Doctor, Doctor!

RAISE 2024

A survival guide for ward cover

R A I S E

What is RAISE?

- Raising
- Awareness at
- Induction in common
- Sources of
- Error

Outline of Session

Introduction (10 min)

Introduction

Ensure pre-course questionnaire completed

Case 1 (40 min)

Anticoagulation

Falls

Transfusion

Break (15 min)

Case 2 (40 min)

Prescribing on admission

Insulin prescribing

Palliation

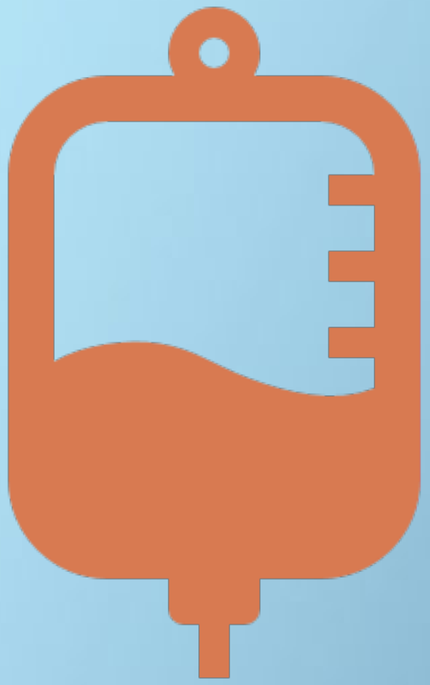
Wrap-Up (10 min)

Signpost to link for post-course questionnaire and feedback form

Pre-course questionnaire

Follow the link if you have not completed the pre-course questionnaire

bit.ly/RAISE2024Pre



Case 1 - Beryl

Anticoagulation

Falls

Transfusion

Doctor, Doctor!



- “Hello, are you the ward cover doctor? My patient Beryl has just come up from AMU and no one has prescribed her warfarin or checked her INR.

- I’ve sent off an INR sample – please could you review the result and prescribe her warfarin?”

Warfarin Prescribing

What do you need to know/assess?

- Indication
- Target INR
- Current INR
- Concurrent medications affecting INR

- When dosing warfarin **trends** are important so make changes every 2-3 days
- Often better to give much lower dose than omit altogether if INR not done - check with senior
- Sub-therapeutic readings may need to be cross-covered with LMWH

ADD SCREENSHOTS OR HAND OUT EXAMPLES OF WARFARIN PRESCRIPTION CHARTS IN YOUR TRUST

BERYL

You review Beryl’s INR result and find that it is 8.1.

On assessment you find no evidence of bleeding.

What do you do?

INR + ?bleeding	Action
INR 5.0 – 8.0 + no bleeding	Withhold Warfarin for 1 or 2 doses and reduce subsequent maintenance dose
INR 5.0 – 8.0 + minor bleeding	Stop Warfarin Give Vitamin K – 1-3mg by slow IV injection Restart warfarin with INR <5
INR >8.0 + no bleeding	Stop Warfarin Give Vitamin K – 1-5mg orally using IV preparation Repeat vitamin K after 24 hours if necessary Restart Warfarin when INR <5
INR >8.0 + minor bleeding	Stop Warfarin Give Vitamin K – 1-3mg by slow IV injection Repeat vitamin K after 24 hours if necessary Restart Warfarin with INR <5
Major bleeding	Stop warfarin Give Vitamin K – 5mg by slow IV injection Give Beriplix / Octaplex after discussion with haematologist

ENSURE THIS IS COMPLIANT WITH YOUR TRUST GUIDELINES

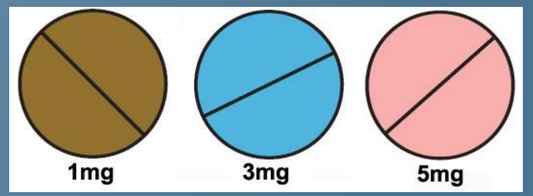
R A I S E

On discharge

- Ensure to document in notes, discharge summary & yellow book
  - Indication for warfarin
  - Target INR
  - Duration of therapy
  - Dose of warfarin until next INR check



