Dartford and Gravesham NHS
NHS Trust

DARENT VALLEY HOSPITAL

Critical Care Directorate

The Ideal Anaesthetic Induction Project

Dr. Mansoor Sange / CT/ August 2020

Dear Trainees,

A warm welcome to Dartford and Gravesham NHS Trust!

Darent Valley Hospital is a District General Hospital with a busy Accident and Emergency Department and Maternity Department. It offers a comprehensive range of acute hospital-based services to around 270,000 people in Dartford, Gravesham, Swanley and Bexley. The hospital opened in September 2000 with specialties that included day-care surgery, general surgery, trauma and orthopaedics, cardiology, maternity, paediatrics and general medicine.

In October 2013 the Trust took on a number of services at Queen Mary's Hospital, Sidcup and Erith & District Hospital as part of the dissolution of the South London Healthcare Trust. The Trust offers a comprehensive range of acute services, with a bed-base of 544, to around 400,000 people in North Kent and South East London. The hospital building is run as part of a Private Finance Initiative (PFI). This means the building is owned by a private sector company, The Hospital Company (Dartford) Limited, and the Trust leases the building. Many non-clinical services, such as portering, domestic cleaning, security and facilities maintenance, are provided by Serco. The hospital also operates Elm Court, which is located in Priory Mews Nursing Home in Dartford. This provides 39 beds for patients from Darent Valley Hospital who have completed their acute phase of care but still need some rehabilitation, assessment, mobilisation or who are waiting for longer term care arrangements to be finalised.

The services provided by the Trust at Queen Mary's Hospital include elective day surgery and outpatient services in general surgery, gynaecology and paediatrics; diagnostics and therapies. Erith & District Hospital provides X-ray services; outpatients and physiotherapy. Oxleas NHS Foundation Trust is responsible for the buildings at Queen Mary's and Erith hospitals and the Trust works with it and other provider organisations operating from the sites.

The trainees will be assigned to anaesthetic lists at Darent Valley Hospital, Dartford and Queen Mary's Hospital, Sidcup. These lists include specialities like Gen Surgery, Major Colorectal, Urology, Gynaecology, ENT, Orthopaedics and Ophthalmology. There are dedicated daily trauma and extended CEPOD lists during weekdays. We now have all day CEPOD lists and weekend trauma lists that are consultant led.

This induction pack covers the activities at Darent Valley Hospital. There is a separate document for QMH, Sidcup. There are six main theatres and three daycare theatres at DVH. The surgical specialties include orthopaedics, urology, general/vascular surgery and gynaecology. ENT surgery and Ophthalmic surgery is only undertaken in daycare. There is an interest in laparoscopic colorectal surgery and there is a dedicated state of the art theatre for this purpose – the OR1. This hospital has a dynamic urology department with an interest in the treatment of renal stones and tumours.

The main theatres are situated next to the ICU, A & E and the department of radiology. There are two separate dedicated maternity theatres. The A & E department has recently undergone extensive refurbishment in order to improve the level and efficiency of service provided to the patients.

The anaesthetic machines have been upgraded this year. We are using the Drager Atlan machines in the anaesthetic rooms and the Draeger Perseus in theatres. All machines have advanced modes of ventilation including APRV. Sonosite ultrasound machines and Stortz C-Mac videolarygoscopes are easily available. The Spacelabs monitoring equipment both in Intensive Care and in the operating theatres has also been recently upgraded.

There is a drive towards enhanced recovery after major colorectal surgery and towards improvement of the management of patients with fractured necks of femur. A successful Enhanced Recovery Programme is in place to look after hip and knee replacement surgery patients.

There is a busy maternity unit with over 5,500 deliveries per year and a well-established epidural service. There is dedicated consultant obstetric anaesthetic cover during the week.

There is a well-established Consultant pre-assessment service next to the Daycare Lounge for DVH and another one at QMH, Sidcup.

There is a surgical admission lounge (SAL) located near the operating theatres. Most of the patients operated on in main theatres are admitted to the SAL on the day of surgery. This is where you will be able to see your patients for Anaesthetic Pre-assessment on the day of surgery.

There is an acute pain team led by a consultant anaesthetist and 3 acute pain nurses. There are daily morning ward rounds to review patients. There are 3 chronic pain consultants who run a separate Chronic Pain service. Paediatric and obstetric anaesthesia is provided by anaesthetists with a specialist interest in these areas.

There are separate induction documents for the Intensive Care Unit and the Obstetric Unit.

I would request all trainees to arrange to see their Educational supervisors in the first 2 weeks of August to get their Initial appraisal done.

We have an “Ideal Anaesthetic Induction Project” in place where your peers have written down some notes to help you.

Please remember – you can contact any time by emailing me - msange@nhs.net.

Welcome again to Darent Valley! I am sure that you will enjoy your time here.

Mansoor Sange

RCoA / FICM Tutor for DVH

Anaesthetic Department

Consultants

Name	*Role*
Dr. Vyakarnam Prasad	*Clinical Director / Major Colorectal / Educational Supervisor*
Dr. Islam Abdo	*ICU / Lead well being*
Dr. Salman Ahmad	*Obstetrics / ICU Outreach / Lead Acute Pain*
Dr. Dhiraj Ail	*ICU / Regional Anaesthesia / Ultrasound/ Lead Medical Examiner*
Dr. Basil Al-Shakarchi	*Ortho / Trauma*
Dr. Zak Belagodu	*ICU / Trust Simulation Lead / Educational Supervisor*
Dr. Dawn Harpham	*Obstetrics / Exam Preparation*
Dr. Andrew Hartopp	*Obstetrics / Regional Anaesthesia*
Dr. Francoise Iossifidis	*Deputy Medical Director / Obstetrics*
Dr. Dimitri Konstantopoulous	*Obstetrics / Paediatrics*
Dr. Sanjay Kuravinakop	*Chronic Pain / Simulation / Educational Supervisor*
Dr. Raman Madan	*Airway lead*
Dr. Madhu Mali	*Chronic Pain Lead / Foundation year Educational Supervisor*
Dr. Georgia Monantera	*Perioperative Medicine / Educational Supervisor*
Dr. Sanjay Parmar	*Obstetrics / Lead Clinical Governance / Major Colorectal / Educational Supervisor*
Dr. Vidhi Patle	*Obstetrics*
Dr. Mike Protopapas	*Lead Clinician for Intensive Care*
Dr. Anu Relwani	*Paediatrics / DVH Leadership Tutor*
Dr. Mansoor Sange	*ICU / FICM and RCoA Tutor / SEC NHS Clinical Senate Member / Simulation*
Dr. Shamim Sarfi	*Obstetrics / Paediatrics*
Dr. Malli Satisha	*Obstetrics Lead / NELA / Educational Supervisor*
Dr. Darshin Sethi	*Obstetrics / Airway / Educational Supervisor*
Dr. Rashid Suleman	*Emergency Medicine Consultant / ICU / Organ Donation Lead*
Dr. David Tyl	*ICU / Neurointensive Care / Post ICU Rehabilitation*
Dr. Azfer Usmani	*Chronic pain / Educational Supervisor*
Dr. Baber Zaheer	*Obstetrics / Rota in charge / Lead Paediatrics / Educational Supervisor*

