**Ward Induction for Junior Doctors**

**Welcome to DME**

Welcome to the DME in Addenbrookes’. We’re delighted to have you working with us and hope that you find your time with us educational and enjoyable.

This document is an introduction to working on our wards. It has been designed in consultation with your predecessors and with the consultants in the department with the dual aims of improving the quality, safety and efficiency of our care for our patient and making your transition into the ward smoother, easier and more productive.

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We look after frail elderly patients with complex medical, psychiatric and discharge planning issues.

There are 6 DME wards in Addenbrooke’s at the moment.

4 “CORE” DME wards – C6, G6, F4 and G4 (G6 is also the Trust delirium ward)

1 **F**railty and **A**cute **M**edicine for the **E**lderly (FAME) ward on EAU 4.

An Orthogeriatric (**E**lderly **T**rauma **U**nit – ETU) Ward on D8 .

In addition, we have a rapid access clinic for urgent GP/admission avoidance referrals on EAU 3 (RADAR – **R**apid **A**ccess **D**ME **A**ssessment and **R**eferral) and a syncope ambulatory care pathway for ED referrals (also on EAU 3)

**DME Firms**

There are soon to be 5 DME firms. Each firm consists of 2 consultants and their teams currently rotating on roughly 5 weekly blocks (except G6, EAU 4 and ETU). The FAME ward is covered by the consultants within the department rotating on a 2 weekly basis.

**DME 1** Dr James Diver/Dr Roman Ortuno G4 ward

**DME 2**  Dr Jane Wilson/Dr Shaun D’Souza F4 ward

**DME 3**  Dr Duncan Forsyth/Dr Colin Mason G6 ward

**DME 4**  Dr Stephen Wallis/Dr Caoilfhionn O’Donoghue C6 ward

**DME 5**  Dr Richard Biram/Dr Claire Nicholl To be confirmed

**FAME** All above + Dr Tim Burton but not Dr Forsyth EAU 4

**RADAR** Dr Gordon Campbell (Mondays/Thursdays) EAU 3

Dr Jo Hampton (Wednesdays/Friday mornings)

 Dr Mason and Dr O’Donoghue (Tuesdays)

 Dr Wallis/Dr Biram/Dr Diver (ad hoc basis)

**Syncope** Dr Hampton (Tuesdays)/Dr Wallis/Dr Wilson EAU 3

**ETU** Dr Vindlacheviru/Dr Chileshe D8 ward

Firms 1-4 have a SpR (or clinical fellow), a GP VTS or Core Medical Trainee and a Foundation Trainee. FAME has a rotating SpR from another firm and a Clinical Fellow as well as a a GP VTS or CMT and a FY doctor.

**Additional duties**

The SpR on Firm 2 (F4) attends Princess of Wales Hospital for OPD on Tuesday mornings and for a ward round and MDT on Welney Ward on Wednesday afternoons.

The SpR on Firm 3 (G6) attends Brookfields Hospital on Tuesday mornings for PD clinics with Dr Forsyth.

The SpR on Firm 4 (C6) occasionally will be asked to visit Fulbourn Hospital for medical reviews of elderly psychiatric inpatients when requested.

1. **Ward timetables**

The timetables for each ward are attached as **Appendix 1**.

1. **OPD clinics**

OPD clinics are covered by the consultant and a SpR. When a consultant is on leave, there may be a reduced clinic of follow-up patients for the SpR to cover.

Core Medical Trainees (CMTs) **must try** to attend at least 1 clinic a fortnight (and to see at least 2 patients a clinic). To ensure safe levels of staffing on the wards, it is likely that these clinics will be with one of the other firms (or the Stroke team). The trainee should identify which clinics they will attend as early as possible so that safe levels of staffing can be ensured in their own firm while they are at clinic. CMTs can liaise with Dr Mason to discuss how to organize attendance at OPD clinics.

