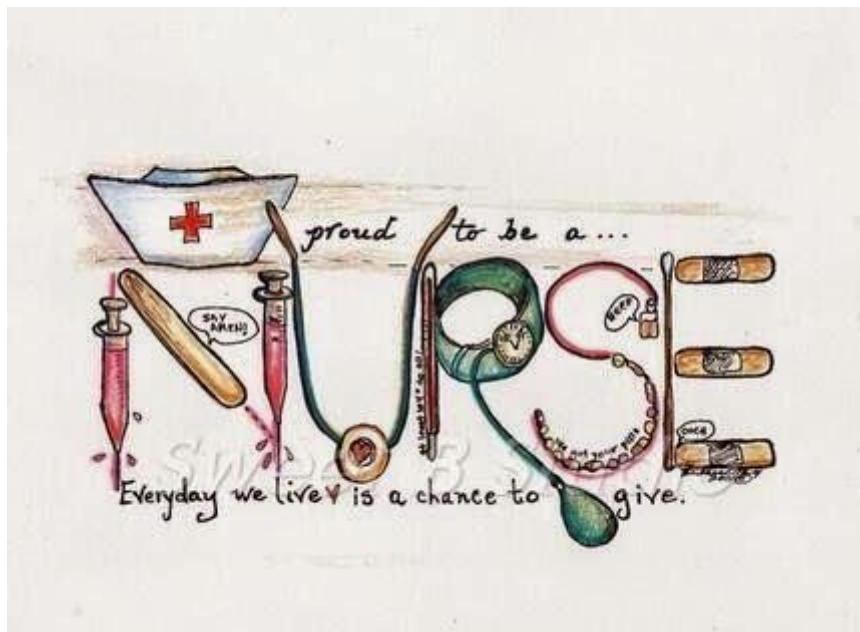


# WELCOME TO G7



# STUDENT WELCOME PACK

Composed by C.N. Steve Edwards.

Updated 23.07.2017

Welcome to Ward G7. We are here to facilitate your learning, please make the most of our staff nurses variable skills & knowledge whilst on your placement.

### Who are we?

We are a 14 bedded mixed sex ward for older people. We primarily care for patients with dementia in an acute setting. We care for the patients here holistically with a more therapeutic outlook than other medical environments, whilst maintaining high levels of medical care.

On admission to G7, the nursing staff arrange a convenient time with the patients family to meet & complete a Post Admission Meeting (PAM). This provides us with an opportunity to meet the family, introduce the named nurse, explain the role of G7 & discuss the families expectations. This opportunity can also lead to discussions about the potential options of suitable discharge location.

Dementia is a big factor in our care. We have several observational bays in which our patients with a higher risk of falls & challenging behaviour or with more specific needs are allocated. We aim to have staff allocated to these bays to offer support to these patients which enables them to have more one to one care.

We also have two 'side rooms' which we use to care for patients in isolation who may have contagious infections and pose a potential infection risk to other patients and people around them. These rooms can also be used for patients who may be over stimulated in a bay environment.

We have a day room which has a television and is equipped with many activities to assist with patient stimulation. We also have some interactive stimuli to assist with patients sensory needs. We encourage patients to use this for meals to enable socialisation; increase an individual's feeling of self worth and potentially reduces the risk of self neglect.

There are activities arranged daily to build therapeutic rapport between ourselves and our patients. We also fully support and encourage the families to participate.

We have on the ward teaching sessions organised by the trained nurses. The subject material varies week to week and is vital to the development of all staff in a specialist area.

Multidisciplinary meetings are bi-weekly on a Monday & Thursday morning. These are an opportunity to discuss patient progress, needs & discharge planning arrangements.

We hope you enjoy your placement if you have any concerns or worries please speak to the ward manager or either charge nurse.

A few friendly faces to start with.....

Matron	Steve Hicks
Senior Sister / Ward Manager	Kate McEvoy.
Charge Nurse	Steve Edwards.
Ward Secretary	Ildiko Nagy



Please feel free to come and talk to us whenever you like. We are a friendly team and strive to make sure that everyone feels valued. If you have any concerns or questions, again please ask. There is no such thing as a silly question and an unasked question is an opportunity missed.

