NHS

Bradford Teaching Hospitals

NHS Foundation Trust

Junior Doctor Handbook

2023/24

Contents

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Welcome

Welcome to the Bradford Teaching Hospitals NHS Foundation Trust (BTHFT). BTHFT became one of the first Foundation Trusts in April 2004.
A year earlier we became a teaching hospital to train the next generation of doctors. During this time the NHS has changed and the public now expect ever better services. We have invested in educational facilities including our impressive Simulation Centre and Technical Skills Lab in Field House.

We hope this handbook is useful whether you are new to BTHFT or returning in a different specialty. The handbook is updated annually, based on original work by Neil Singh, Julian Howes and Sarah Jowett, with input and updates from Adam Pilgrim, Geraldine Afemikhe, Ellie Clegg and David Robinson. Any comments or suggestions are welcomed: please email alida.towns@bthft.nhs.uk. Finally, please note that an electronic version of the handbook is available on the intranet).

Induction

You will receive both a general induction and departmental induction here at BTHFT. The general induction will cover generic hospital policies, actions to be taken in an emergency etc. The departmental induction will be organised by your designated team and will be much more specific with regards to what your day to day duties entail. It is important that you attend both inductions as they are often essential for patient safety and are necessary to progress throughout training.

Bradford Royal Infirmary and St Luke's Hospital

The Bradford Royal Infirmary (BRI) and St Luke's Hospital (SLH) are the two hospitals which make up the Bradford Teaching Hospitals NHS Foundation Trust. The BRI is the larger of the two hospitals and covers the majority of the acute specialities, and now includes a Renal Dialysis Unit for acute in-patients. The main Dialysis Unit remains at SLH, alongside rehabilitation wards for elderly care, stroke and neurology. Various outpatient clinics are also on site at SLH. Site maps are on the back page of the handbook.

Rotas and Work Schedules

An electronic copy of your rota will be given to you by your relevant department. Many specialties are now using electronic rotas; you will receive a link to Employee Online and be notified of your login details via email.

You must arrange a meeting with your clinical supervisor to discuss your work schedule as per the New Junior Doctor Contract 2016. Samples of work schedules and advice can be found on the BMA website.

Exception reports will be sent to your educational supervisor. In addition, the reports should copy in the Guardian of Safe Working Hours for issues related to safe working practices or the Director of Education for issues related to training.

The process in BTHFT for exception reporting is discussed at Trust Induction. Advice regarding exception reporting can be found on the BMA website. There is also a link to the full guidance in Junior Doctor Contract 2016.

Any rota queries can be answered at your local departmental induction or via your rota co-ordinator

Surviving on call

On call shifts are the most stressful shifts you will work. They are often very busy and you will be expected to work independently, but there is always help available from your seniors if you need it. If you feel that you do not know how to manage a patient you should discuss it with the FY2/CT on call or the registrar (depending on the seriousness of the clinical situation/urgency). Remember you are not alone if you do not know what to do so talk to your seniors, it is better to discuss a patient than make a mistake. The staffing/structure of on call, managing admissions and the wards is different in surgery and medicine. Please ensure this is discussed at local departmental induction.

For assistance with the deteriorating patient or recent discharges from a critical care setting Critical Care outreach team can be called on ext. 2099 or #6775 from 8:00-17:00 every day. The team comprises of experienced ICU nursing staff who will take referrals from anyone in the MDT.

Short Notice Rest Facilities for Junior Doctors

There will be times when trainees find themselves too tired to get home safely following an overnight period of work. In this circumstance, a room may be booked at short notice to allow a period of sleep. On Monday to Friday mornings, this may be requested from 0800 by contacting Lynn Hadley, Accommodation Supervisor:

- Telephone 01274 364102
- Mobile 07790 905786
- Accommodation Office - C floor Field House.
- Name, grade and specialty details will need to be provided.

On Saturday and Sunday mornings, or bank holiday mornings, a room can be arranged at main reception at BRI. The key will need to be signed out, and the same Name, grade and specialty details left.

Unlike for a pre booked room, there will be **no charge** to the junior doctor for this facility. The charge will be met by the doctor's division, via the finance department.

Crash Calls: The crash call number is 2222. When carrying the crash bleep you are legally obliged to attend a crash call.

The crash bleep will tell you where the emergency is, if you can't hear it call switch board to find out. If you don't know where a ward is ask another member of staff. You **MUST** attend a crash call immediately.

Foundation Year / Core trainee Jobs

Whether you are completing a rotation in a surgical or medical post the information below regarding different departments in the trust will be helpful.

Foundation Year 2 / CT Jobs Critical Care

BRI has an intensive care and high dependency unit run by anaesthetists and experienced critical care nursing staff. Patient referrals to the unit are made following discussion with the consultant of the parent team. Patients on the critical care unit should be reviewed daily by a member of the parent team.

Social Media

- Postings on Facebook or Twitter is not private of privileged information
- GMC good medical practice – guidance on conduct within social media
- Do not discuss or refer to patients even if you think you have done so anonymously
- Do not 'friend' patients
- Do not provide 'medical advice'
- Do behave / post responsibly
- Remember you represent the trust and the profession even if not at work

Critical Care and the septic patient

A high proportion of critical care patients are admitted with severe sepsis, prompt management of sepsis has been shown to reduce mortality, and should be initiated in every patient within ONE HOUR of the recognition of sepsis.

Many of you will recall the Sepsis Six with BUFALO (see below). By doing the BUFALO (6 things) within an hour of initial assessment of the patient, you will double your patient's chance of survival.

All Trust staff have a critical role to play by ensuring our patients with sepsis get the right care and treatment in a timely way.

- Consider sepsis in patients with NEWS of ≥5 (or 3 in one modality)
- If sepsis likely - check for red flags.

Adult red flags

- BP <90mmHg; Lactate >2mmol/l
- New requirement for O2 to keep sats >90%
- Heart rate >130/min; Respiratory rate >25/mim
- Responds only to voice or pain / unresponsive
- Purpuric rash OR intra-abdominal sepsis due to bowel Perforation.

- **HIGH RISK SEPSIS (formerly SEVERE SEPSIS)** = sepsis + RED FLAG organ dysfunction - mortality 20-35%
- If one of more red flags then start BUFALO within the hour AND CALL FOR SENIOR HELP
    - **B**lood cultures
    - **U**rine output measurement hourly – consider a catheter
    - **F**luid therapy (resuscitation fluid of 500mls of IV crystalloid over 15 minutes)
    - **A**ntibiotics(treat the source if identified and consult the Abx guidelines)
    - **L**actate check
    - **O**xygen
- In EPR - click *"Add a Request/Care plan"*; search for sepsis; choose a bundle; use it! Use the Sepsis screening tool Complete the sepsis tool for all patients having blood cultures, suspected of sepsis and those with NEWS of 5 or more or 3 in one modality.
- **SEPTIC SHOCK** = sepsis + BP<90 or lactate >4 mmol/l despite fluid resuscitation - mortality 40-65%

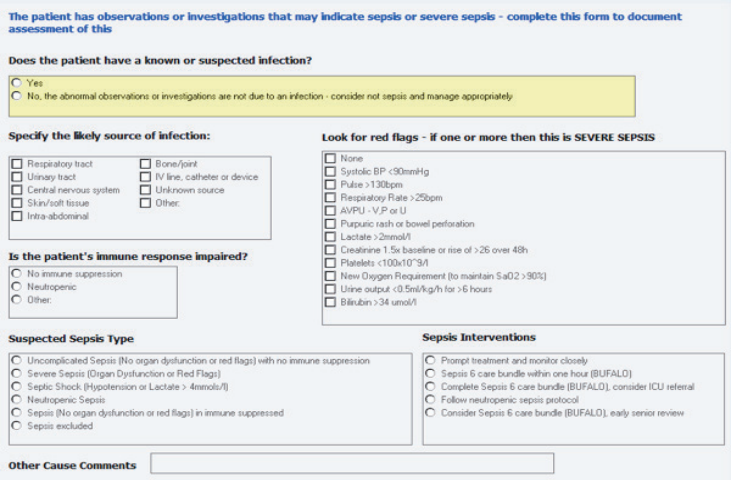
Sepsis Alerts / screening tool and completion of sepsis 6 bundle

Please see guide below for completion of the sepsis screening tool and the sepsis 6 care plan / bundle.

It is extremely important that when a patient shows a sepsis alert on EPR that this is completed and patient reviewed immediately in order to prevent patient deterioration and save lives. Please do not continuously bypass this alert, a sepsis patient can deteriorate rapidly therefore it is important it is spotted and treat quickly.

If the alert shows and you feel the patient is not sepsis then the screening tool still needs to be completed, do not bypass.

The screening tool


The patient has observations or investigations that may indicate sepsis or severe sepsis - complete this form to document assessment of this

Does the patient have a known or suspected infection?

- Yes
- No, the abnormal observations or investigations are not due to an infection - consider not sepsis and manage appropriately

Specify the likely source of infection:

- Respiratory tract
- Urinary tract
- Central nervous system
- Skin/soft tissue
- Intra-abdominal
- Bone/joint
- IV line, catheter or device
- Unknown source
- Other:

Look for red flags - if one or more then this is SEVERE SEPSIS

- None
- Systolic BP <90mmHg
- Pulse >130bpm
- Respiratory Rate >25bpm
- AVPU - V,P or U
- Purpuric rash or bowel perforation
- Lactate >2mmol/l
- Creatinine 1.5x baseline or rise of >26 over 48h
- Platelets <100x10^9/l
- New Oxygen Requirement (to maintain SaO2 >90%)
- Urine output <0.5ml/kg/h for >6 hours
- Bilirubin >34 umol/l

Is the patient's immune response impaired?

- No immune suppression
- Neutropenic
- Other:

Suspected Sepsis Type

- Uncomplicated Sepsis (No organ dysfunction or red flags) with no immune suppression
- Severe Sepsis (Organ Dysfunction or Red Flags)
- Septic Shock (Hypotension or Lactate > 4mmols/l)
- Neutropenic Sepsis
- Sepsis (No organ dysfunction or red flags) in immune suppressed
- Sepsis excluded

Sepsis Interventions

- Prompt treatment and monitor closely
- Sepsis 6 care bundle within one hour (BUFALO)
- Complete Sepsis 6 care bundle (BUFALO), consider ICU referral
- Follow neutropenic sepsis protocol
- Consider Sepsis 6 care bundle (BUFALO), early senior review

Other Cause Comments

1. Has the patient a known or suspected infection? Yes

If yes complete the likely source of infection box, is the patient immune response impaired and red flag box.

A box will also be viable below the other cause comments box which highlights when and why (red flags) the sepsis alert was activated.

On completion of these boxes the suspected sepsis type and sepsis interventions will autofill. It will only not autofill if you have ticked none in the red flag box. This means you will have to manually complete the suspected sepsis type box.

The sepsis interventions box will then auto fill and direct as to what intervention is appropriate for your patient.

2. Has the patient a known or suspected infection? No

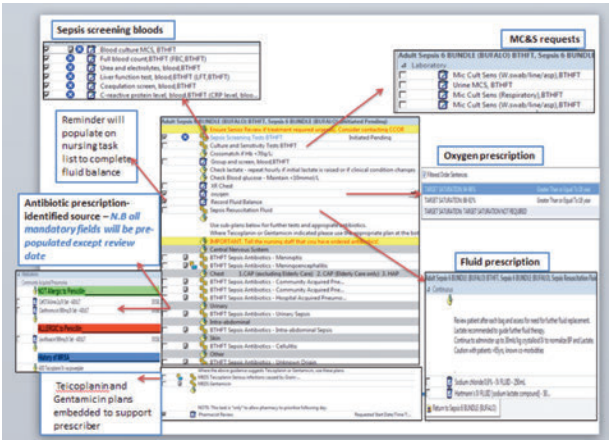
In the sepsis type box tick sepsis excluded.

Complete the other causes comments box as to why you are excluding sepsis. You will be unable to exit the screening tool if the comment box is not completed.

Once completed uses the green tick in the top left corner to exit.

Sepsis 6 bundle/care plan

If highlighted in the sepsis interventions box that the sepsis 6 care plan is required this can be found in care plans. When double clicking on the care plan the following care plan will appear.



This care plan provides requests for bloods, blood cultures and xrays.
It also provides you with Oxygen prescription and antibiotics prescriptions.
To access these you click on the boxes at the side and these will be requested.