- Arrange INR check at usual clinic (GP or anticoagulation clinic)
  - Pharmacy may not dispense warfarin without this being done



ENSURE THIS IS COMPLIANT WITH YOUR TRUST GUIDELINES

Warfarin Prescribing - 3 Key Points

- Document indication, dose and target INR
- Remember to put out repeat INR for following day if adjusting
- Unexpected INR
  - ? Right dose of warfarin
  - ? Medication interactions
  - ? Need to cover with LMWH

Doctor, Doctor!



- “Hello, sorry to bother you again. Our lady Beryl has just had a fall.
- Please could you come and review?”

Inpatient Falls

- You arrive on the ward to find that Beryl has been helped back into bed by the nursing staff

- How would you assess her?
- What approach would you use?
- Are there any tests or investigations you would consider?



ADD SCREENSHOTS OR HAND OUT EXAMPLES OF FALLS ASSESSMENT FORMS IN YOUR TRUST IF APPLICABLE

Inpatient Falls

- Full set of observations including blood glucose
- Establish circumstances of fall
- Is the patient on anticoagulation?

- **Symptoms** – chest pain, LOC, confusion, head injury, vomiting
- **Examination** – ABCDE, brief cardiovascular and neurological examinations, look for midline C-spine tenderness, pain or reduced movement in joints, and head injury
- **Investigations** – consider ECG, CT head if relevant
- **Review** – regular neurological observations according to Trust Protocol

When to do a CT head





Within 1hr

- GCS <13/change from baseline GCS
- Suspected open/depressed skull #
- Signs of basal skull #
- Post traumatic seizure
- Focal deficit
- >1 episode of vomiting

Within 8hrs

- If LOC/amnesia since injury and 1+ of:
  - >65yrs
  - Hx bleeding/clotting disorders
  - Dangerous mechanism of injury
  - >30min retrograde amnesia

BERYL

- Beryl's observations and glucose are within normal range
- She tells you herself that she got tangled up in her dressing gown and tripped, landing on her right hand side
- She is not in any pain

- Examination is normal
- Beryl has a CT head several hours later which is normal
- You document your findings and ask the nurses to fill out an incident form and carry out regular neurological observations

Inpatient Falls - 3 Key Points

- ABCDE assessment
- Consider and assess for precipitants of falls - “fall” is not a diagnosis
- Indications for CT head as per NICE guidelines for head injury or local guidelines

Doctor, Doctor!



- “Hello doctor, it’s one of the staff nurses here. My patient Beryl had a fall last night – I think you reviewed her didn’t you?
- She had another fall during the day and now has a big haematoma on her thigh. The day team said she might need a transfusion – could you review?”

Before you transfuse – question!

- ***Risk vs Benefit***
  - Risks include previous transfusion reactions, risk of becoming overloaded
  - Transfusion naïve
  - Out of hours - fewer staff, less monitoring
- ***Suitable Alternatives***
  - Consider if patient stable or refusing transfusion
  - Iron/vitamin supplementation (PO/IV)
  - EPO

But remember! Transfuse the patient who is compromised and whose life is threatened

- ***Before you transfuse***
  - Take sample for haematinics and iron studies – these will be affected by the transfusion

