The Health Academy

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Core Therapies
(Integrated Occupational therapy and physiotherapy teams)
Student Handbook 2022

Royal College of Occupational Therapists

CHARTERED SOCIETY OF PHYSIOTHERAPY

Welcome to

Chorley Medicine

The Health Academy

Lancashire Teaching Hospitals NHS Foundation Trust

1. Introduction

We hope that you enjoy your time on placement with us at Lancashire Teaching Hospitals NHS Foundation Trust (LTHTR).

We have created this pack as a useful resource to help you to settle in with us. The purpose of this document is to provide you with information to help you on your first visit, as well as serving as a useful reference point until you are familiar with the hospital sites. The document will also help to clarify some questions you may have relating to your clinical work in the department you will be attending.

LTHTR was formed on 1st April 2005. We are one of the largest and highest performing trusts in the country, providing district general hospital services to 370,000 people in Preston and Chorley, and specialist care to 1.5m people across Lancashire and South Cumbria.

We provide care from three facilities:

- Chorley and South Ribble Hospital
- Royal Preston Hospital
- Specialist Mobility and Rehabilitation Centre

We are a regional specialist centre for:

- Adult Allergy & Clinical Immunology
- Cancer (including radiotherapy, drug therapies and cancer surgery)
- Disablement services such as artificial limbs and wheelchairs
- Major Trauma
- Neurosurgery and Neurology (brain surgery and nervous system diseases)
- Renal (kidney diseases)
- Vascular

2. Our placements

We would like your placement to be a two-way learning process between your Clinical Educator and yourself. We are here to support you in becoming a clinician and offer you the opportunities to develop your clinical skills. We expect that you will have a positive attitude to learning, take responsibility for your own learning outcomes and share this with your Clinical Educator.

The placements we offer are

- Acute medicine
- Acute stroke and stroke rehab
- Surgery and vascular
- Oncology
- Paediatrics
- Critical care
- Neurosciences
- Neurology
- Neuro rehab unit (NRU)
- Lancashire Integrated Frailty team (LIFT)
- Hands team (Outpatient)
- Orthotics
- Burns and plastics
- MSK outpatients
- Specialist mobility and rehabilitation centre
- Women's health
- Orthopaedics (Trauma and elective)
- Emergency medicine

Role emerging placements

- Health and well being
- SMRC
- Trauma orthopaedic and acute medicine working with patient's living with cognitive deficits

3. Trust Vision and Values

The Trusts mission is to provide excellent care with compassion.

We have three equally important strategic aims:

- to provide outstanding healthcare to our local communities
- to offer a range of high-quality specialised services to patients in Lancashire and South Cumbria,
- to drive innovation through world-class education, training and research.

We are constantly striving to improve, and working towards becoming an outstanding, high performing organisation.

Our values define who we are and how we behave.

- **Caring and Compassionate** - We treat everyone with dignity and respect, doing everything we can to show we care.
- **Recognising individuality** - We respect, value and respond to every person's individual needs.
- **Seeking to involve** - We will always involve you in making decisions about your care and treatment, and are always open and honest.
- **Team working** - We work together as one team, and involve patients, families, and other services, to provide the best care possible.
- **Taking personal responsibility** - We each take personal responsibility to give the highest standards of care and deliver a service we can always be proud of.

4. Your placement is with the medical therapy team

Team structure

Our Medical Therapy team includes:

- 1 Band 7 PT
- 0.4 Band 7 OT
- 2.6 Band 6 OT
- 1 Band 6 PT
- 2 Band 5 PT
- 1 Band 5 OT
- 2.4 Integrated Therapy Assistants

We cover the following speciality areas across medicine:

- Respiratory Medicine
- Renal
- Gastroenterology
- Cardiology
- Endocrine
- Elderly Medicine

Working hours, facilities & contact number

- Our working hours are 8am – 4pm
- We have male and female locked changing facilities available
- Lockers are available, please let your educator know if you will require one.
- Our office contact number is 01257 245176 – please contact this number if you require any additional information prior to starting your placement
- Sickness absence should be reported on the above number to your clinical educator at 8am

5. Directions

Chorley and South Ribble District General Hospital
How to find us - by car: From the M61 motorway:
Directions to the hospital are well sign-posted on public highways from all directions. The hospital site is situated within three-quarters of a mile from junction 8 of the M61 motorway. When leaving the motorway at Junction 8, follow signs towards Chorley (A6) along short dual carriageway. At the first roundabout, turn left, continuing to head towards Chorley (A6). At the second roundabout, take second turning onto the B5252 (Euxton Lane). The main hospital entrance is 200 yards on the left at the traffic lights.
Alternatively, input **PR7 1PP** into your SatNav

