Respiratory Medicine

Introduction:

The respiratory wards are Witham Ward and Respiratory Support Unit (RSU). The respiratory team consists of the consultants, junior doctors of all levels, Pleural ACPs and Respiratory CNSs. Each week you have 2 consultants doing teaching ward rounds in both wards. Nursing handover which is also called board round starts 9 am sharp from RSU then Witham ward. After finishing board round, we start preparing the blue sheets for the ward round.

RSU has 11 side-rooms, divided into 9 patient beds, 1 escalation bed and 1 procedure room. Patients admitted to RSU are respiratory patients with severe disease requiring non-invasive ventilation (NIV). The procedure room is for chest drain insertion and management, pleural taps and other procedures that require doing in a special setting. The escalation bed is reserved for any deteriorating patient with increasing oxygen requirements and needing NIV. Witham Ward is divided into 3 bays with 6 beds each bay. It is considered a step-down ward for RSU patients or respiratory patient that do not require assisted ventilation.

Duties:

Consultants see the new patients, sick patients or patients for discharge daily. All patients will be seen 3 times a week by the consultants. Two registrars should be available to discuss patients with and if they are not available the consultants will have a more visible presence.

All patients will need to be seen daily by junior doctors or consultants with an up-to-date patient's problem list. Bloods, microbiology results and recent scans should be written on the blue sheet and clerking proforma, if possible.

Phlebotomists will do a daily ward round, however, if blood results are paramount to a patient's discharge or someone is acutely unwell, then you will be expected to do these in the morning. Medically fit patients will need blood tests once a week.

Drug charts should be checked and rewritten before the weekend; at least 3 spaces should be left on the drug chart before going into the weekend. Any stopped medications should be written on the task list with a reason of stopping and criteria for represcribing them.

On Tuesdays, you will have a day admission for thoracoscopy; their name will be in the ward diary. A chest x-ray will be done after the procedure, and it is your duty to check the chest x-ray for pneumothorax and declare the patient fit for discharge.

Teaching:

Teaching is on Tuesdays 12:30-14:00, a teaching programme will be available during the first week of the rota. Junior doctors will have to present an interesting case they came across.

Guidelines:

You should familiarize yourself with the management guidelines of the following:

- COPD.
- Pneumonia.
- Asthma.
- Chest drains management.
- Pleural effusion.
- Pneumothorax.

Guidelines and care bundle are available on the intranet.

Chest drains:

For chest drains and pleural procedures, a written consent and pleural procedure form should be completed and put in patient's notes. Moreover, a chest drain chart must also be put in the notes. These procedures are usually done by Pleural ACPs.

A swinging chest drain means that the chest drain is within pleural space. If it is not swinging, then it is either blocked or out. Firstly, you should flush the drain and that may resolve the blockage. If it doesn't, a chest x-ray will be needed to check position. If dislodged or coming out, the chest drain needs to be removed.

In a case of pneumothorax, a bubbling drain means that there is persistent air leak. If it is not bubbling, the air leak may have resolved, thus a chest x-ray should be requested.

If the plan was to remove a chest drain, a post-removal chest x-ray should be done and checked before discharge.

Asthma:

All patients should have a peak flow chart, with their best PEFR documented on the chart.

Nebulisers should be stopped 24 hors prior to discharge. Patients are declared fit for discharge if PEF >75% of best after stopping inhalers. A course of prednisolone 40mg for 7 days should prescribed on discharge if PEF was <50% on admission or <75% and not taking inhaled steroids.

Ensure prescription and supply of reliever and preventer as inhalers might arrive the following day from pharmacy.

Contact respiratory CNSs if additional advice is needed.

COPD:

Target O2 saturation should be 88-92% and all patients should have oxygen prescribed.

VTE prophylaxis should be prescribed.

Nebulizers should be stopped for 24 hours prior to discharge unless they have nebulizers at home.

Prednisolone 30mg should be prescribed between 5-10 days depending on the patient. Some patients require a slowly reducing course of steroids, usually 5mg every 3 days to stop or to their maintenance dose.

Non-invasive ventilation:

This should be considered early in patients with a PaCO2 >6.0 kPa with evidence of acidosis (PH <7.35) despite bronchodilator therapy.

An ABG should be performed one hour after commencement of NIV.

NIV is usually continued for 4 nights even when the gases have improved.

Oxygen assessment:

These are carried out by the respiratory CNSs but if you are considering someone for home oxygen and their saturation is below 92% on air, they will need an ABG on air then a referral for respiratory nurse specialists to assess for long term oxygen therapy (LTOT).

ABG machine code:

E-learning for using the ABG machine is available on ESR from "My learning → 'All' from search tab→ 'cobasb123".

After finishing the e-learning, ask ward sister Sophie to watch you use the machine then she will give you the barcode with the log-ins.