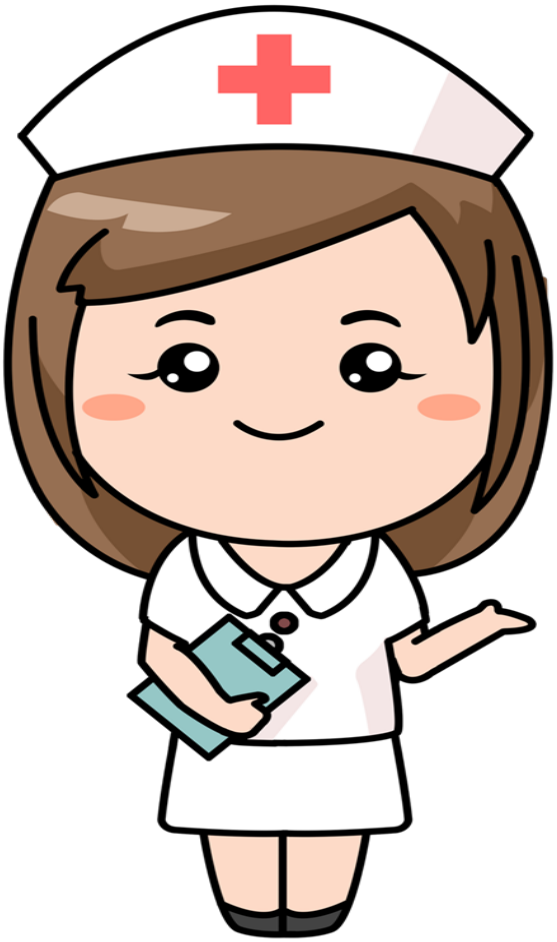
WARD D10
Information Pack



Your first weeks of duty:

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

Practice Assessor:

Welcome to ward D10!

D10 is located on D level, Centre Block of Southampton General Hospital.
It is an acute medical ward that specialises in the isolation care, including all medical specialities.
D10 is a 18 bedded ward of 15 side rooms and 1x 3 bedded bay.

Ward Manager/Senior Sister: Nanette Kinnaird

Sisters:

Marta Oliveira
Caroline Childs
Cristiana Nascimento
Debbie Ridley
(Joanne Gardner)

Ward Clerk: Hannah Smith
Ward Secretary Marion Walshe

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

Contact Number: 023 8120 8334/3843

At the beginning of your placement you will be allocated a practice assessor. You will be allocated to work either alongside your practice assessor or will be allocated to work with a suitable practice supervisor for that shift.

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 practice assessor. Many of our patients have 'complex discharges' so take full advantage and get involved with them.

D10 has recently changed to CLIP as a new 'mentorship' type model which has replaced the current style of mentorship. Students will work together on the majority of shifts (dependent on your daily goal). Your daily goal is for you to set and discuss with your practice assessor, this is entered on to a log sheet. These sheets are completed by student and practice supervisor, then reviewed with the practice assessor. Each student may be released to have some learning time per day to find the theory relating to their daily goal. Students will cover each other whilst having their 'learning time'; they will provide all care for those patients. You will be expected to provide the care for a team of patients up to the level of your scope of practice. This style of mentorship has received excellent feedback from both nursing staff and students.

(If you are struggling to think of a daily aim- refer to EAOPP to confirm what you are being assessed on!)

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. (NIC Board round 0830-0900)

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 D10 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 assessor as soon as possible so the necessary plans can be facilitated:

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)

Tissue Viability nurses - x 8628, bleep 9236
Outreach Team (Critical care nurses) - blp 9191 (third year students only)
ID TEAM : blp 1430
IPT: blp 2573 ext: 8165
CF nurse: blp 1811

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.

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.

INFECTIOUS 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!