## Starting on the ward



On ward G7 we work a varied shift pattern to facilitate the 24 hour care requirements of our patients.

Shift times are .....

Early	7.30 – 15.30
Late	12.00 – 20.00
Long day	7.30 -20.00
Twilight	18.00 – 01.00
Night	19.30 – 08.00

10.00 to 20:00hrs [usually this member of staff will start the ward activities]

These do not vary on weekends/bank holidays.

Each shift you may take 30 minutes break (For long shifts this means two breaks)

### **G7 WARD VISION**

- We will “go the extra mile” to provide a positive patient experience.
- We will deliver an individual patient centred high quality of care.
- We will provide a clean, safe environment for our patients.
- We will be open and approachable, ready to listen to, and answer, any concerns.
- We will ensure our patients are treated with dignity and respect.
- We will work as a team, supporting each other, each member’s importance of equal value.
- We will be a caring, compassionate nursing team who place a strong emphasis on providing excellent “essential care”.
- We will work closely with all members of the multidisciplinary team to ensure our care delivery is thorough and lengths of stay reduced.
- We will respond to feedback and effect change as necessary.

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## Working on the ward

There are several professionals you will see on the ward who ensure patients are treated properly and efficiently and that day to day routines are completed to time.

### Senior Ward Sister/Charge Nurse

Heads the nursing team on the ward and is also known as the ward manager.

### Sisters/Charge Nurses

Supports the senior sister/charge nurse and all nursing staff on the ward.

### Health Care Support Worker

Supports nurses in most aspects of care for the patient. Personal/hygiene care and nutrition holds the bulk of their daily routine. This means they support the patient in washing and dressing and eating and drinking but also encourage the patient to become more independent with these activities. They also help monitor the patient's intake/output and take observations vital to their medical care.

Other professionals you may see on the ward:

Consultant psychiatrist.

Admiral Nurses.

Physiotherapists

Occupational therapists

Doctors and Nursing Case Managers

Social workers

Tissue Viability Nurses

Speech and Language Therapists (SALT)

Dieticians

Social Workers

## Daily Routines

### **Mornings**

- Handover from night staff in treatment room
- Nurse in charge will allocate staff to teams, sort out breaks
- To ensure the environment is safe before starting work
- Ensure magnetic doors are working
- Throughout the shift monitor patients are in attendance on the ward
- Assist patients to sit up or out in a chair for breakfast and to assist with breakfast
- Trained staff to do the morning medication round. This needs to be completed in a TIMELY manner; under NO circumstances should medication be left unsupervised on patient tables
- Patients are treated & receive individualised care according to their needs
- To make beds /clean bays (housekeeper will take lead in this role when on duty)
- To take physiological observations 09.00 or as patient condition deems necessary
- To complete end of bed paperwork pressure area manakin TAP, MUST etc.
- Tidy up bed spaces, lockers (inside and out), and bays
- Every two hours attend to patients on Turnaround project
- Update changes on nursing handover.
- Daily ward activities.

### **Late shifts**

- Handover to be given from early staff to late staff
- Morning Breaks between 12 – 14 hours
- To assist with lunchtime meals
- Trained staff to do lunchtime oral and IV medication round.
- Daily care notes to be written risk assessments etc.
- Dressings or any other care interventions to be carried out
- Patient observations and BGL as required
- Bed side notes to be updated
- To update hand-over sheet
- To assist patient into bed for a rest if required
- Two hourly turnarounds to be continued during the shift
- Trained staff to do teatime oral and IV medication round
- To assist with teatime meal
- To assist patients into bed after teatime, if requested

### **Night shift**

- Handover at the nurses' station
- To settle patients into bed, ensuring they are comfortable
- Trained staff to do evening oral and IV medication round
- To tidy up bays and bed spaces whilst settling
- To complete any 21:00 physiological observations
- To perform regular checks on patients; 2 hourly if on Turnaround project, 4 hourly otherwise. Ensure absconding patients are seen at these times
- To check night cleaning roster
- Stock up i.e. treatment room, sluice, and medication trolleys etc.
- Update handover sheet and diet grid/ensure RED trays are displayed on white board.