Transfusion time – requesting blood



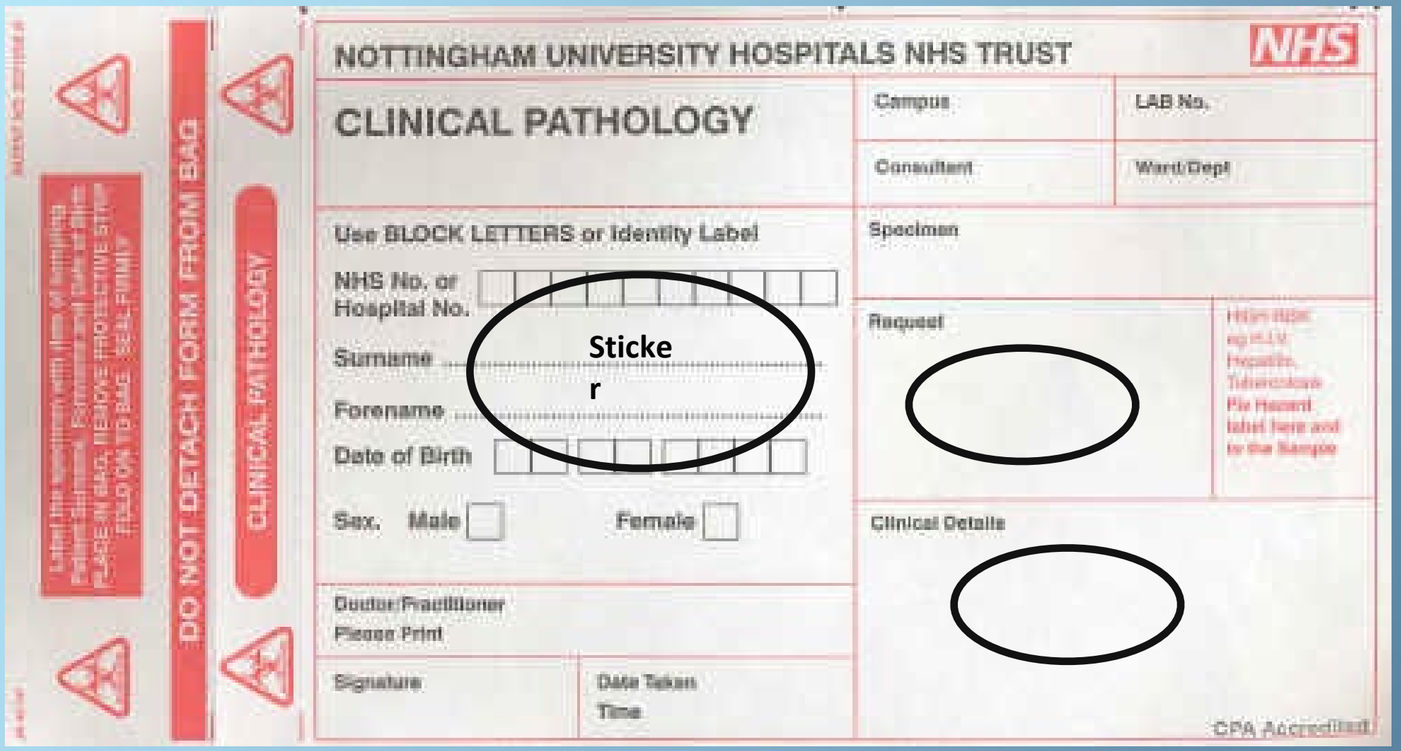
TWO separate samples

Blood bottles HANDWRITTEN at BEDSIDE

Separated by 30 MINUTES if taken by SAME PERSON

ENSURE THAT THE BOTTLE IN THE PICTURE IS THE CORRECT COLOUR FOR YOUR TRUST. AMEND TRANSFUSION REQUEST POLICY AS PER LOCAL GUIDELINES. DOES YOUR TRUST ALLOW SIMULTANEOUS SAMPLES AS LONG AS SIGNED BY A SECOND TRAINED PERSON?