***TB**

Pulmonary TB is caused by the bacterium *Mycobacterium tuberculosis (M tuberculosis)*. TB is contagious. This means the bacteria is easily spread from an infected person to someone else. You can get TB by breathing in air droplets from a cough or sneeze of an infected person. The resulting lung infection is called primary TB.

Most people recover from primary TB infection without further evidence of the disease. The infection may stay inactive (dormant) for years. In some people, it becomes active again (reactivates). Most people who develop symptoms of a TB infection first became infected in the past. In some cases, the disease becomes active within weeks after the primary infection.

***CDIFF**

Clostridium difficile, also known as C. diff, is a bacteria that can infect the bowel and cause diarrhoea. The infection most commonly affects people who have recently been treated with antibiotics. It can spread easily to others. C. difficile infections are unpleasant and can sometimes cause serious bowel problems, but they can usually be treated with another course of antibiotics.

***ESBL gent resistant**

ESBL stands for Extended Spectrum Beta-Lactamase, an enzyme (chemical) made by some germs which prevents certain antibiotics from working. Germs that are able to produce this enzyme are more resistant to many of the antibiotics prescribed to treat infections, making an infection caused by an ESBL germ more difficult to treat.

***CPE**

Carbapenemase Producing Enterobacteriaceae (CPE) is bacteria or ‘bug’. These ‘bugs’ can live in the gut of humans and animals. At times CPE are harmless and there are no signs or symptoms because a person’s immune system keeps them in check. This is called ‘colonisation’. If they get into other parts of the body e.g. the urine or the bloodstream, they can cause an infection and will need treatment. Patients who have a weakened immune system may be more at risk of developing infection.

CPE infections can be difficult to treat because they are resistant to some antibiotics. CPE can also pass their resistance on to other bacteria, making them harder to treat as well.

***MRSA**

MRSA is a type of bacteria that's resistant to several widely used antibiotics. This means infections with MRSA can be harder to treat than other bacterial infections. The full name of MRSA is meticillin-resistant Staphylococcus aureus. You might have heard it called a "superbug".

MRSA infections mainly affect people who are staying in hospital. They can be serious, but can usually be treated with antibiotics that work against MRSA. This infection lives harmlessly on the skin of around 1 in 30 people – usually in the nose, armpits, groin or buttocks. This is known as "colonisation" or "carrying" MRSA.

Some examples of signs and correct PPE to use:

Appendix F	ISOLATION SCORING TABLE		
RISK CATEGORY:	HIGH above 45 = (C5)	MEDIUM 25 – 45 side room on ward	LOW below 25 No isolation

Condition/infection	Route of transmission	Single room/length of isolation	Risk category	Score	gloves	Aprons	Other PPE	Variable factors	Signage
Resistant Organisms									
ESBL (Extended-Spectrum B-Lactamases) producing coliforms + Multi Drug Resistant Acinetobacter (remains sensitive to Meropenem and Colistin)	Contact & Droplet	See Variable factors	MEDIUM LOW	20 - 45	YES	YES	Sputum colonised and productive facial protection when within 1 metre/3feet of patient. If likely risk of contamination of uniform thumb loop gown	**Medium risk** = 35-45 Gentamicin Resistant. Patients in HDU/ICU. Patient in Oncology. Sputum colonised and productive, has open drains, or on advice from Microbiologist or IPT. **Low risk = 20** Gentamicin sensitive. Patients that are not in Oncology/HDU/ICU. Sputum colonised and **not productive.**	
Carbapenem-resistant Enterobacteriaceae (CRE) + CRAB Carbapenamase resistant Acinetobacter Baumannii Resistant to Meropenem	Contact	Yes – indefinitely	HIGH MEDIUM	45-55	YES		Thumb loop gowns facial protection if likely risk of splash contamination to face or patient has a productive cough when working within 1 metre/3feet of the patient.	**High = Above 45** potential for aerosolisation. Respiratory with cough, Open drains present. Individual risk assessment by Microbiologist or IPT	