Car parking:
Chorley and South Ribble Hospital has three main public car parks. Please park in one of these on your first day.
Please complete and return the car parking permit form. We will endeavour to secure you a car park permit that you will be able to collect from the car parking office at CDH 2-3 days later.
How to find us - by local transport:
Bus service
Bus services to and from Chorley and South Ribble Hospital are as follows:
Numbers: 114 119 125 126 210 301 302 C8 C9. For more information contact Chorley Bus Station on: 01257 241693.
Disabled access:
All entrances to Chorley and South Ribble Hospital are accessible by wheelchair, either by being on ground level and/or having low gradient ramps. The hospital also has lifts to all floor levels.
Patients and public are advised that should they require assistance once they reach the hospital, they should contact the Main Entrance Reception (General Office) on 01257 245661 who will arrange staffing assistance.

There is a shuttle bus service between both sites which students can use. Please request the timetable if you would need to use this to travel between the two hospital sites at the start and end of your day.

6. Food, Dining Facilities and other essentials

Chorley Hospital
Costa Coffee 9am-4pm, by fracture clinic and near to out patients. Serves hot drinks, sandwiches and snacks
Café Education centre 3 Mon-Fri- Serves breakfast, hot food lunchtimes, sandwiches and snacks
RVS shop by main entrance serves sandwiches, snacks, drinks, newspapers and toiletries

Both sites have a cash point near the main entrances

7. Learner Support and Wellbeing

The mental wellbeing of our students is of paramount importance. We understand that there are a lot of plates to spin while you are undergoing your training, be it holding down a part-time job, having dependants at home, having assessment deadlines running along clinical practice, financial issues, dealing with matters of conflict or struggling with some aspects of the clinical learning to name a few.

Our experienced Learner Support Team can offer advice, guidance and support to all students, trainee doctors, apprenticeship HCA's and other learners.

Support with;

- Academic / Health / Personal / Conduct / Placement Issues — to name a few!
- Are you finding work / training difficult due to health, family or personal issues? Please tell us, we can help.
- Have you concerns with regards to your current placement, lack of teaching, supervision or rota issues?
- Concerns with regards to patient wellbeing? It won't change unless you tell someone.
- Have you been subject to or witnessed bullying, discrimination or harassment during your placement? It needs to stop.
- Are you worried about a trainee or student for whatever reason and not sure who to contact?
- Has a trainee, student or clinical supervisor / teacher / member of staff really impressed you? — Please let us know!

You can contact us

Learner.Support@lthtr.nhs.uk

01772 528444

8. What to bring on your first day

- Uniform: Please **do not** attend in your uniform, instead bring one set of uniform with you. All other items in the dress code policy must be adhered to
- A smallish bag which would fit into a small locker.
- You may wish to bring a packed lunch and a drink on your first day
- If you are on a respiratory placement please bring a stethoscope with you

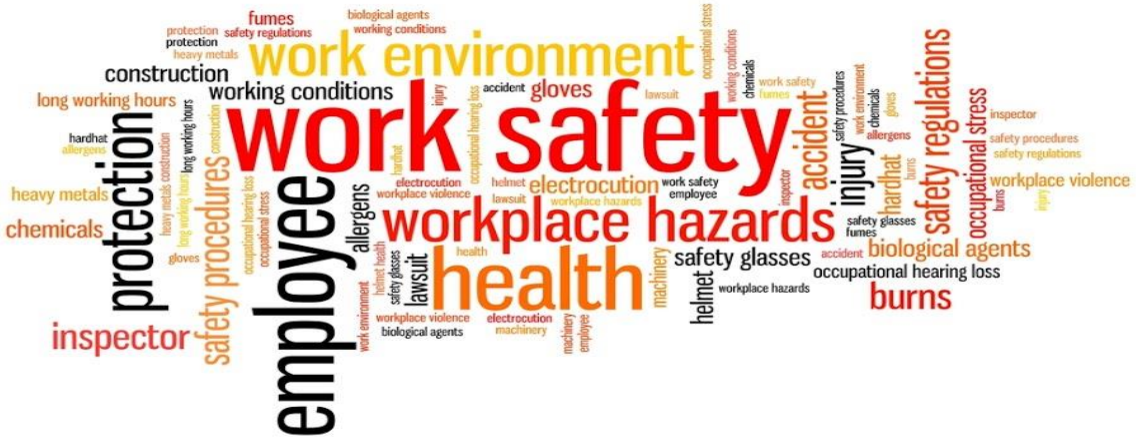
9. Induction

The Local Induction process will take place throughout the first two weeks of your placement.

