Welcome to the Surgical Assessment Unit

Welcome!

Welcome to SAU. This is an information pack to help you during your placement with us.

SAU is a fast paced emergency admission unit admitting patients from ED, GP, Urgent Care and their homes. We care for patients under 6 specialities; general surgery, vascular, orthopaedics, ENT and urology.

About SAU…

Ward Manager – Lyndsey Atkinson.
Sisters – Leá, Amber, Lucy, Rob, Jay and Tom.

Shift pattern – 08:00 -20:30 (3 days a week).

Contact telephone number: 01772521700

Contact email: saurph@lthtr.nhs.uk

You will be given the codes on your first day. Please arrive in your own clothes and bring your uniform to get changed into. Thanks!!

Emergency Call!

Pull the emergency call bell and shout for help.

If you are asked to call for an emergency, dial x2222.

Be clear whether you are asking for a peri-arrest call, a cardiac arrest call or security. State your ward location and bay/area where the emergency is happening.

Your ‘Practice Assessor’ is _____

Your ‘Practice Supervisor’ is _____

Dates from: _____ to: _____

Your ‘Learning Environment Manager’ is Amber Pilling.

Your first 3 weeks of off duty:-

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Unit routine.

On arrival, there will be a printed handwritten handover and we will stand in the office facing the whiteboard. The whiteboard is where all the information is kept in one place and must be kept up to date at all times during the shift.
There are 2 mix sex triage bays, 1 x female bay, 1 x male bay and 2 side rooms.

You will be allocated in the morning to work in the bays with other students. The nurse overseeing your team will go through the handover and will highlight any outstanding jobs and the deteriorating/critically unwell patients who will need attention.

As the shift changes it may become a priority that you move areas on the ward, in order to keep patients safe and ensure the unit runs effectively.

Upon starting the shift, you must introduce yourself to patients, become familiar with your patients, complete the medication rounds, perform personal hygiene care and receive handover from the ward round.

Nurses, Doctors and ACPs.

When a patient arrives to the unit their NEWS score and pain score must be completed within 15 minutes of arrival, escalate any issues and provide analgesia.

From there the following should happen within 6 hours.

Triage by RN, HCA, AP or student.

⇩

Clerk by ANP, Junior Doctors or SHO.

⇩

Senior review by registrar or consultant.

During this time, patients will need 4 hourly observations recorded and fluid balance documented (unless requested otherwise). You should be mindful of the ever changing plans in place (documented on the whiteboard and quadramed) such as taking blood, giving medication, chasing scans, escalating deteriorating patients, liaising with the MDT, handing over and discharging patients.

Multidisciplinary Team (MDT).

You will be working alongside multiple types of people who are apart of the SAU multidisciplinary team.

These include:-

-Doctors
-Registered nurses
-Assistant practitioners
-Health care assistants
-Advanced nurse practitioners
-Bed managers
-Pharmacy
-Physiotherapy and occupation therapy
-Nutritional team and dietitians
-Stoma nurses, urology nurses, vascular and upper GI nurses
-Discharge facilitator
-Social worker
-Mental health liaison team
-Safeguarding team
-Pain team
-HALS
-Diabetic specialist nurse
-Infection control
-Theatre
-Hospital at night nurses

Abbreviations.

Abbreviation	Meaning	Special consideration
AAA	Aortic abnormal aneurysm	
AKA	Above knee amputation	
AXR	Abdominal X-Ray	
BD	Twice a day	
BKA	Below knee amputation	
BPH	Benign prostate hypertrophy	
BM	Blood glucose level	
CABG	Coronary artery bypass graft	
CBD	Common bile duct	
CFF	Clear free fluids	
CKD	Chronic kidney disease	
CNS	Clinical nurse specialist	
CT	Computer tomography scan	

Abbreviations.

Abbreviations	Meaning	Special considerations
CXR	Chest X ray	
D+F	Diet and fluid	
DNAR	Do not attempt resuscitation	No not attempt CPR
DN	District nurses	
DVT	Deep vein thrombosis	
ERCP	Endoscopic retrograde cholangiopancreatography	Patients need to be NBM 6 hours before
EOL	End of life	
FBC	Full blood count	
FF	Free fluids	
HTN	High blood pressure	
HF	Heart failure	
IVABX	Intravenous antibiotics	
IVI	Intravenous infusion	

Abbreviations.