## Paperwork we use on our ward

Turn Around Project – [used also for falls prevention] We use this to ensure all patients are turned and repositioned if they are unable to do themselves- this ensures skin integrity, and comfort.

Braden - We use this tool to assess a patient's risk of skin breakdown-ask your mentor to go through this with you.

Press – Forms Green Orange Red please ask mentor.

MUST- This tool is used to assess the patient's BMI and risk of malnutrition. It gives us a good idea as to whether a patient may need additional nutritional supplements and dietary advice.

SIRFIT- This tool is essential to assess a patient's risk of falling and documenting if a patient does.

Moving and Handling – Assesses the best way to move a patient safely.

Wound care plan – This is we document the way we have dressed and assessed a patient's wounds. The tissue viability nurses often give us this advice.

Food Chart- If we have reason for concern or the patient has a high or medium MUST score we will document all they have to eat to assess if it enough or improving.

Hydration Charts – every patient should be on this form / this is a double – sided form & the reverse needs to be completed each day.

Fluid chart –If we are needed to monitor patients input/output we use the fluid chart. The fluid chart should be filled out accurately and timely. At the end of the day the readings should be balanced.

MEWS- [NEWS] recorded on the iPad this scoring tool we use as an alert when a patient's health is deteriorating. Ask your nurse more about this, if you haven't used it before!!!

VIPS- This is a document that is in place whenever a patient has a cannula, it alerts staff that the cannula should only be insitu for 3 days and ensures staff are checking the site to which the cannula is sited.

Bowel Charts – are an important part of nursing care & all levels of nurses need to complete If a patient suffers from a loose stool inform the nurse in charge immediately.

- Daily care plans - the completion of this documentation will be explained.
- Weekly Care Plans – each patient must have their care plan reviewed & up dated each week.

## Competencies

There are many sign off competencies that you MUST achieve in your supernumerary period, these will be signed by you preceptor.

<b>PAPERWORK</b>	<b>PRECEPTOR</b>	<b>SIGNATURE</b>
TURNAROUND		
SIRFIT		
MUST		
PRESS		
MOVING AND HANDLING		
WOUND CARE		
FOOD CHART		
FLUID CHART		
MEWS		
VIPS		
CATHETER CARE		

<b>CLINICAL SKILL</b>	<b>PRECEPTOR</b>	<b>SIGNATURE</b>
MANUAL BLOODPRESSURE		
BLADDER SCAN		
ECG		
FEMALE CATHETERISATION		
ANTT		
NG/PEG USAGE		
TURNAROUND		
OBSERVATIONS		
BLEEP		
MRSA SWABS		
CATHETER BAG EMPTYING		