This will comprise of:

- Trust and department orientation, including housekeeping information
- Location of emergency equipment
- IT access

- Reading & Acknowledgement of mandatory Trust policies such as Health & safety, Fire Safety, Infection Control, ID, Information Governance, Staff Code of Conduct, Social Networking and Dress Code policies.
- Adult Basic Life Support training if applicable.
- Trust Moving & Handling Training if applicable.
- COVID-related policies & procedure



10. Your placement

Prior to starting your placement please contact your allocated clinical educator. Here they will be able to advise you which speciality within medicine you will be allocated to. We have provided an overview of the caseload of patients you will be treating to direct your pre-placement reading.

Respiratory Ward

Caseload of patients:

- COPD
- Bronchiectasis
- Asthma
- Pulmonary Fibrosis
- Pleural effusions
- Pneumothorax
- Lung cancer patients
- Critical care step down patients
- See Respiratory Physiotherapy assessment within document

Learning opportunities

- Respiratory assessments
- Identification of appropriate management/treatment plans
- Secretion management – ACBT, Aerobika, Flutter, Manual techniques, Cough Assist, IPPB
- Patient education on self management – exacerbation avoidance, breathlessness management, energy conservation
- Functional assessments of mobility
- Equipment provision to optimise and maintain independence and ease of completing activities of daily living
- Routine and complex discharge planning
- Shadow Home First Discharge service
- Multidisciplinary working
- Develop strong communication skills with patients, relatives, secondary sources and appropriate members of the MDT

Cardiology

Caseload of patients:

- Myocardial Infarcts
- Heart failure
- Pulmonary Oedema
- Post pacemaker
- Angina
- Postural Hypotension
- Acute Kidney Injury

Learning opportunities:

- Shadow Cardiac Rehab
- Shadow Cardiac Nurses
- Post op requirements following interventions
- Functional assessment
- Patient Education
- Equipment provision to optimise and maintain independence and ease of completing activities of daily living
- Routine and complex discharge planning
- Shadow Home First Discharge service
- Multidisciplinary working

- Develop strong communication skills with patients, relatives, secondary sources and appropriate members of the MDT

Gastroenterology

Caseload of patients:

- Liver cirrhosis
- Hepatic Encephalitis
- Ascites
- Alcohol excess
- Crohns
- Irritable Bowel Syndrome (IBS)
- Constipation
- Acute/Chronic Pancreatitis
- Gall bladder disease
- Eating disorders
- Critical care step down patients
- Cancer: Colorectal, gall bladder, pancreatic, Oesophageal

Learning opportunities:

- Opportunity to shadow Hospital Alcohol Liaison Team
- Functional assessment
- Cognitive screen and assessments
- Patient Education
- Equipment provision to optimise and maintain independence and ease of completing activities of daily living
- Routine and complex discharge planning
- Shadow Home First Discharge service
- Multidisciplinary working
- Develop strong communication skills with patients, relatives, secondary sources and appropriate members of the MDT

Endocrine

Caseload of patients:

- Diabetes
- Adrenal insufficiency
- Addisons disease

- Cushing syndrome
- Hyperthyroidism
- Hypothyroidism
- Hashimoto Thyroiditis
- Grave disease

Learning opportunities:

- Shadow Home First Discharge service

Elderly Medicine

Caseload of patients:

- Falls
- Fractured neck of femur patients
- New confusion
- Delirium
- Dementia
- Long standing neurological conditions eg. Parkinsons
- Functional decline
- Critical Care Step downs

Learning opportunities:

- Shadow falls team
- Shadow Frailty Team
- Shadow Home First Discharge service
- Functional assessment
- Cognitive screen and assessments
- Patient Education
- Equipment provision to optimise and maintain independence and ease of completing activities of daily living
- Routine and complex discharge planning
- Multidisciplinary working
- Develop strong communication skills with patients, relatives, secondary sources and appropriate members of the MDT

11. Documentation

Within the trust we follow the **SOAP** format for all therapy documentation. Below we have attached a prompt sheet for you to familiarise yourself with.

You can also print this page as a visual prompt to assist your note writing.

SOAP Notes

Heading

Profession Specific or Joint assessment – please include all members of staff present for treatment session. Eg:

Joint session – Physiotherapy & Occupational Therapy – J.Bloggs (StPT), T.Smith (B6PT) & B.Thompson (B5OT).