The aim of the screening tool is to identify or exclude sepsis quickly but also to provide streamlined access to essential requests if your patient is septic, therefore saving time and increasing a patients chance of servival.

The Emergency Department

The BRI Emergency Department (ED) can be frantic. Only Foundation Year 2 doctors and above work in the BRI ED. Although it may be daunting at first, a 2-day induction and the support from seniors will soon have you settled in. The BRI ED is divided into 5 areas that you will rotate around each day. BRI A+E see both Adult and Paediatric patients.

How to bleep someone

1. Pick up the phone and dial 88
2. Then enter the 'bleep number' of the person you wish to contact
3. Now enter the extension number from which you are calling. This is often written on the phone. (Ignore the 10 digit number the voice on the phone requests)
4. Now press # and the voice on the phone will inform you whether the bleep was successful or not. If so – it will bleep and put the phone down.
5. Await the person to call you.

Telephone Communication

This is often a difficult skill for newly qualified junior doctors to master. There may be occasions where you will find yourself "grilled" by a registrar or consultant you have contacted for advice. Here are some tips for dealing with this:

- Open the patient's electronic record and ensure you are up to date with the problems the patient presented with as well as their previous health problems
- It is useful to review what medications they are taking and be aware of the most recent vital signs
- Use **SBAR.** This is a system that allows you to convey the situation and what you require from the person on the other end of the phone.

S	**Situation** • State your name and unit. • I am calling about... who is a... year old man/woman. • The reason I am calling is ...
B	**Background** • State admission diagnosis and date • Relevant medical history • A brief summary of treatment to date
A	**Assessment** • State assessment e.g. observation, examination, what you've • done to manage them.
R	**Recommendation** • I would like (state what you would like e.g. advice or review) • Determine timescale • Is there anything else I should do? • Record name and contact number of contact.

1 Handover

1.1 Generic Standards for Training (July 2008) highlights handover in Domain 1, Patient Safety. It stipulates that trainees in hospital posts must have well-organised handover arrangements ensuring continuity of patient care.

1.2 Bradford Teaching Hospitals Foundation Trust has approximately 43 junior doctor rotas. It cannot be expected that there will be a "one size fits all" for all rotas covering all specialties and their subspecialties, however all clinical areas must have robust processes for handover.

1.3 All handover processes must comply with key areas of best practice and high quality patient care.

1.5 Handover is the transfer of clinical information at the time of transition of responsibility for patients, usually between day and night teams.

1.6 The aim is to ensure that all acutely unwell and "at risk" patients under the jurisdiction of the clinical team are known to all members of the clinical team.

1.7 The handover process within each clinical area may be different at different times of day, but each handover should have its own clearly defined protocol using the guidelines below.

1.8 Each directorate/specialty is responsible for implementing a clear handover process based on best practice. These should follow the principles as described below in section 2.

2. Key Handover Standards

2.1 Clinical Service Areas

2.1.1 Each clinical service area will identify fixed key handover times which occur during a 24 hour period, 7 days per week. Examples of a minimum would include;

- Night to Day shift
- Day to Evening staff
- Evening to Night staff

2.2 Timings

2.2.1 Each rota should be designed to allow a minimum of 30 minutes handover time between shifts.

2.2.2 The start time and duration of handover for each shift should be specified and each rota should be altered accordingly, in consultation with the Medical Workforce Team.

2.3 Venue

2.3.1 The venue of the handover meeting should be specified for each clinical service area.

2.4 Staff

2.4.1 Handover should be co-ordinated and led by senior staff. The at least one principle handover of the day should be attended by the consultant on duty that day.

2.4.2 The medical staff required for each handover should be defined and involve the whole clinical team at all levels.

2.4.3 Their roles and responsibilities within the handover process should be defined. It should be agreed who will:

- Record the handover meeting
- Lead the handover process
- Agree timings of further meetings (if needed) during the shift.

2.5 Structure of Handover

2.5.1 The outgoing doctor(s) will give a verbal report to the incoming team

2.5.2 This will be supported by a written or electronic record of cases/issues being "handed over". This will cover;

- New admissions
- Unwell or unstable patients
- Patients who are well but may potentially deteriorate eg post-op patients.
- Outlying patients
- Awaited investigation results
- Tasks which need to be completed before the end of shift

- Discussions/debriefing with patients or relatives
- Limits to clinical plan e.g. DNAR or not for intensive care.
- Severe Allergy

2.6 Post Handover

2.6.1 On completion of handover there should be an agreement of how the work be divided

2.6.2 Agreement should be made as to further meetings during the shift.

2.6.3 Ensure that the fast/crash bleep for the area has been allocated to the appropriate Doctor.

2.7 Documentation

2.7.1 Each specialty should use an agreed proforma for handover. Appendix 1 gives an indication of the information to be collected.

2.7.2 The date, start and end time, venue and members of staff present should be recorded.

2.7.3 The written record from the outgoing team should be annotated with the roles and responsibilities of the incoming team.

2.7.4 This should be used throughout the shift to plan on-going care.

2.7.5 This documentation should be passed from each clinical service area, to the receiving team taking responsibility for that area at each handover. This continuum of information should be maintained at ach handover.

2.7.6 This document should be kept in an agreed place (e.g. a shared drive system), for easy reference throughout the shift.

2.7.7 Each member of the team should make their own notes relevant to their own roles and responsibilities

2.8 Future Trust Solutions

2.8 BTHFT will actively seek to use innovative methods for real-time electronic bed management systems which will enable teams to review, share and archive handover information.

3. Governance

3.1 Each specialty/directorate will be responsible for drawing up handover arrangements which meet the above standards. These plans should cover all handovers and all areas of clinical care.

3.2 Handover will be audited annually.

Confidentiality

Maintaining confidentiality and adhering to data protection when dealing with patients is of utmost importance. You must ensure that paper containing patient details e.g. handover sheets are disposed of appropriately in the confidential waste. Any information that identifies patients must not be sent by email unless it is a bthft.nhs to bthft.nhs account or a @nhs.net to @nhs.net account. Only encrypted memory sticks can be used on the Trust computers.

E-mail accounts

You will need a secure email account for all your jobs as a junior doctor. You will be allocated a trust email address upon commencing in post. All log in details are given at Trust Induction.

If you have an external email account e.g. doctors.org you should not use this for Foundation Trust business or for emailing patient details. Sending emails from @bthft.nhs.uk or @nhs.net to an external email account is not secure unless the email is encrypted. Ironport encryption can be added to your @bthft.nhs.uk email account by contacting it.servicedesk@bthft.nhs.uk.

Incident Reporting and Serious Untoward Incidents (SUIs)

An adverse incident is an event or circumstance that led, or could have led, to unintended or unnecessary harm, loss or damage. Serious incidents are those which involve serious injury, major permanent harm or unexpected death, or where a hospital acquired infection is responsible.

The Trust is open about mistakes so that lessons can be learnt and disseminated. All incidents must be reported and are investigated. A report and lessons learnt will be disseminated through the Clinical Governance meetings.

If you are involved in an incident, always discuss this with a senior, ideally your clinical supervisor. There is an intranet based reporting tool found on the home page called DATIX, through which it can be reported. Seek advice from you supervisor regarding any report you may need to write in these situations.

Information Governance Serious Incidents Requiring Investigation (SIRI)

An information governance incident would include the loss or unlawful use of patient data. This includes the finding of a handover sheet in a public place. If an information governance incident occurs it is important that this is reported. The information governance team will grade the incident using the Serious Incidents Requiring Investigation (SIRI) grading tool. The incident will either be graded as level 1 or level 2. Level 2 incidents must be reported to the Health and Social Care Information Centre who subsequently inform the Department of Health and the Information Commissioner's Office.

For assistance with whether or not something is an information governance incident please speak to a senior or contact the information governance team on extension 4840 or information.governance@bthft.nhs.uk.

Quality Improvement Department

Our approach to quality

At BTHFT we aspire to provide care of the highest quality in collaboration with those who use our services. As an organisation we embrace learning and continuous improvement. We believe that if we can embed this culture we will get the assurance we need about the quality of the services we provide.

What is Quality Improvement?

Quality Improvement (QI) isn't just about improving the quality of something. It's about using a recognised, evidence-based methodology to test different approaches to solve a problem, where the solution to the problem isn't already known .

It can give everyone at every level the skills they need to lead change. It's about thinking differently, and being innovative, whilst focusing on what matters most to our service users and staff.

The methodology we use at BTHFT is called the Model for Improvement .

[1] The Health Foundation https://www.health.org.uk/publications/quality-improvement-made-simple

[2]Institute for Healthcare Improvement http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx

The Model for Improvement

This is an approach to continuous QI where changes are tested on a small scale based on theories and ideas and helps them to evolve into knowledge that can inform action and produce positive outcomes.

It helps us to think about how a change is related to an overall aim and how we can establish whether the change has been successful or not.

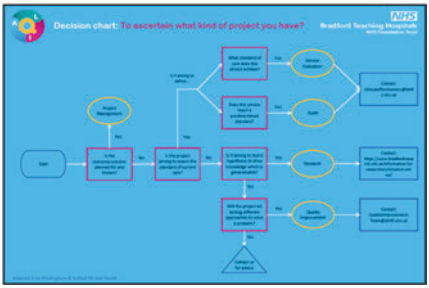
The model consists of two parts:

Part 1: Three questions help us define what we want to achieve, what ideas we think might make a difference and measures to help us understand if change is an improvement.

Part 2: The PDSA (Plan Do Study Act) cycle – steps taken to test change ideas. The cyclical approach helps changes to be refined and improved through repeated cycles of testing and learning. This provides a way to support continuous improvement.

Getting started

Are you completely new to Quality Improvement or new to our Trust and wondering how to change your good idea into measurable improvement? Our easy 5 steps guide should help you get started on the right track.



Step 1 – Check out our decision tool to work out if this is research, audit, service evaluation or quality improvement.

Step 2 – Complete the Yorkshire and Humber Improvement Academy Bronze QI training. This will take no more than 45 minutes. https://improvementacademy.org/our-training/bronze-quality-improvement-training.html

Step 3 – Watch one of our Bite Size videos - Quality Bites - From Audit to Improvement - YouTube (8 minute video) - to help you understand how audit differs from QI but how you can use audit to help with your QI project.

Step 4 – Sign up to Life QI, our online QI platform, here https://www.lifeqisystem.com/

Step 5 – Email the QI team for support quality.improvement@bthft.nhs.uk

Documentation Standards for Trainee Doctors

These standards are written based on GMC Good Medical Practice guidance and commentary by The Health Foundation and Kings Fund with regards safe and effective communication and continuity of care. Further detail with respect to the generation of documents within the Electronic Patient Record (EPR) will be provided at induction.

All records should be completed accurately. Therapy and intervention should only be prescribed and administered when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs.

It is important to keep colleagues informed when you are sharing the care of individuals with other healthcare professionals and staff. Poor communication, particularly during handover from one team to another, and during discharge from hospital, is the commonest cause of poor quality care.
Discharge letters must contain adequate clinical information including results of key investigations, clinical progress and management, changes to medications, follow up arrangements and any expected actions for other teams.

Patients value being able to build a relationship with a professional who knows their medical history and treatment plans without being reminded. Patients also look to clinicians for information about their illness and treatment, and are critical of being given conflicting or inconsistent information. Everyone working in health care has an important role to play in maximising continuity.

You must use Clinician Workflow to clerk patients and then on ward rounds (Post take/ Progress) where possible. Dynamic notes and other free-text notes should only be used in exceptional circumstances.

Clinicians Workflow is specifically designed to guide you through a thorough assessment and generate documents that present all key information (clerking, diagnoses, comorbidity, vitals, examination findings, allergies, home and inpatient medications, investigation requested and procedures carried out).

Entering information in Clinicians Workflow also reduces duplication, saving time. Diagnoses, comorbidity, medications, procedures do not need to be documented repeatedly.

By using the Clinicians Workflow you will know everything about the patients you are caring for and be in a position to confidently present them to your senior colleagues using the Visit Summary.

Clinicians Workflow also auto-populates the Visit Summary, SBAR page, handover spreadsheets (Discharge and Dr Work List) and discharge documentation as part of the Depart screen, allowing safe and effective communication across the MDT, between shifts and back to primary care.

For every abnormality observed on history, examination or investigation, for every medication prescribed (including oxygen), and for every intervention given (including those associated with mobility and activities of daily living) a diagnosis must be recorded.

