School of Medicine

Year 6

2012/13

**Clinical skills**

**in-course assessment**

Student name ..........................................................................

If this book is found,

please contact me at: ..............................................................

<https://education.med.imperial.ac.uk/Skills/Skills.htm>

**Introduction to Skills learning and assessment in Year 6**

Year 6 continues the programme of skills learning and assessment begun in Year 5.

During the year you should take every opportunity to practice the skills, guided by the checklists in this book and working in the skills labs and with members of the clinical teams in firms and GP surgeries.

When you feel competent to perform the task, find an appropriate member of staff and ask them to watch you perform the skill.

They will judge you against the criteria in this log book, and complete the **DOPS** (Directly Observed Practical Skill) form which will give you feedback on what you have done.

If you have passed the skill, continue to practice it to retain and improve your competence (it may come up in any of your end of year examinations and you will certainly need it for foundation posts). If you have failed you must retake it once you have gained more experience. Blank forms can be downloaded from the intranet.

You should not need reminding that these are part of your professional development as a doctor. Cheating in these assessments (forging signatures etc.) is a fitness to practise issue and will be treated very seriously.

**Who can test you on your skills?**

Any member of staff who performs the skill regularly as part of their job. This may be one of the medical team, but other members of the heath care team, such as nurses, physios or phlebotomists can also assess you on various skills.

**How to get assessed?**

It is the student’s responsibility to identify opportunities to practise each skill and arrange to be assessed. At the beginning of the attachment you should discuss with your tutor where the opportunities are likely to occur. Try to complete your assessments early in the attachment, to allow you time to repeat any unsatisfactory ones.

**What is an acceptable score?**Your assessor must sign the ‘Meets’ or ‘Above’ expectations on the ‘Overall ability’ section for you to pass the assessment. If you have not passed you will need to revise, practise and submit yourself for assessment again. There is no limit to the number of attempts you can make, but you **must** successfully complete all DOPS.

**Entering the examinations**

Every skill must be successfully completed by the end of year 6 in order to enter the end of year examinations and to graduate.

**Looking after your portfolio**

Your record of skills achievements is an essential record of your progress. If you lose it, you may have to repeat skills. We advise you to scan each completed form (e.g. using a scanner or camera) and upload it to your computer, both as a permanent record for yourself and as a backup in case you lose your book

|  |  |  |
| --- | --- | --- |
|  | **Performed on** | **Best learned where?\*** |
| **Clinical skills & procedures introduction** | | |
| **Near patient testing** | | |
| Perform Pulse oximetry and interpret findings | Patient | Senior Attachment |
| Set up and manage a cardiac monitor | Patient | Senior Attachment, A&E |
| Perform and report a 12 lead ECG | Patient | Senior Attachment, A&E, GP |
| Measure and record peak flow rate | Patient | GP |
| Perform a pregnancy test | Patient | GP |
| **Clinical procedures** | | |
| Administer oxygen at defined concentrations | Patient | A&E, Senior Attachment |
| Cannula insertion | Patient | Senior Attachment |
| ...and set up IVI | Patient | Senior Attachment |
| Venepuncture | Patient | Senior Attachment |
| ...and managing blood samples | Patient | Senior Attachment |
| Male catheterisation | Patient | Senior Attachment |
| Skin suturing... | Patient | A&E |
| ...and use of local anaesthetics | Patient | A&E |
| ...and Sharps disposal | Patient | A&E |
| Obtain written informed consent | Patient | Senior Attachment, A&E |
| **Patient education** | | |
| Teach use of peak flow meter | Patient | GP |
| **Therapeutic procedures** | | |
| Subcutaneous injection | Patient | Senior Attachment |

\*This indicates the best place to learn and get assessed on each skill.   
However there are plenty of opportunities throughout Year 6 and you can get assessed at any point.

