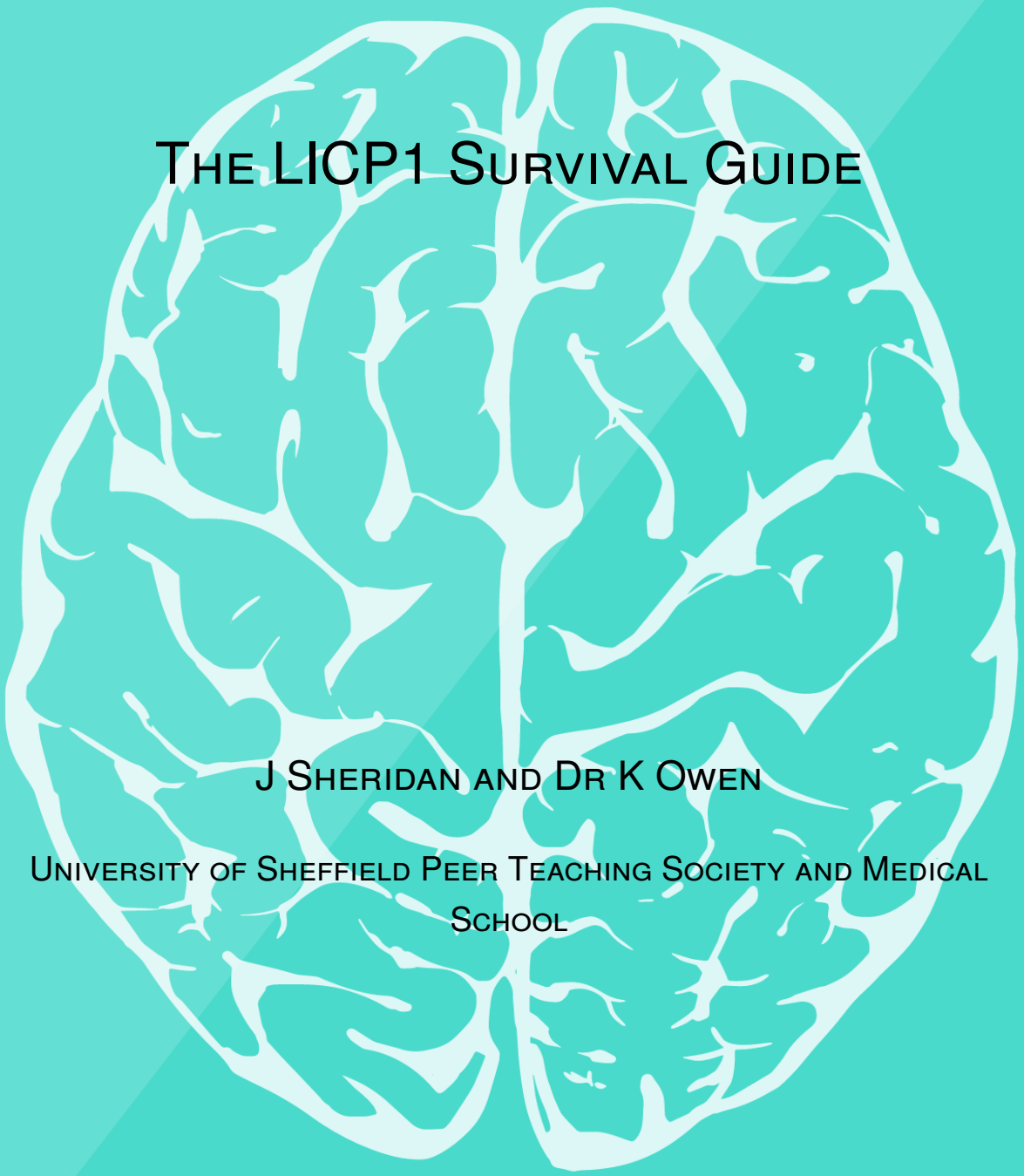
# The LICP1 Survival Guide



J Sheridan and Dr K Owen

University of Sheffield Peer Teaching Society and Medical School

## Preface

The following document is intended as a guide to 2b students starting their first longitudinal integrated placement (LICP1).

This guide was compiled, revised and designed by Jonathan Sheridan, an elderly medical student, in collaboration with Dr Katy Owen, clinical teacher and former teaching fellow. This includes information drawn from ”A Guide to F1 for Sheffield MBChB Graduates” and other associated guides written by Dr Katy Owen, and resources noted at the end of this guide.

We hope this guide will help you get the most out of placement and make your time on placement enjoyable!

# Contents

## Introduction to being on wards

Firstly, congratulations for making it to clinical years! Welcome to the LICP1 guide, written by a former and a current medical student. Our aim is to help introduce you to the clinical environment, and to give some tips and tricks to get the most out of placement.