ADD COPY OF YOUR BLOOD FORM AND CIRCLE/HIGHLIGHT PARTS THAT JUNIOR DOCTOR NEEDS TO FILL IN



Positive identification

Patient name

Patient date of birth



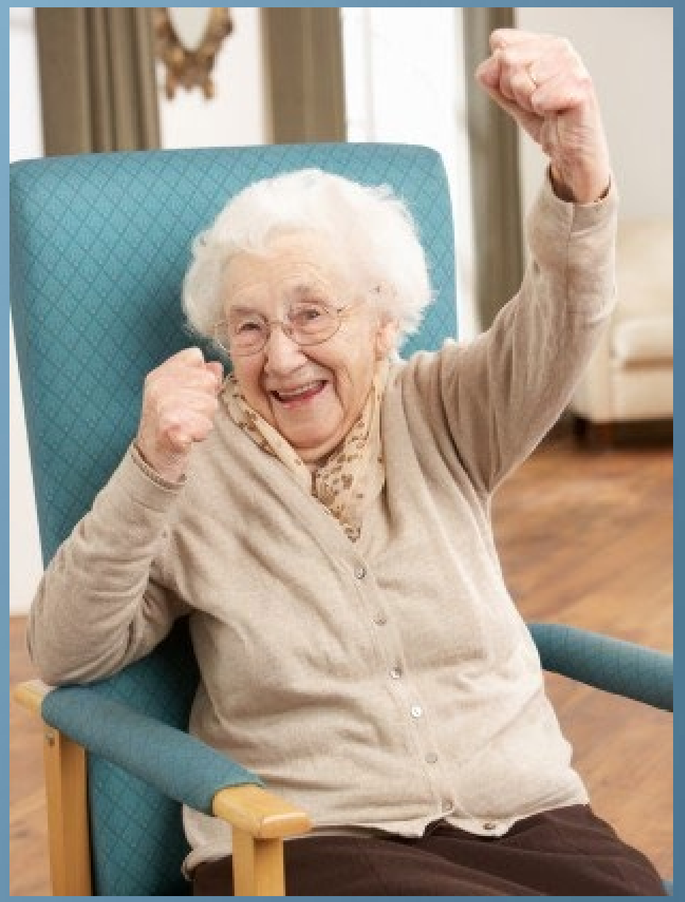
Patient ID band

Summary

- Confirm name, date of birth and hospital number with wristband and verbally
- Always handwrite samples at the patient's bedside
- In **non-emergency** situations ensure that haematinics and iron studies have been checked before you transfuse

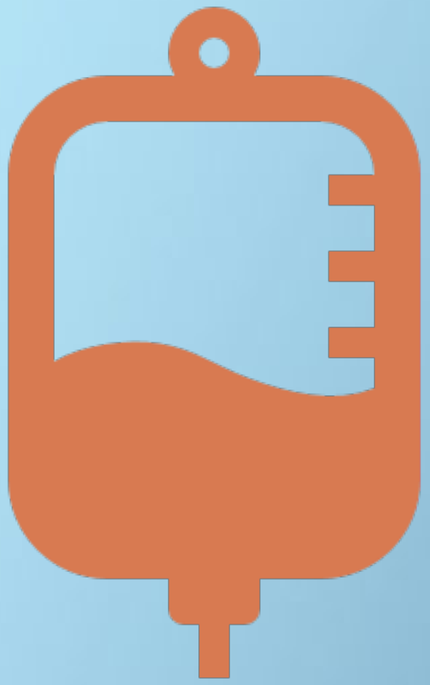
BERYL

- Beryl is safely discharged from hospital one week later – well done!



BREAK TIME





Case 2 – Bert

Safe Prescribing
Insulin
Palliation

Doctor, Doctor!



- “Are you one of the surgical clerking doctors? I’ve got a gentleman here waiting to be clerked and he doesn’t look very well. He’s got a high NEWS score. Please could you come and see him next?”

BERT

- You arrive to clerk Bert
- He is an elderly, frail gentleman with multiple co-morbidities
- Your working diagnosis is biliary sepsis
- He meets the criteria for red-flag sepsis

- As part of your clerking you need to prescribe him antibiotics, oxygen and complete a risk assessment for VTE

Antibiotic Prescribing

CONSIDER ADDING OR HANDING OUT EXAMPLES OF YOUR TRUST'S DRUG CHART TO SHOW HOW TO PRESCRIBE ANTIBIOTICS ACCORDING TO BEST PRACTICE PRESCRIBING GUIDELINES

Ensure that you document:

R2 D2

- **Reason:** including any deviation from guideline
- **Route**
- **Dose**
- **Duration:** needs end/review date



ALWAYS CHECK ALLERGY STATUS BEFORE PRESCRIBING!