## .

## SKILLS

Criteria and sign-off forms

The Assessor for each activity will assess how well you have met the expectations

|  |  |  |  |
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| **Above expectations**  **+++** | **Meets expectations**  **+** | **Borderline**  **+ / -** | **Below expectations**  **-** |

**Use a fingertip pulse oximeter and interpret the findings**

* Ensure the oximeter is clean, in working order and the finger probe is attached
* Check batteries or mains lead
* Oximeters are self-calibrating (but quality control checks can be performed)
* Explain to the patient what you are going to do and obtain consent
* Inspect the patients hands for the following prior to attaching the finger probe as they can adversely affect the reading:
  + Nail polish especially blue, green or black. All nail polish should be removed prior to measuring the pulse oximetry
  + Synthetic nails. These should be removed.
  + Dye on fingers, i.e. nicotine stain may also effect the readings
  + Cold hands, Raynauds disease, poor peripheral circulation
  + Excessive motion i.e. patients with marked tremor
* Attach the probe to the finger and ensure it is correctly placed.
* Check signal strength - most oximeters show the signal strength on the display. If low try a different finger. If an adequate signal cannot be obtained the SaO2 will not be accurate.
* Clean probe according to manufacturer’s instructions. This is usually by wiping the inside of the probe with a 70% isopropyl alcohol or detergent wipe
* Record the results in the patient notes or on observation chart as appropriate:
  + Date and time the record and write your name, designation (medical student) and signature
  + If the patient is on supplementary oxygen, record the percentage.

**Warnings**

* Pulse oximeters do not measure carbon dioxide. Do not be falsely reassured by the patient with a normal SpO2 but who is developing respiratory failure due to carbon dioxide retention
* Carbon Monoxide binds to the same sites as oxygen and the pulse oximeter cannot differentiate the two to any great extent. This means that SpO2 will be overestimated in heavy smokers and will be high in carbon monoxide poisoning
* Severe anaemia can theoretically produce a falsely high reading (in the same way that cyanosis is not seen in severe anaemia). Methylene blue (used in some surgical procedures) can give a false low reading
* Bright external lights may also effect the accuracy of the reading (such as in an operating theatre). Don’t use a finger probe on an ear etc.

**Interpreting your findings**

A pulse oximeter is an indirect measure of hypoxia (SaO2 via blood gases is a direct measure). Cyanosis is a crude “eyeball” method of hypoxia and causes of cyanosis are therefore identical to causes of a low SpO2.

In fit young people SpO2 is normally above 97%, above 92% is considered normal.

A low SpO2 in acute asthma is a sign of severity. An elderly patient with acute COPD will often have a low SpO2 (below 90%), however their baseline SpO2 (when exacerbation free) may be quite low and they may have acclimatised to a level of hypoxaemia

**Use a pulse oximeter and interpret the findings**

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| **Consent**  Explains the purpose of the examination.  Checks for patients understanding  Asks permission in a way which permits refusal | |  | |  | |  |  | |
| **Performing procedure**  Prepares equipment  Performs procedure in a logical sequence, appears practiced  Explains what they are doing to the patient  Attends to the patient’s comfort and dignity.  Clears up, including disposal of sharps | |  | |  | |  |  | |
| **Patient safety**  Hand hygiene before and after  Checks patient identity  Aseptic / clean technique, as indicated  Labels specimen & forms legibly and accurately | |  | |  | |  |  | |
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**Set up and manage a cardiac monitor**

**Why use a cardiac monitor?**

The cardiac monitor provides a warning of rhythm disturbances.

It is used in patients who are potentially vulnerable to these such as in operating theatres and recovery (where the various stresses can induce cardiac problems) and in monitoring patients in acute medical situations where they are vulnerable to cardiac events (such as patients with chest pain in A&E).

**Limitations**

The ECG monitor gives only crude information about rhythm problems (and as such is badly named). To assess ischemia, or to diagnose arrhythmias a standard 12-lead ECG recording is needed.

**Electrode placement**

Placement is much less critical than for a 12-lead ECG, so long as you can see well-formed complexes, the monitor will its job.

Electrodes are placed to the right and left of the sternum at roughly the 2nd interspace and a third roughly at the apex.

Stick the electrodes on the patient’s chest as above.

Attach the 3 wires to them and plug the other end into the monitor

Switch the monitor on.

The monitor will show a waveform (which may or may not look like a conventional ECG trace depending on electrode position). There is also often a digital display of the pulse rate.

An alarm can usually be set to sound if the pulse rate falls or rises above predefined levels.

The most usual reason for the alarm to sound is because electrodes have fallen off or the patient’s movements have resulted in non-cardiac interference. When an alarm sounds check the patient first to confirm the finding, and then make any necessary adjustments to the machine.