Clerking a patient

Following the components of the Clerking in Clinicians Workflow enter the:

- Presenting complaint
- Detail the history of the presenting complaint in a free text area of your choice (-e.g. Specialist History or Clinical Summary). It is not necessary to complete all the free-text areas
- Record all past medical, surgical and mental health history including disabilities and dependency in Problems and Diagnosis as a Chronic condition –e.g. old MI, chronic ischaemic heart disease, diabetes, presence of prostheses/ devices/ stent, wheelchair dependence, difficulty walking (if uses a stick)

Problems and Diagnosis

Classification: **Medical and Patient St**

		Add new as **Chronic** ▼	Problem name	
Name		Classification	Actions	
	HTN - Hypertension	**No flag**	**This Visit**	**Chronic**
	MS- Multiple Sclerosis	**No flag**	**This Visit**	**Chronic**
	Old myocardial infarction	**No flag**	**This Visit**	**Chronic**
	Type 2 diabetes mellitus	**No flag**	**This Visit**	**Chronic**
	Wheelchair dependence	**No flag**	**This Visit**	**Chronic**

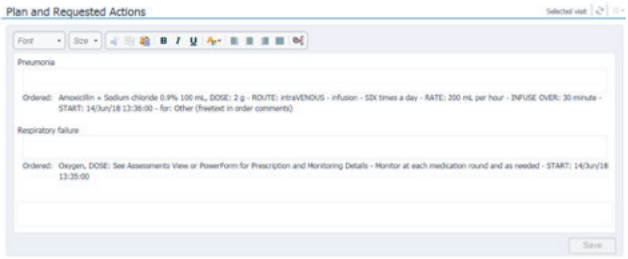
- Home medications should be recorded via Home Medications and Document Medication by History
- Allergies recorded should be reviewed and new ones added
- Social and Family history should be recorded under Histories, Social/ Family and by categories using the drop down menus.
- Vitals will be entered automatically from the recorded observations. The remainder of your examination can be entered below your history of presenting compliant or in a second dedicated free-text area – Examination.
- Your working diagnosis should be entered in Problems and Diagnosis as "*This Visit*" along with any associate complications and investigation abnormalities- e.g. respiratory failure (if the patient is hypoxic and needing oxygen), hyponatraemia (if the sodium is low), abnormal liver function (if LFTs are deranged), LBBB/RBBB/ ectopics. Diagnoses can be ranked using the arrows to the left of the diagnosis.

Classification: **Medical and Patient St**

		Add new as **This Visit** ▼	Problem name	
Name		Classification	Actions	
1 ▼	Pneumonia	**No flag**	**This Visit**	**Chronic**
2 ▼	Respiratory failure	**No flag**	**This Visit**	**Chronic**
3 ▼	Acute renal failure	**No flag**	**This Visit**	**Chronic**
4 ▼	Hyponatraemia	**No flag**	**This Visit**	**Chronic**
	HTN - Hypertension	**No flag**	**This Visit**	**Chronic**
	MS- Multiple Sclerosis		**This Visit**	**Chronic**
	Type 2 diabetes mellitus		**This Visit**	**Chronic**
	Wheelchair dependence		**This Visit**	**Chronic**

- Management Plan. Your plan should be recorded in Plan and Requested Actions. Here you will see your diagnoses. Medications and Investigations can be linked to your diagnoses during the request process so that you do not need to write these as separate entries.

Plan and Requested Actions



- To save the note choose Select Other Note on the left hand menu.

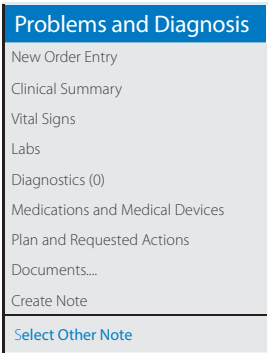
Ward Round Documentation

Ward round documentation can be completed via Clinician Workflow using the Post Take or Progress tab. We advise that you optimise the component to the following. When you generate the document using Select Other Note all the key information will be documented without you having to type it again.

- To save the note choose Select Other Note on the left hand menu.

Use Clinical Summary as your free-text area to document the ward round. Note observations, current diagnoses and problems do not need to be documented as free-text again.

It is the importance to link every abnormal finding on history/ examination/ investigation and every physical intervention including nurse led care and assessments by allied professionals with diagnosis in Problems and Diagnosis as "*This Visit*."



Avoid documenting abnormality in free-text without a diagnosis-e.g.

- 'eGFR 25*' Renal Failure
- 'Na 126*' Hyponatraemia
- 'Consolidation Pneumonia
- 'pO2 6 pco2 12' Type 2 Respiratory Failure
- 'BMI 36' Obesity

To save the note choose **Select Other Note** on the left hand menu.

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NEWS Key

0	1	2	3

Chart 4: Clinical response to the NEWS trigger thresholds		
0	**Minimum 12 hourly**	• Continue routine NEWS monitoring
1 - 4	**Minimum 4 - 6 hourly**	• Inform registered nurse, who must assess the patient • Registered nurse decides whether increased frequency of monitoring and / or escalation of care is required
3 in single parameter	**Minimum 1 hourly**	• Registered nurse to inform medical team who will review and decide whether escalation of care is necessary
Total 5 or more	**Minimum 1 hourly**	• Registered nurse to immediately inform the medical team and request urgent medical review within 30 minutes • Consider providing clinical care in an environment with monitoring facilities if appropriate. • Consider critical care outreach review.
Total 7 or more	**Continuous monitoring of vital signs**	• Registered nurse to immediately inform the medical team– this should be at least at specialist registrar level. If unable to attend within 30 minutes escalate to the consultant. • Clinical care in an environment with monitoring facilities if appropriate. • Consider referral to and transfer of care to a level 2 or 3 clinical care facility i.e. higher dependency unit or ICU. This will need consultant to consultant referral.

NEWS chart overleaf

MID 19012106
version 2 - Sue Franklin
BFD0001

1019012106

NEWS key 0 1 2 3	FULL NAME		DATE OF BIRTH		DATE OF ADMISSION	
	DATE / TIME					DATE / TIME
A+B Respirations Breaths/min	≥25	3				≥25
	21–24	2				21–24
	18–20					18–20
	15–17					15–17
	12–14					12–14
	9–11	1				9–11
	≤8	3				≤8
A+B SpO_2 Scale 1 Oxygen saturation (%)	≥96					≥96
	94–95	1				94–95
	92–93	2				92–93
	≤91	3				≤91
SpO_2 Scale 2† Oxygen saturation (%) Use Scale 2 if target range is 88–92%, eg in hypercapnic respiratory failure †ONLY use Scale 2 under the direction of a qualified clinician	≥97 on O_2	3				≥97 on O_2
	95–96 on O_2	2				95–96 on O_2
	93–94 on O_2	1				93–94 on O_2
	≥93 on air					≥93 on air
	88–92					88–92
	86–87	1				86–87
	84–85	2				84–85
	≤83%	3				≤83%
Air or oxygen?	A=Air					A=Air
	O_2 L/min	2				O_2 L/min
	Device					Device
C Blood pressure mmHg Score uses systolic BP only	≥220	3				≥220
	201–219					201–219
	181–200					181–200
	161–180					161–180
	141–160					141–160
	121–140					121–140
	111–120					111–120
	101–110	1				101–110
	91–100	2				91–100
	81–90	3				81–90
	71–80					71–80
	61–70					61–70
	51–60					51–60
	≤50					≤50
C Pulse Beats/min	≥131	3				≥131
	121–130	2				121–130
	111–120					111–120
	101–110	1				101–110
	91–100					91–100
	81–90					81–90
	71–80					71–80
	61–70					61–70
	51–60					51–60
	41–50	1				41–50
	31–40	3				31–40
	≤30					≤30
D Consciousness Score for NEW onset of confusion (no score if chronic)	Alert					Alert
	Confusion	3				Confusion
	V					V
	P					P
	U					U
E Temperature °C	≥39.1°	2				≥39.1°
	38.1–39.0°	1				38.1–39.0°
	37.1–38.0°					37.1–38.0°
	36.1–37.0°					36.1–37.0°
	35.1–36.0°	1				35.1–36.0°
	≤35.0°	3				≤35.0°
NEWS TOTAL						**TOTAL**
Monitoring frequency						Monitoring
Escalation of care Y/N						Escalation
Initials						Initials

Special circumstances

- ICU/HDU discharge - NEWS within 1 hour and then minimum 4 hourly for 24 hours
- Post op - NEWS immediate on return from theatre, then ½ hourly for 2 hours, then hourly for 4 hours, then 4 hourly for 24 hours
- Post op day case - NEWS immediate on return from theatre, then ½ hour later. If stable then NEWS on discharge
- Post medical procedure - NEWS post procedure, then follow post procedure guidelines
- AVPU=3 (Unresponsive- if sudden then contact medical team immediately. Check blood glucose level, and start 15 min obs on GCS. Continue hourly obs until stable
- Intra hospital transfer of ventilated ICU patients - commence 15 min obs on transfer chart then continue on ICU chart pre and post transfer
- Blood Transfusion - Continue frequency according to NEWS guideline. In addition, T,P,R & BP just before transfusion, 15 mins after the start and again once the transfusion of the unit is complete. Repeat for all subsequent units. Document the start and end of transfusion on the NEWS chart

Delegated consent

Foundation Year 1 – Doctors.

It is important that foundation doctors understand the principle of consent and can undertake consent for a small number of procedures. They require specific training and need to be observed taking consent for the first time. This should be recorded as a mini-CEX. Foundation year 1 doctors can only take consent for the following list of procedures and it is certainly not appropriate to delegate consent for interventional procedures to FY1 and FY2 doctors.

List of procedures where FY1's can take consent (with evidence of training and assessment)

- Colonoscopy
- Gastroscopy
- Sigmoidoscopy
- Blood transfusion (verbal)
- Lumbar puncture (verbal)
- Bone marrow examination
- Peripheral Long Line Insertion

Foundation Year 2 – Doctors.

Foundation doctors in the second year of training may not have taken consent in other Trusts. It is compulsory they receive training and are observed taking consent for the first time with a Mini-CEX.

List of procedures where FY2's can take consent (with evidence of training and assessment)

- Colonoscopy
- Gastroscopy
- Sigmoidoscopy
- Blood transfusion (verbal)
- Lumbar puncture (verbal)
- Bone marrow examination
- Peripheral Long Line Insertion

- Bronchoscopy (Respiratory trainees only after Mini-CEX)
- Renal Biopsy (renal trainees only after Mini-CEX)
- Pacing (cardiology trainees only after Mini-CEX)
- Cardioversion (cardiology trainees only after Mini-CEX)
- Trans-oesophageal Echo (cardiology trainees only after Mini-CEX)
- Endoscopic ultrasound (gastro trainees only after Mini-CEX)
- Manipulation of fractures without skin or neurovascular compromise (Emergency medicine after Mini-CEX)
- Arthroscopy of the knee & ankle, Joint injection (orthopaedics after Mini-CEX)

Foundation doctors in particular should be empowered to refuse to take consent for any procedure for which they have not received the appropriate training.

Trainees under pressure to deviate from this guidance should report this directly to the FTPD or Director of Education via the education office or email. This can be done in confidence if required.

Guidance for when one trainee in a medical or surgical speciality can supervise another trainee to perform an invasive procedure

General

Given the mix and experience of junior doctors coupled with the varying complexity of many invasive procedures it would be both cumbersome and unworkable to produce written guidelines of when and how one trainee can supervise another trainee when performing an invasive procedure.

However a number of clear principles apply which should be used as a framework to ensure not just the safety of patients but also allow appropriate training of medical staff. These principles should be adhered to and MUST be followed for any procedure for which the patients' written consent would normally be sought.

Principles

1. Both the Supervising and Supervised trainees must be comfortable about performing the procedure proposed.
2. The patient should be aware and agreeable to the trainee under supervision performing the procedure.
3. The supervising trainee must be fully competent and experienced at performing the procedure concerned and to have performed it without complication and independently recently.
4. The supervised trainee must be at a stage of training and experience where it would be usual for that trainee to perform under supervision the proposed procedure and that they will utilise the skills learnt.
5. Wherever practicable the supervised trainee should have practised the procedure during a simulated training session.
6. The supervising trainees' clinical supervisor (usually a Consultant) should be aware and agreeable to the proposed supervision of another trainee for that procedure.
7. Assistance from a more experienced member of staff must be readily available at times of uncertainty or complication. The more complex a procedure the more immediately available potential assistance should be.