Non-Consultant Medical Staff

Name	*Role*
Dr. Rajendran Sucharita	*Associate Specialist / Governance Lead QMH*
Dr. Yusuf Dhahi	*Specialty Doctor*
Dr. Suresh Bheeman	*Specialty Doctor*
Dr. Jacob Thomas	*Specialty Doctor*
Dr. Debadutta Misra	*Specialty Doctor*
Dr. Shirin Dastur	*Specialty Doctor*
Dr. Sivakumaran Shamini	*Specialty Doctor*
Dr. Feby K. Paul	*Specialty Doctor*
Dr. Binu Ravindran	*Specialty Doctor*
Dr. Ashwini Keshkamat	*Specialty Doctor / RCOA SAS Committee member*
Dr. Katie Watkins	*Specialty Doctor*
Dr. Devaraj Dyamanna	*Specialty Doctor*
Dr. Abrar Shafique	*Specialty Doctor*
Dr. Motsim Sheraz	*Specialty Doctor*
Dr. Krasimera Hristova	*Specialty Doctor*
Dr. Medappa Kaliyenda	*Specialty Doctor*
Dr. Daniel Lake	*Specialty Doctor*
Dr. Enoch Onya	*Specialty Doctor*
Dr. Sean Cordoso	*Specialty Doctor*

Acute and Chronic Pain Nursing Team

Nadia Ienciu	Bleep 241, extn. 8652
Alison Neale	Extn. 8856

Other Important members of Staff

Siva Kabilan	General Manager
Trish Bannister	Systems Activity manager, extn 8651
Helen Goode	Principle Anaesthetic and Chronic Pain Secretary, Extn 8648
Corina Foy	Anaesthetic Secretary, Extn 8741 (Thurs – Frid)
Olivia Turner	Systems Activity Administrator

The Directorate Offices are located on Level 3, Administrative Block, East Wing just after the Surgical Assessment Lounge.

Medical Staffing

Medical Personnel, Jade Building

All trainees should report to Medical Personnel on their first day to ensure the necessary paperwork, e.g. GMC Registration, CRB check is complete.

Medical Staffing Manager, Extn 8714
Medical Staffing Assistant, Extn 8673

Educational Supervisors List

Trainee	*Stage*	*Consultant*
Dr. Rehan Ganchi	*FY2*	*Dr. Madhu Mali*
Dr. Eelyn Chan	*ACCS CT1 - ED*	*Dr. Sanjay Parmar*
Dr. Sum Yu Pansy Yue	*ACCS CT1 - ED*	*Dr. Salman Ahmed*
Dr. Sian Fraser	*ACCS CT1 - AM*	*Dr. Satisha Mallikarjunappa*
Dr. Conor Walsh	*ACCS CT1 - AM*	*Dr. Georgia Monantera*
Dr. Sze Ki So	*ACCS CT1 - AM*	*Dr. Zak Belagodu*
Dr. Isabelle Goldrick	*ACCS CT2*	*Dr. Mansoor Sange*
Dr. Rochelle Pierre	*ACCS CT2*	*Dr. Zak Belagodu*
Dr. Alexander Warrilow- Wilson	*ACCS CT2*	*Dr. Prasad Vyakarnam*
Dr. Danielle Donoghue	*ACCS CT3*	*Dr. Shamim Sarfi*
Dr. Natasha Piddock	*CT2*	*Dr. Sanjay Kuravinakop*
Dr. Samuel Chequer	*CT2+*	*Dr. Azfer Usmani*
Dr. Anish Thillainathan	*ST3*	*Dr. Darshinder Sethi*
Dr. Natasha Amaradasa	*ST4+*	*Dr. Satisha Mallikarjunappa*
Dr. Gabrielle Grounds	*ST5*	*Dr. Prasad Vyakarnam*
Dr. Azher Ashraf	*ST5*	*Dr. Baber Zaheer*
Dr. Julie Wing / Darragh Hodnett	*ST5 (till Nov)*	*Dr. Mansoor Sange*

All trainees are requested to please meet up with your Educational Supervisors in the first 2 weeks of commencing your training at Darent Valley for your entry Appraisal.

Occupational Health

All the trainees must report to the Occupational health during the first week and make sure that all documented evidence of vaccination and screenings are produced and comply with their regulations.

Extension: 8451

Location: West Wing Level One

Library

Trainees can access the Library using their access cards 24hrs/day and it is mandatory that you comply with their rules and regulations.

Extension:	8548
Email:	library.dvh@nhs.net
Location:	West Wing Level One

Bleep System

Dial 78 – bleep Number – Enter your Extension number– wait for confirmation – hang up

Theatre	On-Call	Bleep 242
ICU	On-Call	Bleep 230
	Second bleep	Bleep 699
	Outreach	Bleep 476
Maternity	On-Call	Bleep 300
ODA	On-Call	Bleep 364

Bleep system is tested twice a day. Please answer all test calls promptly.

When an Arrest Call is put out, the floor level and ward will be announced. If there is an arrest in the corridor/street/library or main reception, the equipment is kept behind the main desk in Reception.