**It can be daunting in your first full clinical placement.** Many do not know where to start or what to do. Part of this guide will focus on ward rounds, the bread and butter of ward medicine. We will also cover how they are documented, and how you might use these activities to learn the most during placement time. Be confident and introduce yourself to the clinicians and the team. Try not to feel bad about forgetting names and asking to be reminded, everyone in hospitals does this (some of us several times a day).

**Be proactive and reactive.** It's important to actively seek opportunities and to react to things that arise. Such as asking to take histories, or volunteering to take bloods when you overhear Doris in bed 8 needs them. Get them sign offs done ASAP!

**Practise makes perfect.** Take histories/clerk and examine as much as you can. This will make them slick for exams, and you will get used to common presentations. Get a group together early and practise histories and examinations with each other until it's all second nature (Don't worry it always feels awkward when you start).

**Collaborate.** A general tip for clinical years. Share resources with each other. If you live with medics it can be nice to come home and each share one thing you learned on placement that day. Talk to friends when something emotionally affects you. You will see upsetting things in this career and it's healthy to be honest with how it makes you feel, rather that bottling it all up.

**It's not personal.** Wards can be busy and it can be easy to fall through the cracks. It's important to be empathetic to the clinicians and other team members. They don't intend to ignore, but patients always come first!

**Take a breath.** Anyone can become overwhelmed, this is normal and valid. Don't force yourself to stay in situations you feel uncomfortable with. Ask to leave or excuse yourself, sit down and take a breath.

**Drink water!** Or whatever drink you prefer. Make sure you stay hydrated, it's easy to get distracted on placement and you might give yourself an AKI!

**Don't neglect yourself.** No career is worth actively making yourself unhappy for. It can be very easy to neglect things you enjoy when starting placement. Keep playing your sport, go to the pub, say yes to that PopTarts night.

# 1. The Ward Round



## 1.1 A Rough Guide and Documentation

### What is a ward round?

A ward round is the process of reviewing inpatients under the care of the ward. Ultimately patients are under the care of the consultant, who usually leads the round, but speciality trainees may also do this. Nurses, and other allied health professionals may also join ward rounds so that they are updated on the clinical plan.

**The overall aim of the ward round is (usually) to progress people towards discharge**, or at least towards events that progress them towards discharge.

> You might hear people also say **post-take ward round** this is just a way of saying a ward round of the new admissions that have been clerked but not seen by senior clinician.

### The Patient List

A patient list identifies all of the patients belonging to your team, where they are located and their clinical details such as presenting complaint and investigation results. When reviewing each patient, as well as asking the patients how they are feeling, their prescription chart and observation chart will be reviewed.

One of the team documents the ward round in the patient notes (try to jot down your own note or volunteer to do this, it's good practise!). At the end of the ward round, the investigations and plans for each patient will be reviewed and tasks allocated. This is an excellent opportunity to make sure you understand the reasoning behind the plans made for each of your patients.

### Prepping Notes

This occurs before the ward round or before seeing a patient, depending on the way the ward works. There are many reasons this is important. It helps keep important information such as problems list (including resolved ones), important investigation results, past medical history etc. easily accessible for the next person reading the notes. It makes writing discharge summaries or any subsequent documents much much easier! Patient notes are also legal documents, so it's important to be clear in, why they were admitted, what has happened since, and what the plans are.

Ask a doctor to show you how to prep notes for your ward, and offer to prep them later on in the placement. It's something you will do day in and day out as a doctor and could help the ward round run more smoothly! Should you try to prep notes, make sure to read anything from the overnight or documentation from any other members of the MDT (I was caught out by this early in LICP1!).

### Making a Patient Progress Note

You will develop your own way of doing this over time and you won't be expected to be making these during 2b, so don't stress too much at this stage! There are various ways to take patient notes and it is best to start generic. Medical and surgical notes tend to be different levels of details and specialities will have their own elements that are included. One basic framework to fall back on is the SOAP note;

**Subjective**; How the patient is feeling today and how they have been since their last review in their own words. Explore each symptom they mention and ask the patient to describe them in their own words. If you need to directly quote remember to use quotation marks to show this. This is essentially a mini history taking!

**Objective**; How they appear, such as "comfortable at rest". Included are things such as fluid balance, any normal/abnormal examination findings, and any relevant clinical measurement e.g. Wells' score

**Assessment/Impression**; Arguably the most important part. Assessment of the current situation based on the previous information. This will usually include things like changes know diagnoses, a differential diagnosis, and any progress towards previously established goals. Often clinicians note this as their "Impression".

**Plan**; This details what will happen next with the patient. This may include further investigations, therapeutic needs, discharge plans etc. Remember making a plan for clinical problems is not expected at 2b! If you feel comfortable give it a go, or ask why certain plans were decided on.

This is just one of the various frameworks for making progress notes. They're good to keep in mind if you feel stuck and can help structure clear and consistent notes. When you feel confident ask to scribe for a patient or two on the ward round. See if you can link the SOAP elements to the example note later in the guide.