**Clinic Schedule**

**Monday** PM Dr Forsyth/Dr Mason (alternating)

**Tuesday**  AM Dr Biram/Dr Ortuno/Dr Diver (alternating)

 AM PD clinic (Brookfield’s, Dr Forsyth)

 AM Dr Wilson (Princess of Wales Hospital in Ely)

 PM (1st, 3rd, 4th) Parkinson’s clinic, Brookfield’s, Dr Forsyth

PM TIA/Neurovascular clinic – Stroke consultants

**Wednesday** AM Dr Wallis/Dr O’Donoghue (alternating Wednesdays)

**Thursday** AM Dr Nicholl/Dr D’Souza/Dr Wilson (alternating)

PM TIA/Neurovascular clinic – Stroke consultants

 PM POPs (pre-op surgical) Dr Biram/Dr Chileshe/Dr D’Souza

**Friday**  PM Dr O’Brien (general DME)

If SpRs are going to be unavailable for clinic, they should give at least 6 weeks’ notice to the Consultant in charge of the clinic, the relevant departmental secretary and email Clinic 2 (or Clinic 12 for Dr Forsyth/Dr Mason’s clinic) so that clinic numbers can be adjusted. With regards to Brookfield’s hospital, the clinic co-ordinator must be notified.

In addition, there is a RADAR clinic on EAU 3 on most mornings for urgent referrals from GPs. CMTs and GP VTS trainees are most welcome to attend these if service needs on the wards allow.

1. **Admissions and outlying patients**

We take patients

 Directly from ED

 Transferred from FAME/EAU 4 ward

 Transferred from MSEU ward

Transferred from other medical wards as triaged by the SAFE team

Transferred from surgical wards if deemed appropriate by Dr Biram

The consultant or SpR will review all new patients and transfers to the ward before 4.30pm.

Occasionally, “stable” transfers already seen by another team on another ward will be reviewed the following morning. However, it is crucial that a handover occurs – if this is not forthcoming from the preceding team, this should be actively sought. The handover should consist of a medical update, previous communication with and expectations of patients and families and what the current discharge plan is.

Inform the Parkinson’s team that a PD patient has been admitted (joint email to Duncan Forsyth, Karen MacGinley, Paul Worth and Jacqueline Young – all via Addenbrooke’s internal e-mail).

**Outlying patients**

These are relatively rare but the main reasons are

 Patients transferred to CCU, ICU or D4/IDA (intermediate dependency)

 Patients transferred elsewhere to a monitored bed

 Patients with Clostridium difficile diarrhea transferred to N2 ward

Patients transferred to Trust DTOC wards (must be “medically stable”)

It is particularly important that outlying patients are highlighted on weekend handovers so that they don’t “get lost”

1. **Discharges**

**Discharge planning**

**Appendix 2** has a summary of the discharge planning terminology that we commonly use.

We are always trying to predict when a patient will be medically fit and safe for discharge. Planning care needs on discharge is part of the comprehensive geriatric assessment (CGA) of a patient and is the major focus of the ward MDT meetings and the daily board rounds.

We can help patients to be discharged earlier and more safely by

 Engaging in the MDT meetings and board rounds

Preparing discharge summaries in advance (at least the day before)

 Informing pharmacy of likely discharges in advance

 Avoiding unnecessary medication changes on the day of discharge

 Identifying patients suitable for the discharge lounge

**Discharge summaries**

Accurate and detailed discharge summaries are vitally important in DME. The process has changed quite a lot recently (October 2014) with the introduction of eHospital/EPIC.

Some principles:

There are specific templates and smart phrases available within the Trust and within DME for discharge summaries. Familiarise yourself with these as soon as you can

There have been considerable issues with the quality of summary information for transfers to other hospitals since the advent of ehospital. (usually for inpatient rehab). These patients need a separate transfer letter that includes current medicines and admissions prior to admission to be done via a tab on EPIC along with the discharge summary.

Write the summary you would want to read if you were receiving it!

 Be explicit (but reasonable) about what the GP needs to do on follow up

Record any end of life discussions that have taken place - consult the SpR or Consultant when wording sensitive information in the letter

Don’t forget the importance of delirium as a diagnosis in the discharge summary – this tends to be underreported is now a

Do not routinely book OPD without discussion with the consultant

With eHospital, follow up tests and appointments need to be ordered on EPIC ideally at the time the discharge letter is being done

If patients are for follow –up investigations, be clear regarding who is going to follow up the results. Many consultants prefer to be emailed about these investigations

Don’t forget to record the patient’s weight

Consider information you can put in a discharge summary that might:

 Prevent the patient deteriorating after discharge

Help the GP (specific follow up plans, end of life discussions, results of scans, urine/sputum culture results)

 Help prevent readmission

1. **Deaths**

**ALL PATIENTS WHO DIE REQUIRE A DISCHARGE SUMMARY TO BE WRITTEN ON EPIC AND SENT TO THE GP PRACTICE.**

**THIS SHOULD CONCISE AND MAKE CLEAR THAT THE PATIENT HAS DIED.**

**(the failure to do this has led to a number of GP complaints in recent times!!)**

Discuss all death certificates with the consultant and record the discussion and cause of death on the certificate in the notes. Always consider whether or not a discussion with the coroner’s office is appropriate or not.