Correct Procedure Protocol

The 'Correct Procedure Protocol' was introduced into the BTHFT in 2008 in response to a National Patient Safety Agency (NPSA) alert. The aim is to reduce the risk of wrong site surgery / wrong procedure. It is important to remember that 'wrong site' is not just about left or right but also includes the wrong patient, incomplete procedure, wrong procedure, wrong limb, digit or organ.

The protocol defines the responsibilities of health professionals taking consent:

- Avoid abbreviations (e.g. L or R for left or right)
- All documentation must be available and consulted (notes, x-rays etc)
- Consent form should be completed at the bedside with the patient present
- Site should be clearly marked with a permanent black marker
- A green Patient Procedure Band must be applied at the time of consent BY THE CONSENTING DOCTOR

The Patient Procedure Band

No patient should leave a ward for any invasive procedure without a green band, **with the exception of patients undergoing radiological interventional procedures – see section below.**

- Details procedure and site, date, patient identifier
- Signed and applied by consenting doctor at the time of consent
- Checked and signed by operating surgeon in Anaesthetic room, Gastroenterology Unit or Radiology Department
- Checked and signed by Anaesthetist in Anaesthetic room

Consent procedure for radiological interventional procedures

For radiological interventional procedures the ward-based team will no longer be expected to discuss the specific details and risks of the procedure itself, beyond the concepts needed to ensure the patient is broadly in agreement. That step will be done in radiology.

The new process will be:

- Ward team discusses need for procedure, alternatives, etc., with patient and documents this in EPR.
- If patient agrees, procedure is requested via EPR.
- No green band.
- Radiology will arrange the time and date of the procedure and send for the patient, to go to a room near the procedure room (but not the procedure room itself).
- Radiology staff will discuss the details of the procedure, associated risks, etc., and get a signed consent form if the patient still agrees.

Prescribing

7 Steps to Safe prescribing

There are trust guidelines on how to prescribe both correctly and safely. Juniors will receive guidance on how to prescribe accordingly and the pharmacy department produce an excellent booklet to complement this. Seven steps to SAFE! prescribing are:

1. Find out EXACTLY WHAT MEDICINES the PATIENT TAKES AT HOME
This would eliminate our most common prescribing error – an incomplete medication history, so make that extra effort to get it right. If possible, **use TWO sources to confirm this** – SystmOne, the GP prescription print-out, the fax from the medical Centre, own drugs, information obtained from relatives/ carers as well as that provided by the patient. (Encourage patients to bring all their own medicines from home – this avoids missed doses at admission). It may not always be possible to get the medication history at one attempt – so do not leave the job half done. **Ultimately, you must ensure that your prescribing on admission matches the clinical needs of the patient.**

2. You must complete the ALLERGY section.

3. You must consider THROMBOPROPHYLAXIS. Review the trust VTE guidelines on the intranet before prescribing.

4. Prescribe ONCE-A-WEEK drugs correctly
This includes Methotrexate, Alendronate or Risedronate.

5. Comply with the ANTIBIOTIC POLICY directions about how antibiotics should be prescribed
Choose the antibiotic according to the Antibiotic guidelines on the intranet. Write down why the antibiotic is needed and the number of days of treatment needed.

6. Take time to think about WHEN DIABETIC DRUGS should be given
Diabetic drugs are normally given at meal times – and NOT at night (except for very long acting insulins).

7. Tell GPs on the TTO what drugs we have changed.

Remember: Are you ABSOLUTELY sure that you are prescribing for the right patient? Are your looking at the right prescription and the right set of notes? Do the medicines in your hand really belong to the patient you intend to treat (could they be the husband's or wife's or belong to the patient previously occupying your patient's bed)?

Oxygen Prescribing

Oxygen must be prescribed. Staff should use an appropriate device and flow rates in order to maintain saturations within the target range (94-98% in normal subjects, although the lower limit falls slightly with age and is about 95% in adults over 70 years of age, 88-92% for patients with COPD).

Antibiotic Prescribing

There is an antibiotic prescribing policy within the trust. This gives examples of appropriate antibiotics to prescribe for a wide variety of infections. It is readily accessed from the Trust intranet home page under Adult Antibiotic Protocol

Whenever an antibiotic is prescribed, previous results should be reviewed on the ICE system. This may reveal previous culture and sensitivity reports and helps to identify patients who have previously been colonised with appropriate organisms. These cases may need to be discussed with the microbiologists if an appropriate antibiotic is not available.

Certain antibiotics are controlled by the microbiologists, these include linezolid and meropenem. These should only be prescribed on the recommendation of a consultant microbiologist. They are supplied on a named patient basis and require a code before pharmacy will dispense them.

When prescribing antibiotics be aware of which antibiotics can and cannot be used in patients who are allergic to penicillin. A summary sheet is available on every ward and every drug trolley.

Prescribing for Patients with Drug Allergies

Serious reactions can ensue if a patient known to have an allergy is given that drug, indeed there was a high profile death in this trust from Penicillin allergy in 2001. Unfortunately a cluster of eleven incidents involving antibiotics being prescribed and or administered to potentially allergic patients occurred in 2011/12.

The prescriber must:

1. Confirm the drug the patient is allergic to, ie penicillin.
2. Complete the details of the reaction in EPR.
3. Check the patient has an allergy wrist band and if not ask for this to be changed.

In the event of a serious allergic reaction the anaphylaxis box can be accessed in every crash trolley within the trust.

The Insulin Chart - prescribing and administration for Adult Patients

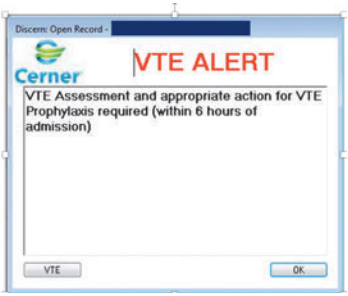
Contents:

THINKGLUCOSE™
Inpatient care for people with diabetes

VTE

VTE risk assessment and VTE prophylaxis prescription where appropriate will be an important task in your role as a junior doctor.

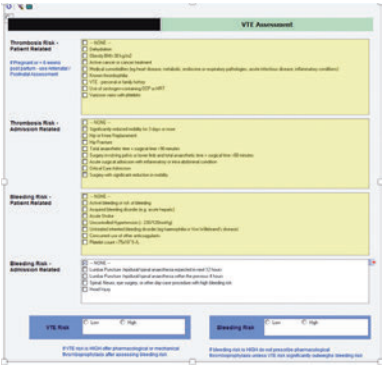
All patients (including all acute and elective inpatients and surgical day cases) require VTE assessment on admission and a repeat assessment within 24 hours of admission or if their condition changes. Depending on the degree of risk patients should be given advice regarding early mobilisation where possible and receive treatment to reduce risk if appropriate.



Risk Assessment

Initial risk assessment is the responsibility of the admitting medical team and should be discussed with a senior member of the team if there is concern regarding whether a patient should receive VTE prophylaxis.

On admission to hospital the following alert will be displayed on the patient's record. To perform a VTE risk assessment you should click the 'VTE' box, if you are yet to review the patient you can click 'OK' to bypass the alert. The alert will continue to be displayed every time you open the patient record or try to prescribe a medication until the alert has been actioned upon. When you press 'VTE' you will be taken to the risk assessment screen. On completion of the risk assessment screen the system will inform you whether the patient is high risk for VTE and/or bleeding.

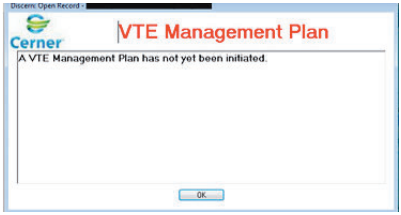


You should use the risk assessment to inform your prescribing.

All patients require repeat assessment within 24 hours; the system will alert you to review the existing risk assessment. For prolonged stays prophylaxis should be reviewed regularly. If prophylactic LMWH is anticipated to continue beyond 7 days a platelet count should be checked 5-7 days after the initiation of LMWH, if the patient is found to be thrombocytopenic the LMWH should be discontinued and patient discussed with haematology.

Prescribing

Tinzaparin is the LMWH used in Bradford Trust. Where pharmacological prophylaxis is contraindicated the patient should be considered for mechanical prophylaxis i.e. TED stockings.

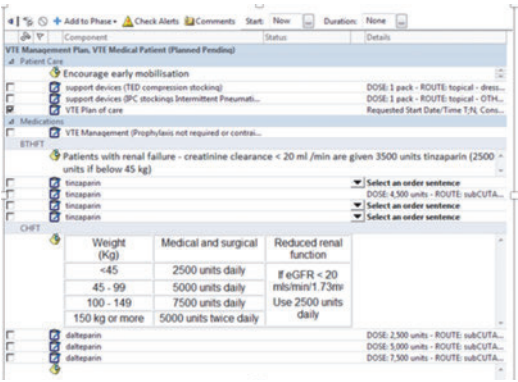


Contraindications to TED stockings: PAD, peripheral neuropathy, sensory impairment, CCF, severe leg oedema, very fragile skin.

VTE prophylaxis should be prescribed via the EPR Power Plan 'VTE Management'. This can be accessed in the 'Requests/Care plans' by clicking the 'Add' button. Tinzaparin can be prescribed without the initiating the VTE management plan but the system does not recognise that you have acted on the VTE risk assessment and will continue to display the alert to the right.

Power Plan Prescription on EPR ➡ type in "VTE Management" and select options required

- TED stockings (if required – more applicable for surgical pts)
- 4,500 units Tinzaparin OD (check patient weight - <50kg - 3,500 units, >100kg - 7,500 units)
- If patient has renal dysfunction with Creatinine Clearance <20ml/min then Tinzaparin dose should be reduced to 3,500 units. If patient also below 45kg then further reduce dose to 2,500 units.
- If patient is already anti-coagulated or VTE otherwise contraindicated select option *"VTE prophylaxis not required"*
- Tinzaparin cannot be prescribed if platelets <50 ➡ needs discussion with Haematology



Once you have selected the treatments you require press the initiate button and then the sign button to finalise and transfer the treatments to the drug chart. If the patient is not suitable for prophylaxis and you have selected 'VTE prophylaxis not required or contraindicated' it will be documented on the drug chart so that the nursing stuff are aware that VTE prophylaxis has been considered.

Discharge

On discharge the vast majority of patients will stop VTE prophylaxis. If extended prophylaxis is indicated this will need to fully explained to the patient and clearly documented. Extended VTE prophylaxis is standard procedure following fractured neck of femur, hip replacement, knee replacement and major abdominal or pelvic surgery for cancer.

Full VTE guidelines can be found on the intranet by searching VTE.

Arterial Blood Gas

At your induction you should be given a code for the blood gas machine. Your individual code should work on all blood gas machines across the trust.

Often the machine is undergoing or requires maintenance so you may have to find an alternative one. There are arterial blood gas machines on ward 4, in the upstairs of the biochemistry lab, ward 21, A&E and ICU.

Blood and Blood Component Transfusion

For blood or blood transfusion related queries – ring:

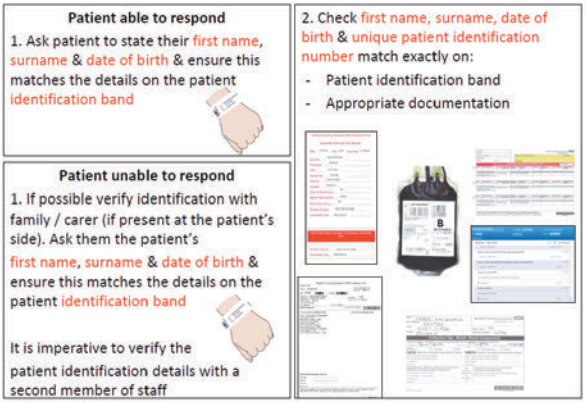
- Transfusion laboratory ext. 4204
- Transfusion practitioners ext. 2454
- Haematologist on call

Blood transfusion is a common procedure among hospital in-patients, and it is one that is nationally associated with severe adverse events. There are some which cannot be prevented but there are others which can. The events that can be prevented far outnumber those that cannot. Of these, the most common is transfusing the patient the wrong blood. **THIS CAN BE FATAL!**

There are strict protocols which MUST be adhered to throughout the transfusion process.