Annual and Study Leave

Please note that Annual Leave and Study Leave will need to be booked at least 6 weeks in advance and will be strictly on **first come first serve basis.**

Make sure that you all follow these rules:

- You have to apply for all leave via CLW Rota only.
- Leave at short notice cannot be sanctioned, unless needed for emergency purposes/compassionate grounds. This has to be approved by the college Tutor / Clinical Director.
- At any given point, **not more than two core trainees and not more than two specialist trainees can be away on Annual / Study Leave.**
- Private Study Leave is at the discretion of the College Tutor and is not a Statutory right. This is usually given only in the few weeks preceding an exam attempt.

Study Leave

Your study leave application needs approval of both the rota manager and the educational supervisor. The study leave budget has no yearly limit for trainees, but the number of courses is limited and has to be appropriate for the stage of training. The courses are classified as mandatory, optional and aspirational. The ES has to decide on the appropriateness of the course before signing it off using the list that is published here https://bit.ly/3eNGfWF. A copy of this list is in the induction pack.
The study leave is still subject to rota rules first. The trainee can claim reimbursement via Trust and Trust pays the trainee via payroll. Please see the study leave flowchart that is a part of the induction pack.

For exam courses the trainees are allowed funding for one course per part of the exam per attempt. For e.g. a trainee can attend maximum one viva and one OSCE course for the Primary SOE/ OSCE attempt. They can attend more than one course but will get money only for one course per part of exam per attempt. Please contact the medical education department if there is any doubt / query regarding this recent change.

Entitlement:

Annual Leave	14 days per 6 months
Study Leave	15 days per 6 months

Exam days are given and not deducted from your leave entitlement. Days in between examinations must be taken as Annual Leave.

Unfortunately, Annual Leave and Study Leave cannot be carried over to the next contract unless there are extenuating circumstances.

Sick Leave

In the unfortunate event of sickness, please email Mrs. Helen Goode and inform the Consultant you would be working / Starred Consultant telephonically as early as possible. You will have to keep Helen informed on a daily basis if you continue to be off sick. A Return to Work form will have to be filled in when you return to work.

If you are sick when on-call, please let the on-call / starred Consultant and the Anaesthetic Secretary know ***as soon as possible.***

At present there are Trust guidelines relating to sickness absence, which states that following 3 episodes or 8 days absence in a 12-week period, a discussion will take place with the Clinical Director. All sick leave taken is notified to the Medical Personnel department and to the Deanery via the Educational Supervisors Report.

Rota

We operate a full shift cover:

Normal Day	8.00 am – 6.00 pm
Long Day	8.00 am – 8.30 pm in Theatre / Obstetrics 8.00 am – 9.00 pm in ICU
Night	8.00 pm – 8.30 am in Theatre / Obstetrics 8.00 pm – 9.00 am in ICU

We operate a 1 in 8 ITU, theatre and Obstetric rota. If you have to take leave during your Long Day/Night Shift, it has to be a direct swap for a similar shift with your colleague and this has to be identified before you apply for leave. You must also swap weekends as a block and not individual days. **Please fill in the appropriate swap form.**

Anaesthetics Services

- 6 Main Theatres
- 3 Day Care Theatres
- Intensive Therapy Unit – 10 beds
- Obstetric Unit – 2 theatres
- Emergencies in CT Scanner/Interventional Radiology
- Pre-Operative Assessment – SAL / Daycare
- Acute Pain
- Chronic Pain

Anaesthetics Training for the following specialities is provided:

- Colorectal/Vascular/General Surgery
- Orthopaedics and Trauma
- Gynaecology
- Urology
- Day Care Anaesthesia, including Paediatric Day Care ENT
- ICU
- Obstetrics
- Non-Theatre including CT / Interventional radiology and interventional cardiology
- Peri-operative medicine
- Pain

If the elective list you are posted to is cancelled, you **must** report to the starred consultant to be re-allocated. You will be expected to keep a record of logbook/workplace assessments for each training list.

Theatre On-Call Responsibilities:

Day on Call

- Take over bleep 242 at 8.00am. The trainees only need to do an Acute Pain Ward round if the acute pain nurse is on leave.

- He/she will assess patients for CEPOD lists at 8.00am. Please discuss the CEPOD cases with the Consultant in charge of CEPOD lists (star consultant).

- Pre-assess any fracture NOF as a priority and discuss with trauma consultant.

- Attend ward patients for pain relief as required.

- Attend Trauma/Emergency calls by liaising with the ICU on-call person.

- Handover theatre CEPOD cases and potential pain problems to the night on-call person at 20.00 hours. 30 mins have been allotted specifically for this handover.

- Please read and follow the Pain Protocols. A copy of the list of acute pain patients will be given to you at handover.

Night On call

- Please collect the bleep at 2000 in theatres. You may have to bleep 242 if they are not in theatres.

- Please receive a detailed handover from the outgoing person regarding any CEPOD cases, any potential problems in recovery or any pain issues on the ward.

- Please make sure that at least the first 2 patients on CEPOD list and any Fracture NOF patients are seen by the night anaesthetist.

- Please handover to the day anaesthetist at 0800. 30 mins are allotted on the rota for this handover.

- On Saturday and Sunday, it is the responsibility of the Night Anaesthetist to do the Acute Pain Round before handing over to the Day Anaesthetist. This will have start at 7am to realistically finish on time.

THE CARDIAC ARREST BLEEP IS A BATON BLEEP AND MUST NEVER BE LEFT UNATTENDED / UNANSWERED. All cardiac arrest calls are to be attended by the Theatre on call (242) unless there is a clear communication with the ICU on call person that they will attend. If you cannot attend for any reason, please call and inform the ICU on call person immediately.

ICU Night On-Call Responsibilities:

- 20.00 HOURS – Take over Bleep 230 and care of ITU patients.
- Attend hospital at night meeting if duties allow
- Liaise with Outreach Team Bleep 476.
- During 20.00 to 08.00 hours to assess unwell patients on the wards and attend cardiac arrest and Trauma Calls. Please attend the selective MET calls as explained below.
- Discuss all admissions to ITU with ITU Consultant during 0800 – 18.00 hours and with on-call Consultant after 18.00 hours.
- Handover ITU/Ward patients at 20.00 hours. 60 minutes are allotted in the rota for this handover.
- When there is a junior trainee looking after the ITU out of hours, it is the responsibility of the senior trainee on for theatres to support and supervise him/her in the first instance.
- Support and supervise theatre emergency work out of hours as appropriate.
- Please familiarise yourself with the ICU protocols and policies. You will have a separate ICU induction.

