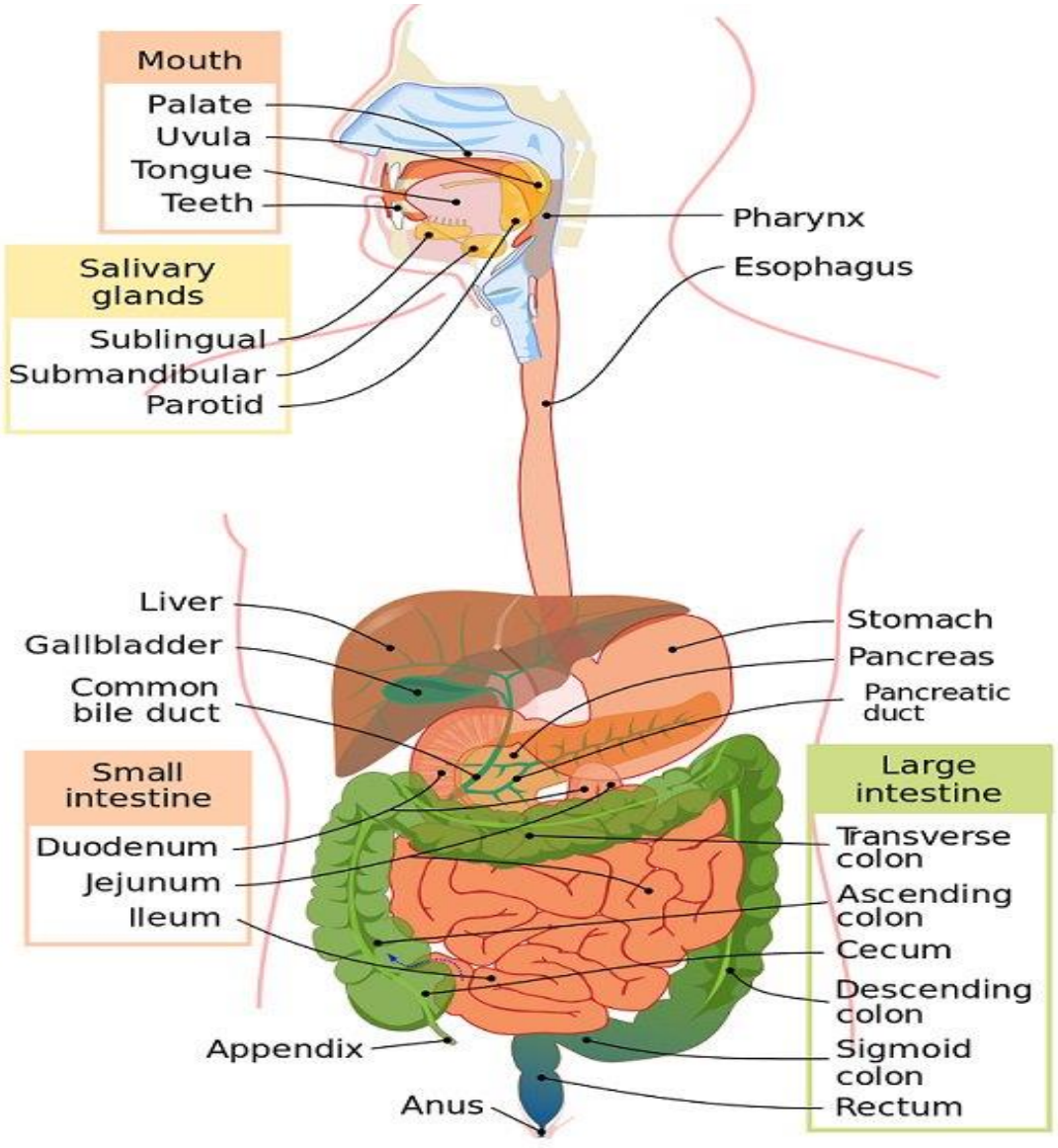
WARD D8

Gastroenterology, Hepatology and Renal.

Student Handbook



Student Name:

Practice Assessor:

Practice Supervisor:

Your first 2 weeks off duty:

Monday	***Tuesday***	***Wednesday***	***Thursday***	***Friday***	***Saturday***	***Sunday***
Monday	***Tuesday***	***Wednesday***	***Thursday***	***Friday***	***Saturday***	***Sunday***

Our ward contact details are:

Main Ward Telephone number: - 02381206506 or 02381204625

Office Telephone number: - 02381281204624

Extension 6506/4625 whilst within the hospital

We are a 24 bedded unit comprising of 4 bays and 2 side rooms for isolation. We have mainly gastro, hepatology and renal patients; however there could be patients with other medical conditions.

To promote patients privacy and dignity we practice same sex accommodation. D8 is predominantly a male ward however female patients are sometimes admitted to the side rooms.

Our Matron is Katie McEvoy and our Ward Leader is Sandra Souto. There are 4 other ward Sisters; Viv Hudson, Neide Almeida, Shukri Hassan and Alison Worsfold who are happy to provide support and advice.