You'll notice some of the senior consultants barely scribbling anything in the notes, but this is down to experience and intuition of what features actually don't need their attention for that day's review. Some fast surgical ward rounds include literally: date, time, "WR: Consultant's name", "Patient OK today", "NEWS 0", "Plan: continue", and a signature!

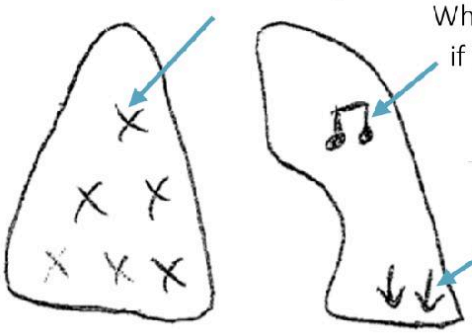
## 1.2 Scribbles

You may have to pick up many of these as you go along; there are lots, so don't be afraid to ask if you're unsure. The NHS actually recommends minimal use of acronyms and abbreviations… but tell that to doctors…

Try not to use scribbles or acronyms that you're not sure about, as you'll get in a confused pickle. Describe what your pictures means, and expand on your acronyms if needed. See a small guide to various scribbles on the next page.

## Lungs

Crepitations. Describe in notes as coarse/fine, basal or scattered throughout



Wheeze. Describe in notes if inspiratory/expiratory and location

Reduced air entry (AE). Also depicted by shading. Describe in notes the location and percussion note.

## Heart Sounds

Normal heart sounds are sometimes described as:

"I+II+0" or "1+2+0"

This describes S1, followed by S2 with zero other sounds.

"I  + II" indicates an ejection systolic murmur; loudest at the start and quietest just before S2.

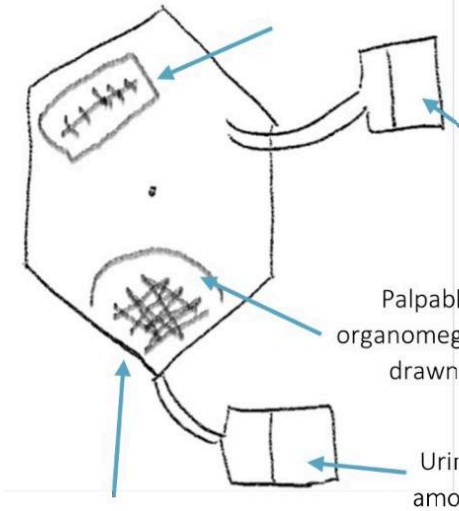
"I  + II" indicates a pansystolic murmur.

**Cardiologists draw these infinitely better and have lots of other variations! These are the super simple ones to look out for.**

Not everyone uses scribbles for heart sounds;

## Abdomen

Wound with dressing. Describe post-op oozing as "strikethrough" onto the dressing.



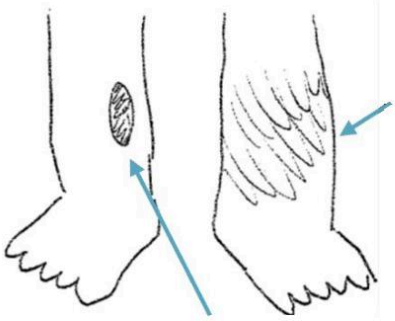
Abdominal drain. Describe insertion site and liquid draining.

Palpable bladder. Other organomegaly or masses can be drawn like this as well.

Urinary catheter bag. Describe amount, colour and consistency (sludgy, debris etc).

Pain may be depicted by shading. Describe in notes location and severity. Is it rebound or not?

## Other Areas



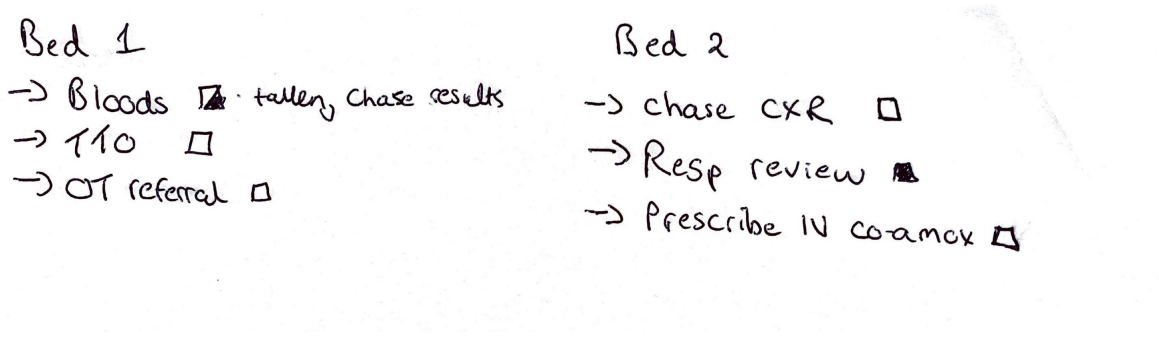
Shading is usually discolouration or erythema. Describe colour/area/skin changes in notes.

