The Surgical Take In Accident & Emergency

Before you start (e.g. people to meet, preparation, etc.)

Meet in the doctors office on C7 at 0730 or 1930 There you'll be handed over your bleep and meet the rest of the on call team - Consultant, Spr, SHO and FY1 The team handing over should have printed a list from EPIC - patients are added to the on call consultant's team e.g. Upper GI and the oncall consultant must also be updated on epic through the “Update” or “Change” order for every new patient.

The department (e.g. location/layout, important places/things, etc.)

Ed is divided into resus, areas A, B and C. You should be able to see from track board on EPIC which area your patient is in but always check with whoever has bleeped you. Many patient's will be waiting in chairs and you'll have to find a space in area C to examine them and for them to wait. Check with the nurse in charge. All trauma calls go to resus.

The speciality team (e.g. MDT, other hospitals/depts, team structure, consultants/SpRs/CTs/other, etc.)

The typical rotation (e.g. acute block, ward block, annual/study leave, etc.)

The typical week (e.g. meetings, MDTs, clinics, theatres, teaching, etc.)

The typical day (e.g. timetable, patient list, ward round, jobs, handover, dos & don'ts, etc.)

Meet at 7.30 am/pm on C7. Check with the reg how they want the shift to run - some prefer to be told about every patient. Some will want you to text them when they get to x amount of patients and they will come down at that point. Check with the person handing over to you who is waiting to be seen and any urgent jobs Be aware that many people don't know who to contact. It should be all Day - GP calls go to the GP triage nurse who then tells the FY1. ED should tell the FY1 when the patient arrives - ED calls go to the SHO Night - all patients go to the SHO as the FY1 is covering the wards.

An updated copy of the list for the team on call is printed for handover in the morning and evening.
Most teams prefer this to be landscape format.

**The typical patient (common cases/workup/investigations/surgical/medical issues/differential diagnoses/management plans)**

The most common presentations that are referred to surgery include: -Abdominal pain (with or without sepsis) -Jaundice -Gastrointestinal bleeding (upper or lower) -Post-operative complications - Lumps and bumps

All patients need a full history and examination, followed by some initial investigations. Initial point of care blood tests will be ordered by the ED nurses and will be taken by the ED phlebotomists. These include a venous blood gas, point of care CRP, creatinine, liver function test, full blood count and amylase. If the patient is likely to undergo emergency surgery, a group and screen may be requested.

Imaging that may be required typically include an erect CXR, ultrasound of the liver and gallbladder (for gallstones), or of a swelling (if suspecting an abscess or hernia) or CT abdomen and pelvis with contrast or KUB. It is important to ensure that imaging is performed while the patient is still in the ED as it is often difficult to arrange when they get moved to the ward. During daytime hours it is often easiest to go up to level 3 to discuss ultrasound scans in person.

Initial management tends to be similar for most patients whilst awaiting senior review. This includes: - Keeping patient NBM. -IV fluids -Septic screen if signs of sepsis and initiation of antibiotic therapy - Regular analgesia

**Admission/discharge/patient turnover (e.g. routes of admission, admission clerking, typical patient stay, turnover, discharge issues, social, hospital@home, follow-up, etc.)**

Patients can only be admitted to CDU if they are still A&E patients they can't be admitted to wards if they haven't been seen by a doctor - this can be the A&E doctor if they've been seen by them first. Patients should have a senior review before being admitted to the wards.

Make sure you add all the patients to the EPIC list for the on call team and are listed as under the consultant oncall. Try and ensure the VTE's, regular medications, analgesia, anti-emetics, antibiotics, best practices are done and that all patients have daily bloods requested. It's easier to cancel blood requests than it is to go and bleed a patient when you're post take! It will create a great deal of extra work for the house officers covering the ward if these are not completed in ED on admission as they will be bleeped about this overnight.

If a patient is reviewed in ED for whom you are unable to get an USS (e.g. ?cholecystitis ?appendicitis) who isn't unwell enough to require admission in hospital they may be eligible to return to the Surgical Ambulatory Care Unit on J3 the following morning for review by Consultant/ SpR. There are three available USS slots at 8:40, 9:00 and 14:00 that patients may be booked in for which need to be
requested as an outpatient order on the ED discharge (USS request with the blue house icon). Clinic code for booking patients to the ambulatory unit is SURGAMB JMHB.

Common jobs and how to do them

Patient responsibility (e.g. senior support, handover, out of hours)

Out of hours the first person to contact will be the SHO on call. Sometimes the Reg and SHO will be operating and not receivable on the phone. In this case you will need to change onto scrubs and go into the theatre to discuss the patient; main theatres are on the 3rd floor near the main elevators.

Useful telephone numbers/bleeps (seniors, juniors, other departments/hospitals)

Check that everyone has the right bleep and these match rotawatch. If they don't then make sure you take note of them as even if switchboard is updated it save you a lot of hassle if you can tell people the bleep they should be trying instead of yours.

The usual Bleeps are: F1 159-014 SHO 156-0543 Reg 156 0316

Money, pay, rotas and work/life balance

Definitions/glossary

There is a guide available on connect to provide more details about General Surgery on calls.

Important learning tools (e.g. resources, papers, books, seniors, hospital policies)

Other important information (top tips, the reality, what you wish you'd known)