1. Patient identification

- Positive patient identification, using the patient identification band, is essential at all stages of the blood transfusion process



2. Decision to transfuse

- The decision to transfuse must be based on a thorough clinical assessment of the patient and their individual needs.
- It is imperative to ensure that the transfusion of blood/blood components is appropriate (refer to appropriate guidelines on the Trust intranet)
- If there are any uncertainties or further advice is required consult a haematologist
- Document the decision and the outcome in the patients records

3. Consent

- Informed verbal consent including risks benefits and alternatives must be obtained and details documented in the patient clinical records. Complete the consent section of the blood/blood components prescription/record

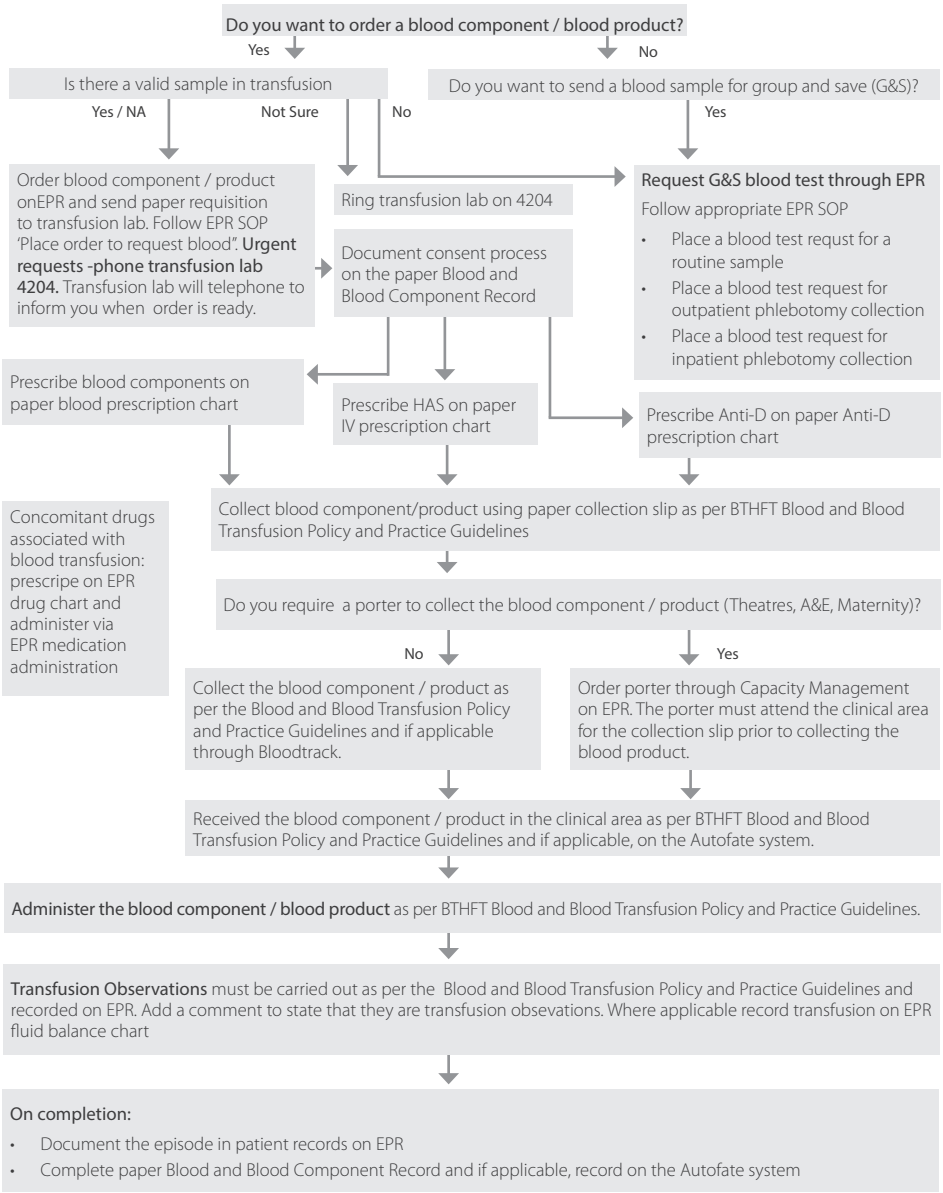
4. Prescription

- Prescribe on a blood/blood components prescription/record (paper record). Risk assess for transfusion associated circulatory overload (TACO) and complete the TACO checklist on the blood/blood components prescription/record. Ensure that special requirements are documented on the prescription (Refer to the appropriate BTHFT guidelines for special requirements on the Trust intranet)

5. Requests for blood/blood components

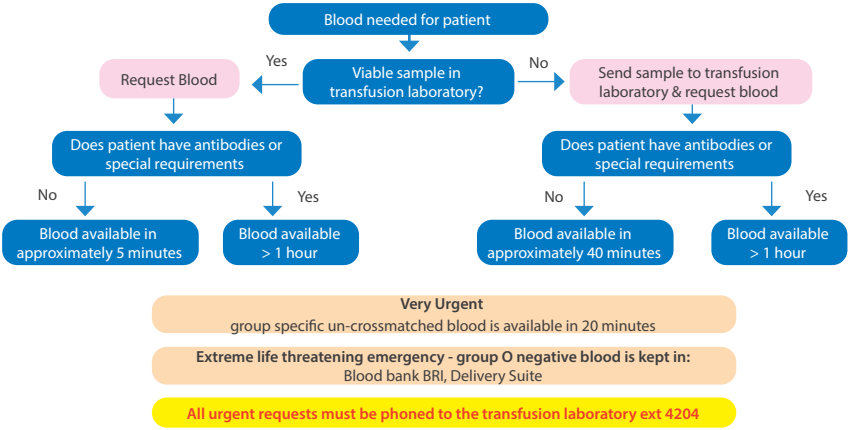
- Ensure that special requirements e.g. CMV negative, HEV negative or irradiated products, are communicated to the blood transfusion laboratory.

The Blood Transfusion Process and EPR



6. Group screening and cross matching

- If there is any chance that the patient may need blood during admission or if there is any uncertainty of this always send a group and screen (G&S) sample (Also refer to the BTHFT Maximum Surgical Blood order Schedule)



7. Sampling procedure

- All staff obtaining pre transfusion blood samples must be appropriately trained and competency assessed

Errors or omissions of patient identification details on samples/requisition forms will result in them not being processed and a correctly labelled repeat sample and requisition form will be needed

8. Administration

- Blood and blood components can only be administered by appropriately trained and competency assessed staff
- The patient must have access to nurse call system, be able to be readily observed and resuscitation facilities must be available

Minimum Observations

- Temperature, pulse, blood pressure, respirations
  - Before
  - After 15 minutes - also ask the patient how they feel at this point
  - On completion

} Each unit

- Visually monitor throughout - additional observations as needed

9. Transfusion Reactions

- Any signs of a transfusion reaction must be acted upon **quickly**. A minor reaction can turn into a severe reaction. All severe reactions should be discussed with a consultant haematologist. (refer to the BHTFT acute transfusion reaction Guideline)

10. Policies and guidelines

- Refer to the appropriate policies and guidelines on the Trust intranet for further information.
  - Blood and blood component transfusion policy and practice guidelines
  - Irradiated blood and blood component policy
  - Guidelines for the use of fresh frozen plasma and cryoprecipitate (Adults)
  - Guidelines for the use of platelets (Adults)
  - Indications for the use of red cells (Adults)
  - Guidelines for the use of Cytomegalovirus blood components
  - Massive Haemorrhage Guidelines (Adult)
  - Guidelines for the management of acute transfusion reactions (Adults)
  - Guidelines for the management of patients who refuse blood/blood product

Infection Prevention and Control

It is important to take steps to prevent the spread of infection, both to staff and patients. Follow the infection control policies and protocols that are published on the Trust intranet 'Policies' site. If in doubt contact the IPC Team on ext 4049.

Basic precautions help reduce the risk:

Hand hygiene – either wash or alcohol gel your hands before and after every contact with a patient or the patient's bed area. In the case of patients with diarrhoea and vomiting, hands should always be washed because alcohol has no effect on Clostridium difficile spores and little effect on norovirus which can both be removed by soap and water.

Dress code – the general rule 'bare below the elbows' applies. Shirt sleeves must be rolled up above the elbow, no wrist jewellery including wrist watches, no jewellery (except one plain band ring and plain stud earrings allowed), no nail extensions or nail varnish. There should be no dangling clothing or accessories including name badges – these should not be worn on neck lanyards. Headscarves can be worn but should be plain, not have tassels and be tucked in and changed daily to reduce the risk of any cross infection

Aprons – wear disposable aprons to prevent your clothing coming into contact with all patients or patient's immediate environment. Yellow aprons are worn for all patients in side rooms and white for all other patients. Discard the apron after use and use a new one for each patient. Therefore examining a patient or performing a procedure will require an apron to be worn. This applies to all patients whether they are in isolation rooms or not.

Gloves – should be worn to prevent contact with blood or body fluids for all patients

Masks – should be worn when patients have diseases which spread by the airborne route- there are two levels of precaution: droplet - where a fluid repellent surgical face mask is sufficient e.g. influenza; aerosol - when a close fitting FFP3 respirator should be used e.g. open pulmonary TB (check the Source Isolation Protocol on the Trust intranet).

Side rooms – Check the patients infectious status (Side room priority Red, Amber or Green) by reviewing the side room priority board before entering a side room and checking what extra precautions may be needed. Patients with diarrhoea should be isolated in a single side room within 2 hours of onset of symptoms.

Alert organisms and Alert conditions – there are alert organisms that the infection control team will inform the clinical team about if they are isolated in samples and alert conditions that you need to tell the infection control team about. These may require special precautions such as the patient being placed in isolation or colonisation suppression therapy.

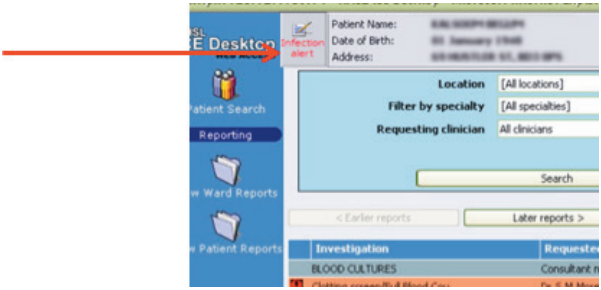
Examples of alert organisms

- MRSA; Multi-resistant Gram-negative bacteria including Carbapenamse-producing Enterobacteraciae (CPE); Glycopeptide resistant enterococci (GRE)
- Bacterial and viral causes of diarrhoea (including C difficile, Norovirus)
- Group A Streptococcus

Examples of alert conditions (phone the infection control team on 4049)

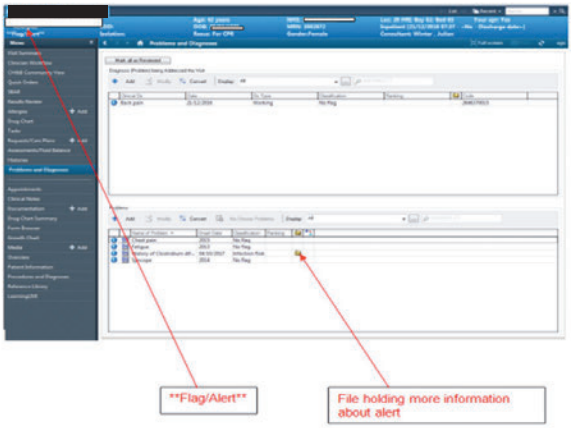
- Suspected infective diarrhoea and/or vomiting
- Soft tissue infection, e.g. cellulitis
- Tuberculosis
- Chickenpox/Shingles
- Scabies
- Fever related to foreign travel and rare infections
- Infection with alert organisms diagnosed outside the Trust
- Transfers from hospitals abroad (antibiotic resistance is more common)

Infection alerts on ICE and EPR – Check for infection alerts for organisms such as MRSA, previous C diff, GRE, CPE on ICE shown by a box in the top left of the results screen for all patients:



Click on the box to view the alert and follow any specific instructions.

EPR



MRSA - Check previous results, current screening results and remember to check for an Infection alert flag on ICE & EPR for all patients. The infection alert flag shows that this patient has a history of MRSA. If there is current or past history of MRSA then you need to:

- Review antibiotic prescriptions – you may need to adjust these to ensure MRSA is covered – see the Antibiotic protocols
- Prescribe colonisation suppression treatment – check the MRSA protocol for details

Also prescribe colonisation suppression for other patients at moderate risk of MRSA:

- care home resident
- extensive skin disease
- admissions within the last 12 months

- this may be stopped if MRSA screening results are negative

C difficile - Check previous results and for the Infection alert flag on ICE & EPR for all patients.