**Set up and manage a cardiac monitor**

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**Perform and report a 12-lead ECG**

**Equipment**: ECG Electrodes, ECG machine with paper, Gauze /alcohol/wipes

Clippers for hair removal

*Before* and *after* each patient contact or procedure, clean hands as appropriate with soap and water or alcohol gel.

* Identify the patient
* Discuss the procedure with the patient and obtain verbal consent.
* Gather and prepare equipment including the ECG machine.
* Prepare the patient: lying with head raised sufficiently for comfort, expose the patient’s wrists, ankles and chest area; maintain their privacy and comfort.
* Identify electrode positions and clean sites, with gauze and 70% isopropyl alcohol to ensure good electrode contact. Shave excessive chest hair.
* Check the electrodes are in date and moist.
* Apply the limb electrodes on the inner aspects of wrists and ankles

Apply the chest electrodes for V1-V6

* V1 – 4th intercostal space to right of the sternal edge
* V2 – 4th intercostal space to left of the sternal edge
* V3 – halfway on a line joining V2 and V4
* V4 – 5th intercostal space; mid-clavicular line
* V5 – 5th intercostal space; anterior axillary line
* V6 – 5th intercostal space; mid-axillary line
* aVL – left wrist
* aVF – left ankle
* aVR – right wrist
* N (neutral) – right ankle (NB names used for limb leads may vary)

Position and connect the leads to the relevant electrodes as labelled or colour coded.

Check the machine is calibrated to a paper speed of 25mm/s and sensitivity is set to 10mm/milivolt.

Ask the patient to lie still, relax and breathe normally.

Record the ECG

Check the recording is technically satisfactory

Label the ECG:

* Patient’s Name, Date of Birth, Hospital number,
* Time and Date of the ECG,
* Any relevant symptoms e.g. chest pain or pain free.

Disconnect the leads, Remove the electrodes and wipe away any gel

Clear up and return machine to proper location.

Document the procedure in the patient’s notes and consult senior colleagues as required.

**Report the ECG to your supervisor** (see Imperial Clinical Skills intranet for lessons on ECG interpretation and how to report <https://education.med.imperial.ac.uk/e-lectures/ECGs/player.html>)

**Perform and report a 12-lead ECG**

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**Measure and record a peak expiratory Flow rate**

* Before and after each patient contact or procedure, clean hands as appropriate with soap and water or alcohol gel.
* Identify the patient
* Discuss the procedure with the patient and obtain verbal consent.
* Check that the pointer is at zero.
* Ask you patient to stand or if not possible to sit in a comfortable, upright position.
* Instruct the patient to
  + - Hold the peak flow meter horizontally (and keep fingers away from the scale).
    - Take a deep breath and close your lips firmly around the mouthpiece.
    - Then blow as hard possible – a short sharp puff like “blowing out candles on a birthday cake”.
* Look at the pointer and note the reading.
* Reset the pointer back to zero.
* Do this three times and record the highest reading in the patients notes
* Sign and date the entry.

**Measure and record a peak expiratory Flow rate**

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**Perform a pregnancy test**

* Discuss the need for the test with the patient and gain verbal consent
* Give the patient a clean container and ask them to produce a sample of urine
* Put on a pair of non- sterile gloves
* Follow the instructions for the test kit being used
* Read the result
* Dispose of the urine and equipment safely
* Perform Hand hygiene
* Discuss the result with the patient
* If appropriate discuss reasons for possible false negatives/false positives with the patient (main problem is false negatives due to testing too early)
* Deal with questions or concerns from the patient

**Perform a pregnancy test**

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**Administer oxygen at defined concentrations**

See BMJ’s ABC of oxygen. Acute Oxygen Therapy at: <http://ukpmc.ac.uk/articles/PMC1113909>.

This article is a good discussion, but quite old, see BTS Guideline on Emergency Oxygen esp tables and algorithm Vi4 - vi9 for up to date information: <http://www.brit-thoracic.org.uk/Portals/0/Clinical%20Information/Emergency%20Oxygen/Emergency%20oxygen%20guideline/THX-63-Suppl_6.pdf>

* Before and after each patient contact or procedure, clean hands as appropriate with soap and water or alcohol gel.
* Identify the patient
* Discuss the procedure with the patient and obtain verbal consent.
* Select an appropriate mask in discussion with your supervisor
* Connect the mask to the O2 supply
* Adjust the flow rate to give an appropriate concentration
* Position the facemask on the patient and secure
* Monitor the patient appropriately (pulse oximetry, blood gases, etc.)