Abbreviations	Meaning	Special considerations
IVDU	Intravenous drug user	
IDDM	Insulin dependent diabetic	
IHD	Ischaemic heart failure	
IBS	Irritable bowel syndrome	
MDT	Multidisciplinary team	
MFFD	Medically fit for discharge	
MH	Mental health	
MRCP	Magnetic resonance cholangiopancreatography	
MRI	Magnetic resonance imaging	
MST	Morphine sulphate tablet	Controlled drug given twice a day
MSU/CSU	Mid stream urine/ catheter stream urine	
NBM	Nil by mouth	
NG	Naso-gastic tube	

Abbreviations.

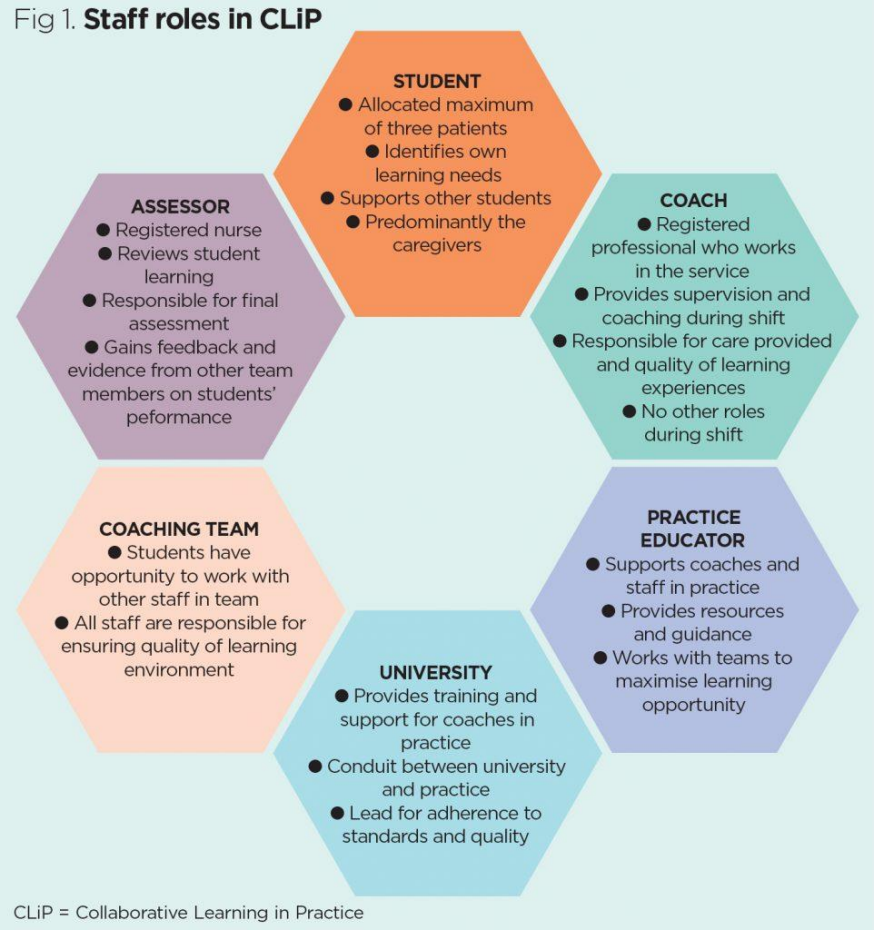
Abbreviations	Meaning	Special considerations
NIDDM	None-insulin dependent diabetic	
NKDA	None known detected allergies	
NPU	Not passed urine	
OA	osteoarthritis	
OGD	Oesophagogastroduodenoscopy	
OD	Once a day	
PCA	Patient controlled analgesia	
PCCN	Patient contribution to case notes	
PID	Pelvic inflammatory disease	
Px	Prescribed	
PRN	As required	
QDS	Four time a day	
RWT	Routine ward test	

Abbreviations.

SFBC	Strict fluid balance	
SFFD	Surgically fit for discharge	
S+S	Soup and sweet	
SBO	Small bowel obstruction	
SOB	Short of breath	
TAH	Total abdominal hysterectomy	
TDS	Three times a day	
TPN	Total parenteral nutrition	
TWOC	Trial without catheter	
TIA	Transient ischaemic attack	
UGI	Upper gastrointestinal	
USS	Ultrasound scan	
VTE	Venous thrombo-embolism	

Spoke placements.