If there is a past history of *C difficile*:

- Review prescriptions for antibiotics and acid suppression – are they necessary?
- Use the antibiotic protocol or consult microbiology before prescribing any antibiotic outside the protocol.

CPE - Check for any alert on ICE & EPR or high risk:

- Any previous history of CPE
- Known contacts of CPE
- Patients who have been hospitalised abroad in the last 12 months

Patients who have been hospitalised in UK hospitals where there has been spread in the last 12 months (appendix 1 of the MDR-Gram-negative organisms protocols shows a list - currently hospitals in North-West England and London)

All patients with isolates of CPE or at high risk of CPE:

- Need isolation in single rooms (infection status Red).
- Antibiotic prescriptions should be discussed with a consultant microbiologist/ID physician.

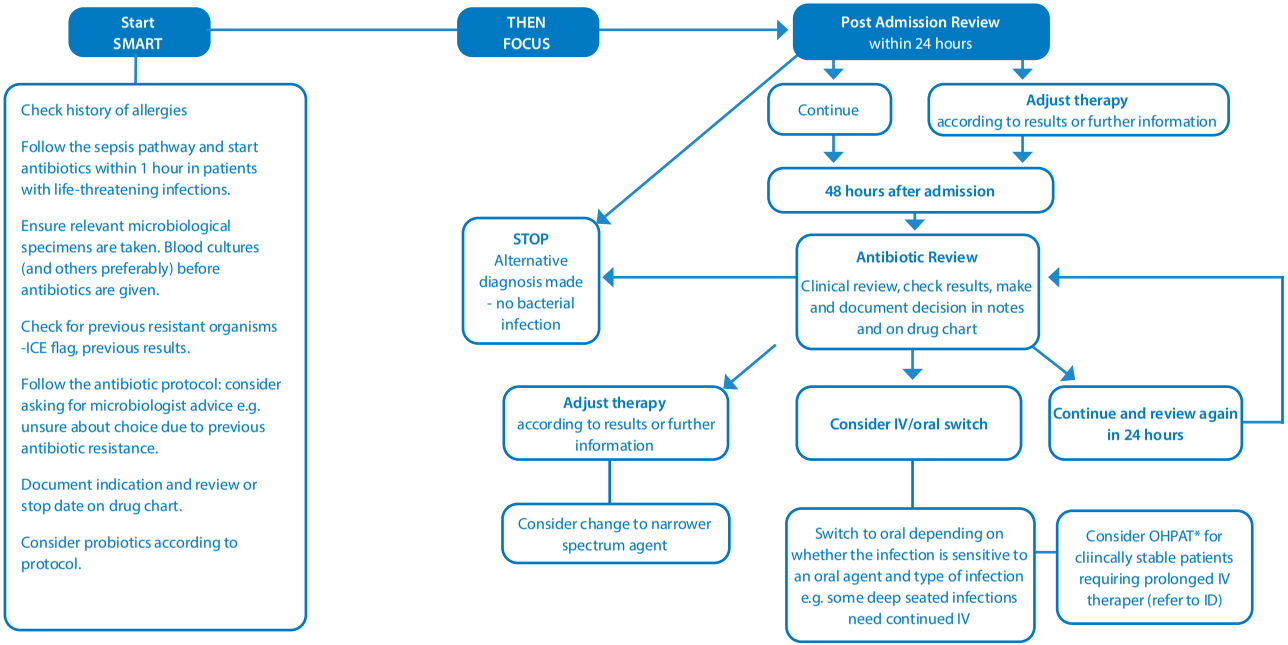
Patients at high risk of CPE will require screening by rectal swab – see the MDR-GNB protocol.

IV cannulation – use the cannula pack provided which contains the appropriate skin antiseptic and other equipment needed. Use an aseptic non touch technique; non-sterile gloves should be worn to prevent blood contact with your skin. Always use a SEPP device (2% chlorhexidine in 70% alcohol) provided with the cannula pack for skin cleansing prior to insertion of the IV cannula, write the date of insertion on the dressing and start the VIP score chart.

Blood cultures - ensure that the risk of contaminating cultures is minimised. Use the blood culture pack and a vacuum collection system from a separate venepuncture, injecting the culture bottles first. Clean the skin and bottle tops with 2% chlorhexidine in alcohol (FREPP for the skin and green Clinell wipes for the bottles. Ensure a non-touch technique is used. The blood culture packs include a leaflet showing the approved method of collection. The pack also includes a sepsis screening tool and high risk sepsis pathway - which should be completed and placed in the notes of **every patient having a blood culture**.

Antimicrobial Stewardship

Right Drug, Right Dose, Right Time, Right Durations for Every Patient



Antimicrobial Prescribing Review Group
June 2013

OHPAT - Outpatient or Home Parenteral Antimicrobial Therapy

Infection risk labelling

Microbial pathogens can be classified into hazard groups according to the risk of infection to employees. Most common pathogens fall into hazard group 2. Hazard Group 3 (HG3) include pathogens that could cause severe infection and specimens that may contain these pathogens are required to be handled differently in laboratories. To inform laboratories of the risk due to HG3 organisms there is a requirement under Health and Safety regulations to label forms and specimen containers with infection risk labels.

Check out the BTHFT Standards for specimen and request form labelling which can be found on the Pathology intranet pages and includes a list of HG3 organisms.

The commonest HG3 organisms are:

- blood borne viruses (BBVs) - HIV, HBV, HCV
- travel related infections such as typhoid and malaria
- tuberculosis

Patients with the following conditions may have HG3 organisms:

- hepatitis
- high risk of HIV
- fever within 3 weeks of travel abroad
- suspected tuberculosis

N.B. Hazard Group 4 organisms include viral haemorrhagic fever (VHF) e.g. Ebola and need even more precautions. No specimens should be sent from patients suspected of VHF without prior permission from the laboratory (follow VHF protocol and guidelines)

Doctors ordering pathology investigations

Doctors completing pathology investigation requests (i.e. those completing the documentation) must follow the responsibilities below:

- As part of taking a patents medical history, determine if the patients may present a HG3 risk, for example have a fever within 3 weeks of travel abroad, are in group at high risk of BBV etc.
- Where a patient is suspected of having an infection or carriage due to an HG3 organism, ensure that labelling is applied to pathology requests and specimens and this information is communicated to the IPC team and the ward staff who might be involved in pathology requests.

- Check the ICE & EPR results for flags that indicate that a patient requires infection risk labelling, and if so ensure that labelling is applied to pathology requests and specimens and this information is communicated to other members of the ward staff who might be involved in pathology requests.
- Check any information given in microbiology results that indicate the presence of a HG3 organism and communicate the need for infection risk labelling to other members of ward staff who might be involved in pathology requests.

Identifying patients that are positive for HG3 microorganism

1. **Results showing HG3 organisms**
   Results from microbiology showing HG3 organisms will have a note in the report stating this and the need for infection risk labelling.
2. **ICE & EPR flags and Alerts (located in the patient notepad)**
   Flags may refer to the current admission, others will be permanent depending on the nature of the infection or carriage due to a HG3 organism and this will be apparent from the wording of the flag.
3. **Information from the IPC team or ward handover or communication notes**
4. **Information from the patient from an IPC risk assessment or during medical history taking**

If there is a risk of infection to those processing the samples in the labs you must add "Infection Risk" or "Danger of Infection" labels to both the sample and the request form.

If you do not have "Infection Risk" or "Danger of Infection" labels you can write "Infection Risk" on the form and highlight this using a highlighter pen.

Information to Include on Pathology Request Form

To ensure samples are processed safely always include relevant clinical information about possible or known infection risk e.g.

- Blood borne viruses (Hepatitis B and C, HIV) - known positive, possible viral hepatitis, injecting drug users (unless known to be negative)
- Patients with fever within 3 weeks of travel abroad or suspected of having typhoid, paratyphoid, brucellosis or malaria
- Has laboratory tests indicating infection risk labelling is needed

Attaching Infection Risk Labels to Blood Tubes

Place the infection risk label around the top of the blood tube, ensuring the written information is visible

Death Certification

Our duty as doctors does not end with the death of a patient as we are required to complete a medical certificate of the cause of death (MCCD) and if disposal of the body is by cremation we are also required to fill out appropriate certificates relating to this.

Failure to complete a MCCD in a timely and accurate manner may not only cause distress to the family but also result in administrative and legal problems.

Confirmation of Death

It may seem self-evident but it is vital to confirm that death has occurred and record this accurately in the notes. It is generally accepted that death can be confirmed clinically by the following:

- Absence of carotid pulsation for one minute
- Absence of heart sounds on auscultation for one minute
- Absence of respiratory movement and breath sounds for one minute
- Fixed dilated pupils
- No response to painful stimuli

Caution should be exercised however in patients who are hypothermic and who may have taken drug overdoses. Discuss these patients with your seniors.

Cause of Death

This part of the certificate is divided into two parts. Part one is divided into:

I(a)

I(b)

I(c)

This records a causal sequence passing from the proximate cause of death in I(a) to the underlying cause in I(c). Completion of this section can cause problems and this is usually due to a lack of understanding of the logical sequence of events and disease processes that culminated in death. Another common error in completing this section is to interchange the mode of death for the cause of death e.g. heart failure is not a cause, but myocardial infarction is.

When completing part one consider the sequence of events that led to death and record this at I(a). Work backwards until the underlying cause of death is found, that is, the process that initiated the chain of events leading to death. Obviously on a number of occasions when one condition leads to death, only I(a) will need completion e.g. meningococcal meningitis.

It is important to provide as much information as possible thus, if a patient has died of a tumour, endeavour to record the site, histology and whether it was a primary or secondary neoplasm.

Certain circumstances will arise when more than one condition may have resulted in death and such joint causes should be entered on the same line indicating in parenthesis that the causes are "joint". For coding purposes, the first condition is regarded as being the underlying cause of death.

Part Two

This section records conditions that have contributed to death but are not part of the causal sequence. It is not a repository for irrelevant unrelated conditions that might have been present at the time of death.

Timing

The MCCD has a section that allows the intervals of time between the onset of a condition and death to be recorded. This section is important for coding and statistical purposes and you should attempt to make an estimate between the onset of each condition in parts one and two and death.

Contributed to by Employment

A box is provided on the MCCD to record if death was contributed by employment. If it was, you should tick the box and inform the Coroner. A list of industrial diseases appears on the reverse of the MCCD.

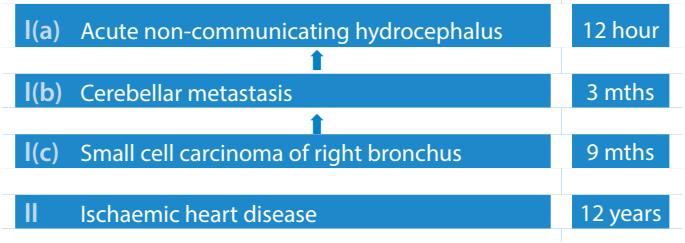
The Back of the Medical Certificate of Cause of Death

Two important boxes are provided.

Box A should be completed if the case is formally reported to the Coroner. It does not need to be initialled if the case was merely discussed and not formally referred.

Box B should be initialled if further information will be subsequently available such as histology, microbiology, toxicology etc.

Example of completed MCCD



Medical Examiner Office

The Medical Examiner Office provides independent scrutiny of the cause of non-coronial deaths.

Following national investigations into high profile failures in care that led to patient deaths, the scrutiny of patient records and involvement of the bereaved was recommended. The Medical Examiner was therefore introduced into government legislation in 2009.

Medical Examiners (MEs) are senior doctors from a range of specialties that have chosen to receive specialist training and to spend some of their time working as medical examiners. In addition, they are supported by Medical Examiner Officers (MEOs), often from a variety of clinical backgrounds, and work in a timely manner to meet the legal requirements for registering deaths.

Role and Function of the ME Office:

- **To carry out a proportionate review of the medical records** to ascertain:
  - What caused the death of the deceased?
  - Does the coroner need to be notified of the death?
  - Was the care before death appropriate?