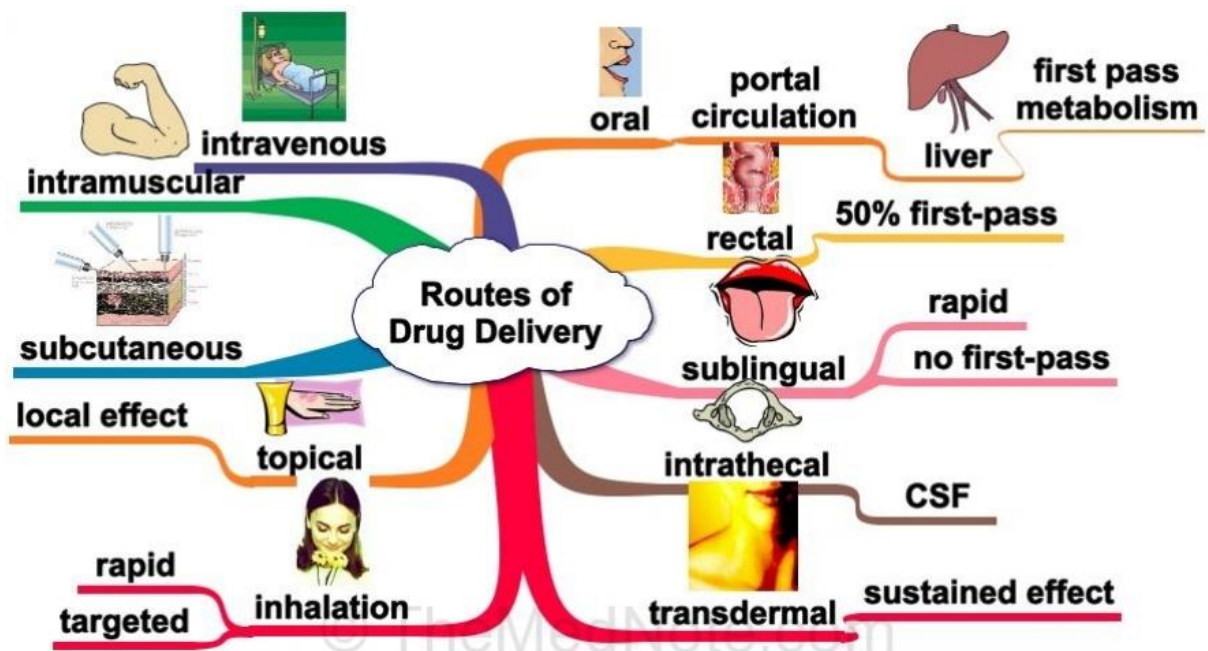


IT ACCESS	PRECEPTOR	SIGNATURE
EQUEST		
EDOCS		
EMAILS		
HUNTLEIGH		
ECAMIS		

## Handy information

Drug 'lingo'

Drugs are administered via several different routes.



Drugs as well as observations have times specified to them they can be

BD- bi daily – twice a day

TDS – three times daily

QDS – quarterly – four times a day

Or another rate specified.

## **Commonly used abbreviations**

UTI- urinary tract infection	LRTI- lower respiratory tract infection
PMH-past medical history	PA- pressure areas
CKD-chronic kidney disease	
COPD chronic obstructive pulmonary disease.	
IVAB-intravenous antibiotics	HTN- hypertension (high blood pressure)
SOB-shortness of breath	ECG- electrocardiogram
AF-atrial fibrillation	TTE- trans thoracic echocardiogram
D+V-diarrhoea and vomiting	CXR- chest X Ray
IHD-ischaemic heart disease	(A) USS- (abdominal) ultrasound scan
CCF-congestive cardiac failure	CTB- CT scan of the brain
LVF-left ventricular failure	MRI- magnetic resonance imaging
IVI- intravenous infusion	NG(T)(F)- nasogastric (tube)(feed)
IDDM-insulin dependent diabetic	BM/BGL -blood glucose level monitoring
Tx w/Ao...-transfers with assistance of..	PPM-permanent pacemaker
CDiff - clostridium difficile	PT-physiotherapy
NIDDM-non insulin dependent diabetic	OT-occupational therapy
OD-once daily	TDS-three times a day
BD-twice daily	QDS-four times a day
MOP – Medicine of Older Persons	TAP – Turnaround Project
PBP – Postural Blood Pressure	IVabx – Intravenous antibiotics
BO – Bowels Open	TWOC – Trial WithOut Catheter

