior arrives. Often they will want to see sick or new patients first, so prioritise prepping these ones first.

WR: Names of all that attend

- Date, time, make sure paper is labelled with patient identifiers
- Main Diagnosis and Issues list at top of page
- Obs (most recent and anything that has happened last 24hrs e.g. temp spikes, high NEWS etc)
- Bloods
- Recent relevant scans
- You can make comments such as 'noted recent discharge from PT/OT or diabetic team input etc'
- It's always good to check if patients are having their bowels open, passing urine okay and check CBGs if these are being monitored e.g. DM or on steroids
- If on medications that have certain timeframes, also useful to document how many days they have been taking this
- You may have to do WR alone, if so, write everything down clearly and in a systematic way
- Examine chest, heart, abdomen, calves (as pt are immobile)
- End with impression/plan
- **Note: you will be continuing the plan largely from seniors previously and may be making small amendments. Again, if you are ever unsure or worried, ask a senior for support**
- **When asking/informing a senior DOCUMENT IN THE NOTES 'Dr X aware of this' or 'Discussed with and agreed following plan with Dr X'.**

Top tips: When doing a ward round with seniors, always good to clarify how long patients will be on certain medicines, what parameters need to be met to stepdown from IV to PO, or if someone is nearing discharge, clarify what medicines they will go home with, what follow up and in what timeframe if required

Top tips: Get enrolled to order bloods on phlebotomy rounds early / in your induction week. I believe the first time this is sorted you will need to do this via your line manager (department coordinator) but you can call IT for support. If you move from EDGH to CQ it will not carry over so you will need to contact IT on first day and switch this to the new site.

Top tips: You can add on bloods by calling the lab (either biochem or haem lab dependent on test) or printing off another form and writing 'add on' if they have recently received the correct bottles, sometimes it is worth trying this before rebleeding someone

Top tips: When prescribing transfusions for patients, there is a separate booklet to the drug charts/epma which you prescribe blood on. The nurses on your ward will know where this is. You will need to call blood bank to order what you want 'e.g. 2 units of RBCs'. Check with blood bank if any pink top samples need to be sent up, and if so, how many. You will usually need to send a x-match form up with samples. These samples will need to be handwritten.

Top tips: Radiology forms – handwritten yellow card for CT, MRI, USS
If requesting MRI you will need to do an MRI questionnaire also to take with this (if patient does not have capacity there is a different questionnaire form to do with a relative)

Psychiatry

Dr Tino Harahwa

Psychiatry FY1 placement at EDGH is an inpatient job in which you will be allocated to one of two wards: Amberley ward (female inpatient ward) or Bodiham ward (male inpatient ward). The department of psychiatry is not part of ESHT and is part of a separate trust, the Sussex Partnership Foundation Trust which means things like annual leave are dealt with separately.

Your role is supernumerary, meaning that you only work Monday to Fridays 9am-5pm; you do not work on-calls, nights, or weekends. You're not allowed to locum within psychiatry, but should you want to you can pick up medical or surgical FY1 on-calls with ESHT.

SPFT utilises their own online system for documentation, but still use paper drug charts. You will have an extensive three-day induction (where you don't need to go on the ward!) which includes a whole afternoon where they take you through how to use the IT system so don't worry too much about learning a separate IT system. For investigations like bloods and imaging however, you still utilise eSearcher so you will need to copy over blood results, imaging reports etc. from eSearcher.

On the ward there should usually be a Psychiatry core trainee along with a GP trainee with you as far as junior doctors.

Typical Day

09:00: MDT Handover (location depends on which ward you're assigned to; your team should point you to where to go)

09:30-13:00: Ward Round

13:00-14:00: Lunch

14:00-17:00: Additional ward round/jobs/SDT

Location

The department of psychiatry is located at the back of the EDGH site in its own building where you require card access to enter and leave. It is split across two floors with the ground floor being where the doctor's office where the junior doctors are based is located, along with consultant offices and the community team's offices. There is an old age psychiatry inpatient ward downstairs, but Amberley ward and Bodiham ward are located on the first floor, and this is where you'll be for the ward round and patient reviews.

Ward Round

Unlike the medical or surgical ward round, the psychiatry ward round consists of the team (usually you, the consultant, a staff nurse and there may be an additional junior doctor) staying in one room then patients come to you for review. Sometimes the patient's family, members of their community mental health team and other allied professionals such as social workers, or members of the patient's drug and alcohol team (STAR) may join the ward round as well. In the review your role will primarily be to type up the review; you need to document who is present in the review (name and role), everything discussed, a mental

state examination (you do this), then a diagnosis/formulation and plan (the consultant will inform you of this).

Each patient review tends to be around half an hour so each day you'll typically see about 5-6 patients in the ward round, the number of patients you see in ward round varies depending on the consultant's schedule. Generally, patients are booked into their time slot for the ward review, and you can access this information on the team outlook calendar. In the ward round you will also see new patients who will have been admitted out-of-hours.

