

## F1 SURVIVAL GUIDE

<b>Specialty</b>	Frailty Medicine
<b>Location/s</b>	Tennyson, Milton and Byron are Brown Zone Level 2. Keats is Blue zone level 2. Pembroke (orthogeris) is Green zone level 3
<b>Team</b>	Team varies depending on the ward, but generally there should be 2 FY1, 2-3 SHOs, Reg (some wards wont have a regular registrar), and at least 1 consultant (some wards have 2 e.g. Tennyson had Dr Maitra and Dr Paranjyothi)  Doctors, Nurse in Charge, Nurses, Clinical Support Workers (support nurses in doing jobs like cleaning patients, patient transfers, swabs etc), Ward Manager (oversee the running of the ward), Line Manager for all frailty wards is Liz Bell, Ward Clerk

<b>Different Roles / Type of uniform</b>	Scrubs/Professional workwear
<b>In charge / How to identify</b>	Consultants (dependent on which Frailty Ward you are on)
<b>Key Contacts</b>	Dr Sanjay Suman (Clinical Director Therapies and Older Persons Program)
<b>Computer Systems</b> - Across the Trust / General	EPR, DartOCM, PACS, iLab, Solus etc
<b>Computer Systems</b> - Specific to department	None specific to frailty.
<b>Induction</b>	Induction is held at the start of the rotation, usually on Teams. It will cover what services the frailty department provides, what is to be expected of juniors, common presentations of geriatric patients and medicine which is specific to geriatrics (e.g. multifactorial falls, polypharmacy, sedation use in patient's with cognitive impairment etc)
<b>Board rounds</b>	Start at 9AM with the MDT, however F1s are expected to start at 8:30AM
<b>Departmental Teaching</b>	Every Thursday 12:30-13:30, usually on Teams. Lunch is provided.
<b>Shift patterns</b> - Rota - Breaks	Standard Gen Med rota. 08:30-16:30 normal days. On call long days (once a week) 09:00-21:30. Weekends (Fri-Sun 09:00-21:30) 1 in 4 weekends (zero days on Wed preceding and Monday following weekend)
<b>The typical day / What to expect</b>	F1s start at 08:30AM. Expected to prep notes for new patients, prep EDNs for patients expected to go home soon and review new investigation results

	<p>Board round starts at 09:00AM, led by nurse in charge with MDT present. Lists are generated+printed by NIC/ward clerk</p> <p>Number of consultant-led ward rounds depends on ward Consultants should see all patients at least twice a week, and will review all new and sick patients. Juniors will carry out ward rounds alone on other days.</p> <p>Ward jobs are to be completed after ward round</p>
<b>Referrals</b>	<p>General Medicine Specialty referrals are mostly done via in-reach. In-reach mobile numbers can be found on the Gen Med Live Rota sheet at the bottom and will tell you what times you can contact them (e.g. resp is 9am-1pm only).</p> <p>EOL pathway patient referrals can be done online via clinical referrals on the intranet</p> <p>Some referrals can be done via EPR. Go to 'Enter Order' and type 'Referral' and a list of all referrals will pop up. Not all referrals are found here, but some include Diabetes nurses, Dietician.</p> <p>Palliative referrals need to be done via the bleep found on the Induction app</p> <p>Resp nurse referrals are also done via bleep on Induction</p>
<b>Audits</b>	<p>Speak to your consultant if you are interested in doing an Audit during your time on the ward. They will be more than happy to help.</p>
<b>Useful Resources</b>	<p>CFS app, IQCODE questionnaire. Induction App. Green Book. Microguide for abx prescribing.</p>
<b>Top Tips</b>	<p><b>Frailty specific top tips</b></p> <p>Polypharmacy</p> <ul style="list-style-type: none"> <li>- Patients will often come in with endless medications. You will pick this up during this rotation, but try to use your clinical judgement. A 94-year-old on a high dose statin is not necessarily important and can be reduced or even stopped.</li> </ul> <p>Multifactorial falls</p> <ul style="list-style-type: none"> <li>- evaluate drugs which are high risk for falls e.g. ACE inhibitors/BBs in patients with low bp. Consider reducing the dose. Or patients on drugs which are at high risk of making them drowsy, increasing their falls risk. Weigh up the benefit/risk ratio and decide whether these can be held/stopped.</li> </ul> <p>Difficult conversations</p> <ul style="list-style-type: none"> <li>- You will be exposed to many difficult conversations in frailty, e.g. DNAR discussions, breaking bad news, palliation/EOL discussions etc. Use your time in frailty to learn how seniors deal with these and take opportunities to have these conversations yourselves.</li> </ul>