# Crib Sheet

## Infection Prevention

- When a patient is isolated ensure the correct poster on the door is showing.  
Green – Confirmed infection  
Yellow – Suspected infection  
Red – No infection
- If Infection control call with a presumptive MRSA screen you need to:
  1. Complete isolation risk assessment form (not usual to isolate on this ward)
  2. Ensure correct hand hygiene is applied and PPE used
  3. Ensure area is cleaned with Antichlor
  4. Document **Presumptive** and **Confirmed** result in medical notes.
  5. Document in medical notes that the patient has been informed of result
  6. Document that you have asked doctors to prescribe ointment and washes
  7. Put Alert stickers on Medical notes.
  8. Ensure nasal ointment and washes are prescribed and used.
  9. Inform patient/relatives – Give blue record book and leaflet
  10. Hibiscrub 5 day washes tick list to be completed  
**Use the MRSA packs to ensure everything is completed.**
- If your patient has Unexpected/Unexplained Diarrhoea (type 5-7 stool)
  1. Complete Good Practice Guidelines. If score >35 – ISOLATE
  2. Complete risk assessment
  3. Ask for Medical review.
  4. Inform bed manager that a side room is required.
  5. YOU HAVE 2 HOURS TO ISOLATE!!! (if not possible document the reason why, clearly!!)
  6. Send a sample!!
  7. Ensure Stool Chart and Fluid Chart are maintained and accurate
- If Infection Control call with a confirmed Stool result (for example C-diff)
  1. Start C-diff pathway
  2. Ensure patient has a MUST
  3. Fluid chart must be completed and BALANCED
  4. Room to be cleaned using Actichlor daily
  5. Correct PPE to be used and correct Hand Hygiene in place
  6. Inform patients/relatives and give leaflet
  7. Document result in medical notes
  8. Inform medical team to ? prescribe abx
  9. Document you have discussed with patient and given leaflet
  10. Document you have spoken with medical team
  11. Label the notes with an Alert sticker  
**Use the C-DIFF packs to ensure everything is completed.**
- Infection Control with complete a spot check usually within 24 hours of the confirmed result.  
If the points are not done above – WE FAIL!!

**DOCUMENT, DOCUMENT, DOCUMENT**

# Crib Sheet

## Food & Fluid Charts

### MUST

- Think does your patient need to be on a FLUID chart?
  - Too many unnecessary FLUID charts = less accurately completed.
  - Does your FLUID chart have a reason recorded in the 'Requirement' box at the top of the page?
  - Does your FLUID chart have a kg/ml weight on it?
  - Are you recording on the FLUID chart REAL-TIME (hrly/2hrly)?
  - Is your FLUID chart being totalled/accumulated?
  - Is it being signed at the bottom of the page each shift?
  - IS the PSAG board updated with a RED TRAY Symbol?
- 
- Does your patient have a MUST of MEDIUM or HIGH? If they do, do they have a PINK=Medium or RED=High Fluid Chart insitu?
  - Are they being completed EACH mealtime?
  - Is the care-plan at the top of the page completed each day?
  - Does a Dietician referral need to be completed?
  - Have you documented to say that you have completed a Dietician referral?
  - Have you made the Dr's aware that they have a MUST of Medium or High by documenting it in the medical notes?
  - Is the PSAG board updated with a RED TRAY Symbol?
- 
- Is the MUST completed every 7 days for LOW MUST?
  - Is the MUST completed every 7 days for MEDIUM MUST – are they on a ORANGE food chart?
  - Is the MUST completed every 2-3 days for HIGH MUST – are they on a RED food chart?
  - Has a MUST been completed within 24 hours of the patient arriving to G7?
  - Is the MUST being completed fully (not just weight documented)
  - If your patients MUST score has changed have you acted on this (Dietician referral, start on food chart)?
  - Is it documented in Care-plan and Medical Notes?

### REMEMBER:

- Ensure DIET GRID is Updated and Correct!
- Ensure PSAG board is Correct with RED TRAY Symbol as required.
- Ensure Handover states RED TRAY

# Crib sheet – Falls

There are many different ways of preventing falls within a hospital setting:

**Observational bays** – These allow patients to be seen easily and readily from the Nurses station, please make sure we are effectively utilising this resource as they are limited and because peoples falls risk status can fluctuate. We should be moving the reduced falls risk patients down the ward, to free up observable beds for new admissions or patients that become a falls risk whilst in our care.

**Turnaround project** – This tool is not only for pressure but to reduce falls. It works by reminding people to check patient for toileting or transfers so patients do not attempt these tasks alone. The biggest cause of falls in hospital is patient toileting, where they attempt to stand or transfer unaided and fall.

**Call bell** – All patients should have access to a call bell (regardless if they are able to use it or not), this enables patients to contact the Nurse if they require anything rather than attempting it unaided.

**Walking aids** – Patients that require a walking aid should have access to it. If patients are not able to access mobility aids please contact therapy department to arrange more for the patients. Please be safe with transfers, if unsure contact therapy/check their previous entries for information.