**(Cambridgeshire Coroner’s Office – 0345 045 1364)**

Document any discussions with the coroner’s office clearly in the notes. Any such discussions require the completion of a coroner’s referral form to be faxed by the bereavement office along with the completed death certificate to the coroner’s office.

Make sure to list significant comorbidities in part II of the form after discussion with the Consultant.

Record the time, date of death and people present when confirming death – this is now much easier to see with the ehospital system.

Please attempt to complete cremation forms in a timely fashion so that families don’t suffer undue delays when making funeral arrangements

1. **Annual and study leave/on call/late shifts/lieu days**

There should be an attempt by the doctor taking leave to arrange cover with medical staffing as soon as possible – ideally let medical staffing or your consultant know before the 8.15 morning report so that an attempt can be made to acquire a service needs doctor at this meeting. Leave forms need to be signed by your educational supervisor and by the consultant who will be present on the ward when you will be away. Prolonged periods of absence should be flagged up well in advance so that cover arrangements can be organized. Late days and days off should be identified as early as possible so as we can predict and prevent times of unsafe levels of ward staffing.

SpRs need to email their consultant, the relevant departmental secretary and clinic coordinator as far in advance as possible to inform them of any clinic absences so that clinic sizes can be modified accordingly.

On days of unexpected sick leave, you should contact both medical staffing asap to inform them so that they can try to arrange cover and you should also contact your SpR or consultant.

**8. Life on the ward**

**a. Terms to avoid in Medicine for the Elderly (Appendix 3)**

Acopia – never a diagnosis and offensive to patients and relatives

Social admission – again, not a diagnosis.

Mechanical fall – falls should be considered in terms of precipitants and the patient’s risk factors and the management plan focused accordingly

“Off legs” – like the above, non-specific term

“Collapse ? cause” – is it a syncope? was it a fall? Not a diagnosis.

“CVA” – archaic term. Not an “accident”. Use the term stroke instead.

“Failed discharge/failed OT”

“Bed blockers” – the vast majority of patients would rather be anywhere else

Patronising/age inappropriate phrases eg “she’s cute”, “dear”, “my love” and so on

See Appendix 4 for some further thoughts on this (“The Geriatric Profanisaurus”)

**b. Talking to patients and relatives (Appendix 4 and 5)**

Talking to relatives must either be done with the patient’s consent or in their best interests if they are unable to give consent. **Record this on EPIC.**

Proactively look to meet relatives or to call them for collateral – even it is only to introduce yourself and to provide a brief summary of the plan and to ask if they have any other concerns or questions.

Be particularly proactive in seeking out and communicating with relatives of patients who are delirious, suffering pain or who are doing poorly. Give relatives of patients with delirium a delirium information sheet (**Appendix 6**) – downloadable from CONNECT and **record that you have done so in the medical record** (This is now a NICE DELIRIUM QUALITY STANDARD of care).

**Always record the name of the relative you spoke to on EPIC** for your own benefit and for the benefit of others who might be involved in the future.

Document discussions using the words and terms used rather than using medical jargon.

Be mindful of how to talk to patients with dementia. Always be respectful and age-appropriate. Be clear, direct, calm and kind. Reassure and validate feelings. Use humour if the patient enjoys it but don’t use it at their expense.

**Appendix 6** includes the VERA acronym that serves as a guide to health care professionals as to how to communicate appropriately with patients with dementia/delirium.

1. **Ordering tests**

Tests should be ordered as indicated but as a guide:

Almost all patients: FBC, RP, LFT, Bone, CRP, TSH, CXR, ECG

“Dementia screen”: B12/Fol/TSH (if not in last 3-6/12). Consider CT head but don’t do in all e.g. if had done recently or before for the same indication

Anaemia: iron studies, B12, fol, prot electrophoresis (PPROT), urine BJP – check on eMR or in the old notes if this has been worked up before or whether it is a new problem

If the patient has a raised ALP, do a GGT to see if it is biliary or bony (or both)

Bloods are ordered on EPIC and stickers are printed out by the PAs or can be printed out directly by the ordering staff. PAs should be bleeped when there are bloods to be done and especially when urgent.