New admissions

If new patients are admitted in hours, it is the junior doctor on the ward's responsibility to clerk them in. There is a new admission form on the IT system you need to fill in which will guide you on what information you need from the patient but essentially, you're required to take a full psychiatric history from the patient including their developmental history, forensic history, mental health history etc. then do a mental state examination. You're then required to fill out another form with the physical assessment where you can document the full physical examination (CVS, Respiratory, Abdo and Neurological exams). Then you're also required to prescribe all their usual medications and any new medications they may need but this is on a paper drug chart unlike everything else which is electronic.

Every new admission also requires a baseline ECG and specific baseline bloods (FBC, U+Es, LFTs, bone profile, HbA1c, lipid profile, haematinics and Vitamin D, TFTs, and prolactin if they're on an anti-psychotic). Please be aware that the nurses in psychiatry are not trained in a lot of physical health things, so it is your responsibility to take bloods, do ECGs etc. Once you have admitted a patient, they will be seen by the consultant in the next ward round.

If a patient is admitted out-of-hours, the on-call doctor should do all the above but just double check as if there are things they're not able to do overnight such as bloods or ECG it then becomes your responsibility to do them.

Jobs

Generally, patients in the department of psychiatry are medically fit, with their primary issues being the psychiatric health which is managed by the consultant. Occasionally they may have medical problems and your primary role as the junior doctor in psychiatry is to be responsible for patients' physical health; you're essentially like a GP. So, if patients have any physical health complaints (the most common issues encountered are urinary symptoms, rashes/skin lesions) they will either tell the nurse they need a doctor review who will handover to you, or the patient may find you themselves.

Once you've reviewed a patient you're able to take bloods (these need to be handed into the pathology lab in EDGH for processing), do an ECG (there is one machine shared between Amberley and Bodiam), and you can initiate most treatment such as antibiotics, as well request imaging (this is done at EDGH so request forms need to be handed in to EDGH) and make referrals to medical specialties via eSearcher or bleep, or whatever system the specialty utilises for formal referrals. But please be aware there are things you cannot do within the department of psychiatry such as catheterising patients, cannulating patients for

IV fluids/treatment, initiating oxygen therapy etc., for these things you have to send the patient to A+E. When sending patients to A+E if they're stable they can go to A+E themselves (please note that if the patient is under section then nursing staff need to organise someone to escort them over), or if they're not stable then you have to call 999 for an ambulance to take them over. You cannot put out MET calls in the department of psychiatry so you should call 999.

The other main thing you will spend your time doing is writing discharge letters for the patient which is done electronically. Patients can be discharged without a discharge letter then you can complete it later if you're busy at the time for example but try to complete discharge letters on the same day or at the very least the same week of discharge if you're able so they don't pile up. On the discharge letter you need to be clear about the patient's diagnosis including the ICD code so please always double check this with the consultant. You also need to complete a risk assessment and crisis plan for the patient within the discharge letter. The discharge proforma will guide on all of this and is well structured, so don't worry too much about what to include in the letter.

Supervision

You will be assigned a clinical supervisor whilst on rotation in psychiatry and you have dedicated time, about half an hour, for supervision with them once weekly. You can utilise this time to do Mini-CEXs and CBDs and other portfolio things, as well as discussing any concerns or issues that crop up.

Teaching

Every Wednesday afternoon you have protected teaching time (meaning you're off the ward for this, you can even go home if the teaching is remote) where you have teaching sessions as well as Balint group with other trainees. Attendance for these is mandatory and monitored, but you can log it as non-core teaching on your Horus.

Part of the teaching is the Sussex Academic Programme where all trainees deliver a teaching session, usually consisting of a case presentation, and you are required to deliver one of these sessions to other trainees and consultants that are part of Sussex Partnership Foundation Trust. You will be told what day you must deliver your teaching session at the start of the rotation so you can prepare for it. Your clinical supervisor must attend when you're presenting which means you can utilise this opportunity to do a "Developing the Clinical Teacher" form for your Horus portfolio with them.

Annual Leave

As previously mentioned, as SPFT is separate to ESHT, issues of annual leave are dealt with separately. Within the department of psychiatry it is the junior doctors' responsibility to coordinate their own leave, so generally you and the other doctors on your ward will create a rota so you know when everyone will be on the ward and when they are on nights/zero days etc. Once you have ensured they will be at least one junior doctor on the ward on a day you want to take off as annual leave, you're then required to fill out an annual leave request form which you have to get your consultant to counter sign then you hand it in/email it to the administrator. Provided there is cover on the ward, there generally should be no issue with getting leave.

You have 9 days of annual leave for the rotation as usual. But be aware that as SPFT is a separate trust you cannot save your days and carry them over once you finish your psychiatry rotation.

Top tips: If you're interested there is the opportunity to attend the ECT suite where they carry out ECT on Tuesday and Friday mornings. You have to coordinate with the other junior doctors on the ward to ensure someone will be there for ward round then you can go down to the ECT suite to observe for the morning.