

Welcome to D7

Gastroenterology and Hepatology Ward.

(30 bedded unit including 4 siderooms and soon to include a
GI bleed and Liver Unit.)

Student Nurse Pack

Student Name:.....

Mentor:.....

Buddy:.....

Uni Link:.....

Ward Information

Ward Manager: Nanette Kinnaird

Ward Sisters: Zayla Estales, Karen Roberts, Neide Campos and Roxanne Meade

Student Link nurse: Zayla Estales

Telephone: 02381 206506

Matron: Tracey Aldin

Shift times:

Early- 0730- 1530 (inc 30min break)

Late – 1200-2000 (inc 30 min break)

Long day- 0730-2000 (Inc 2x 30 min breaks)

Night – 1930-0800 (inc 1 hour break)

If you are sick please contact the ward directly and the university.

MDT members:

- **Therapy staff- inc Physio and OT**
- **Alcohol Nurse Specialist**
- **Gastro/ Hep Nurse practitioners**
- **Inpatient Diabetes Outreach Team (IDOT)**
- **Discharge Officer and Senior discharge practitioner**
- **Doctors**

Daily Routine.

07:00 – Sit patients up/out for breakfast

07.30 - Handover to day staff including allocation of teams and meal-time coordinators for the day. Key nurses to meet with and review patients for whom they are responsible.

08.00-09.00 - House keeper/CSW to attend as meal time coordinator.

08.20- NIC to complete board round with Therapy staff

08:30 - RN to start drug round and check charts, CSW to assist with feeding, Catch up on any outstanding morning observations.

09.00- Turns due

10.00 - Teams to work together to deliver patient care, include turns, Discharge Planning, all staff to complete fluid charts and Turnaround.

10.30- Morning huddle to catch up on staff progress.

11.00- Lunch breaks start- half hour each. Turns due- sit out for lunch.

12.00 - Late shift - bedside handover. Protected meal times 12.00-13.00, assist with feeding. House keeper/CSW to attend as meal time coordinator.

13.00 - Lunchtime drugs, check charts. Turns due- back to bed for rest.

14:00 - 15:00 Rest Period for patients, lights out and curtains closed if able.

14:00 - HCA to support RN with observations, MUST, and other assessments. RN to complete nursing notes.

15:00 - MDT referrals. Turns due.

- Nurse in Charge to attend board round with MDT

15:30 - Early staff home. Team Huddle to review updates and teaching.

16:00 – PM breaks to start.

17:00 – Turns due, sit out for dinner.

17:30- RN Drug round and IVs, HCA to attend to patients needs, and assist with feeding. Protected meal time 17.00-18.00, HCA to attend as meal time coordinator.

18:30 - Late staff to complete documentation, inc check charts, fluid complete patient core and turns.

19:00 - RN to feedback to Nurse- in-charge and update handover sheets. Turns ongoing.

19:30 - Handover to night staff.

20:00 - Night Nurse-in- charge to allocate workload, all staff to do observations and start settling/turns. HcA to complete hot drinks round.

20:45- 2230- RN drug round and IVs, HcA to continue settling/turns.

01:00 - Breaks to start- 1 hour each. Patient turns due.

03:00 – Turns due

04:00 - updating of any outstanding assessments. Patient care as required.

05:00 - new fluid charts and turn around charts. Turns due.

06:00 - as above Inc observations. Patient core and turns.

07:00 - update handover sheet. Turns due- sit people up for breakfast.

Common Procedures

Barium enema

A barium enema is a test that helps to highlight the large bowel so it can be clearly seen on xray. During the test, a white liquid called barium sulphate is given as an enema. It can be used in diagnosing ulcerative colitis and Crohn's disease, diverticulosis and intussusception.

Colonoscopy

Colonoscopy is the endoscopic examination of the large colon and the distal part of the small intestine with a camera on a flexible tube passed through the anus for the visual diagnosis of polyps or ulcerations and for biopsy or removal of suspected lesions. Usual indications include gastrointestinal haemorrhage, sudden changes in bowel habits and suspected cancer. Colonoscopy can be used to diagnose colon cancer and inflammatory bowel syndrome.

Flexible sigmoidoscopy

Flexible sigmoidoscopy is a test that uses a flexible, narrow tube with a light and tiny camera on one end, called a sigmoidoscope or scope, to look inside the rectum and the lower, or sigmoid, colon. It can show irritated or swollen tissue, ulcers, and polyps.

Oesophagogastroduodenoscopy (OGD)

Also known as gastroscopy or endoscopy, this is an examination of the oesophagus, stomach and the duodenum. A thin, flexible tube called an endoscope is used to look inside. The diseases most commonly sought by endoscopy are reflux oesophagitis, oesophageal varices, oesophageal cancer, gastric ulcer, gastric cancer, duodenal ulcer, and coeliac disease.

Capsule Endoscopy

Capsule endoscopy involves swallowing a small capsule, which contains a colour camera, battery, light source and transmitter. The camera takes two pictures every second for eight hours, transmitting images to a data recorder about the size of a portable CD player that patients wear around the waist. It assists in diagnosing GI conditions in the small bowel such as: bleeding, malabsorption, chronic abdominal pain, and chronic diarrhoea.

Manometry

Manometry is measurement of pressure within various parts of the GI tract. It is done by passing a catheter containing solid-state or liquid-filled pressure transducers through the mouth or anus into the lumen of the organ to be studied. It is done to evaluate motility disorders in patients.

Endoscopic ultrasonography (EUS)

A thin, flexible tube called an endoscope that has a built-in miniature ultrasound probe is passed through the mouth or anus to the area to be examined (usually oesophageal and stomach linings as well as the walls of the upper and lower GI tract.) It also allows for very detailed imaging and analysis of the pancreas.