Don’t order bloods unnecessarily on Fridays and on weekends unless it will change management. Also be aware of the workload for PAs for ordering “routine bloods” on a Monday

Be selective ordering tests – only order when they are necessary and remember to review the results or arrange for someone else to do so.

If bloods are essential, check early in the day that they have been taken

If a patient’s discharge depends on the results of blood tests, consider ordering them the evening before rather than on the day of discharge so that the patient won’t be delayed going home due to waiting for routine results.

If organizing tests in clinic or on discharged patients, ensure that you are keeping an eye out for the results. On EPIC, results of tests ordered should be automatically routed to your in-basket but this is not true of all investigations (e.g. cardiology) yet so it is still worth keeping your own records of test to chase. If you are moving job or leaving the Trust, make sure that you have made arrangements for someone to follow results (e.g. email the consultant responsible and/or their secretary).

Further guidance on ordering tests is provided in **Appendix 7**.

1. **Checking results**

The results of investigations and outcomes of consults should be known by the end of the day. Bloods should be compared to previous results to identify trajectories of recovery or otherwise. EPIC easily facilitates this.

If bloods are taken late and not back by the end of the day, URGENT results to be checked should be handed over to the DME doctor on call. It is not reasonable or fair to ask on call doctors to check all non-urgent blood results.

1. **Prescribing**

The rule of “start low and go slow” underpins all prescribing in the elderly.

New prescriptions of analgesics, psycho tropics, sedatives and laxatives in particular need to be reviewed shortly after discharge by the patient’s GP (or in opd if for follow-up) to ensure that they are still appropriate.

If a patient weighs < 50 kg, max paracetamol dose is 3g/day; dalteparin dose should be reduced to 2,500IUs.

If a patient is on ACS protocol, don’t forget to switch over to prophylactic dalteparin afterwards if their VTE assessment suggests they need it

Avoid making minor medication changes on the day of discharge unless absolutely necessary as these are likely to delay the patient going home

Check the times that Parkinsons’ drugs are taken at home and prescribe them at these times.

The best available evidence based tool for avoiding potential errors in prescribing in Geriatric Medicine is **the STOPP START tool.** While we do not expect that you apply this tool to every patient coming through DME, we do recommend that you familiarize yourself with this before and throughout your time with us. We have been regularly auditing our adherence to the principles of STOPP START in recent years.

The STOPP START tool is attached as **Appendix 8**.

**f. Record keeping**

Our chart entries should be structured to **provide a clear current assessment and future plan**.

EPIC has eliminated the issues of timing, legibility and labelling of pages and dating and timing of notes. Please still remember to give your bleep though.

Many of us use smartphrases/smartlinks as a format for our ward round and MDT notes. Familiarise yourselves with these as soon as you can.

Recording of discussions with patients and relatives has been covered above.

1. **Weekend handover**

In addition to a house officer on the Core DME wards, there is SpR and Consultant cover on the weekends between 8am and 2pm. After these times, senior cover for the wards reverts back to the medical team on call.

There should be a copy of the DME SpR and Consultant weekend on call rota in the doctor’s office on every ward.

**The weekend handover is a crucial part of Friday afternoon’s work.**

Patients who require a senior review by the SpR or Consultant on call should be identified by the most senior member on the team on Fridays. As well as placing them on the weekend ward handover list, the consultant and SpR should also ideally be emailed or called in advance.

The team on call over the weekend should print out the list for each DME ward on Saturday and Sunday morning to identify those patients who need review or blood results checking over the weekend.

1. **Learning opportunities in DME**

We have a wide selection of cases presenting to our wards. Treat every new patient as a potential learning opportunity. Consider agreeing a CbD or mini-CEX in advance with pre-set learning objectives if a case seems to have particular learning value. More senior trainees should consider planning ACATs in advance where they lead the ward round with the consultant present.

The DME has a departmental educational session on **Friday mornings at 11.15am in the J3 seminar room**. You should have been emailed a timetable in advance of these meetings with the schedule.  There is a good chance that you will present at this at least once during your time with us. If you do present, consider agreeing a portfolio teaching assessment beforehand with predetermined learning objectives. Please try to keep these presentations interactive and focused on a few key learning objectives rather than excessively didactic or full of “information overload”.