Bed managers (surgical) – 7043
CVAT – 3410 (3rd only)
Critical care outreach - 3388 (3rd only)
Dietitian – 2467
Diabetic specialist nurse – 2254
ECG – 2253
HALS – 8428
Hot clinic – 1364
Infection control – 2592
Mental health liaison team – 3507
Nutritional nurse – 3057
OT – 3935
Pain team – 3436
Palliative care – 2095
Parkinson's nurse – 3577
Physiotherapy – 3323
Spinal nurse – 2613
Stroke specialist nurse – 2384
SALT – 2426
Upper GI nurse – 4788
Urology nurse – 2979
Vascular nurse – 4606
Theatre - 3389



Specialities.

General Surgery.
Mr Mitchell
Mr Beverage
Mr Parkin
Mr Bhowmick
MR Barrow
Miss Jadav
Mr Peristerakis

Vascular.
Mr Calvey
Mr Riding
Mr Zeynali
Mr Shoab
Mr Spachos
Miss Drinkwater
Mr Egun
Mr Joseph
Mr Banihani

Plastics.
Iyer
McKirdy
Ekwobi
Srinivasin
Dalal
Hamilton
Rimouche
Laitung

ENT.
Mr Ashmmed
Mr Banerjee
Mr DeCarpentier
Mr Varadarajan
Mr Kasirajan
Mr Cardozo

Orthopoedics
Mr Austin
Mr Baker
Mr Baumann
Mr Canty
Mr Howell
Mr Hughes
Mr McEvoy
Mr McLouchlan
Mr Woodruff

Urology
Mr Haq
Miss Blades
Miss McHugh
Mr Zelhof
Mr Mokete
Mr Finney
Mr Javle
Mr Smolski

We work to a colour code system on the whiteboard to easily identify the patients parent team, please familiarise yourself with the teams and the consultants.

Documentation.

Documentation is key for keeping patients safe and is NMC required. Remember <u>“if you didn’t document it, it didn’t happen”.</u>

We must document when the patients arrives into your care, when changes are made to their care plan, if they deteriorate and conversations with them and their families which has an impact on their hospital journey.

Follow these guidelines when writing in your Kardex so nothing is missed!!

<u>Guidance for writing in patients Kardex.</u>

Note about introducing yourself to your patient.

1) How does the patient look?
- Weary? pale?
2) What are their hygiene needs?
- Shower? Have they had a shave? Bed bath?
3) What is the patient’s mobility status?
- Mobile? Mobility aids used? Hoist transfer? Do they need Physio/OT/LIFT?
4) What is their skin integrity?
- Sacrum and heels red blanching? Any pressure sores?
-Waterlow completed over 10? Leaflet, care plan and blower box in situ? SEM reading?
5) Fluid balance and oral intake and output status?
- NBM? CFF? D+F? Voiding? Catheter, NG, stoma, urostomy etc.
6) Is IVI running?
- IV fluids? Sliding scale? Heparin? IV abx? IV fluids checked on quadramed
7) What are the patient’s observations?
- Are they scoring? Does it need escalating? What plan is currently in place?
8) Is the patient in pain or nauseous?
- offer analgesia and antiemetic’s.
9) What is the patient’s management plan?
-A/w senior review? Bloods? Cannula? Any scans? Have you updated their DNAR status?

A-E Assessment.

A – Clear/talking
- Adjunct airway? Tracheostomy/laryngectomy?
- Noisy?

B – Talking in sentences
- Respiration rate – is it normal/fast/slow?
- O2 saturations – requiring oxygen therapy? Cyanosis?

C – Blood pressure – lying and standing? Low/high?
- Fluid resuscitation? Needs medication to reduce high BP?
- Heart rate – fast/slow/regular/irregular.
- Need an ECG?
- Temperature – high/low – any medications?

D – AVPU/ PEARL.
- GCS (15/15)?
- Blood sugar

E – Check skin/rashes/sores/wounds/any blood loss?
- Pain score. Have you given analgesia?

Handing over - SBAR

Patients details.

Why they have come to hospital.

Covid status.

Any allergies?

Is the pt aware/ their family of transfer?

All past medical history.