	<p>It is always okay to say to patients/NOK you do not know answers to some questions but you will seek advice from a senior and get back to them, and of course do not go beyond your competency</p> <p>Social history and functional/cognitive baseline history is very important in frailty.</p> <ul style="list-style-type: none"> <li>- Start your ward round documentation with this so your consultant knows what is appropriate in terms of management. Download the Clinical Frailty Score app onto your phones – it generates a score to quantify how frail a patient and is very good to include when prepping notes (as well as TEP status)</li> <li>- Try to find out if patient requires assistance with ADLs, where they live (home or placement), do they have a POC, do they have stairs at home (will need stairs ax before d/c)</li> </ul> <p><b>Assessing Cognition</b></p> <ul style="list-style-type: none"> <li>- Daily 4ATs can be performed to assess a patient's cognition status (especially important if patient has acute delirium)</li> <li>- Patient's may often have cognitive impairment but no formal diagnosis of dementia – NOKs will often ask for referrals to memory clinic, however this can only be done via the GP as assessment cannot be done when a patient is acutely unwell. In the acute hospital setting, an IQCODE questionnaire can be done to give a preliminary diagnosis of probable dementia (include this in the EDN and request that the GP refers the patient to memory clinic)</li> </ul> <p><b>Sedation in aggressive patients</b></p> <ul style="list-style-type: none"> <li>- Aggressive patients may require sedation. Try to discuss with your consultant as sedatives and benzodiazepine use have increased morbidity and mortality. Non-medication alternatives including asking family to help calm a patient down. First line medications include haloperidol, or second line lorazepam. Do not use haloperidol in patients with Lewy body dementia or PD.</li> </ul> <p><b>General top tips</b></p> <ul style="list-style-type: none"> <li>- Ensure all patients are examined daily, even if MFFD to ensure new issues are missed. All patient's should have bloods at least once a week, even if MFFD.</li> <li>- Try and get your documentation done before lunch time and create your jobs list as you go through your ward round to help your afternoon flow easier and quicker, and prioritise your jobs list (sick patients first)</li> <li>- EDNs – try to send TTOs first before 4pm (some are straightforward and can even be done during ward</li> </ul>
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	<p>round if determined MFFD at ward round). The EDN can be written later on and allows pharmacy to process meds so patient can be discharged quicker</p> <ul style="list-style-type: none"> <li>- When writing the EDN, it is good practice to state changes to regular home meds/new medications started and whether the patient had a DNAR during admission</li> <li>- There will be days where phlebs don't do their rounds. Check around lunchtime whether phlebs have come or not, as you may have to do urgent bloods yourself to ensure results are back before the end of the day</li> <li>- Ensure before you leave, all patients who have had bloods done have had their results checked request bloods for patients who may need them for the day</li> <li>- Scans: ensure 'Consent Form 4's (for patients who cannot consent) and MRI Safety Questionnaires are complete and given to MRI to ensure a time can be booked, otherwise scan will be delayed</li> <li>- If you have handed over anything to evening team, document that it has been handed over</li> <li>- When handing over things for the weekend team, use your clinical judgement. The weekend team will be very busy and things like routine bloods are not a necessity!</li> </ul>
<p><b>Conclusion</b></p>	<p>Frailty medicine is an extremely important specialty—patients over 65 use 65% of acute hospital bed-days, so you will learn a lot which is very relevant to your career as a whole regardless of which specialty you specialise in. You will learn general medicine however this is nuanced in care of the elderly, e.g. not all investigations are always appropriate if too invasive, or certain medications may not always provide benefit if it places patients at higher risks of falls. You will strengthen your clinical judgement in this rotation, as well as your procedural abilities (bloods in elderly patients are much harder with collapsing veins!)</p> <p>A frailty rotation also gives you the opportunity to hone in on your soft-skills, including difficult conversations and being able to clinically identify whether a patient is for palliation/close to EOL.</p> <p>Utilise every opportunity you have in frailty medicine as what you learn in this rotation will help you become a more rounded and competent doctor!</p>