At 12.30 pm every Friday, there is an X ray meeting chaired by either Dr Sara Upponi or Dr Melanie Hopper from the Radiology department. Please use this meeting to showcase interesting and educational cases that you encounter in your time with us. Please do not use it as an opportunity to get an early “heads up” on scans that are being done on the morning of the conference unless the case is considered to have particular educational value.

There are many clinics and other services linked to the DME in the hospital and in the community. Discuss with your educational and/or clinical supervisor in advance if you would like to (or need to) gain experience in these while you are here.

Audits make a major contribution to patient safety and quality of care, are a good learning experience and a mandatory requirement in most job interviews. Dr Mason is the current DME audit lead**.** If you would like to audit something new, discuss with your consultant and liaise with Dr Mason as early as possible during your rotation.

1. **Medical students**

Between October and March, we receive 4 blocks of Stage 1 CUH medical students in DME for 5 weeks at a time. We also intermittently receive Stage III students throughout the year. At present, the students are divided up in 2 groups whereby they spend their initial few weeks attached to either C6 or F4 before being allowed more flexibility for the remainder of the rotation to attach themselves to the other wards and firms.

Please help integrate students by:

Welcoming them and showing an interest in them

Being enthusiastic, willing and professional (remember your potential as a powerful role model to students)

Educating them early on against ageist and unhelpful terms that are occasionally used by people looking after older patients (**Appendix 3**) – remember that you are potentially a very powerful role model

Involving them in ward work, interpreting bloods and ecgs, presenting cases and so on

Asking them to elicit individual clinical signs or getting them to do brief focused history taking regularly and often

1. **CQUINS**

There are currently 2 CQUINs that are particularly important to us in DME:

1. Dementia CQUIN - a comment on this must make it into the discharge summary. If you are unclear what to write, discuss with a senior.

2. Frailty CQUINS – currently consist of clinical frailty score and enhanced discharge summary based on collateral history

1. **Common DME syndromes**

DME wards contain a wide variety of pathology and complex clinical cases.

There are a number of “geriatric syndromes” that are particularly common.

Falls

 Delirium

 Syncope

 Congestive cardiac failure

 Dementia

 Orthostatic hypotension

 Fragility fractures

 Pain syndromes

 Urinary incontinence/retention

 Constipation

Parkinson’s disease and parkinsonism

Many of these conditions already have departmental guidelines on CONNECT and have well defined guidelines from NICE and the British Geriatrics Society.

Please make particular note of and get in the habit of explaining and offering the information leaflet on Connect for relatives of patients with delirium **(Appendix 6)**.Remember the principles of how to talk to a patient with delirium/dementia **(Appendix 5).**

You will learn to become comfortable managing these conditions in DME. Consider augmenting learning and showing evidence of it by supplementing your ward experience by using typical cases as mini-CEXes or CbDs.

1. **International visitors**

The department often has overseas observers, here to learn UK practice of Geriatric Medicine. These visitors provide you with a unique opportunity to discuss and compare health and social care practice within our differing health and social care systems.

1. **Additional resources**

“Lecture Notes: Elderly Care Medicine” – Dr Nicholl, Dr Wilson

“Best of Five MCQs for the Geriatric Medicine SCE” – Dr Forsyth, Dr Wallis

Hospital guidelines on delirium, falls, Parkinson’s, vitamin d, laxatives etc on CONNECT

BGS website – [www.bgs.org.uk](http://www.bgs.org.uk)

NICE and SIGN websites

AEME @elderlymeded – Association for Elderly Medicine Education – mini-GEMs

Apps – Delirium (OPAC/NHS Scotland), FRAX tool, FocusAF, Wells Score

1. **Appendices**

**Appendix 1** Ward timetables

**Appendix 2** Discharge planning terminology

**Appendix 3** “The Geriatrics Profanisaurus”

**Appendix 4** Talking to relatives

**Appendix 5** Talking to patients with dementia and the “VERA” acronym

**Appendix 6** Information for carers about delirium

**Appendix 7** Pathology guidance

**Appendix 8** The STOPP START TOOL

**Appendix 9** Useful Contact Numbers

**Appendix 10** Twenty (One) Tips for junior doctors working with older people