S: Subjective Assessment

- Consent – Verbal, non-verbal or in patients best interests
- Include any information handed over by members of staff – Eg. Fall overnight, is awaiting an xray
- Include anything else the patient reports if clinically relevant

***** When completing an initial assessment with a patient is it recommended to review and include the following information:***

HPC: History of presenting condition

- What has led to this hospital admission
- What are they currently being treated for
- What is their current management

PMH: Past medical history

- Include all past medical history – this is usually available on the doctors clerking in entry in A&E or in the daily ward round notes

SH: Social History

- Where does the patient live?
- Who do they live with?
- What kind of property is it? - Does it have steps to access, do they need to complete stairs, where are their bathrooms located?
- Do they have any equipment? – Grab rails, commode, raised toilet seat, bathing equipment (shower over bath or walk in shower, bath seat/rails), bed lever, elevated bed rest.
- How do they usually transfer: in/out of bed, on/off the toilet, out of a chair
- How do they usually mobilise? – Stick, frame, returner, hoist, bedbound?

- Can they complete their own personal care?
- Can they complete their own activities of daily living?
- Do they have any support from family or a formal care package?
- How is their cognition?
- Have they been coping prior to admission? Have family raised any concerns?

O: Objective assessment

- ***Please see additional section for respiratory assessment***
- Have they had their vital signs checked recently?
- Are they stable for therapy input today?
- How do they appear in bed?
- Check active range of movement of limbs and muscle power – document any weakness deficits
- If unable to complete active range of movement review their passive range

Rx: Treatment

- What treatment have you completed during the session? *Please note this is not an extensive list*

This could include the following:

- Personal care assessment
- Cognitive assessment
- Orientation
- Bed exercises
- Bed transfer
- Sit to stand
- Chair transfer
- Mobility

Be sure to include required amount of staff to complete functional sections. For example: sit to stand from bed with minimal assistance of 2.

A: Analysis

- Identify the patient's problem list – eg: muscle weakness, variable sitting balance, reduced exercise tolerance, fear of falling ect.
- Clinically reason why you think this is their presentation
- Analyse any response to treatment
- How did they tolerate the session? How did they engage?

P: Plan

- SMART goals for patient
- Specific therapy plan for next session – *aim to progress mobility from 3m with wheeled zimmer frame to functional distance required for home*
- Recommendations for ward staff – *Patient can sit out with assistance of 2 for all meals / can use the bedside commode for toileting*

** It is your responsibility to ensure all documentation is countersigned **

Respiratory Physiotherapy Assessment

What information do I need to know?

Information gathering is crucial before completing an assessment of your patient. This can be done over the phone from the referrer or from the patient notes.

History of Presenting Condition (HPC):

- What has the patient come to hospital with?
- Overview from admission to Physiotherapy referral
- Onset of respiratory symptoms
- What treatment have they had / are currently having?

Past Medical history (PMH):

- Do they have any long term respiratory conditions?
- What is their usual volume and colour of sputum?
- Are they on home NIV/CPAP?
- Are they set up on any physio adjuncts ? Eg. Cough assist, LVR bag, Aerobika
- Are they known to any outpatient/Community respiratory services? Eg. Vent team, MND, Community COPD
- Do they have a cardiac history?
- Any other medical conditions?

Drug History:

Pre admission medication:

- Do they have inhalers?
- Are they on home nebulisers?
- Are they on mucolytics?
- Any Analgesia (oramorph/diazepam)?
- Diuretics?

Review this admissions medications:

- Inhaler- check they have the correct technique
- Are they on Saline Nebulisers?
- What bronchodilators are they on ? (Salbutamol, Ipratropium, aminophylline, Magnesium)
- Any analgesia?
- Mucolytics?
- Cardiac medications?
- Anticoagulants ?

Social History:

- Property type and who they live with
- Exercise tolerance/Mobility
- Ability to complete ADLS
- Smoker/Ex smoker
- Are they on long term oxygen therapy? (LTOT)

****It is also useful at this point to know your patients ceiling of care and escalation plan****

Patient assessment

Completing an A – E Assessment will give you a comprehensive overview of the patient to allow you to identify their main presenting problem and to clinically reason an appropriate treatment.

A – Airway

B – Breathing

C – Circulation

D – Disability

E – Exposure / Environment

(A) – Airway

Is the Patient maintaining their own airway

- Is the airway patent?
  - Comfortable breathing with no upper airway added sounds, indicates a patent upper airway
  - Non patent airways can present with stridor
- Is it occluded?
  - Please optimise the patients head position into neutral wherever appropriate. Rolled towels can be helpful to aid positioning

- Inserting an Nasal or Oral airway can be beneficial to maintain the patients airway if they are appropriate to insert.
- If they are not maintaining their own airway they need escalating to the critical care team and resus team as they are at risk of a peri arrest

• Do they have a Tracheostomy ?
- What model is it? (eg Tracho twist, Trachoe Twist plus)
- What size is it? This is stated on the back plate of the tracheostomy and will determine your suction size choice.
- Is it cuffed or uncuffed? Is the cuff inflated?
- Check what inner tube is in situ – fenestrated or unfenestrated?