Antibiotic Prescribing

At <u>48 hours:</u>

Review available microbiology, observations and inflammatory markers

Document decision to:

C3PO

- Continue
- Cancel
- Convert to ‘PO’ if on IV



Antibiotic Prescribing - Dosing and Monitoring

Gentamicin (once daily)

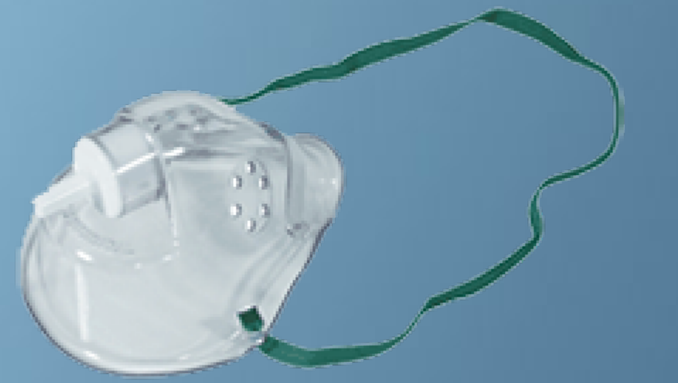
- Level should be within 4hrs of next dose (“trough”)
- Taken before 2nd dose **or** if previous dose was high
- Trough level should be <1mg/l

Vancomycin

- Starting dose depends on renal function
- Level 1hr before next dose but **do not wait for levels before giving**
- Trough 10-20mg/l
- Adjust the **next** dose if trough level out of range

ENSURE THIS IS COMPLIANT WITH YOUR TRUST ANTIBIOTIC GUIDELINES

Oxygen Prescribing



- Oxygen is a drug
- Need to ensure dose, route is prescribed

- Most patients will have target O_2 saturations of 94-98%
- Patients at risk of type 2 respiratory failure (NOT just all COPD patients as default) will have target O_2 saturations of 88-92%
  - Check current and previous blood gas results if unsure

BUT in an emergency it is better to give too much until the patient is stable, then the oxygen can be weaned down if necessary

SOME TRUSTS WILL HAVE TARGET OF 92-96% RATHER THAN 94-98% CHECK WHICH YOURS IS

VTE Assessment and Prescribing



ADD YOUR TRUST'S DRUG CHART
AND/OR VTE RISK ASSESSMENTS

R A I S E

Doctor, Doctor!



“Hello doctor. We’ve got a chap called Bert who’s just come up from the admissions unit.

He’s an insulin-dependent diabetic and his latest blood glucose is 3.1. What should we do?”

How do I give rapid acting glucose?