Medical Emergency Team (MET) Calls

Previously all MET calls used to be attended by the ICU bleep 230. After a review of the workload of the ICU on call anaesthetist the following has been agreed from August 2017.

- All MET calls will be attended by Outreach nurse 24/7
- All MET calls will be attended by the medical registrar 24/7
- The ICU anaesthetist will attend MET calls 24/7 originating from ED, Cypress ward, Palm ward, Laurel ward, Chestnut ward and AMU. This is because these are the areas where most calls originate from and more importantly ED will be operating MET calls in line with sepsis screening and the emergency laparotomy pathway.
- We have generally agreed that ED will be calling the MET team if:
    - They are seriously worried about a patient.
    - If after an initial period of review of 2 hours by the ED doctor the patient NEWS score warrants a MET team review as per protocol

- Once the patient has been reviewed and a decision has been made to refer to a specialty for admission a NEWS score should be done prior to the patient going to the ward. This will prevent patients going to the ward only to MET call on arrival

The above will be subject to the following conditions:

- The ICU anaesthetist will be available to attend any MET call if requested to do so by the outreach team or the medical registrar

- The ICU anaesthetist will be available to attend MET calls if the outreach nurse is in recovery looking after an ICU patient or outreach is unavailable for that particular shift. This should be highlighted at the night hospital handover.

- If a patient in ED is clearly a surgical patient, then the outreach and Anaesthetic team will take over and expedite further treatment in conjunction with the surgical team. This will be part of the emergency laparotomy pathway.

Obstetrics On-Call Responsibilities:

- Work pattern: 0800 – 2030 hours.

- Handover at 8.00am and 8.00pm. 30 mins allotted for each handover.

- Attend labour ward - for ward rounds, epidurals and caesarean sections.

- Familiarise with all the equipment, guidelines and protocols in the Obstetric Anaesthetic folder and adhere to them.

- Always discuss difficult/problematic cases with the Obstetric Anaesthetic Consultant.

- Support and supervise the Theatre on-call/ITU on-call person in cases of emergencies.

- Responsible for follow up of labour epidurals and appropriate documentation.

Please always inform the Consultant of any Major Haemorrhage in Obstetrics.

Working at night

From August 2017, the way in which the Night on call team works has changed. The Theatre, ICU and obstetric anaesthetists now work as a team. Each team will have a designated leader (starred anaesthetist) who will have an overall view of what is happening in all three areas of the hospital. This will usually be a senior trainee / SAS doctor of appropriate experience. Any clinical issue in any of the three areas has to be first discussed with the starred anaesthetist who may be able to help. If a consultant contact is felt to be required, then the starred anaesthetist can ring up the consultant. If the starred trainee is busy or if there is not enough time, then a consultant can be contacted directly. All anaesthetists are encouraged to talk to each other so that the hospital can be managed

as a whole. If one area is less busy, then that anaesthetist will be expected to apply their skills in another area of the hospital. All junior trainees will be expected to help out in both obstetrics and ICU under the **direct supervision** of senior trainees to enhance their training opportunities. For e.g. a core trainee can attend the obstetric unit LSCS at night under the **direct supervision** of an SAS doctor to assist in the conduct of anaesthesia. They can at no point be left on their own. The obstetric anaesthetist can leave the obstetric suite and help out in other areas as long as they are able to attend to a Category 1 LSCS on time.

When to call the Consultant out of hours?

You should consider calling the **Anaesthetic Consultant on call** for

- All under 16-year olds.
- Adults and Children with airway problems.
- ASA 4 – 5 patients.
- Members of staff or other VIP's
- ICU patients going to theatres
- Major Obstetric haemorrhage

You should consider calling the **ICU Consultant on call** for

- All ICU admissions
- **All patients who are refused admission to ICU – this is mandatory.**
- ICU patients going to Theatre
- Any ICU patient whose condition deteriorates significantly or requires escalation of care that was not expected.
- Organ donation patients.
- Major trauma/head injuries.
- Cardiac Arrests
- Transfer of patients to other hospitals
- Any sick adult patient in the hospital that you are worried about.

Critically ill Paediatric Patients

All paediatric referrals are discussed with tertiary referral centres (usually the Evelina unit at Guy's). If deemed necessary, specialist paediatric teams retrieve them. It is very exceptional for a paediatric transfer to be done by the Darent Valley team. This is usually for neurological emergencies. Paediatric patients are usually transferred to recovery or one of the anaesthetic rooms in main theatres where they can be stabilised prior to transfer. Dr Zaheer (Consultant Anaesthetist) is the lead clinician for paediatric anaesthesia. There is a dedicated paediatric trolley in ED and theatres. Please contact the Anaesthetic Consultant on call for any advice regarding any paediatric patients.

Please Remember – this list is not exhaustive. If in doubt, please call the Consultant. Patient safety is paramount!

Teaching

Thursday 08.15 am – 12.00 pm.

Both Consultants and Trainees will present topics. More guidance will go out with the teaching rota. There will be a senior trainee in charge of the Teaching rota for six months. The teaching programme is trainee driven.

Monthly Audit/M&M Meetings
(Dates can be obtained from Departmental Office)

The topics will be put up well in advance and it is your responsibility to swap your dates if you are on Annual Leave/Study Leave/On Call.

You should also let the Consultant chairing that particular teaching know of any such changes. There is a dedicated Audit Meeting every month lasting half a day and you are expected to attend these.

Your attendance at the teaching and Audit meetings will be recorded and will form a part of your ESSR.

Intensive Care Medicine Training

ICM at DVH is recognized for all stages of training required for a CCT in Anaesthetics. The only stage it is not recognized is for the Advanced Year for a CCT in ICM.