(B) Breathing

• What respiratory support is the patient on?
- Simple Facemask - *How many litres are they on?*
- Nasal cannula – *How many litres are they on? Are they a nose or mouth breather?*
- Venturi Mask – *What % and flow are they on?*
- HFNCO – *What litres and flow are they on?*
- CPAP/NIV – *What pressures and oxygen support are they on*

- Check the recent chest xray & compare to any previous films if available

Look:

- What is the patients respiratory rate?
- What is their Work of breathing?
- What is their Pattern of breathing?
- Are they using any accessory muscles?
- Any signs of fatigue or apnoea?

Listen:

- Auscultate!
- Do they have air entry throughout? Which lobes have reduced air entry?
- Do they have any added sounds? Which lobes are the added sounds present?

Description	Sounds	Potential Causes
Normal Breath Sounds	Soft and low pitched, should be heard throughout the lung fields	Normal Breathing – air passing through large & small airways
Coarse Crackles	Bubbling	Air passing through secretions
Fine Crackles	Crumpling of tissue paper	Pulmonary Oedema, Pulmonary Fibrosis
Polyphonic Wheeze	High pitched & musical	Narrowing of the airways – eg. COPD or Asthma
Monophonic wheeze	Single tone wheeze	Large airway narrowing – eg. secretions, tumour or foreign body

Pleural rub	Friction of pleural rubbing together. 'Walking on snow'	Pleural effusion or pneumonia
Absent sounds	Nil audible	Collapse, consolidation, pneumothorax, lobectomy
Stridor	Upper respiratory tract wheeze/snore	Inability to maintain upper airway

Feel:

- Assess the patient's chest expansion

– Are they getting equal expansion, does Left = Right
- Are they gaining basal expansion?
- Are there any palpable secretions?
- Where can you feel the secretions?
- Any surgical emphysema present?

(C) Circulation

- Heart rate
- If the patient is bradycardic or tachycardic be mindful of their stability for treatment
- Blood pressure
- Be mindful of low blood pressure if you are completing treatments that will change intrathoracic pressure as this will increase blood flow resistance and drop blood pressure further
- In hypertension patients be mindful treatment choices may aggravate patients and elevate this further
- Capillary refill
- A time of > 2 seconds can indicate hypoperfusion
- Overall are they haemodynamically stable enough to treat?

(D) Disability

- Alertness
- GCS or AVPU
- What is the cause for the drop in consciousness? If this is new then please escalate to the medical team for urgent review
- Fluid balance
- Is there a cardiac element of their symptoms? Are they fluid overloaded? Are the dehydrated?
- Bloods
  - Blood results can give you an indication of inflammatory responses with white cell count (WCC) and CRP results

  - HB – this is the haemoglobin in the patient's blood, this is important for oxygen transport to your organs. A low count can result in symptoms of shortness of breath
  - Platelets – Are they appropriate for airway insertion or manual techniques
- Blood sugars

– low blood sugars may result in drowsiness and confusion

- Temp
  - Can indicate an infective cause of patient symptoms

(E) Exposure / Environment

- Attachments – chest drains, IV's, catheter, slings/braces

- Position – in bed or chair

12. Reflections

Reflective templates for both the Gibbs' and Kolb reflective model cycles have been included for your use, but you may use others if you already have a preferred model.

Please share regular reflections with your educator to demonstrate consolidation of your learning.

Gibbs' 1998 Reflective Model

Description of the experience
Feelings and thoughts about the experience
Evaluation of the experience, both good and bad
Analysis to make sense of the situation

Conclusion about what you learned and what you could have done differently
Action plan for how you would deal with similar situations in the future, or general changes you might find appropriate.
Gibbs, G. (1988) Learning by Doing: A guide to teaching and learning methods. Further Education Unit. Oxford Polytechnic: Oxford.

Kolb's 1984 Reflective Model

Concrete Experience (Doing/ having an experience)
Reflective Observation (reviewing/ reflecting on the experience)
Abstract Conceptualisation (Concluding/ learning from the experience)
Active Experimentation (planning/ trying out what you have learnt)

Kolb, D.A. (1984) Experiential Learning: Experience as the Source of Learning and Development. New Jersey: Prentice-Hall.

SWOT Analysis

Please complete this in your first week and provide to your clinical educator.

Strengths	Weaknesses

Opportunities	Threats

The Health Academy

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust