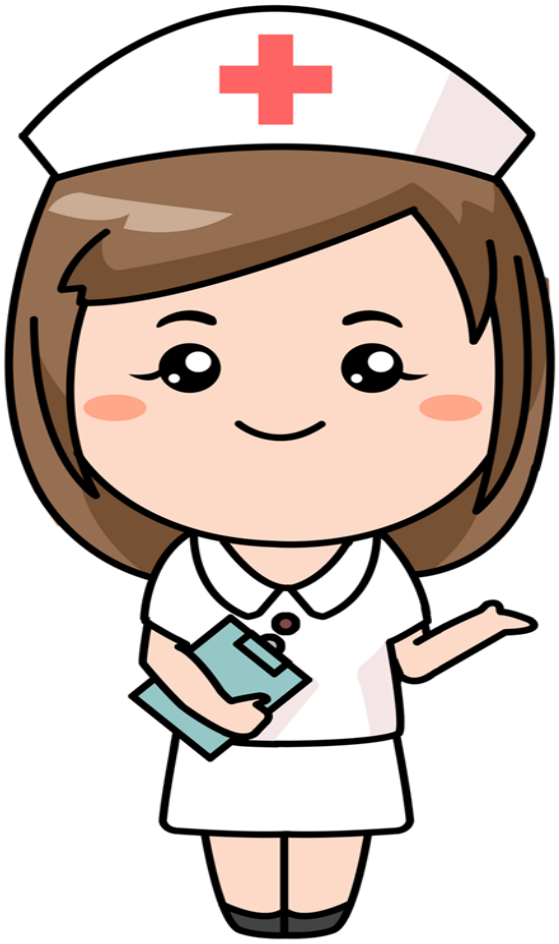
WARD D9
Information Pack



Your first weeks of duty:

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

Student:

Mentor:

Buddy:

Welcome to ward D9!

D9 is located on D level, West Wing of Southampton General Hospital.
It is an acute medical ward that specialises in the treatment and care of patients suffering with gastrointestinal, renal and hepatic disease.
D9 is a 28 bedded ward.

Ward Manager/Senior Sister: Gillian Lambert

Sisters:

Priya Kochummen
Sophie Bamforth
Jennifer Julian
Ranjith Thelapparambil
Florence Mano

Ward Clerk: Sue
Ward Secretary Marion

Shifts:		
	Early	07:30 – 15:30hrs
	Late	12:00 – 20:00hrs
	Twilight	16:00 - 00:00hrs
	Long Day	07:30 – 20:00hrs
	Night	19:30 – 08:00hrs

Contact Number: 023 8120 6495/3158

At the beginning of your placement you will be allocated a mentor and a buddy. Students should aim to work with their mentor 2 - 3 times a week or with their buddy.
If you are unable to be on duty for any reason please let the ward know as soon as possible. Effective care planning can only occur when co-ordinators know who is actually on duty.

During your time on the ward you will have ample opportunity to develop and refine your 'essential care' skills, and become competent at providing holistic care to patients. More advanced skills that can be learnt include catheterisation, injection techniques, management of enteral feeding. There are opportunities to observe and participate in a number of investigations and procedures, both nursing and medical; please discuss these opportunities with your Mentor. Many of our patients have 'complex discharges' so take full advantage and get involved with them.

D9 has recently changed to CLIP as a new 'mentorship' type model which has replaced the current style of mentorship. Students will work together on all shifts in an allocated bay which is nominated as the 'Learning Zone'. The coach (previously known as a mentor) will discuss with the student the daily aim for the student at the start of the duty. There will be a 'day coach' who will oversee the learning zone; however the students will take the lead in running the bay. Each student will be released to have 1 hour of learning time per day to find the theory relating to their practice. Students will cover each other whilst having their 'learning time'; they will provide all care for those patients; day coaches will use a daily log to feedback to the students coach after each shift; coach will review daily log with student and establish next daily aim. This style of mentorship has received excellent feedback from both nursing staff and students.

Ward Routine

NB. Timings are very approximate and each day is very different. This 'routine' is just to give you a general idea of how the ward aims to function on a day to day basis.

0730- Handover from night shift to day shift. Staff will then be allocated to a team of patients.

0800 - Day shift begins – check charts, do daily weights etc. patients helped to sit out for breakfast and beds stripped. Morning drug round commenced.

0815-0900 - Breakfasts arrives and are given out with a meal time co-ordinator (MTC). Any patients that are unable to feed themselves are helped to eat. After this, patients are assisted to get up and have a wash/bath.

0900 – Turn those patients on the turnaround project.

0900 – 1200 - from this point doctors will begin to do ward rounds and review patients. Phlebotomists, pharmacists, physios, OTs will also be around. Patient care (continues throughout the morning)

1100 - Turn those patients on the turnaround project.

1200 - Late shift commences. Handover given and allocation to teams.

1215 - 1300 Lunches arrive and are given out which is overseen by the meal time co-ordinator, patients on the red tray system are assisted with their dietary needs. Midday drug round is commenced.

1300 – Turn those patients on the turnaround project

1300 - 1500 during this time, nurses should hopefully be able to complete their documentation and follow up what doctors have ordered. Fluid charts are updated and observations are rechecked.

1500 - Turn those patients on the turnaround project.

1500 - 1700 since most hospital departments close and doctors leave at 1700 this period of time can be quite busy as discharges are sorted and problems chased up. Staff completes any tasks that have not yet been done (dressings etc.)

1600 - Turn those patients on the turnaround project. Afternoon observations performed. Staff breaks are started.

1700 - Afternoon drug round commences. Turn those patients on the turnaround project

1715 - 1745 Suppers arrive and are given out which is overseen by the meal time co-ordinator, patients on the red tray system are assisted with their dietary needs.

1900 - Turn those patients on the turnaround project.

1830 -1930 Evening drinks are made and served. Nursing documentation is completed. Fluid charts completed and catheters emptied.

1930 - Night staff arrive and handover is given.

2000 Day staff leave. Night time drug round commences. Patients are settled for the night, and ward is tidied. Observations done and documented.

2100 – Turn those patients on the turnaround project

2300 - Turn those patients on the turnaround project

2300 - 0700 Ward kept as quiet as possible to optimise patient sleep. Buzzers answered as necessary. Regular observations are done where needed on sick patients and two hourly turns are maintained for those on the turnaround project at 1am, 3am, 5am, and 7am. During the night, the crash trolley will be checked, bed state brought up to date etc.

0600 - 0730 - Morning observations performed by night staff

Learning Opportunities

As well as your regular clinical experiences on D9 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, colonoscopies, 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.

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 GI tract. Most occur in the pylorus or the duodenum. Major causes include *Helicabacter 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.

- **Gastric Varices** – Dilated submucosal veins in the stomach, which can be a life threatening cause of bleeding in the upper gastrointestinal tract. They are most commonly found in patients with portal hypertension, or elevated pressure in the portal vein system, which may be a complication of cirrhosis.

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, and 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.

- **Liver Cirrhosis** – Scaring of the liver caused by long term liver damage. The scar tissue prevents the liver from working properly. Cirrhosis can eventually lead to liver failure.

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.

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 (2º 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.

Acute Kidney Injury is a sudden episode of kidney failure or damage that happens within a few hours or days. It causes a build-up of waste products in your blood and makes it hard for the kidneys to keep the right balance of fluid in the body.

General

Myocardial infarction - heart attack
Cerebrovascular accident - Stroke
Infections!!!!
Chronic Obstructive Pulmonary Disease - Bronchitis and Emphysema
Asthma

A-E Assessment

A - Airway	Is the airway patent? Any signs of airway obstruction? Treat airway obstruction as a medical emergency: - Obtain help immediately, untreated can cause hypoxaemia with the risks of hypoxic injury to the brain, kidneys and heart; cardiac arrest and death. - Methods of airway clearance include; airway opening manoeuvres, suction, oropharyngeal or nasopharyngeal airways. - Give oxygen at high concentration using a non-rebreathe at 15L
B - Breathing	Look, listen and feel for general signs of respiratory distress: sweating, central cyanosis, use of accessory muscles and abdominal breathing. Count respiratory rate. Assess the depth of each breath, the pattern of respiration and whether chest expansion is equal on both sides. Record the inspired oxygen concentration. Listen to patient's breath sounds. If the patient's depth or rate of breathing is judged to be inadequate, or absent, use bag-mask ventilation to improve oxygenation and ventilation whilst calling for help.
C - Circulation	Look at colour of hands: are they blue, pink, pale or mottled. Assess the limb temperature. Measure the capillary refill time. Count patients pulse rate. Palpate peripheral and central pulses assessing for presence, rate, quality, regularity and equality. Measure patients' blood pressure. Look for other signs of poor cardiac output such as reduced conscious level and low urine output.
D – Disability	Make an initial assessment of the patients conscious level (AVPU or GCS) Examine the pupils (size, equality and reaction to light) Measure blood glucose to exclude hypoglycaemia Common causes of unconsciousness include profound hypoxia, hypercapnia, cerebral hypo perfusion or the recent administration of sedative or analgesic drugs.
E - Exposure	To examine the patient properly full exposure of the body may be necessary. Respect patient's dignity and minimise heat loss.

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 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 - methicillin 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 - esophagogastroduodenoscopy
PBC - primary biliary cirrhosis
PE - pulmonary embolus
PEG - percutaneous endoscopic gastrostomy
PFT - pulmonary function test
PTC - percutaneous trans hepatic cholangiogram
QDS - four times daily
SC - sub-cutaneous
SOB - shortness of breath (dyspnoea)
TDS - three times daily
TIPSS - trans jugular intrahepatic porto-systemic shunt
TPN - total parenteral nutrition
TPR - temperature, pulse and respirations
TTOs - to take out
TWOC - trial without catheter
USS - ultrasound scan
UTI - urinary tract infection
V/Q scan - ventilation perfusion scan
WCC - white cell count

Resources

The ward has a number of folders containing useful information on policies, procedures, diseases etc. These can also be found on the Staffnet. There are also a few containing pertinent journal articles **(we would welcome any additional articles you could give us that you have found to be of use).** Around the ward are notice boards and posters that give more information. Patient information leaflets are another valuable source of data.

Notes

Common drugs used on D9:

Below is a list of commonly used drugs on the ward. This is not an exhaustive list and you will come across others on a day to day basis.
The BNF is a good resource:

- Amoxicillin
- benzyl penicillin
- Chloramphenicol
- Cefuroxime
- Co-amoxiclav
- Doxycycline
- Flucloxacillin
- Metronidazole
- Tazocin

- Aspirin
- Amlodipine
- Atenolol
- Bumetanide
- Bisoprolol

- Clopidogrel
- Furosemide
- Isosorbide mononitrate
- Ramipril
- Spironolactone
- Aspirin
- Omeprazole
- 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
- Carbocystine
- Tiotropium
- Tranexamic acid
- Rifaxamin