No more that 5 working days of any leave can be during a 3-month block of training in ICU. If any of this leave is taken it will delay the sign off of the module.

There is a separate Induction Pack for ICM training that you will receive when you have your ICM induction.

Audit and Research

Audit is an integral part of good training and also Clinical Governance.

It is your responsibility to meet Anaesthetic Consultants at the earliest and choose topics for conducting audits. You should also familiarise yourself with Critical Incident Forms and report them in the event of such an incident.

The Departmental Lead Clinician for Audit is Dr Azfer Usmani and Deputy Lead is Dr. Devaraj Dyamanna.

General Information

Computers
Trainees are expected to obtain their user ID and Passwords and use the computers in the Trainees Room and Library.

Catering Facilities in the Hospital
Where to eat?

The Original Food Restaurant
Location: East Wing, Level One.
Opening Times: 07.30am – 7.00 pm – serve Breakfast, Lunch and Dinner

Costa
Location: Main Entrance
Opening Times: 24 hours

Marks and Spencer's Simply Food

Location: Main Entrance
Opening Times: Weekdays 07:00-21:00
Weekends 08:00-20:30

Vending machines available outside Original Food and in Accident & Emergency for out of hours

Competencies Record

Please indicate your competencies in the list below and return this for to the College Tutor by the end of August.

Undertake pre-operative assessment:

Check an Anaesthetic machine

General anaesthesia for:

ASA grade 1 or 2 patients

ASA grade 3 patients

ASA grade 4 and 5 patients

Insertion of LMA Endotracheal Intubation Rapid Sequence Induction

Cardiopulmonary Resuscitation Adult Paediatric

Establish and Manage Regional Anaesthesia (please tick those that apply)

Epidural block ☐

Subarachnoid block ☐

Caudal epidural anaesthesia and analgesia ☐

Penile block ☐

Inguinal field block ☐

Intravenous regional anaesthesia ☐

Regional anaesthesia of the upper limb (specify technique) ----------

Regional anaesthesia of the lower limb (specify technique) ----------

Resuscitate and manage the trauma patient ☐

Inter-hospital transfer of critically ill patients ☐

Epidural blockade for labour analgesia ☐

General anaesthesia for obstetric surgery ☐

Central Venous Line Insertion - Jugular approach ☐ Subclavian approach ☐

Femoral line insertion ☐

Arterial line insertion ☐

Vascath insertion ☐

General anaesthesia for the child

Ages 11 – 16 years Ages 5 – 10 years

Ages 2 – 4 years Age less than 2 years

DEPARTMENT OF ANAESTHETICS

RECORD OF DEPARTMENTAL INDUCTION
(ALL GRADES OF STAFF)

Name of Doctor: ……..

Post Held: …….

Date of Appointment: ……

Date of Departmental Induction: ……...

Departmental Induction by (*print name*): Dr. Mansoor Sange

Please tick items covered:

Department Structure and Staff	☐
Shift System	☐
Daily duties	☐
Training Arrangements and Educational Supervisors	☐
Orientation Main Theatre, Day Surgery Unit, ITU, Delivery Suite, A and E	☐
Main Theatre Anaesthetic Machine and Monitors function and checking	☐
Portable ventilators and transfer monitors	☐
Main theatre syringe drivers	☐
Patient and blood warming devices (Bair Hugger, Hotline)	☐

Signature of Doctor performing induction: ……

Signature of Doctor undergoing induction: ……

The Ideal Anaesthetic Induction Project

By Dr. Megan Thomas, Dr. James Jackson, Dr. Shamini Sivakumaran, Dr. Rajin Maahi

A day in the Life of Bleep 242

Bleep 242 is the anaesthetic/theatre/CEPOD on-call bleep. It is generally held by the anaesthetic core trainee (unless they are currently doing ICU module, in which case their paired SpR will hold). Occasionally it is held by an anaesthetic staff grade doctor (usually to cover absence).
CEPOD is the emergency theatre. This is available 24/7 if needed. The actual theatre location for CEPOD is normally theatre 3 (however during the covid-19 pandemic, the CEPOD theatre has moved around, at the time of writing we are currently using theatre 4). The trauma list is 08:00-18:00, every weekday with a morning half day list at weekends. Patients may be added to CEPOD list from the trauma list if they are not able to be completed during the allocated time. In which case, an orthopaedic theatre is opened out of hours in place of CEPOD theatre.

Long day (08:00-20:30) weekday.
Staff covering CEPOD: core trainee (with exceptions see above) and consultant (who is often also the starred consultant overseeing the whole department). Usually this consultant is on for 24 hours and therefore will be around for both handovers if needed.
08:00 meet at the theatre reception and print a CEPOD list from Patientcentre (the printer is located opposite the reception desk in the storeroom.
Hand over 242 bleep.
Discuss cases that have already been seen and those that surgeons have given specific instructions for (i.e. like emergency laparotomy to go first).
Hints and tips for board on Patientcentre:

-Click on patients name for more details of request
-Once you have seen patient for anaesthetic assessment click on the cross and it turns into a tick.
- Drag and drop patients to create an order
-Check date that the surgeon wants to operate, often they add in advance and patient may be due to come in at later date.
-The ward the patient is on should be visible. If it is not they may not be in the hospital and are due to return for operation.
-The booking doctor often leaves their bleep number/a mobile number on the CEPOD list if you want to contact them to clarify anything

Generally, unless there is an operation that takes higher priority, the urologists will take the slot for the first case if they have one (i.e. emergency stenting) and then gynaecologists will perform (usually two) surgical management of miscarriage (or minor procedure such as drainage of Bartholin's Cyst). The SMM patients arrive at 08:00 and so it will be the responsibility of the day holder of 242 to see them. Unless otherwise stated they will be on gynaecology assessment unit/early pregnancy unit. This is unit is located in same vicinity as Mulberry Ward (level 2). N.B. gynaecology team hand over between 08:30 and 09:00 therefore first SMM will be sent for after this. Communicate with theatre front desk once you have seen first patients and then they will be sent for. Once urology/gynaecology cases are complete then general surgical team will start their cases.