From hypo box

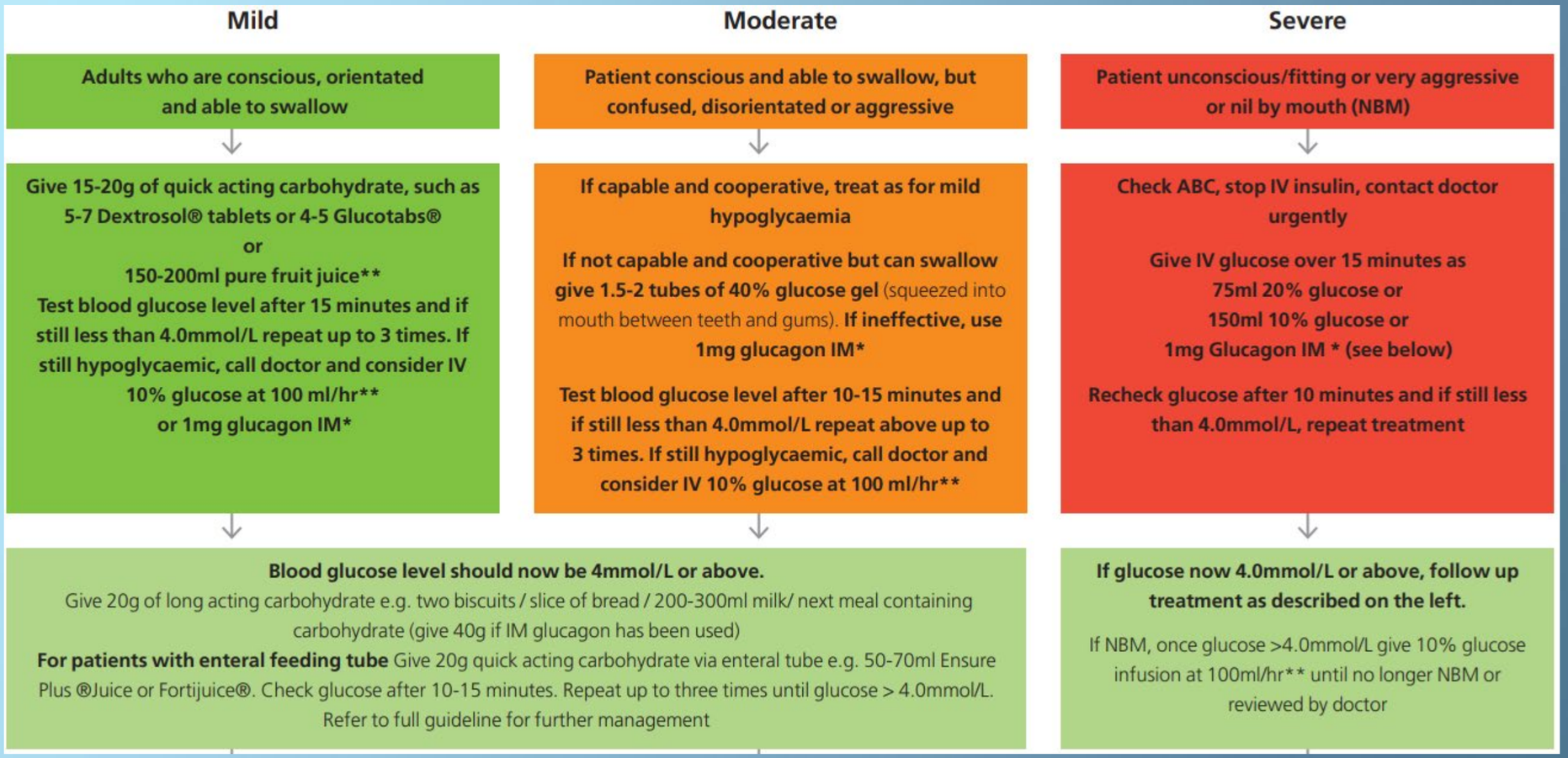
ONLY IF PATIENT SAFE TO HAVE ORAL OPTIONS

- 5 glucose tables (4g carb per tab)
- 1x60ml glucose drink (15g carb per bottle)
- 2 tubes glucose gel (10g carb per tube)



- **NB – Lucozade, Ribena etc. no longer contain enough sugar to treat hypoglycaemia so are not valid treatments**
- **Common pitfall - milky drinks contain lactose (not glucose) so will not raise BG quickly and dairy will inhibit absorption of sucrose. Milky tea and sugar will not treat a hypo.**