Ulcers can be drawn like this but need a description as well of colour/size/depth/oozing or sloughing.

## 1.3 The Jobs List

Jobs list are usually compiled during ward rounds. These will detail what needs to be done to manage every patient on the ward, even if nothing active has to be done. This could include getting/chasing bloods, arranging scans, discharge summaries etc. These will often be listed in terms of urgency, with sick patients taking priority due to risk of deterioration. There may also be time-sensitive jobs such as drug levels, which would be noted to help doctors plan their day.

Jobs lists present an excellent opportunity to practise clinical skills and examination. Try to construct a jobs list during ward round of your own and see how it matches up to the doctors. Additionally you can ask to do some of the jobs where appropriate. Don't be afraid to ask if you can do the bloods of a patient on the list! The last thing you want is to have to chase sign offs near the end of LICP1! Take a look at what a jobs list might look like;

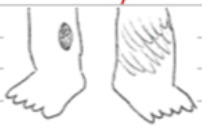



Although this is a brief jobs list you can still learn a lot. You might ask to take bloods/interpret the results, ask what a TTO is, why co-amoxiclav was prescribed etc.

## 1.4 How a round is documented

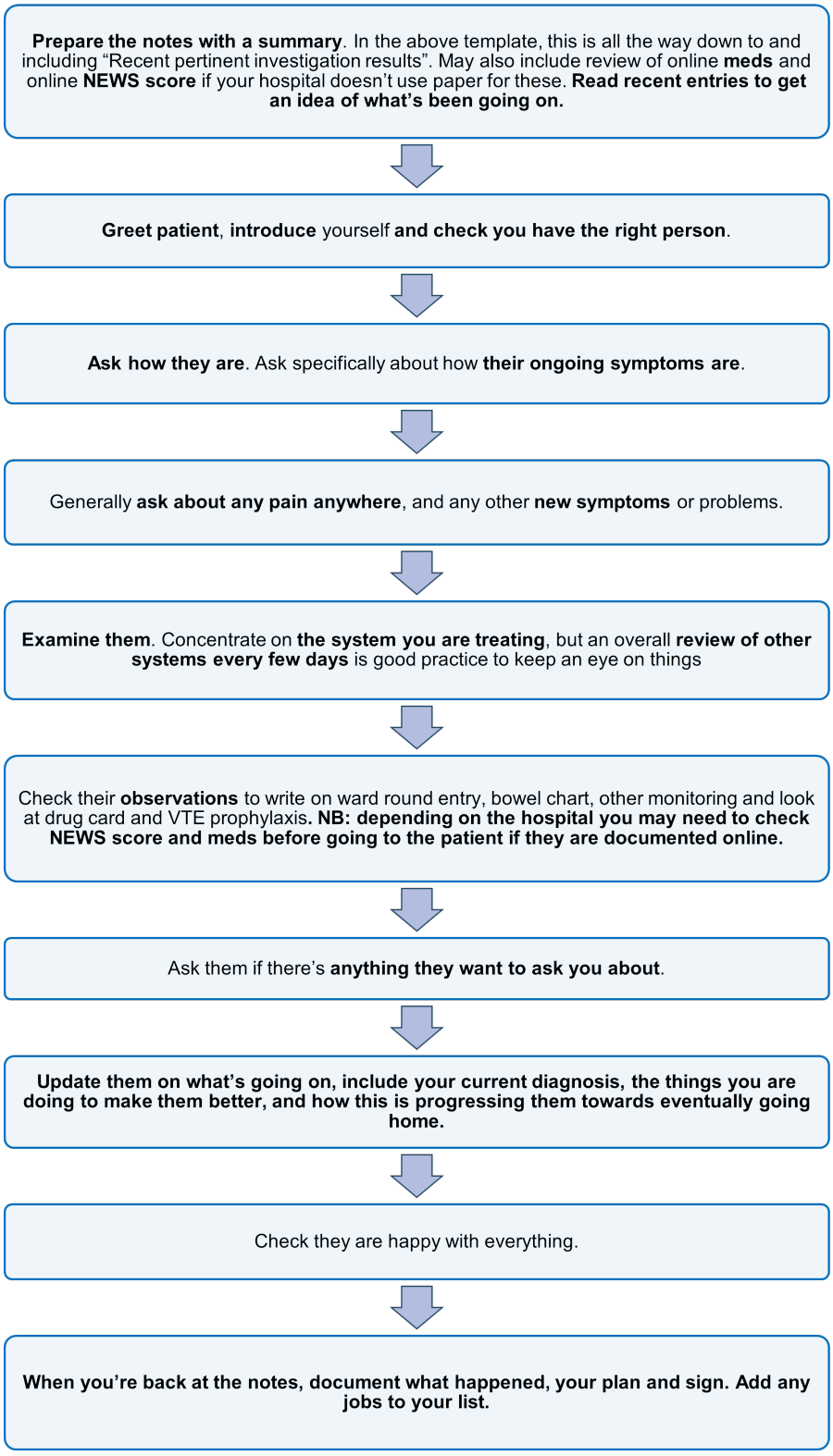
*The template below shows how to document likely content of senior ward rounds (albeit more likely in a medical specialty), and is just a guide, eventually you will work out your own way of doing it.*

| Patient progress record<br><br>Hospital: .....Northern general hospital.....<br>Ward: .....1 ..... | PATIENT STICKER HERE<br><br>Name Joe Bloggs<br>DOB 30/06/1993<br>Hosp no AB1234<br>NHS 1234 5678 92134<br>Consultant Dr XXX |
|---|---|