Endoscopic Retrograde Cholangiopancreatography (ERCP)

This procedure allows diagnosis and treatment of problems in the liver, gallbladder, bile ducts, and pancreas. The procedure combines xray and the use of an endoscope. The scope is guided through the patient's mouth and throat, then through the oesophagus, stomach, and duodenum. A tube is then passed through the scope, and a dye is injected that will allow the internal organs to appear on an xray.

Magnetic Resonance Cholangiopancreatography (MRCP)

This test uses MRI to obtain pictures of the bile ducts. The machine uses radio waves and magnets to scan internal organs and tissues.

List of Common Drugs

Benzodiazepines like Chlordiazepoxide, diazepam, lorazepam, oxazepam

Pabrinex, thiamine, Vit B compound

Naltrexone, acamprosate, topimaratate

Immunosuppressants such as ciclosporin and tacrolimus

Creon

Albumin, HAS

Terlipressin, Tranexamic acid, Propranolol

Proton pump inhibitors e.g. pantoprazole, Esomeprazole, Lansoprazole

Electrolyte replacement drugs like Sando k, magnesium glycerophosphate, phosphate Sandoz

Rifaximin

Mesalazine

Senna, Lactulose, Bisacodyl, Magnesium Hydroxide

Furosemide, Spironolactone, Bumetanide

Metoclopramide, Cyclizine, Ondansetron

Acamprosate

Common diseases

Below are outlined some of the more common problems encountered in the ward setting. It is up to you to study them in more detail!

Gastrointestinal

Peptic Ulcers - these are lesions that develop throughout the GT tract. Most occur in the pylorus or the duodenum. Major causes include Helicobacter Pylorii infection, Non-steroidal anti-inflammatory drugs, and hypersecretion of HCl (Zollinger-Ellison Syndrome). Treatment includes PPIs, antacids, H2 Blockers and antibiotics. The most common complications are haemorrhage, perforation and malignant transformation.

Inflammatory Bowel Disease - non-specific inflammatory disorders of the GT tract of unknown aetiology. Complications include stricture formation, adhesions, perforation, abscesses and increased risk of malignancy.

Crohn's - Inflammation involves all the layers of the bowel wall. Lesions are 'patchy' and can occur in any part of the bowel. The bowel becomes oedematous, fibrotic and ulcerated. Patients complain of abdominal pain, diarrhoea and fever. Malnutrition and malabsorption are common.

Ulcerative Colitis - This disease is limited to the large intestine. Inflammation is usually continuous, affects only the mucosa and tends to cause thinning of the bowel. Patients may complain of chronic diarrhoea and rectal bleeding. This is a disease of relapses and remissions.

Malabsorption - Patients with gastrointestinal disorders often suffer from malabsorption and require parenteral feeding. This could be done via nasal tubes, PEGs or with TPN via a central line. We have a specialist nutrition team that supports us with these patients.

GI Bleeds - Patients suspected of having a gastrointestinal bleed can be extremely unstable and need close monitoring.

Hepatic

Acute liver failure - occurs when there has been damage to the majority of hepatocytes (liver cells), causing liver function to be impaired. Causative factors include damage by metabolites, systemic shock or a decline of chronic disease. It is fatal in 80% of patients.

chronic liver failure - inflammation of the liver persisting for more than 6 months. It may result in cirrhosis and cholestasis (failure of bile to reach intestine).

Acute hepatitis - can be caused by a number of agents, including viruses (A,B,C,D), bacteria, drugs, toxins, metabolic disorders or ischemia.

Chronic hepatitis - there are several types including autoimmune (more common in women) and those secondary to B/C viral infection (more common in men aged >30).

Alcoholic liver disease - alcohol is metabolized primarily by the liver. When intake is excessive, the liver is unable to fully metabolise toxins produced and damage occurs. If intake is not curtailed, fatty changes will progress to cirrhosis. It can be successfully managed by cessation of alcohol consumption, good nutrition and treatment of clinical features.

Manifestations of liver disease

Jaundice - yellow pigmentation of the skin and sclera of eyes caused by excess bile pigment deposition. can cause irritation and itchiness.

Ascites - accumulation of fluid in the peritoneal cavity.

Hepatic encephalopathy - biochemical disturbance of brain function due to

raised levels of blood toxins that the liver has been unable to metabolise. Ranges from mild changes in personality, intellect etc. to complete coma. Usually reversible. Classification is as follows;

Grade 1 - confused, altered mood or behaviour

Grade 2 - Drowsy, inappropriate behaviour

Grade 3 - Stupor, inarticulate, marked confusion

Grade 4 - Coma, unrousable

Portal hypertension - prolonged elevation of the portal venous pressure due to congestion or obstruction in the liver. It leads to a build up of Pressure in the structures behind it (spleen and gut anastomoses) causing splenomegaly and oesophageal varices.

cirrhosis - normal liver tissue is replaced by regenerated cells and collagen fibrosis

Definition of some Gastro/Renal terms

Anuria - cessation of the excretion of urine

Dysphagia - difficulty in swallowing

Dysphasia - loss/impairment of power to use or understand language

Dyspepsia - disturbed digestion

Dysuria - difficulty passing urine

Hematemesis - vomiting of blood (bright red or 'coffee ground')

Haematuria - presence of blood in the urine

Haemodialysis - process of removing metabolic wastes, toxins and excess fluids from the blood and replacing with essential blood constituents

Hepatomegaly - enlargement of the liver

Melena – dark, tarry stools indicating the presence of blood

Nephrosis - describes any deteriorating changes in the kidney

Oliguria - low urine output (less than 1 ml/kg/hr)

Polyuria - excessive excretion of urine

Proteinuria- presence of protein in urine

Splenomegaly - enlargement of the spleen

Uraemia - Presence of urea in blood