- **To liaise with doctors** completing the MCCD to agree the wording which accurately and appropriately denotes the cause of death.
- **To offer the bereaved families/carers** an opportunity to have an open and honest conversation with someone who was not involved in providing care to the person who died, and to discuss anything about the care that may be worrying or of concern.
- **To explain to the bereaved families** the medical language used on the MCCD and appropriately signpost them if required (e.g. bereavement support, PALS).
- **To appropriately escalate** any matters requiring further investigation in accordance with clinical governance practices.

All doctors completing MCCDs are advised to search for and read the published guidance 'Completing a medical certificate of cause of death (MCCD)' by the Office National Statistics, which is available online and is updated regularly. The Royal College of Pathologists (RCOP) publishes a list of acceptable and unacceptable causes of death, which is also available online and updated regularly.

The doctor completing the MCCD is expected to attend the ME Office to discuss the contents with the ME on duty before completing the MCCD.

The Medical Examiner Office is located with the Bereavement Services Office and is open Monday to Friday, 08.00 – 16.00 hours, contact on: 2581."

Is there any reason why a death which is 'natural causes' from a medical perspective, would be considered 'unnatural' from the Coroner's perspective?

Is there any other reason why this death should be reported?

Factors that make a 'natural causes' death 'unnatural' from a coroner's perspective are set out in section 4.

2. Determining and appropriate cause of death for certification, regardless of whether the death is reportable or not

Deriving a logical, progressive, comprehensive and thereby defensive cause of death for the purposes of certification requires the consideration of all the circumstances by a clinician in a position of seniority. Deaths can and should be discussed with a clinician ST3 level or above to derive an appropriate cause of death and to confirm whether the death is reportable.

3. The process of communication with the Coroner

If the death is being reported by electronic referral to the coroner's office by a doctor who may be going off shift, when reporting the death it is their responsibility to make available the name and contact details of a doctor who is in a position to complete the medical certificate of cause of death (MCCD) after the referral to the Coroner, i.e.:

He or she has attended (this means treated and/or assessed and not just saw the deceased) the patient in, and for the patient's last illness, **and**

Within 28 days before death, **and**

Is satisfied as to the cause of death **and**

Is satisfied that the death is wholly from natural causes and Is not otherwise reportable to the Coroner.

A death should be reported to the coroner if:

The death occurred **during an operation** or **before full recovery** from the effects of an **anaesthetic** or was in any way **related to the anaesthetic** (in any event a death within 24 hours should normally be referred),

The death may be related to a defect or a failure in a **medical procedure or treatment** whether invasive or not,

The death is a **sudden infant death**,

All **alleged medical or nursing mishaps** or **inappropriate treatment** where a **serious incident** procedure has, or will be recorded,

The death is caused or contributed to by **healthcare acquired infections**,

Any case of possible **late diagnosis** (e.g. meningitis) or **treatment**,

The patient **sustained a fracture** prior to death,

The death was linked with an **abortion**,

Death **due to** or **contributed to by drugs** (including therapeutic) where overdose, idiosyncrasy, poisoning or addiction is involved,

Any deaths caused or contributed to by **reportable** or **unusual diseases** (e.g old or new variant Creutzfeldt-Jakob Disease),

The death may be **linked to** an **accident** or **incident** (wherever or whenever it occurred),

The deceased was **not attended by the doctor** during their last illness or was **not seen within 28 days** or viewed after death,

There is any suspicion that the death may be the **result of a crime** or history of **violence**,

There is question of **neglect** or **self-neglect**,

The death has occurred or the illness arisen **during or shortly after detention in police custody** or **prison custody,**

The deceased was detained under the **mental health act,**

The death could be due to **industrial disease** or related in any way to the deceased's employment,

The death was due to **poisoning**,

It is important to note that this list is not exhaustive, if in any doubt guidance should be sought from the Medical Examiner office.

Death Certification - Adults

(For deaths occurring in all acute hospital wards and departments except AED)

You are not in a position to issue a death certificate if you have not seen the person alive and have not been involved in any way in their care; the death certificate cannot be issued until the appropriate medical practitioner comes on duty and is in a position to issue the certificate.

Monday to Friday, 08.00 – 16.00 hours

Where applicable, the medical certificate should be completed in the Bereavement Services Office on the day of **the death or next working day**.

Discussion must be had with an ST3 or above, preferably the consultant in charge with the patient's care, regarding the cause of death and wording of the proposed MCCD.

Any person subject to a DoLS authorisation who dies any time after 3 April 2017, their death need not be reported to the coroner unless the cause of death is unknown or where there are concerns that the cause of death was unnatural or violent, including where there is any concern about the care given having contributed to the persons death.

Cause of non-traumatic death known	Cause of death unknown
Patient been in hospital *Death certificate may be issued*	Patient been in hospital *Requires referral to Coroner's Office*
Death following an accident - including falls (irrelevant of time since accident) *Requires referral to Coroner's Office*	Death following an accident - including falls (irrelevant of time since accident) *Requires referral to Coroner's Office*
Death < 24 hours of surgery/intervention or if death is as a result of any complication of surgery/intervention (irrelevant of time since surgery) *Requires referral to Coroner's Office*	Death < 24 hours of surgery/intervention or if death is as a result of any complication of surgery/intervention (irrelevant of time since surgery) *Requires referral to Coroner's Office*
Death likely to be linked to an industrial disease *Requires referral to Coroner's Office*	Death likely to be linked to an industrial disease *Requires referral to Coroner's Office*

If you require advice about whether to refer a death or a cause of death, the Medical Examiner Office can be contacted on: 2581.

If in any doubt as to the cause of death, or you suspect the death is unnatural or you have any concerns, you must seek advice from a senior colleague and the Medical Examiner Office before issuing a death certificate.

Referral of Death to the Coroner

If an inquest is held it is the Coroner's duty to establish at inquest who was the person who has died as well as how, when and where did the death come about? Following the inquest, the Coroner will send the necessary details to the Registrar of Births and Deaths for registration purposes.

Guidance for the certification of death

There are three domains to be addressed in relation to death certification:

1. Defining which deaths have to be reported

The point of reference for coroners as to which deaths they are under a duty to investigate is set out within the Coroners and Justice Act:

- The deceased died a violent or unnatural death,
- The cause of death is unknown, or
- The deceased died while in custody or otherwise in state detention.

The following should be considered:

Is this death due to natural causes?

If yes, is it known with a reasonable balance of probability, what the cause of death is and the structure of the cause/s to be written on the certificate?

Cause of non-traumatic death known

In cases of cultural sensitivities regarding the early release of a body and issuing of a death certificate: you may discuss this with the on-call Coroner's Officer by dialling 101, [Dial 9 first for an outside line if dialling from an internal Trust phone] leave your contact details for the on-call Coroner's Officer to contact you. They may give you authority to issue the certificate

Patient been in hospital

- Death certificate may be issued

Death following an accident - including falls (irrelevant of time since accident)

- Complete an electronic 'Referral to the Coroner' form as soon as possible after the death

Death < 24 hours of surgery/intervention or if death is as a result of any complication of surgery/intervention (irrelevant of time since surgery)

- Complete an electronic 'Referral to the Coroner' form as soon as possible after the death

Death likely to be linked to an industrial disease

- Complete an electronic 'Referral to the Coroner' form as soon as possible after the death

NB:

Referrals to the Coroner's office should be made as soon as possible after the death using the electronic referral form, which can be found on the front page of the Trust's intranet – HMC Electronic Referral form.

If you have referred to the Coroner and are awaiting an outcome, ensure you document in the patient's EPR the circumstances and your believed cause of death so that another medical practitioner can discuss with the Coroner's office if required.

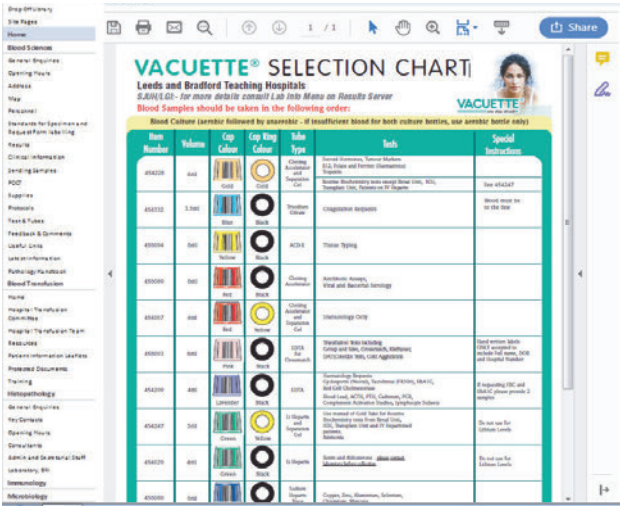
Blood tests

In the BRI there is a 'once daily' phlebotomy service, which usually comes in the morning. However, please be aware that when there are staffing problems in the phlebotomy department, you may be expected to do your own bloods.

Every day you will have to take blood from some of your patients because additional tests are needed or the phlebotomists are unable to obtain a sample.

All blood requests are made through the EPR system, unless the system is unavailable. If pathology requests cannot be made via EPR, please use blank paper request forms. It is a good idea to request blood tests for your patients that will need their blood taking the next day before you go home. Sometimes the phlebotomists will come surprisingly early. This is usually on the day you have forgotten to write your blood cards in advance! The phlebotomists will print the request forms once they arrive on the ward but you can print the request and leave them in the yellow phlebotomy folder.

It is important to know which bottles some of the commonly requested investigations go in. EPR labels / request forms will show which blood tubes to collect. For more unusual requests there is a full listing available on the intranet.



If you can't find the test you require, call the biochemistry lab on ext. 4198.

Radiology

Clinicians are expected to note a level of detail in radiology requests that provides the Radiology team with the required amount of information to initiate the most appropriate investigation.

In patient Requests: A Duty Radiologist is available 9-5 each weekday as the main departmental focus for clinical queries and advice with a specific focus on managing queries relating to acute in-patients and their flow through radiology. The Duty Radiologist can be contacted on 3137 and is located in the X-Ray department next to CT reception at BRI. The duty radiologist can also be contacted out of hours for urgent radiological (CT) requests. In patient x-ray examinations on wards can be made by contacting A&E X-Ray Reception (ext 2122)

- MRI scanning is available for suspected metastatic spinal cord compression at the weekend.
- Interventional radiology requests, including nephrostomy, CT and ultrasound-guided drainage and vascular procedures, should be directed to the consultant interventional radiologist on-call

How to use PACS

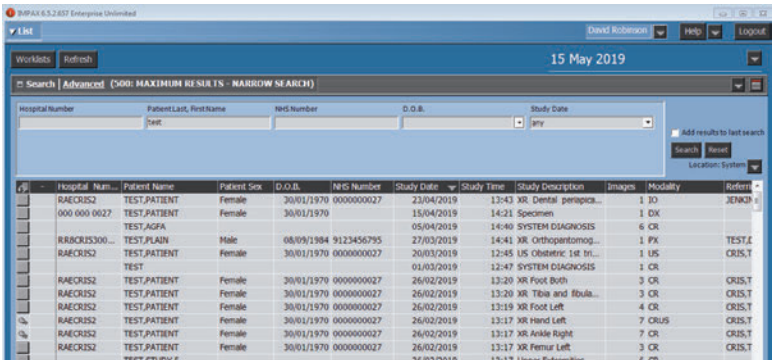
PACS is the system used to access patient radiographs, CT Scans etc. and their reports. The following is a step by step guide on how to access the system:

1. Double click the PACS icon on the desktop

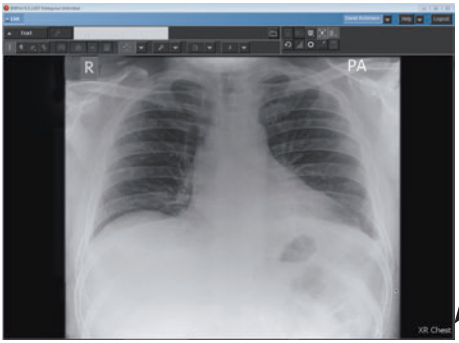
2. Enter your password which should have been arranged at induction, this is the same as the one you log into the desktop as
3. The following screen will appear:

   Enter either the hospital number or the patient's name.