**Pressure mats** – We have received pressure mat equipment for all the MOP wards, we will be having training on this soon, therefore we can utilise its potential. It will be used for patients continually trying to get up from bed/chair unaided where a special/staff member is not able to stay with them.

**Specialising** – This is our last resort to reduce falls within hospital. It consists of a RMN/HCA sitting/observing patient or patients to try to stop them from falling. This is however not a guarantee as patients can fall even with a staff member present constantly. Specials should be own ward staff and the agency that booked replaces said HCA, this is due to the extra training/experience we have on the ward.



# Catheter care and Bowel Charts

## **Catheter Care:**

- Every patient with a catheter needs a catheter care plan, if one isn't present then one need to be retrospectively made.
- Patient catheters in hospital should only be long term catheters, for infection control reasons.
- Long term catheters can last for 12 weeks, therefore patient should only have a maximum of 3 catheter care plans at any one time.
- TWOC's need to be recorded at the bottom on the catheter care plan, for both planned and unplanned TWOC.
- Patients can be discharged with a catheter, however a district Nurse referral needs to be made (except for discharge to Nursing home).

## **Bowel Charts:**

- Every patient needs a bowel chart (some do not come with one from AMU).
  - Bowel charts need to be completed every shift, AM, PM and Night (regardless of bowels open or not).
- If bowels not open for 3 days we need to be highlighting it, giving some intervention or handing it over to medical teams (use some common sense).
- It is both Nurses and HCA's responsibility to complete bowel charts (do not expect each other to complete please check).

These are both basic jobs for Nurses and HCA's and should not be missed.

## Wound care

- Every wound non-hospital or hospital acquired needs to have a wound care plan in the notes associated with it.
- There are copies of each care plan at the Nurses station, please follow these but use your own clinical knowledge to reinforce them.
- All non-hospital or hospital acquired pressure sores of grade 3 or 4 need to be referred to TVN.
- Every patient with pressure damage (however minor) or is much less mobile than usual needs to be placed on a Nimbus.
- Patients that have come from AMU need to have their wounds checked in the first 24 hours of admission to G7, regardless if they have been checked on AMU.



There are different types of dementia.

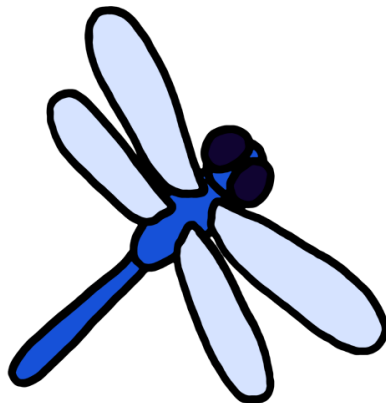
A few are listed below please take time to look them up to gain an understanding.

Alzheimer`s Disease.

Lewy Bodies Dementia.

Frontotemporal Dementia.

Vascular Dementia.



Here on G7, patients with dementia are identified with a Dragonfly symbol on the PSAG. These patients may require increased assistance with personal care, eating and drinking. They may display more physical or verbal challenging behaviours.





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1. How do you *fast bleep* a doctor?
2. What is *SBAR*?
3. What group of medication is *Prednisolone*?
4. List *two* side effects from the above and what is it used for?
5. Give the other name for *Ventolin*.
6. What is the role of *Ventolin*?
7. Give the other name for *Atrovent*.
8. What is the function of *Atrovent*?
9. *Codeine Phosphate* is from what group of medication?
10. List *two* side effects of Codeine Phosphate.
11. *Dihydrocodeine* is from what group of medication?
12. List potential side effects of *Dihydrocodeine*.
13. *Tramadol* is from what group of medication?

14. What is the role of *Tramadol*?

15. List potential side effects of *Tramadol*.

16. Read the four anti-emetics and list the potential side effects

- Ondansetron
- Cyclizine
- Metoclopramide
- Levopromazine

17. Read the three diuretics and list the potential side effects

- Frusemide
- Spirolactone
- Co Amilfruse

18. List four anti-depressants commonly used in the medicine of older persons.