West Middlesex Junior Doctors Handbook in Colorectal Surgery

INTRODUCTION

Welcome to surgery and to the colorectal team!

This guide is meant to be just that, a guide and has been principally written for the Colorectal Surgical firms. It has been designed to try and make your lives a little easier until you settle down into the hospital and help you understand how the firm runs.

About the Firms:

There are 3 colorectal surgeons at West Middlesex Hospital.

Mr Ramesh has his team which comprises of a Registrar, an FY2 and two FY1s.

Mr Smith and Mr Pockney share a team comprising of a Registrar, 2 Core trainees and two FY1s.

The teams work as an integrated unit, being 'assigned' to Mr Smith also means you will work for Mr Ramesh and vice versa. The unit provides a true consultant delivered service.

Timetable (Smith/Pockney)

	MONDAY	TUESDAY	WEDNESDAY **on call for Ramesh team**	THURSDAY **on call for Smith team**	FRIDAY
08:00 **08:30** **09:00** **10:00** **12:30**	Handover (OPD2) Clinic OPD4 (Smith) ALL DAY	Handover Consultant Ward Round Mr Smith's Day Surgery (alt weeks) **Or Mr Pockney's all day list**	MDT meeting PGMC ** Clinic OPD4 (Pockney)	Handover Theatre (Smith) ALL DAY	Handover Consultant Ward Round Pre Assessment Clinic for HO Pockney Clinic
13:30	Pockney clinic wks 2/4 (Teddington)	Colonoscopy List (Smith)	Mr Pockney Day Surgery (alt weeks)		Colorectal team meeting PGMC
14:00					Academic meeting + Journal Club PGMC
16:30	Reg w/r	Reg w/r	Reg w/r	Reg w/r	Reg w/r

** **(everyone to attend - 1 F1 to go to handover to pick up any 'hand back' patients)**

Bleep Numbers for Mr Smith and Mr Pockney's team

SR	301
SHO1	479
SHO2	079
FY1	096
FY1	243
Secretary (Smith)	5872
Secretary (Ramesh)	6839

House Keeping!!

Handover:

- Each morning all the surgical teams congregate in the breast clinic at 8am.
- Handover is given by the previous day and night SHO.
- If a patient is known to the surgical team, they are handed back to that team regardless of the admitting consultant.
- Wednesday and Thursday are the fixed on-call days for the colorectal teams.

Ward Rounds:

- There are usually two consultant ward rounds during the week which are led by the house officers.
- On the other days the ward round are undertaken by either the SpR or the SHO.
- A plan for each patient is made for the day.
- Results of any investigations requested are followed up and reviewed in the afternoon with the seniors.
- There must be a second ward round each day by 4pm

Patient lists:

- The list includes the details of the patient, their presenting complaints and outstanding jobs of the day.
- The list is updated each day by the House Officer.
- This list is confidential and contains patient identifiable information – it is therefore of vital importance it is kept safe and all old copies destroyed in the correct manner.

Locations of patients:

- Usually the patients are on the surgical wards, SYON1, Richmond (elective patients are usually found here) and occasionally SYON2.
- BUT when beds are limited they can be placed anywhere in the hospital!

Discharging of patients:

- Unfortunately has to be done on the ECAMIS which hopefully you all have received training for.
- Discharge summaries must be completed prior to discharging the patient (ie not the day after the patient has left the hospital).
- The earlier they are completed the quicker pharmacy can approve them the earlier the patient can go home.
- The default follow up for a patient is No Follow up unless expressed by a senior.

Clinics:

- Mr Smith has an all day clinic on Monday and is a good opportunity for teaching and completing some assessments. Therefore one HO should try to make it down either in the morning or afternoon.
- Mr Pockney has a clinic on Wednesday morning & Friday morning.
- Mr Ramesh has a clinic on Thursday afternoon.

Theatre Days:

- Mr Smith has an all day list on Thursday, Mr Pockney has an all-day list on alternate Tuesday's, and Mr Ramesh has an all day list on Wednesday. At least one of the HO to attend each main theatre list as after all it is a surgical rotation.
- HOs are also welcome to any of the other colorectal lists, including day surgery.
- Theatre lists are ordered and approved by the consultants the week before. They are only to be changed under the express instruction of the consultant with the approval of the Head of Service for theatres
- **ALL** patients should be consented when attending the OPD. Consent is ***not*** to be performed by F1 grades, although you should observer the process as many times as possible.