Laparotomy: There is a pathway for these patients, and you should be bleeped as soon as a patient has been identified as needing a laparotomy. Ensure group and save/crossmatch has been sent and (if planned) consent the patient for arterial line/CVP/ICU care etc. ASAP. Discuss patient with ICU/nurse in charge on ICU as they are likely to need a bed. When you get time make sure you start NELA audit online and to be considerate to ICU colleagues start ICU paperwork/drug chart before patient gets to ICU. If you need noradrenaline, then this is kept in ICU.
If a patient is taken to recovery before transferring to ICU then arrange CXR there (book on PAS and bleep 505 to inform radiographer that patient is in recovery unit).
LP/central lines/cannula requests: During the day there will be requests for these. Make sure central lines/LPs are booked onto CEPOD list (do not attempt to do on ward).

-LP: There is guideline on intranet regarding this but as an overview find out why patient needs to be done on CEPOD list (make sure that someone has at least attempted to do LP first). If sedation is required, then inform medical doctor that we can perform sedation (if patient starved) and they can do LP. If LP is technically difficult then we can do LP, but they must be present to collect sample and then take to lab. Make sure medics have clearly stated why LP is needed and what tests are required. They need to organise all the equipment to arrive with the patient (i.e. manometer).
-CVP: Ask why patient needs central line. If for TPN, ask if this has been ordered /authorised. If for IV access, then discuss what attempts have been made at peripheral access. There is a vascular access team for PICC lines Mon-Fri during normal working hours.

-Cannula: *(Addendum by Dr. Sange) Trainees are advised not to accept any referrals for a cannula. The anaesthetic department does not provide a ward / ED cannulation service. The cannula must be attempted by the most senior person of the parent team. If a patient is truly difficult to cannulate then they will probably need a central line. Please escalate to anaesthetic consultant on call if there is a problem.*
-Pain patients during day…refer them to acute pain team bleep 241
-ICU patients…refer to ICU team on 230
-MET calls/cardiac arrest calls…ICU team deals with these during 08:00-20:00. They will bleep you if they need help.

<u>Night (20:00-08:30)</u>
Evening handover is at theatre reception. Overnight ICU is covered by SpR holding bleep 230. They have separate handover on ICU.
Up until midnight cases will continue depending on need. Beyond midnight only life or limb threatening cases should be carried out. Discuss with consultant if any disagreement. Inform consultant overnight if any laparotomy/unwell/paediatric/difficult airway cases.
-Pain patients may also be handed over to you for overnight review. There is a book in the recovery unit (under drug cupboard, on left hand side of bench) where all epidurals/PCA and patient details are listed.
Once theatre cases are done join SpR on ICU and see if there are any jobs outstanding. Attend MET calls/cardiac arrest calls after this point.
-'ENT review for transfer'. We often get requests to 'review airway' of patient who needs to be transferred to Medway for ENT review. If the airway is at risk we can intubate for transfer. Please do see these patients but escalate to anaesthetic consultant on call quickly as they can be very tricky and high risk. If the airway is not presently/imminently compromised then we can comment as such, however we cannot predict what will happen on transfer. So please take care in your documentation to be specific in what you write and accurately time and date your examination.

Weekend

Consultant will be on 24 hour on-call, during day light hours they will be on site and will liaise with you about the time they leave hospital (some consultants stay in accommodation on site anyway). Over weekend pain patients will be reviewed by you. During day this is only upon request. If you are on night duty then it is your responsibility to complete pain ward round. See above for where patient list is kept.

No gynaecology routine SMM's done.

Night Rest Room

Discuss with SpR where they intend to rest. There is an ICU registrar room on corridor just by Chestnut way (enter ward and turn right down corridor towards discharge lounge, door is labelled). This may be locked, the key is attached to the ICU SpR bleep (230). There is a bed in trainee room (code C4567X) and there is a dedicated SHO room in hospital accommodation. The key for this can be picked up from security (desk by main reception, level 2). Sign out key and return to desk in morning. The accommodation can be found by following the corridor past surgical wards on level 3 (i.e. Maple, Rowan, Cherry etc.), until you reach a glass bridge, which leads outside of building. Follow the path outside and you will see a single storey building on your left. A carpark can be seen through the gate. The hospital accommodation is in the blocks of flats that line the carpark.

Scrubs

Greens must not be worn in public areas i.e. M&S, Costa so you will have to change before going there.

Teaching

A bleep free session! You do not need to go to ICU/theatres before teaching starts. Start time is 08:30, generally held in library seminar room. By tradition whoever presents buys some breakfast. We return to lists after teaching.

Study leave/annual leave

Forms can be found in Helen's office. Once agreed medical education will send a confirmation email. Once you have attended course/educational activity then email them back with invoice and certificate and payment will occur directly into your account. You have to complete all the compulsory e-learning/courses before you are eligible. Be careful as deadline for receipts is strictly 3 months after event.

Payslips

Pay day is 24th of month unless this falls on weekend, in which case last Friday before. Pay slip held by Helen for collection.

COVID

The following is a summary of how COVID has affected the life of the 242 bleep-holder:

- The location of CEPOD/trauma theatre has moved around to accommodate intubated COVID patients in theatres. CEPOD is currently located in theatre 4 with trauma in theatre 5 but this is subject to change again.
- During the COVID peak all elective operations were cancelled and CEPOD/trauma merged into a single 24/7 list. At the time of writing the weekday 0800-1800 trauma list is up and running again but the weekend AM trauma lists are not. This means there may be more than usual trauma cases to accommodate at the weekend on CEPOD.
- During the peak of the pandemic a 2-month emergency on-call rota was implemented with all trainees and SAS doctors included. This resulted in more on-calls, more cross covering of

shifts (e.g.: ICU/outreach) and a small increase in pay. This emergency rota ended at the end of June 2020 but may have to be considered again if another peak arises.