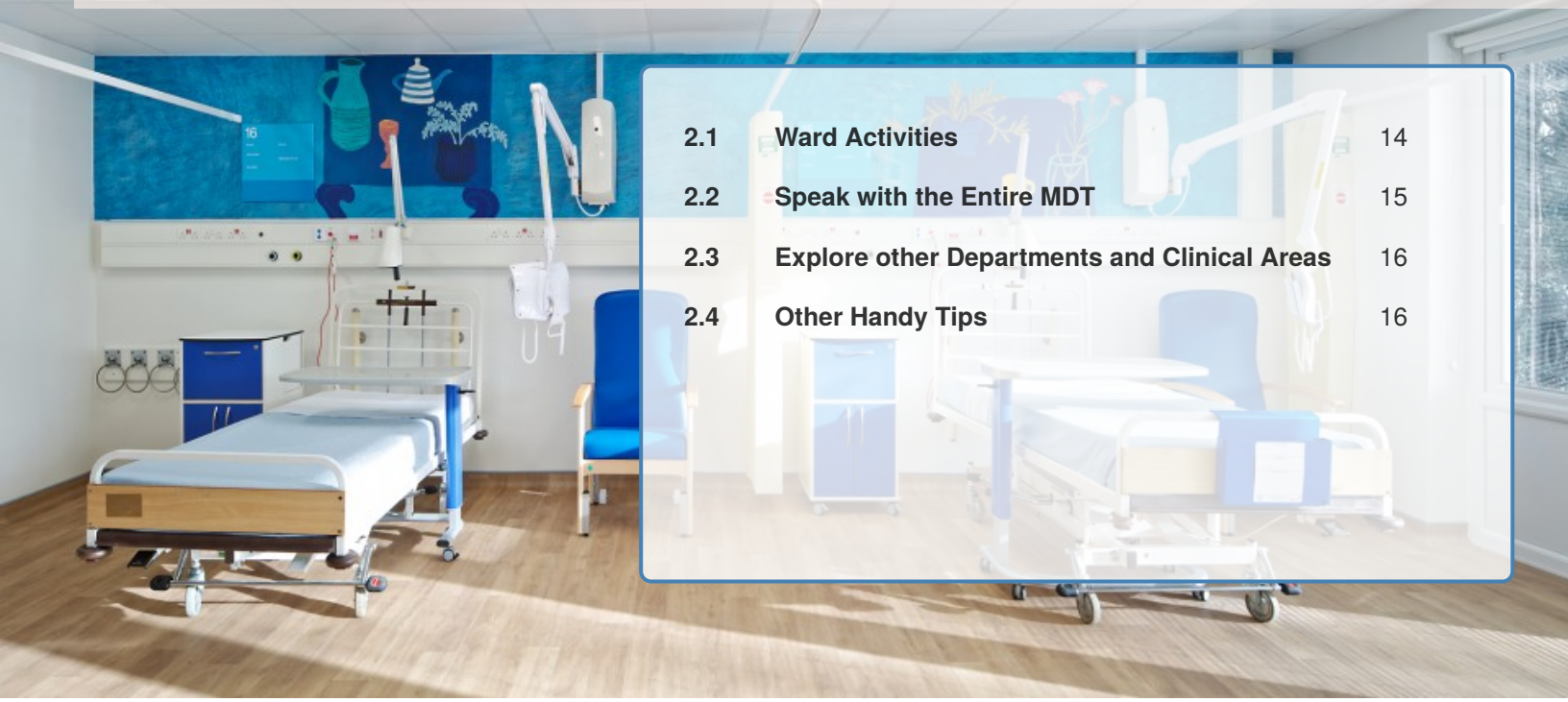
| Date, time and role | **Progress Record** Sign here after each entry |
|---|---|
| 7/4/2020<br>11:00am | **WARD ROUND: Name of senior leading ward round & junior doctor name** |
| | △ (some people draw a triangle which means "diagnosis") |
| | Write your **current problem list** here – what is keeping them in hospital? |
| | 1 |
| | 2 |
| | 3 (if your patient has a lot going on!) |
| | **Past medical history:** |
| | **Summary of events during current admission:** ?cardiovascular disease |
| | This may include recent drug therapies and ?respiratory disease |
| | length of time, recent episodes of becoming ?other diseases listed |
| | acutely unwell, success of certain interventions previously in notes |
| | like surgery or drains) |
| | |
| | **Recent pertinent investigation results such as:** |
| | Chest x-ray: Hb: "120 ↑/↓/↔ (most recent result)" CRP: |
| | WCC: Urea: Creatinine: K+: |
| | **Today** |
| | How is the patient in their own words? "I'm ok today". Pain? Worse symptoms? |
| | Notes are legal documents and should be used to keep a record of important |
| | conversations with patients or relatives. |
| | Recent monitoring: bowels, urine, fluid balance, food intake, drug card. |
| | |
| | **On examination (O/E):** |
| | General end of bed assessment: "comfortable at rest", "short of breath" etc |
| | NEWS score: "X" (if higher than 0, write out of range values) |
| | **Lungs** Creps/wheeze/ Reduced air entry **Heart sounds:** I + II + 0 if normal. |
| | (various squiggles between I + II |
| | to show murmurs) |
| |   **Any other area of body** (legs, |
| | cannula sites etc): |
| |  |
| | **Abdomen:** shade in areas of |
| | pain. Catheters? Drains? |
| | |
| | **Impression:** "heart failure worsening", "new chest infection", "improving"... |
| | **Plan:** 1) continue/stop/change medication 3) start discharge planning |
| | 2) repeat bloods |
| | Signed: Junior doctor name, GMC no/bleep no |

## 1.5 Putting it all Together

*Imagine a scenario where you are the senior doctor (and one day you will be!). How might you construct your ward round? Below is a simplified flowchart on how things would go, ignoring random events occurring to deter your day!*



# 2. What To Do When You Don't Know What To Do!





**You do not need to complete all the activities below. They are suggestions for how to get involved and make your own learning opportunities!** Please prioritise any timetabled learning opportunities that have been organised for you on your LICP by the hospital team.

**If you want to visit departments that are not part of your ward base, it is good practice to call the departments that you are planning to visit before you go.** When you arrive at a department please introduce yourself to the staff, and ask permission before getting involved in any activities. Please ensure that your supervisor or base ward staff know that you are leaving the ward and where you are going if you visit other areas.

**If you do any of the activities below please make sure you are supervised appropriately.** If you are out of your depth in a clinical situation always seek help immediately and inform a senior colleague.

Feel free to peruse the lists below during quiet moments on the ward to make sure you are always getting the best out of your time on placement!

## 2.1 Ward Activities

- Assist on the ward round under supervision:
  - Reviewing patients
  - Documenting in the notes (make sure this is always countersigned)
  - Keeping a list of jobs to do for each patient (do not take lists outside of the hospital – dispose of appropriately)
- Help to carry out jobs for each patient following the ward round, which could include:
  - Clinical skills such as venepuncture and cannulation (under supervision until signed off to do independently)
  - Taking further history or examination
  - Communication with patients and relatives
  - Helping to liase with other specialities about patient care
- Assist a junior doctor or nurse with the admission/clerking in of a new patient to the ward (either on the ward or on an admissions unit).
- Observe drug rounds and practice drug mixing under supervision.
- Measure and record vital signs under supervision.
- Sit in on medical on-call handovers (usually at 8am in on-call meeting rooms) or daily nursing handovers (on the ward).
- Choose several patients on your base ward when they are first admitted, take a history and examine, then follow their journey by attending ward rounds and understanding their care, all the way to their discharge.
- Observe dressing changes and wound care.
- Refer to your clinical skills e-logbook for appropriate skills for your phase. Following satisfactory supervised practice, offer to be the “skills” person for the day (tell the nursing staff and doctors on the ward). Any time venepuncture, cannulas, ECGs, urine dips etc need doing, they can ask you.
- Follow a doctor if need to verify and then certify a patient’s death and visit them in the morgue.
- Arrange to come in on an evening, a weekend day or a night shift with a doctor you have met on your base ward (please ask permission from your consultant and the staff administrating your trust timetable and make sure you aren’t overcrowding the ward during

the COVID-19 pandemic). These busy shifts are great opportunities to help review sick patients and get involved in skills and management, with one-on-one mentoring and guidance from the on call doctor.

- Please ensure you do not miss timetabled LICP activities or teaching.
- Follow a doctor or advanced nurse practitioner carrying a cardiac arrest bleep and attend arrests (observe and help appropriately - try not to stand in the way unless you have been given a useful job). Please ensure all staff at arrests know you are a student and not fully qualified.
- If a patient becomes acutely unwell on your base ward, ask the doctor reviewing them how you can help, and observe the urgent care procedures that follow.