Pre-assessment Clinic

- Friday mornings approx. 9:30 am (Smith / Ramesh – others follow a similar format)
- Normally 4-10 Smith and Ramesh patients (seen by any of the 4 colorectal F1s)
- Nurses see pt first and do relevant bloods, MSU, blood pressure and ECG
- Full history and examination
- Check blood pressure - if HIGH fill in clinic letter to GP (from nurses) Check BM (if diabetic)- if HIGH fill in clinic letter to GP (from nurses)
- Check ECG
- Write drug chart +/- bowel prep +/- heparin and TEDS +/- sliding scale
- Laparoscopic panproctocolectomy + pouch should all get full bowel prep the day before surgery – this is the ***only*** case that requires bowel preparation
- Left sided operations should all get phosphate enema on arrival to the wards

Tips:

- Keep stickers of all patients seen in pre assessment clinic together with the list of patients.
- Inform the anaesthetist of any problem patients at next theatre list. If no time between clinic and theatre, bleep anaesthetist on call (300) to ask advice. (Notes can be held in PAC if nurses are informed)
- Make sure all investigations, clerking etc are available for theatre ***and are FILED in the notes!!***

Other Notes

The management of common surgical conditions can be found on Mr Smith's website at www.jjs.me.uk/teaching

Quality Improvement Initiative

VTE risk assessment forms

- THIS IS NOW A MANDATORY SAFETY ISSUE!!
- A VTE risk assessment form must completed by the admitting doctor and the patient should be reassessed within 24 hours of admission or if the clinical situation changes.
- On the ward round please ensure that each patient's drug chart has a VTE risk assessment form.
- Units not achieving >90% compliance will lose income commencing June 2010.

STEP 1:

- Assess all patients admitted to hospital for level of mobility (tick one box).
- All surgical patients with significantly reduced mobility, should be considered for further risk assessment.

STEP2:

- Review the patient-related factors shown on the assessment sheet against thrombosis risk, ticking each box that applies (more than one box can be ticked).
- A tick for thrombosis risk should prompt thromboprophylaxis according to NICE guidance.
- Risk factors identified are not exhaustive and clinicians may consider additional risks in individual patients and therefore offer thromboprophylaxis as appropriate.

STEP 3:

- Review the patient-related factors shown against bleeding risk and tick each box that applies (more than one box can be ticked).
- Any tick should prompt clinical staff to consider if bleeding risk is sufficient to preclude pharmacological intervention.

Further information available at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088215

Enhanced recovery pathway

What is the Enhanced recovery pathway?

- Aims to decrease the length of hospital admission for patients undergoing colonic resection
- 5-7 days in hospital with the aim of reducing to 3-5 days, 2-days in selected cases

What are the main elements of the Enhanced recovery pathway?

- No bowel preparation pre-operatively
- Clear fluids and carbohydrate loading drinks PO up to 2 hours prior to surgery and solid food up to 6 hours prior
- Avoid use of NG decompression tubes and abdominal drains
- IVI discontinued as soon as adequate oral intake established
- Urinary catheter removed as soon as possible
- Effective postoperative analgesia
- Postoperative early nutrition
- Early mobilisation

Role of the House Officer in the ERP:

- Notes of the ward round should be written in the ERP Proforma.
- Check that the ERP is being filled in correctly and on a daily basis whilst on the ward round (as ERP is for all hospital staff from doctors to nurses and physiotherapist).

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Does your patient require AXR prior to surgical review?

YES	CONSIDER/DISCUSS	NO
Perforation May show signs of pneumoperitoneum **Erect CXR** also required as first line imaging Progress to CT to define site and cause	**Palpable mass** After exclusion of palpable bladder	**Acute GI bleed (upper and lower)** Proceed to endoscopy Uncontrolled bleeding may require transfer for angiography
Small/large bowel obstruction Establish diagnosis and point to anatomical level Progress to CT to define site and cause	**Constipation** May be useful to determine extent of distension/faecal impaction	**Biliary disease e.g. colic, acute cholecystitis** US is initial investigation of choice
IBD flare Determine severity (toxic megacolon)	**Acute pancreatitis** Identify patients requiring NGT decompression of ileus CT early to confirm diagnosis and assess for necrosis US to visualise gallstones (with a view to ERCP)	**Renal colic** Plain film KUB will detect 90% of stones but **will not** detect hydronephrosis – consider CT/US
Please discuss cases of gastroenteritis and chronic pancreatitis with the medical team		**Non-specific abdominal pain** Unless excluding another **appropriate** indication
		Appendicitis
		Diverticulitis

WMUH 2010 Guidelines produced by Mr J Smith, Dr O Shields and Dr K Wooding with reference to Royal College of Radiologist guidelines 2003