Img.1

Pulmonary MDRTB Pulmonary X-DRTB Pulmonary TB (use danger infection label to send sample to lab)	Airborne	Until stepped down by a Respiratory Consultant	HIGH MEDIUM	45 - 65	YES	YES	IT IS ESSENTIAL THAT YOU READ THE TB POLICY FOR GUIDANCE ON REQUIRED PPE	HIGH risk = X-DRTB score is 65 MDTRB score is 55 Medium risk = Pulmonary TB score is 45 IT IS ESSENSTIAL THAT YOU READ THE TB POLICY FOR ISOLATION REQUIREMENTS	
Bloodborne									
Hepatitis B (use danger infection label to send sample to lab)	Bloodborne	No isolation unless uncontrolled bleed risk/large open wounds or having haemodialysis	LOW	15			Standard precautions if likely to come into contact with blood or bodily fluids		
HIV/AIDS (use danger infection label to send sample to lab)	Bloodborne	No isolation unless uncontrolled bleed risk/large open wounds or having haemodialysis		0-65			Standard precautions if likely to come into contact with blood or bodily fluids.	These patients may have other specific infection/organism that require isolation and PPE should be worn as per specific infection/organism	

Img.2

Diarrhoea									
Clostridium difficile	Faeco-oral	Yes until 48 hours symptom free and passing a formed stool	MEDIUM	30-40	YES	YES	Facial protection/thumb loop gown if likely risk of splash contamination to face or uniform		

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Isolation Risk assessment tool

- **All the patients on D10 must have an isolation risk assessment and the appropriate sign on the door.**

University Hospital Southampton NHS
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Appendix K **Source Isolation Risk Assessment Tool**

Name: .....

Hospital Number: .....

Ward: .....

Score	Risk Category	Appropriate Isolation Facility
< 25	Low	As available/Cohort Nursing
25 - 45	Medium	Side-room on main ward +/- bathroom facilities
> 45	High	C5 (negative pressure room)

ALL patients with a suspected/known infectious condition must be risk-assessed and assigned a score using the Isolation Risk Assessment Scoring Table. See Appendix Isolation Policy for Adults with Infectious Conditions.

Reason for non-isolation/action taken if no isolation facility available .....

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Date of Assessment/Review	Infection	Route of Transmission	Score	Risk category	Isolation Facility	Length of Isolation	Initials

	Green sign for suspected or confirmed infectious diarrhoea and or vomiting e.g. C difficile/Norovirus **Hand hygiene with soap and water**		Yellow sign all other infections **other** than Suspected or confirmed infectious diarrhoea and or vomiting e.g. MRSA/TB/ESBL – **Note if the patient is symptomatic of D & V change to a green sign until resolved** **Hand hygiene with alcohol gel or soap and water**		Pink sign non infectious patient isolation not required **Hand hygiene with alcohol gel or soap and water**

Some abbreviations

AF - atrial fibrillation
ARF - acute renal failure
BD - twice daily
BM - blood glucose
BP - blood pressure
CRF - chronic renal failure
CT scan - computerised tomography scan
CXR - chest X-ray
D+V - diarrhoea and vomiting
DKA - diabetic ketoacidosis
DVT - deep vein thrombosis
ECG - electrocardiogram
ECHO - echocardiogram
FBC - full blood count
FFP - fresh frozen plasma
Hb - haemoglobin
IM - intramuscular
IVI - intravenous infusion
LP - lumbar puncture
MI - myocardial infarction
MRI - magnetic resonance imaging
MRSA - methicillin resistant streptococcus aureus
NBM - nil by mouth
Neb - nebuliser
NG - nasogastric (tube)
OD - once daily
OGD - esophagogastroduodenoscopy
QDS - four times daily
SC - sub-cutaneous
SOB - shortness of breath (dyspnoea)
TDS - three times daily
TTOs - to take out
TWOC - trial without catheter
USS - ultrasound scan
UTI - urinary tract infection

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