Student Details

Name: _____

Address: _____

_____

Contact Number: _____

Email address: _____

NOK details

Name: _____

*Relation:*_____

Contact Number: _____

The off duty is completed with approximately 6 weeks in advance; you may request 6 duties/days off within a four week period.

Shift Patterns

Early- 07:30-15:30

Late- 12:00-20:00

Long day- 07:30-20:00

Night- 19:30-20:00

Most staff works a pattern of 2 short days and 2 long days a week. You can work 5 short shifts if you would like.

Sickness and absence

If you are unable to attend your rostered shift due to sickness you must telephone the ward at your earliest convenience and all sickness or absence must be made up. Preferably on the placement you are attending at the time.

Please give a contact number to Kusam (ward secretary) just in case the ward needs to contact you.

If you do not arrive on the ward when you are expected with no phone call, we have no choice but to contact the University.

Appearance

We expect you to arrive on the ward in a timely manner in your correct uniform and shoes with your ID badge on view.

Ward Routine

Day Shift	
07:30-08:00	*Handover of shift*
08:00-09:00	*Morning drug round and patient breakfast*
09:00	*Patient care (continues throughout the morning)*
09:30	*Dr's ward round*
12:00	*Late shift arrive and handover*
12:00-12:30	*Lunch time*
13:00	*Drug round*
14:00	*Board round and rest period*
15:00-20:00	*Update paperwork*
17:00	*Drug round and supper time*
19:30-20:00	*Handover to night staff*

Night Shift	
19:30-20:00	*Handover of shift*
20:00-21:00	*Observations and settling patients*
21:00	*Night time drug round, and tidy trolleys*
06:00	*Observations*
07:30-08:00	*Handover to day staff*

Learning Opportunities

As well as your regular clinical experiences on D8 there are other learning opportunities that you may wish to access. If you have a particular interest or learning need, please discuss this with your supervisor as soon as possible so the necessary plans can be made.

There are a growing number of specialist nurses in the hospital, most of whom are happy to have students accompany them for a day if sufficient time is given to arrange this.

- *Nutrition support nurse - (attached to nutrition team - bleep 2082)*
- *Stoma Nurses - x 6601, bleep 2077*
- *Tissue Viability nurses - x 8628, bleep 9236*
- *Outreach Team (Critical care nurses) - blp 9191 (third year students only)*
- *Alcohol dependency nurses – blp 1808*
- *Discharge facilitator –*
- *Alcohol specialist nurse*
- *Physiotherapy, occupational therapy, speech and language therapy and dietician colleagues visit the ward regularly and are usually happy to spend time with learners. They can also be contacted through their departments.*
- *The endoscopy department frequently contributes to the care of our patients (OGDs, colonoscopy's, TIPSS, stenting, insertion of feeding tubes etc.). They are willing to have students for a day, but it is advisable to negotiate a visit well in advance as they have their own students to allocate!*
- *Radiology and Nuclear medicine are other areas to visit, however it is usually advisable to accompany one of our patients to an investigation, rather than spend a whole day there! It is appreciated if you or a staff nurse calls the department first to check that they are able to accommodate you. (NB - these areas should be avoided if you are or could be pregnant)*
- *-Pharmacists, phlebotomists, social workers, cardiographers contribute to patient care also and may be willing to explain their role and answer questions.*

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 GI tract. Most occur in the pylorus or the duodenum. Major causes include Helicobacter Pylori infection, Non-steroidal anti-inflammatory drugs, and hypersecretion of HCl (Zollinger-Ellison Syndrome). Treatment includes PPI's, antacids, H2 Blockers and antibiotics. The most common complications are haemorrhage, perforation and malignant transformation.*

Inflammatory Bowel Disease - *non-specific inflammatory disorders of the GI 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.*

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 ischaemia.*

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

Alcoholic liver disease *- alcohol is metabolized primarily by the liver. When intake is excessive, the liver is unable to fully metabolise the 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.*

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.*

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- ***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.*

Renal

- ***Acute Renal Failure*** *- The majority of nephrons (functional unit of kidney) suddenly and simultaneously stop working. If the patient survives the illness giving rise to ARF, then renal function normally returns to normal. Causes can be pre-renal, renal or post renal:*

- ***Pre-renal failure*** *occurs when the kidney is inadequately perfused and the filtration rate is greatly reduced. Causes include decreased blood volume, heart failure (poor cardiac output), septicaemia, Rhabdomyolysis and disease of the major renal vessels.*

- ***Renal-renal failure*** *arises due to structural abnormalities within the actual kidney, for example acute tubular necrosis (hypovolaemia/shock), glomerulonephritis or damage by drugs or toxins.*
- *Post-renal failure is secondary to obstruction at any point in the urinary tract (e.g. stone, clot, tumour, prostate).*