## 2.2 Speak with the Entire MDT

- Find out if you base ward has MDT meetings and ask to attend (try to meet a patient to be discussed beforehand by finding out if anyone on the list is an inpatient).
- Observe and talk to a phlebotomist about their role, and ask if you can join them to practise venepuncture (be aware that some phlebotomists may not be comfortable supervising medical students).
- Speak to a pharmacist about how prescribing on the ward works and ask to visit the pharmacy to see discharge medications being organised.
- Test yourself on all the different drugs on patient drug cards/e-prescribing profiles: indications, standard dose, side effects and contraindications, and add them to your formulary as you come across them.
- Speak to a physiotherapist on the ward and ask if you can observe their assessments on patients, or ask to visit the physiotherapy department.
- Speak to an occupational therapist on the ward and ask if you can observe their assessments, or ask to visit the occupational therapy department.
- Speak to a speech and language therapist on the ward and ask if can observe their assessments, or ask to visit the speech therapy department.
- Speak to a specialist nurse such as the tissue viability nurse or diabetic nurse and ask to observe one of their assessments.
- Speak to a dietitian on the ward and ask if you can observe their assessments on patients.

- Speak to the ward clerks to learn about their role.
- Speak to the porters to learn about their role.
- Speak to the domestic and housekeeping staff to learn about their roles.

## 2.3 Explore other Departments and Clinical Areas

- If a patient on your base ward requires a stay in ITU/HDU, arrange to visit them.
- If not already timetabled for you, arrange to visit the outpatient department, and request to sit in on a morning or afternoon clinic, particularly if your consultant or registrar on your ward is running it.
- Arrange to attend an X-ray conference (these are often morning meetings that happen in surgical specialties).
- Arrange to visit the endoscopy department to observe procedures and meet the patients before and after.
- Arrange to visit angiography to observe insertion of pacemakers or observe angioplasty.
- Arrange to visit the ECG Department.
- Observe a CT scan / MRI / ultrasound / x-ray and speak to the radiographers/staff about their roles.

## 2.4 Other Handy Tips

- Ask the doctors and nurses on the ward for patients who will provide good learning opportunities if you were to take a history or examine them, and ask permission to do so.
- Practise presenting your findings to a doctor on the ward to make sure you have picked up all the key signs and symptoms.
- Pair up with another student. Choose a topic like “cardiovascular disease” or “endocrine disease”, and find patients with these. Ask permission from the ward doctors and check the patients don’t mind, then watch each other take a history and examine a patient, and give each other feedback at the end.
- Read up about interesting cases afterwards.

- If you're interested in research and audits, ask your consultant if there are any clinical audits or research currently happening that you can get involved in.
- Ask the nursing staff or observe the patients on your ward: if there is a lonely-looking older patient, sit and have a chat over a cup of tea and a crossword!

# 3. Index



## 3.1 Jargon Buster

| Jargon | Definition |
|---|---|
| **ABG** | Arterial blood gas. You know the one. |
| **ALS** | Advanced Life Support. This refers to the sequence of events that you carry out with very unwell or arrested patients, whether that's defibrillation and adrenaline, or a really good A-E assessment. There's a course for this F1s should be booked onto. |
| **AMU** | Acute medical unit, sometimes MAU (medical assessment unit) or EMU (emergency medical unit). Patients from A&E or the GP who have medical problems and may need to be admitted will be sent here for clerking. There's often an ambulatory care section for patients who are less unwell and may get away without being admitted. |

**ANP** Advanced nurse practitioner, a role which staff nurses on the wards can train for and involves a higher level of patient assessment and management which has similarities with that of a junior doctor but has the benefit of the nurses own experience and background. Often on the on call team, or based on a ward.

**Cardiac arrest or crash call** This is put out by any staff member by calling 2222, if they have a patient whose heart has stopped, or who has stopped breathing (because one usually follows the other!). In hospitals which don't have MET calls, the same call will be used for peri-arrest or "really unwell" patients. The corresponding on-call team (F1, SHO, SpR, ANP, anaesthetists) will hear their bleeps go off very loudly and tell them where to go.

**Cover shift** Being "on cover" means you will have several wards in the hospital for which you are responsible. This only kicks in out of hours, so isn't a thing from 9-5 Mon-Fri. There's evening cover, night cover and weekend day/night cover. You'll get a bleep with a number that all the nurses on those wards may call you on with jobs, or will put jobs on the computer system for you to come and do (hospital dependent).

**Duty matron/ Site Matron/ Bed Manager** Very senior member of the nursing team who manages and coordinates what is happening with patients and staff for either the whole hospital, or particular departments.

**Clerking** Clerking is usually the first point of information gathering by a clinician about a patient's condition before hospital admission. This information is usually used to give provisional diagnosis/differentials and to generate a plan.

**e-prescribing** Where all the patients' prescriptions and details of administration are kept in an online computer system called Electronic Prescribing and Medicines Administration (EPMA). Doctors prescribe on this, and nurses log details of administration.

**Exception Reporting** Usually an online system which allows junior doctors to log extra hours of overtime that they have worked. The trust is obliged to acknowledge these and either give the junior time back in lieu (doesn't happen on busy jobs) or pay them for the overtime. Very important to report properly, so hospital management can pick up on the understaffed jobs and sort them out.