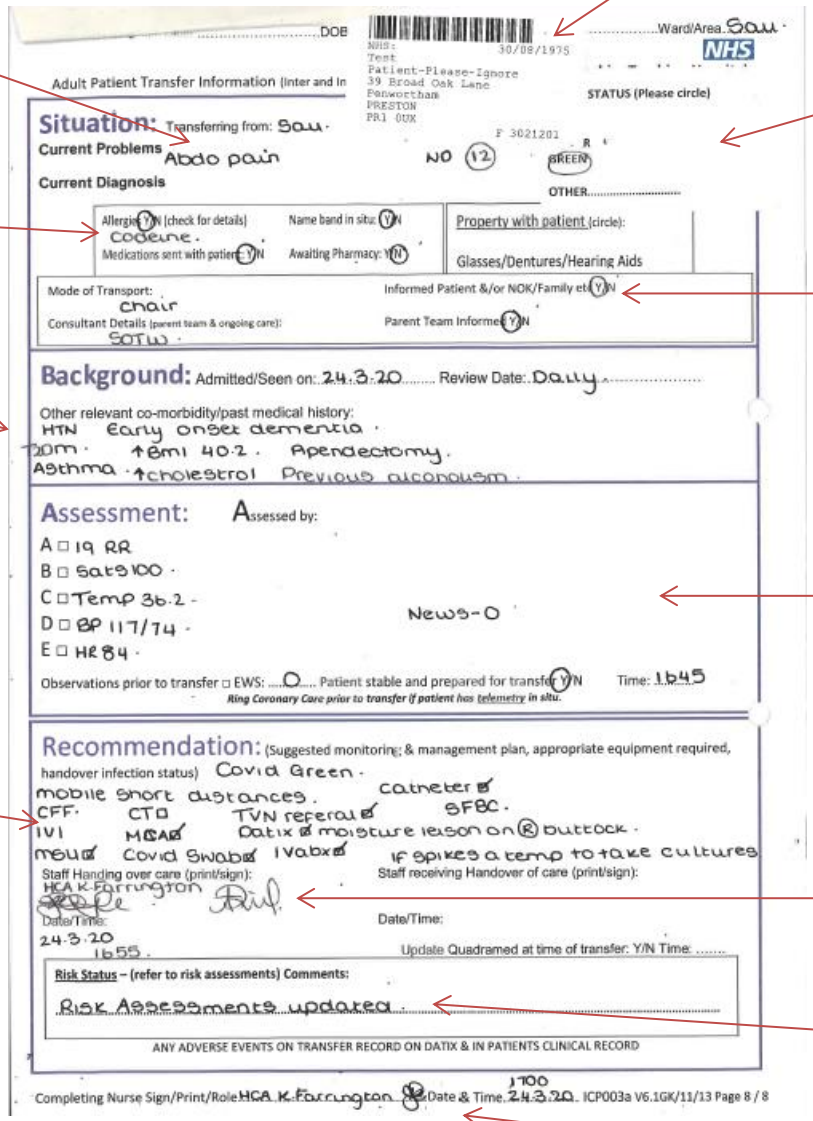
Obs to be recorded 1 hour prior transfer. Are they safe?

Plan:-
Can they E+D?
Any scans?
Mobility?
Fluids?
Antibiotics?
Septic screen?
Mental health assessments?
Pressure damage?
Input/output?

Countersign by SN.

Updated? What is the waterlow?

Sign and date.



DOB 30/08/1975 Ward/Area Saw

NHS

Test Patient-Please-Ignore
39 Broad Oak Lane
Penwortham
PRESTON
PR1 0UX

Adult Patient Transfer Information (Inter and In

STATUS (Please circle)

Situation: Transferring from: Saw

Current Problems: Abdo pain

NO (12) GREEN

Current Diagnosis

OTHER

Allergies Y/N (check for details): Codeine.

Name band in situ: Y/N

Medications sent with patient: Y/N

Awaiting Pharmacy: Y/N

Property with patient (circle): Glasses/Dentures/Hearing Aids

Mode of Transport: chair

Informed Patient &/or NOK/Family etc Y/N

Consultant Details (parent team & ongoing care): SOTW

Parent Team Informed Y/N

Background: Admitted/Seen on: 24.3.20 Review Date: Daily

Other relevant co-morbidity/past medical history:
HTN Early onset dementia
DM ↑BMI 40.2 Appendectomy
Asthma ↑cholestrol Previous alcoholism

Assessment: Assessed by:

A ☐ 19 RR
B ☐ Sat9 100
C ☐ Temp 36.2
D ☐ BP 117/74
E ☐ HR 84

News-0

Observations prior to transfer ☐ EWS: 0 Patient stable and prepared for transfer Y/N Time: 1645

Ring Coronary Care prior to transfer if patient has telemetry in situ.