- ***Chronic Renal Failure*** *is characterised by uraemia arising from a variety of renal diseases. Urine production fails and the kidney does not excrete the toxins and metabolites produced by the body. These build up and cause problems, including water retention. Treatment aims at controlling symptoms, preventing further damage and supportive measures such as dialysis/transplantation.*

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
- **Haematemesis** - 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 ½ml/kg/hr)
- **Polyuria** - excessive excretion of urine
- **Proteinuria** - presence of protein in urine
- **Splenomegaly** - enlargement of the spleen
- **Uraemia** - presence of urea in blood
- **Abbreviations**
- **AF** - atrial fibrillation
- **ALD** - alcoholic liver disease
- **APTR** - activated partial thromboplastin rate (a measure of clotting)
- **ARF** - acute renal failure
- **BD** - twice daily
- **BM** - blood glucose
- **BP** - blood pressure
- **CAPD** - continuous ambulatory peritoneal dialysis
- **CBD** - common bile duct
- **CCF** - congestive cardiac failure
- **COP/AD** - chronic obstructive pulmonary/airways disease
- **CRF** - chronic renal failure
- **CT scan** - computerised tomography scan
- **CVA –** cerebrovascular accident
- **CVP** - central venous pressure
- **CXR** - chest X-ray
- **D+V** - diarrhoea and vomiting
- **DKA** - diabetic ketoacidosis
- **DVT** - deep vein thrombosis
- **ECG** - electrocardiogram

- **ECHO** - echocardiogram
- **ERCP** - endoscopic retrograde cholangio-pancreatogram
- **ETT** - exercise tolerance test
- **FBC** - full blood count
- **FFP** - fresh frozen plasma
- **FOB** - faecal occult blood
- **Hb** - haemoglobin
- **IBS** - irritable bowel syndrome
- **IDDM** - insulin dependent diabetes mellitus
- **IHD** - ischaemic heart disease
- **IM** - intramuscular
- **INR** - international normalised ratio
- **IVI** - intravenous infusion
- **LFT** - liver function test
- **LP** - lumbar puncture
- **LVF** - left ventricular failure
- **M/CSU** - midstream/catheter specimen of urine
- **mane** - in the morning
- **MI** - myocardial infarction
- **MRI** - magnetic resonance imaging
- **MRSA** - methylicillin resistant streptococcus aureus
- **NBM** - nil by mouth
- **Neb** - nebuliser
- **NG** - nasogastric (tube)
- **NIDDM** - non-insulin dependent DM
- **nocte** - at night
- **NSAID** - non-steroidal anti-inflammatory drugs
- **OD** - once daily
- **OGD** - oesphagogastroduodenoscopy
- **PBC** - primary biliary cirrhosis
- **PE** - pulmonary embolus
- **PEG** - percutaneous endoscopic gastrostomy
- **PFT** - pulmonary function test 8
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- **PTC** - percutaneous transhepatic cholangiogram
- **QDS** - four times daily
- **SC** - sub-cutaneous
- **SOB** - shortness of breath (dyspnoea)
- **TDS** - three times daily
- **TIPSS** - transjugular intrahepatic porto-systemic shunt
- **TPN** - total parenteral nutrition
- **TPR** - temperature, pulse and respirations
- **TTO**s - to take out
- **TWOC** - trial without catheter
- **USS** - ultrasound scan
- **UTI** - urinary tract infection
- **V/Q scan** - ventilation perfusion scan
- **WCC** - white cell count

Common drugs used on D8:

- *Amoxicillin*
- *benzylpenicillin*
- *Chloramphenicol*
- *Cefuroxime*
- *Co-amoxiclav*
- *Doxycycline*
- *Flucloxacillin*
- *Metronidazole*
- *Tazocin*
- *Asprin*
- *Amlodipine*
- *Atenolol*
- *Bumetanide*
- *Bisoprolol*
- *Clopidogrel*
- *Furosemide*
- *Isosorbide mononitrate*
- *Ramipril*
- *Spironolactone*
- *Aspirin*
- *Omperazole*
- *Lansoprazole*
- *Pantoprazole*
- *Multi vitamins*
- *Thiamine*
- *Pabrinex*
- *Chlordiazepoxide*
- *Prednisolone / hydrocortisone*
- *Calcichew / calcichew D 3 forte*
- *Lactulose*
- *Vitamin B*
- *Metformin*
- *Glicliazide*
- *Gliplizide*
- *Novo mix 30*
- *Novo rapid*
- *Lantus*
- *Insulatard*
- *Enoxaparin*
- *Calcium resonium*
- *Salbutamol*
- *Ipratropium bromide*
- *Carbocisteine*
- *Tiotropium*
- *Tranexamic acid*

Student tips

- *Only one student on a night shift at a time.*

- *Students must not work more than 2 long days in a row.*
- *No more than 4 students on a shift at one time.*
- *Contact the ward if you are unable to attend your shift.*
- *Please give your contact number to Kusam (ward secretary).*
- *Must take your breaks and leave shift at agreed end of shift time.*

We hope you enjoy your placement on D8!