**Fast-bleep** Your normal bleep will make a loud noise similar to that of a crash call, but it will be with a number to call urgently.

| | |
|---|---|
| **Guardian of Safe Working Hours** | The senior doctor in a hospital trust who is in charge of making sure exception reports are being acted on. They are entrusted with the responsibility of balancing management with the interests of overworked junior staff. |
| **Hot-take** | When the on-call consultant (or the consultant doing the PTWR) picks up patients who haven't been clerked yet and sees them speedily with a junior to help. |
| **ICE** | Integrated Clinical Environment. Tends to be where most hospitals keep information on all the patients in their area, and whether they are admitted or not. Commonly used for blood test and image requesting and results. Sometimes for discharge letters. |
| **JAC** | Computer system for e-prescribing. Cannot find what the acronym stands for, google has let me down! Used in several local regional hospitals but not Sheffield Teaching Hospitals. |
| **Late or twilight shift** | This will be cover or take, and is usually a shift which starts after 12pm and ends some time in the evening, rather than going all the way to the next morning. For example, 4pm-midnight is the classic twilight shift. |
| **Lorenzo** | Another computer system which used for organising details of admitted patients. Some hospitals use this for e-prescribing, some for bed management and in some hospitals, the nurses will use this for all of their inpatient notes. |
| **MDU** | Medical Defence Union. Provides legal cover for doctors. Very similar to MPS. |
| **MET call** | Medical Emergency Team call. This doesn't exist in all hospitals. It's supposed to be put out for peri-arrest patients who are very unwell but are still breathing and have cardiac output. The corresponding on-call team will hear their bleeps go off very loudly and tell them where to go. |
| **MPS** | Medical Protection Society. Provides legal cover for doctors. Very similar to MDU. |
| **PA** | Physician's associate, useful bods who help out with faffy paperwork, letters, ward round, ward jobs! |
| **PACS/KRIS** | Picture Archiving and Communication System. Where all the nice X-rays, CTs and MRIs appear when they have been done. Sometimes called IMPAX |

| | |
|---|---|
| **PTWR** | Post take ward round: this means the ward round which a consultant (and sometimes if very stretched a registrar) does on all the patients who have come in on the previous 24 hours of take . They decide whether the clerking doctor's plan should be continued, changed or added to, and which ward the patient could go to. |
| **ROSC** | Return of spontaneous circulation. This is when the crash team has been trying to get a patient's heart restarted for a while, and they pause to analyse the rhythm and feel a pulse, and realise the heart has started pumping again (wahey!). It doesn't mean the patient has woken up or got better however! |
| **SAC** | Surgical Assessment Centre, sometimes SAU (Surgical assessment unit). Similar concept to AMU, patients from A&E or the GP who have surgical problems and may need to be admitted will be sent here for clerking. |
| **SHO** | Senior house officer. Basically anything from F2- core trainees in their last year of general medicine/surgery, so pre-registrar years. |
| **SpR** | Specialty registrar. All specialties have a registrar level, even GP |
| **Switchboard** | The hospital's call centre, where operatives sit and answer calls from people all over the hospital and the community all day and night. Call switchboard for how to contact anyone in the hospital, including consultants on their mobiles, and other hospitals. They can bleep people for you and transfer you to outside lines. |
| **Take shift** | Being "on take" means you are clerking patients in for your shift. This happens because A&E send patients who have arrived in the hospital to the correct specialty's admission area (usually medicine or surgery). These are usually AMU or SAC. |
| **TTO** | To take out also known as TTA or to take away. In Barnsley it's a D1 (just to be different). The letter and prescribed medications a patient should take home with them, details of which will also be sent to their GP. |

## 3.2 Resources!

**GeekyMedics** Thinking more forward to exams. This absolutely free and fabulous resource will give you everything you need for the OSCE!

**BNF** Goes without saying this is an essential app to have on your phone.

**MDCalc** This is a useful app that contains pretty much every clinical scoring system out there. Just pop in the information it asks for and it does the rest.

**Oxford Handbook of Clinical Medicine**; The true catch all pocket guide to clinical medicine. This can be useful in a pinch if you encounter a condition you don't know (and also if the consultant asks you to go away and read about something specific)

**Oxford Handbook for The Foundation Programme**; A more specific pocket guide for foundation doctors. This is more tailored to foundation doctors but could still be useful if you're stuck on how to solve issues such as a patient with low SATs on the ward.

**MedSoc Welfare** if you are ever feeling overwhelmed, upset, or simply want to talk to someone, the welfare reps are more than happy to lend an ear and direct some resources. Your medic parents could also be very helpful since they've been through this already!

**MedSoc MOSCE** Every year MedSoc runs mock OSCEs, which also raise money for charity. It is one of the only ways to get a formal experience of what the OSCEs are like. Sometimes you do get lucky and the kind doctors of your team will do mini ones!

**Peer Teaching Society Mentor** You should be offered a student mentor who has been through 2b already. They can provide tips and tricks from their own experiences, they signed up for it so are bound to want to help any way they can.