Recommendation: (Suggested monitoring; & management plan, appropriate equipment required, handover infection status) Covid Green

mobile short distances. catheter ☑
CFF. CT☐ TVN referral ☑ SFBC.
IVI MCA☑ Datix ☑ moisture lesion on ® buttock.
MSU☑ Covid Swabs☑ IVabx☑ If spikes a temp to take cultures

Staff Handing over care (print/sign): HCA K.Farrington

Staff receiving Handover of care (print/sign): Rnf

Date/Time: 24.3.20 1655

Date/Time:

Update Quadramed at time of transfer: Y/N Time:

Risk Status – (refer to risk assessments) Comments:
Risk Assessments updated.

ANY ADVERSE EVENTS ON TRANSFER RECORD ON DATIX & IN PATIENTS CLINICAL RECORD

Completing Nurse Sign/Print/Role HCA K.Farrington Date & Time 24.3.20 1700

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Sepsis.

GIVE 3
> O2
> IV ABX
> IV FLUIDS

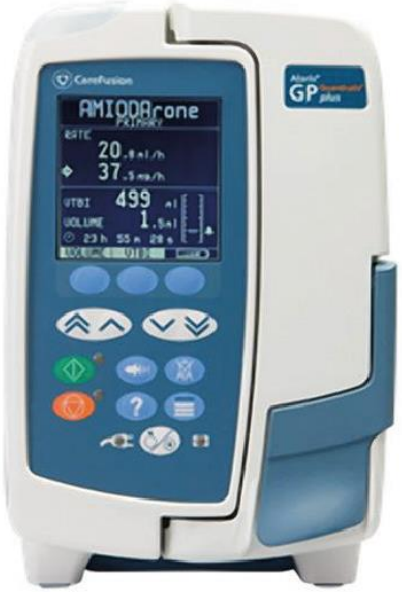
TAKE 3
> LACTATE
> URINE 1HR
> CULTURES

We receive many patients who are diagnosed with sepsis. **Sepsis** is the body's extreme response to an infection. It can be a life-threatening medical/surgical emergency. Sepsis happens when an infection you already have —in your skin, lungs, urinary tract, or somewhere else—triggers a chain reaction throughout your body. It is estimated that sepsis claims 36,800 UK lives annually, and it carries a 35 percent mortality. Sepsis has a 10-fold greater incidence in the over-65s.

Familiarise yourself with the 'SEPSIS 6' pathway. The United Kingdom Sepsis Trust has developed the concept of the 'Sepsis Six'- a set of six tasks including oxygen, cultures, antibiotics, fluids, lactate measurement and urine output monitoring- to be instituted within one hour.

Medical devices.

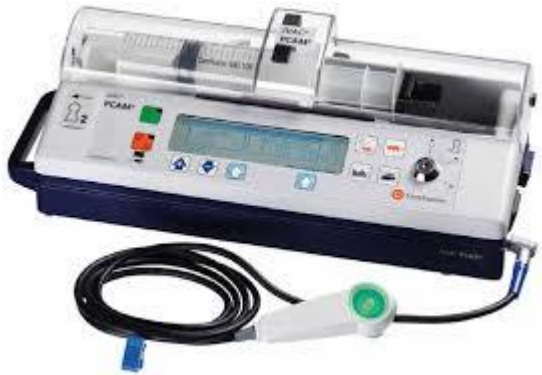
Obs machine – (Mindray)



GP Pump – (Alaris)

GH Pump - (Guardrail)

T34 Pump – (syringe driver)