- After standing down the emergency rota, one extra junior has remained on the rota out-of-hours, in a role named 'floater/4th on-call'. This person generally holds the ICU bleep (230) as the ICU doctor will likely be donned in PPE in ICU and unable to respond to bleeps. This person fields referrals, liaises with the on-call ICU/outreach consultant regarding admissions and when not busy should help the ICU doctor with jobs on the unit.
- As a result of there now being 4 juniors on out of hours (whereas there used to be 3) we are more flexible about where we rest at night. The obstetric on-call doctor has access to the Obs office located on the delivery suite as well as the Obs rest room downstairs near Willow ward. The ICU/floater/anaesthetic on-call doctors have access to the ICU SpR room (by Chestnut ward), the trainee room (by the front entrance to ICU), the ICU seminar room (next door to the trainee room) as well as there being some rooms available in the accommodation (ask security at reception for a 'COVID on-call' or 'anaesthetic on-call' room).
- At the time of writing the acute pain service is back up and running so the 242 bleep holder should only get bleeps about acute pain during the night and during the weekend or if the pain nurses are all unavailable (e.g. on leave). The location of the book which contains a list of all the epidurals and PCAs for the weekend on-call doctor to review has also changed a lot recently, but it is currently back in theatre recovery. You can bleep the pain nurses on 241 to clarify this.
- We are wearing PPE for all cases in CEPOD now and donning/doffing stations are outside theatres and marked. At present we are removing all supraglottic airways in theatres (as well as extubating tubed patients) *before* transferring the patient to recovery.

Megan Thomas
July 2017

Updated by Dr. Sange/Dr. Sam Chequer in August 2020

The Obstetric and ICU bleeps

Obstetric Bleep 300 0800 - 2030 (Night 2000 – 0830)

- Covered by consultant, core trainee and SAS/ >ST3 usually in the daytime.
- SAS and ST3 and above doctors cover nights.
- Changing room code 56789.
- 1st prepare emergency drugs.
    - Draw drugs for both theatres (1 batch phenylephrine sufficient.)
    - Emergency intubation drugs in box.
    - Some prepare ondansetron / tranexamic acid for theatre.
- Prepare syringes of oxytocin.
- Check both anaesthetic machines.
- See electives before 0830 MDT board round if possible. They will be in recovery.
- Elective team brief post 0830 handover in theatres. See Enhanced recovery for patient pathway and drug prescriptions.
- Encouraged to use U/S for lumbar / epidural anatomy 1st patient on elective list.
- See follow ups and enter on database (password from Dr Satisha)
- Cover emergencies as team.
- High-risk clinic in afternoon. Fill in anaesthetic form as appropriate and leave with patient's notes. COVID patient– Performed by video link.
- Some high-risk patients require MDT plan. Leave in high-risk folder.
- Epidural codes 241 / 242
- Usual epidural program is 8ml boluses every 20 mins PCEA with no background.
- Beware of initial full top up and then patient administering further bolus straight away if not used to technique!

James Jackson
June 2017

Updated by Dr. Sange / Dr. Dan Lake - August 2020

ICU Bleep 230 0800-2100 (Night 2000 – 0900)

- ICU covered by consultant and 2 anaesthetists +/- FY2 doctor in the daytime.
- The second doctor on the unit has to carry the 699 bleep. This can be returned to the ICU desk drawer at the end of your shift.
- Theatre changing room code 5689.
- Storeroom code 1357
- Handover in ICU seminar room, night doctor to print 5 handover sheets.
- Ward round as per consultant preference usually around 10 am. Dr. Sange usually starts WR at 8am sharp.
- Review all investigations for patients (bloods, radiology, micro) daily. DartPortal is useful for this.
- Admission proforma and daily notes printed from Patient Centre via clinical documents.
- Discharge forms to be typed and saved on Patient Centre and to be updated on discharge. To be done in the daytime so that its easy to discharge patients at night in case the anaesthetist gats busy.
- Ward drug card will also have to be updated / re-written.

- Bleep holder to attend MET calls (selected)/ trauma calls/ cardiac arrests/ Maternal collapse or emergency.
- Review ward patients as requested.
- Attend micro ward round and document.
- Document evening ward round in notes.
- Night doctor encouraged to attend medical handover on AMU at 2100 (not mandatory) or liaise with outreach nurse (bleep 476) RE sick patients on ward.
- Offer support to SHO covering theatre.
- Review patients and document in notes in appropriate section.

- Avoid metaraminol infusions, insert CVC line and use noradrenaline.
- Edward Lifesciences Flotrac (invasive and non-invasive) monitors for cardiac output are available.
- Discuss all admissions with consultant.
- The first port of call for Airway assessment for transfer to Medway for airway pathologies is bleep 242. If it's a relatively junior anaesthetist, then you may have to help – **refer to Anaesthetic Consultant – not ICU**
- Utilise guidelines on ADAGIO system.
- Encourage theatre colleagues to admit patient if planned ITU admission.
- Transfer difficult airway cases to theatre from resus if concerned regarding intubation.
- Please ensure you contact the lab if sending a CSF sample or a vasculitis screen. If you can please hand the specimen over to the lab personally as this avoids processing delays for these types of samples.
- Room to rest on chestnut ward (if locked the key is in the "green keys" with ICU nurse in charge. Please return key as soon as you have unlocked the door) or ITU corridor (code C3469XZ)

James Jackson June 2017 Updated Aug 2020 – Dr. Sange, Dr. Dan Lake

Referrals in ICU

Most referrals in ICU can be done via bleeping the respective registrar on their bleeps, but there are some exceptions to this.