Hypoglycaemia – 4 is the floor



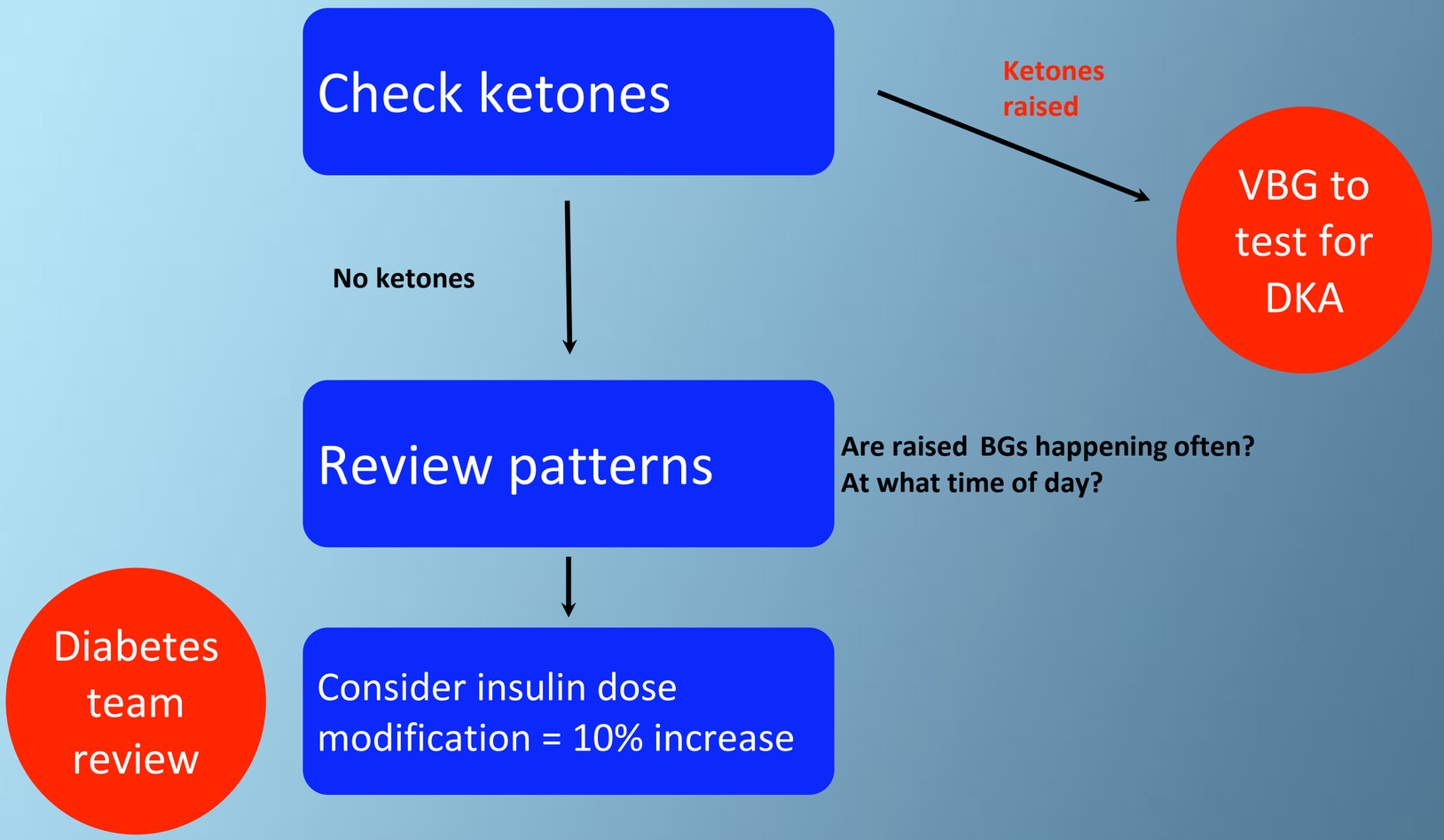
ENSURE THIS IS COMPLIANT WITH YOUR TRUST GUIDELINES

R A I S E

After a hypo

- Recheck BM after 1 hour to ensure treatment success maintained
  - Continue regular BM monitoring especially pre-meals and pre-bed
- Document the hypoglycaemia
  - What's the cause?
- Give long-acting carbohydrate (sandwich, biscuits, normal meal)
- Do **NOT** automatically omit medications/insulin, but review the dose
- Refer to DSN if severe hypo or >2 mild/moderate hypos

Hyperglycaemia – BG >14mmol/L



How do I review BG pattern?