4. Select which radiograph / CT / MRI etc you want to view



5. The image will then appear on the screen

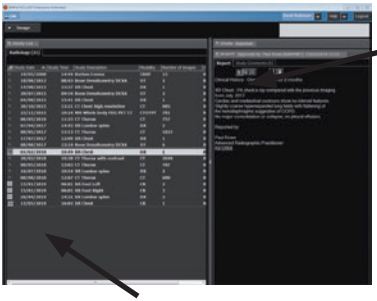


Modality of image

6. In order to review the report of the image, click 'text' at the top left of the screen.

Click "Text" to view report

7. The following screen will appear.



Report from the Radiologist

It is possible to view previous images listed here by double clicking them

NOTE:

It is possible to alter the contrast and rotate images in PACS but how to do this is beyond the realms of this booklet. Practice with the system and simply press the button to return the image to its original state at any point.

How to order an Endoscopy

How to order an Endoscopy for an In-Patient

1. Junior doctors request procedure on EPR from the in-patient encounter.
2. Choose the procedure without (S) unless you wish it to be performed in theatre under GA.
3. **Select procedure to be performed as in-patient**
4. Click on the paper sign to take you to the Guideline pages on intranet for advice re anticoagulation etc
5. The nurse in charge will liaise with the ward in the standard manner (fax a prep sheet)
6. Patient information leaflets and procedure specific consent forms are available on the intranet; on some wards; and from the Endoscopy Unit
7. **Urgent requests during working hours (Monday to Friday, 8am – 6pm) should be phoned through to the department x 2697.**
8. **Emergency requests out of hours for GI bleeding need to be discussed with the on-call endoscopist , number via switchboard.** For patients presenting with an upper GI bleed there is an upper GI bleed pathway (copies on intranet under Gastroenterology), with an easy to follow pro forma for risk stratification and immediate management, including advice on which patients need to be discussed with the on-call Endoscopist. Remember that most patients presenting out of hours with a GI bleed can be endoscoped the next morning. Any endoscopy after 9pm will take place in theatre and will require liaison between the medical SpR, surgical SpR, and the endoscopist. Consent to proceed to surgery should be obtained lest bleeding continues.

How to order an Endoscopy on the Diagnostic Virtual Ward

1. Junior doctors request procedure on EPR from the in-patient encounter
2. Choose the procedure without (S) unless you wish it to be performed in theatre under GA.
3. **Select procedure to be performed as out-patient**
4. Click on the paper sign to take you to the Guideline pages on intranet for advice re anticoagulation etc
5. **Ward team inform DVW of the need for an endoscopic procedure**

6. DVW team will:
    - liaise with the Endoscopy Unit charge nurse to identify a slot on the acute list
    - liaise with the bookers (receptionist on Endoscopy Unit) to book that slot on EPR
7. The DVW team should provide the patient with the necessary information including patient information booklets

How to order an Endoscopy for an Out-Patient

1. Junior doctors request procedure on EPR from the appropriate encounter
2. Choose the procedure without (S) unless you wish it to be performed in theatre under GA.
3. **Select procedure to be performed as out-patient**
4. Click on the paper sign to take you to the Guideline pages on intranet for advice re anticoagulation etc
5. **If bowel prep required request this as a prescription for a future visit**

Doctors Mess

The doctors mess is located on floor 2 (confusingly the one above the ground floor) and is located between wards 23 and 11. Doctors of all grades can use this area to take their breaks and study. There is a keypad on the door and the code is available from the porters on the main desk.

Department of Medical Education – Field House

This is where most of your teaching will take place. It is a separate building behind the main hospital. There is a lecture theatre, library, meeting rooms, offices, occupational health and doctors accommodation. Computer facilities are available in Field House for staff use and are located near the library. There are also rooms that can be booked for meetings/teaching (enquire at the reception in Field House).

Teaching

There is a medical meeting once a month (Grand Round) in Field House, which all grades of medical staff can attend. Details of the event will be published via global email.

FY1s have teaching on a Wednesday 1-2pm. This teaching is bleep free and compulsory for completion of the FY1 year. Hand your bleep to the Medical Education office and ensure you sign in. Inform Mareka Hall if you are unable to attend.

Core Medical Trainees have scheduled teaching on Thursdays at 1pm.

Key Education Staff

Director of Education	Dr David Robinson
Assistant Director of Education	Dr Shafi Khan
Director of Undergraduate Education	Dr Amy Ilsley
Head of Education	Faye Alexander
Postgraduate Medical Education Lead	Alida Towns
Postgraduate Senior Administrator / Yorkshire & the Humber Region STEPP/ SPRAT programme Co-Ordinator	Vicky Williamson
Facilities Team: email - facilities.administation@bthft.nhs.uk	
Resuscitation Administrator	Mansoor Ahmad
Foundation Programme Administrator	Mareka Hall
Education Services Administrator	Ishwa Idrees
3rd/5th Year Undergraduate Administrator	Vacant
2nd/4th Year Undergraduate Administrator	Mehreen Nawaz
Foundation Programme	
Foundation Training Programme Director (Year 1)	Vacant
Foundation Training Programme Director (Year 1)	Dr Shafi Khan
Foundation Training Programme Director (Year 2)	Dr Liz Jones
Foundation Training Programme Director (Year 2)	Dr Russel Ahmed
College Tutors	
Royal College of Anaesthetists	Dr Omar Jundi / Dr Fozia Hayat
Royal College of Ophthalmologists	Mr Paul Brogden
Royal College of Surgeons	Mr David Dickson
Royal College of Psychiatrists	Dr Junais Puthiyarackal & Dr Kandeepan Yugambaranathan
Royal College of Paediatricians	Dr Zainab Ezimokhai
Royal College of Radiologists	Dr Shazia Khan / Dr Timothy Guest
Royal College of Obstetrics & Gynaecologists	Dr Amy Hufton / Dr Sudeepthi Kakara
Royal College of Emergency Medicine	Dr Michaela Blood
Dental Tutor	Dr Divya Keshani
GP Training Programme	
GP Training Programme Director	Dr Gareth James
GP Training Programme Director	Dr Helen Moor
GP Training Programme Director	Dr Hasna Begum
GP Training Programme Director	Dr Jess Keeble
GP Training Programme Director	Dr Abid Iqbal

Please contact the Education Service on ext. 4860 and ask for the appropriate person

Library Services

The Health Library Service will help you to find the information and knowledge you need for your studies, work and professional development. Located in Fieldhouse Education Centre all members of staff can join, students on placement and those who have a Service Level Agreement with us. Membership is free but fines are charged for overdue items. You can register in person or complete the online form http://bit.ly/2mNYRy5 Use our online catalogue to find what is available at http://bradford.nhslibraries.com/ If the book or journal article you require is not available locally it can be acquired from one of our partner libraries. The library staff will also help you to access online journals; eBooks; registering for Open Athens; literature searching and search skills training (info skills training). In addition, a comprehensive current awareness service is provided. Please feel free to sign up at http://bit.ly/LIB123

Library Services provide a quality assured service delivered by professionally qualified and skilled staff working in partnership locally and nationally to provide access to a range of relevant resources, both physical and virtual, that are fit for purpose and provide best value. We constantly score heavily in our Library Quality Assurance Framework. The service provides the means for our users to develop their skills to effectively and efficiently locate and retrieve the information they require in a friendly and welcoming environment that is conducive to study and learning. We are committed to developing the services offered by working in partnership with you and listening to our users. To contact us, email medical.library@bthft.nhs.uk

- Library Lead — Paul Stevenson
- Graduate Trainee Librarian — Matthew Gill
- Graduate Trainee Librarian — Aki Matsumara

Library staffed opening times are:

Monday	8.30am - 5.00pm
Tuesday	8.30am - 5.00pm
Wednesday	8.30am - 5.00pm
Thursday	8.30am - 5.00pm
Friday	8.30am - 4.00pm

Outside these hours access to the Library is available any time via swipe card (Trust ID Badge).

ESR Learning Management System

As part of your induction there are mandatory training modules which are e-learning modules. These are provided and recorded on the Electronic Staff Record (ESR) Learning Management System which is a national record accessed via the Intranet home page using your Smartcard. You can contact the ESR learning management system administrators on extension 3869/4107.

Annual Leave

Advise can be sought from HR regarding your allowance.

Annual leave requests should be prompt to avoid disappointment and require a minimum of 6 week notice.

Study Leave

All study leave applications must be submitted via ALM (ACCENT Leave Manager). Once submitted and approved you will need to obtain a claim from the Postgrad Team. Please email studyleave@bthft.nhs.uk if you need one

Sick Leave

If you are ill you will need to contact both the rota coordinator and the ward you are working on. You will need to fill in an absence form, and may need to attend a return to work meeting on return. Absences should be recorded on your portfolio.

External contact numbers:

Rizwana Lawrence, (Induction Lead – Surgery) 01274 382728

Carol Hancock, (Acute Medicine rota co-ordinator) 07813 315007

Laura Cade, (ED rota co-ordinator) - 07967 673493

Erceline (Erky) Radic, (Speciality Medicine rota co-ordinator) - 07813 315007

Gillian Priestley, (Surgery rota co-ordinator) - 01274 382759

BRI Switchboard, - 01274 542200

Parking

A parking permit or ticket must be used to park at the BRI and St Luke's.
An opportunity to apply for a Parking permits is given at induction. Temporary permits can also be purchased from the library. Problems with car parking, please contact Linda Skelly on 4429.

Counselling

Professional support for trainees is available from college tutors and from the Director of Postgraduate Medical Education in each trust, as well as from your Training Programme Director and Head of School.

- **'Take Time' & 'Workplace Wellbeing'**

  Excellent, rapid access, face-to-face, free confidential support readily available to all trainees

  For trainees in N, W & E Yorkshire - 0113 343 4642

  For trainees in South Yorkshire - 0114 226 1810

These services offer help with personal or work-related issues, including:

loss of confidence, relationships with colleagues, training/exam pressures, anxiety, worry about work and possible errors, loss & bereavement, reaction to trauma, relationship & family problems

For more information, please visit www.yorksandhumberdeanery.nhs.uk

- click on *"Trainee Support"* where you will also find support for overseas doctors
- Advice is also available through your Occupational Health Department and your GP

Helpline for Staff - 0800 085 1376

There is an Employee Assistance Advice line called Confidential Care, which will provide staff with the opportunity to speak to a qualified counsellor who can provide a wide range of support and advice which is tailored to the needs of each caller. Confidential Care is available to all staff and can offer support with issues that are either personal or professional in nature.

Confidential Care is a free, confidential service which is available 24 hours a day, 365 days a year. It offers emotional support, information and advice, debt assistance and legal advice. If face to face counselling is required, a referral to the 'in – house 'staff counselling service will be offered. The service is confidential and any data collected by the helpline is subject to the Data Protection Act.

The service also includes access for staff to a health and wellbeing website www.well-online.co.uk.

External Services

BMA counselling

For a trained telephone counsellor, 24 hours a day, 7 days a week - 08459 200 169

Doctor Advisor Service

To speak to another doctor in confidence for advice - 08459 200 169

Doctors' Support Network

Support group for doctors with mental health issues - 0844 395 3010
www.dsn.org.uk

Support for Surgeons

Surgeon-to-surgeon helpline - 020 7869 6212

Support 4 Doctors

Web-based advice, incl. financial www.support4doctors.org

Samaritans

Confidential, 24-hour listening service - 08457 90 90 90

Many more resources at www.bma.org.uk click on 'Doctors' Health & Wellbeing'

Key Policies

All policies are available on BTHFT intranet site.

General Numbers

BRI Misc	
CT	3133
X-Ray	4153
Main Desk	4024
Main Porters	4258
Porter Super	#6406
Bed Manager	4726 / #6490
Deep Clean	4798 / #6683
Infection Control	4049
Interpreting	3737 / 3837
Admissions	4156
ECG	2760 / 4073
Transport	5640 / 5648
Emergency Ambulance	#6100
Estates	4444
IT Helpdesk	2444
PALS	4021
Pharmacy	4237

Community Hospitals

Eccleshill Community Hospital	01274 323200
Westwood Park Community Hospital	01274 277406
Westbourne Green Community Hospital	01274 276803

Emergency Numbers

Fire (actual / suspected)	Break nearest glass fire alarm point - Dial **112** and state location
Adult Cardiac Arrest (in hospital)	Dial **2222** – state "cardiac arrest", location: and repeat
Paediatric Cardiac Arrest (in hospital)	Dial **2222** – state "paediatric emergency", location: and repeat
Cardiac Arrest (hospital grounds)	Dial **999** – ambulance service.

Maps

The following link will take you to the site maps for Bradford Teaching Hospitals.

https://www.bradfordhospitals.nhs.uk/our-hospitals-2/

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