1. **Cardiology, Gastroenterology, Respiratory, Nephrology and Ageing health** needs a referral via patient centre (select the patient, then go into order entry and there is a tab for specialty referrals and the appropriate one can be selected and filled in). Once filled in, the urgent ones can be discussed with the registrar on the teams.
2. **Neurology** – referrals need to be done via an email to dvhneurology on nhs.net mail. The neurology registrar's bleep number is 101.
3. **Neurophysiology tests** – these are carried out by Kings neurophysiology team. There is a form to fill in which then needs to be scanned and then emailed to the king's neurophysiology team. They will send someone to do the testing here. If the tests are urgent, please contact the team at Kings to try and arrange a slot sooner rather than later.
4. **ENT referrals** – ENT is based at Medway Hospital and out of hours, we need to go via switchboard to Medway and speak to the ENT registrar on call. In hours 9-5 Monday to Friday there is a clinic held in outpatients and you can go down and speak to them directly.
5. **GUM referrals** – clinics are based at Gravesend Community Hospital and referrals can be done via the phone. They are usually very good about giving advice on the phone even if they cannot come and see the patients.
6. **Hepato-biliary surgery referrals** – these should be done by the home team but if in the rare case we are involved. The HPB team is based at Kings. It is useful to sign up to the inter-hospital transfer system on the Kings Hospital Website. The referral system is used for HPB and neurosurgery referrals. If you aren't already signed up, all you need is an nhs.net email address to get a password. The website is https://nww.ihtl.nhs.uk/thubreferrals .
7. **Neurosurgery referrals** – Our tertiary centre for neurosurgery is Kings. The images need to be linked to Kings. The referrals are again via the website https://nww.ihtl.nhs.uk/thubreferrals/. Once the online referral is done, you can ring and speak to a neurosurgical registrar at Kings on 020 3299 9000.
8. **Poisons Helpline** – Toxbase website has all the information needed. You can request a registration on the website or in severe cases it useful to ring and speak to someone for advice on 0344 892 0111.
9. **Severe respiratory/cardiac failure referrals** – There is an online referral form for St Thomas ECMO unit. To make a referral for ECMO/Complex Respiratory advice please use this SignPost® link: https://www.signpost.healthcare/ecmo-referral-pathway . The phone number for GSTT Intensive Care Unit is 02071882511.

10. **Lane Fox Referral** – Some of our patients need to be transferred to Lane Fox Unit to be weaned off ventilators. Referrals are done via email to gst-tr.lfureferrals@nhs.net .
11. **Coroners Referral** – online system with link on ADAGIO. See note on Medical Examiner in ICU induction pack.
12. Dermatology is based at St Thomas Hospital and can be contacted via switchboard.

Discharges on ICU

All of our paperwork is online, and we try and do the discharge paperwork in hours so that the on-call members at night-time do not have fill in paperwork when they are also in the process of admitting patients. Most of the information is filled and saved as incomplete and unverified so that it can be edited by the discharging person who needs to fill in the date and also the information about whom the patient has been handed over to.

For surgical patients, please verbally hand over in-hours to the relevant team members and out of hours to the on call FY1 or SHO.

For medical patients, out of hours please verbally hand over to the on-call team members. In hours Monday to Friday, the teams are ward based and you can ring the ward to which the patient is going to and ask to speak to junior doctor on that ward and hand over to them. It's very important that the doctor's name to whom the patient has been handed over is documented on the discharge summary.

Once the relevant information has been filled in, you can print the discharge summary and save the document as complete/verified so that it can no longer be edited and printed. This remains on PAS. So, there is both an electronic and a paper copy. If unsure which consultant they need to be discharged under, please discuss with ICM consultant

Shamini Sivakumaran -August 2019 Updated Aug 2020 – Dr. Sange

FY2 INTENSIVE CARE / ANAESTHETICS INDUCTION

Most of the information required regarding the daily activities and running of the ward can be found in the "The Ideal Anaesthetic Induction Project - The ICU Induction Pack" which should be made available to you before you start. As the FY2 you will be based in primarily on ICU. There is an option for you to spend the last month on Anaesthetics. This can be discussed with the clinical tutor.

GENERAL: The FY2 will be posted on ICU with 2 additional doctors (2 registrars' or 1 registrar + 1 core trainee). There is one hot week consultant who will cover ITU per week. Handover starts at 0800 and takes place in the seminar room which is located outside the ITU entrance. This lasts for about an hour, and all patients are thoroughly discussed. Following this, all patients will need to be reviewed by the team prior to the consultant led ward round which typically starts around 10:30 (approximately). The reviews are completed on a set proforma (pink daily review sheets; can be accessed/printed via PAS). The daily reviews are done by the FY2, the CT and the SpR. After completion of this, the consultant would join the team and preform the ward round and finalise the management plan for the day. All outstanding jobs will need to be completed following this (i.e requesting imaging, speciality referrals, discharge summaries). A second ward round takes place either late afternoon or in the evening. The FY2 will generally not be present for this.

ROTA: The anaesthetic/ICU rota can be accessed via the CLWRota app (to gain access to the app, get in touch with Dr Zaheer). The shifts for the FY2 are as follows:

Monday: 0800 – 2000
Tuesdays – Thursdays: 0800 – 1700
Fridays: 0800 – 1300
Saturdays – Sundays: 0800-1600

You will be required to do weekend shift once every 4 weeks, you will have the Friday off and work the weekend. You then continue and work the following week as usual. There are no night shifts. Please note that these shifts do not match those of the other trainees as they generally finish an hour later. **Leave:** As you are supernumerary you should be able to take your 9 days leave whenever required – let Dr Baber Zaheer know via email (Anaesthetic Consultant, rota lead) and then request leave via the CLWRota app.

LEARNING OPPORTUNITIES:

- Please discuss with your supervisor if you have any particular aims or skills you would like to gain during either part of the placement. This applies even if you are not considering a career in ICU or Anaesthetics as there will always be applicable skills to gain and the consultants/trainees are happy to help with this. If you have a particular medical or surgical specialty interest, then you can also ask to see particular patients before the ward round and look after during the day.
- You will be working close with a team who have a vast amount of knowledge on basic and advanced physiology and pathology. The trainees based on ICU have either passed their membership exams or are currently studying for it. Therefore, they are a key resource to utilise and engaging in informal discussion with them will be of extreme value. Also, weekly anaesthetic teaching takes place in the education centre every Thursday (0830 to 1300). You are required to attend these. They are consultant led therefore are very beneficial. There is a half-day departmental Audit meeting once a month, during these weeks, no Thursday teaching is held.
- Multiple opportunities to undertake practical procedures such as central lines and arterial lines, and there are also likely to be other opportunities such as ascitic and chest taps/drains. Airway opportunities are readily available in theatres but limited in ICU itself. Take opportunities to attend MET calls and A&E reviews with the bleep holder when you can as these are valuable learning opportunities – you should not be holding the bleep yourself. There is an second bleep (#137) which can be found on ITU and is option for you to carry. The bleep will notify you when a MET call is made.

Dr Rajin Maahi, Foundation Year 2 - Doctor --- April 2019