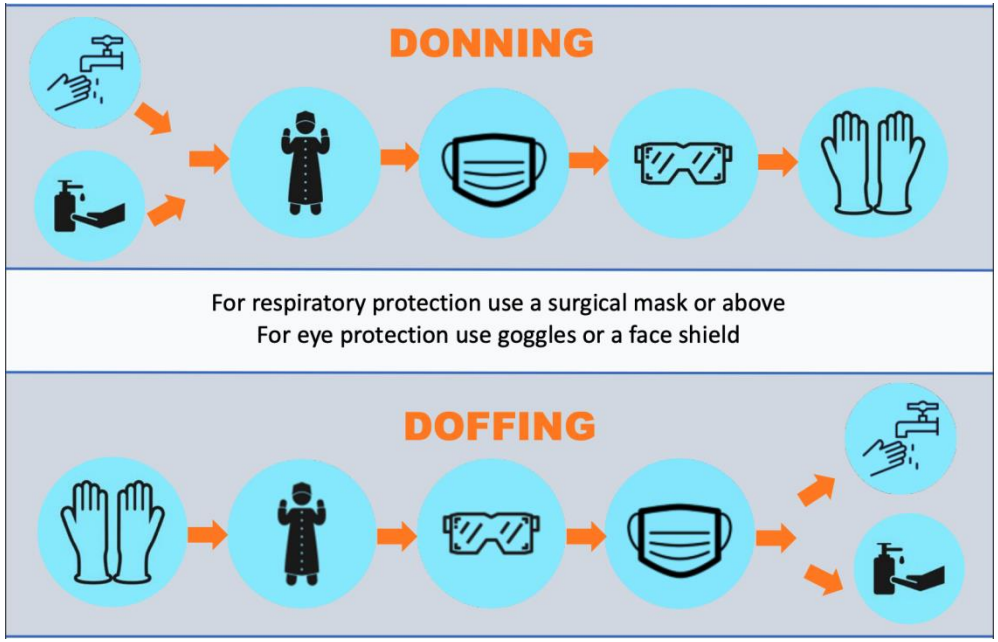


PCA Pump

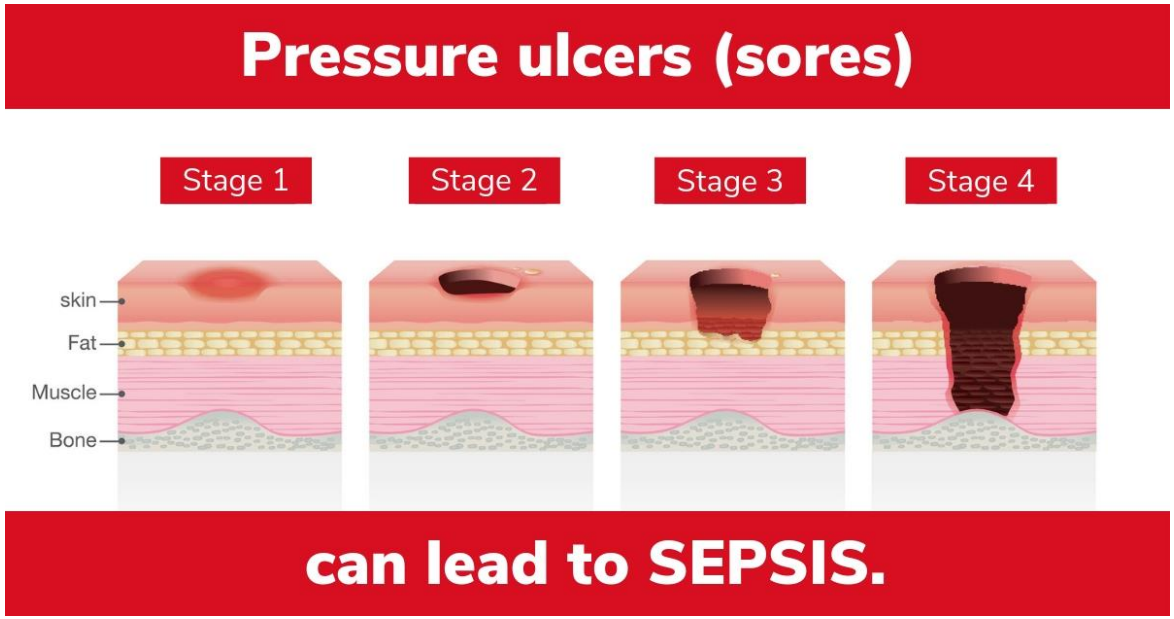
Covid-19.

Covid remains prevalent in the hospital and community. We are required to wear a surgical mask throughout the shift and to maintain a safe distance between staff and patients. Please ensure you have been tested for the FFP3 masks before entering an area of confirmed Covid-19 and wear the correct PPE as per hospital guidelines. Familiarise yourself with the 'Donning' and 'Doffing' process.

We are categorising patients with the traffic light system.
RED = Confirmed Covid 19 from swab or CT.
AMBER = Symptomatic (x2 symptoms), awaiting a Covid swab.
GREEN = Asymptomatic but routinely swab as an inpatient.
BLUE = Contact patient – isolating at home with someone positive or in contact with a red patient whilst an inpatient.



Pressure damage.



When admitting patients we must complete the body map on the paper copy and on quadramed. We should check all pressure areas, especially bony prominences. Above are some examples of the stages of pressure sores. We must datix **GRADE 2** and above **AND** moisture lesions (this can be found on the intranet). Where possible and appropriate, we should dress the sore, contact TVN , document, provide regular pressure area care, complete the pressure ulcer prevention plan, update risk assessments and place a blower box on the end of the bed. Where possible, give patient the pressure ulcer prevention leaflet to be made aware of the sore. Please escalate to the nurse in charge.