Ask yourself: are these raised BGs happening often?
Is there a specific time of day?

General rule: the insulin given before a CBG is usually the culprit!

Basal bolus regime

Morning fast-acting insulin dose = 2hrs after breakfast or before lunch BG

Lunch fast-acting insulin dose = 2hrs after lunch or before evening meal BG

Evening meal fast-acting insulin dose = 2hrs after evening meal or before bed BG

Evening/Night long acting insulin = before breakfast BG

How do I review BG patterns?

Ask yourself: are these raised BGs happening often?
Is there a specific time of day?

General rule: the insulin given before a CBG is usually the culprit!

Twice daily insulin

Morning insulin dose = evening BG

Evening insulin dose = morning BG

3 Key Points

- Think glucose, test glucose
- Hypos – quick fix (glucose) followed by long acting carbohydrate (sandwich, biscuits, normal meal)
- High blood glucose – check ketones and review pattern of BMs

Doctor, Doctor!



“Hello doctor. My patient Bert has been in hospital for several weeks now. The day team today saw him and said that if he deteriorates we’re to stop treating him and make him ‘End of Life’

I think he’s deteriorating now. Please could you review and see what you think?”

BERT

- You review Bert with the weekend on-call consultant
- You and the nursing staff agree that Bert has deteriorated
- The family are present and your consultant discusses this with them

- The decision is made to stop active treatment and commence End of Life Care

- Your consultant asks you to prescribe ‘anticipatory’ medications and make a referral to palliative care if these are not managing Bert’s symptoms

We all will die at some point

It’s about planning

Patients die in hospital

Palliative and End of Life Care

Not just the elderly

Not just cancer

You will be the patient’s advocate

One chance to get it right

R A I S E

Key principles

- Communication and co-ordination of care
- Active symptom management
- MDT
- Care and support to patient and family



Anticipatory medications

- Use these to actively manage symptoms associated with dying
  - Consider when your patient might need them & prescribe for *if* not *when*
  - There is nothing wrong with having “anticipatory” medications alongside active treatment!

- Morphine = respiratory distress & pain
- Midazolam = agitation
- Hyoscine butylbromide = respiratory secretions
- Cyclizine = N&V

ENSURE THIS IS COMPLIANT WITH YOUR TRUST GUIDELINES AND IF THESE ARE THE DRUGS YOUR TRUST USES

There are emergencies in palliative care too…

- Metastatic spinal cord compression
  - Flat bed rest
  - Dexamethasone 16mg OD
  - MRI whole spine within 24hrs

- Hypercalcaemia
  - First step is rehydration with fluids
  - IV bisphosphonate

ENSURE THIS IS COMPLIANT WITH YOUR TRUST GUIDELINES

Verification of death

Absence of signs of life:

- Heart sounds, breath sounds, central pulse
  - If any occur then restart the clock

- Pupillary response to light
- Corneal reflex
- Response to supraorbital pressure

Time of death = time of verification

ADD SCREENSHOTS OR HAND OUT EXAMPLES OF VERIFICATION FORMS USED IN YOUR TRUST

Verification of death

- Documentation in notes
  - Examination
  - Time of death (time verification completed)
  - Who was there (including family, nursing staff)
  - Your name, GMC number, bleep number

This is crucial information for completing the death certificate, cremation forms etc.

BERT

- Bert passes away peacefully a few days later with his family present
- You helped ensure that the last few days of his life were comfortable and dignified – well done!
- Death is not uncommon in hospital and helping achieve a “good death” is something to be proud of



- If you do feel upset or affected please reach out and let someone know how you feel

3 Key Points

- Involve patient and family as much as feasible, always be honest
- Have measures in place to ease symptoms before they develop
- Discuss early with palliative care

Post-course questionnaire

Follow the link to complete the post-course questionnaire & feedback. This will be sent via email.

Once you have completed the post-course questionnaire & feedback you will receive your certificate of attendance.

bit.ly/RAISE2024Post

Hopefully…






ANY
QUESTIONS
?