**Administer oxygen at defined concentrations**

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**Peripheral Intravenous Cannulation**

**Equipment**

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| --- | --- |
| * Clean tray | * Disposable plastic apron |
| * Non-sterile gloves | * 10ml Syringe & needle |
| * Tourniquet | * Sterile IV dressing |
| * Sterile gauze | * Sharps bin |
| * Extension Set (as required) | * Protective field/underlay |
| * 2% Chlorhexidine in 70% Alcohol skin prep (or 70% Alcohol skin prep if not available). | * Cannula (of appropriate size) |
| * 0.9% Sodium Chloride for injection |

* Before and after each patient contact or procedure, clean hands as appropriate with soap and water or alcohol gel.
* Gather the equipment needed including a clean tray and sharps bin.
* Identify the patient (name, DoB, Hosp No.).
* Discuss the procedure with the patient and obtain verbal consent.
* Clean hands and put on gloves.
* Prepare equipment and draw up the flush
* Apply the disposable tourniquet to the chosen limb to gently impeded venous return.
* Encourage venous distension if required (see venesection).
* Select the most suitable vein.
* Clean the area with 2% chlorhexidine gluconate in 70% isopropyl alcohol and allow to dry for at least 30 seconds. Do not repalpate / touch the skin again.
* Stabilize the vein by applying manual traction on the skin.
* Insert the cannula through the skin with bevel upwards, at an angle of 15 to 45 degrees according to the depth of the vein and device used.
* Observe for the first appearance of blood into the flashback chamber of the cannula.
* Lower the angle of insertion and advance the cannula a further few millimetres into the vein.
* Withdraw the needle slightly and observe for a second flashback of blood which will be seen along the shaft of the cannula.
* Holding the needle in place, advance cannula off the needle into the vein.
* Release the tourniquet and place gauze beneath the cannula end.
* Apply digital pressure on the vein just above the cannula tip and support the cannula to prevent dislodgement.
* Remove the needle completely and dispose of directly into a sharps container
* Connect to IVI, or extension tube as required. Flush with 0.9%.sodium chloride if appropriate
* Observe the site for signs of swelling, leakage or discomfort.
* Clean area as required
* Secure the cannula with an appropriate sterile dressing
* Remove gloves and dispose of all used equipment safely and appropriately.
* Document the procedure within the patient’s notes including cannula used, batch, size, site, flush, date inserted, date for removal and any complications (including number of attempts (Max 2).

**Peripheral Intravenous Cannulation**

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**Setting up an Infusion**

**Equipment:**

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| * Non-sterile gloves | * Prescription chart |
| * Drip stand | * Prescribed fluid bag |
| * Giving set | * Clean preparation tray |
| * 2% Chlorhexidine in 70% Alcohol wipe (or 70% Alcohol wipe if not available). | * Disposable plastic apron  (as required) |

* Before and after each patient contact or procedure, clean hands as appropriate with soap and water or alcohol gel.
* *NOTE: Administration of medications (including IV fluids) must be done under the direct supervision and of a suitably qualified colleague who will be accountable for the procedure.*
* Identify the patient identity (name, DoB, Hosp No.) ensuring this matches the prescription chart.
* Discuss the procedure with the patient and obtain verbal consent.
* Check the cannula is satisfactorily situated (look for erythema, increased tenderness, local swelling) & flush to check patency.
* Gather the required equipment including a clean tray.
* Check the infusion fluid matches the prescription; check the expiry date and ensure the outer packaging is intact, check there are no crystals in the bag. Check with an appropriately qualified colleague (for safety always check any medication with another colleague).
* Clean hands and apply non-sterile gloves.
* Remove the fluid bag from packaging
* Select appropriate giving set, and close the roller clamp.
* Rest the bag of fluid on a flat surface and insert the spike from the giving set, into the fluid bag.
* Invert the bag and hang on the stand
* Squeeze and release the drip chamber of the giving set until half fill with fluid (or to the designated fill line).
* Partially open the roller clamp and prime the full length of the line with fluid, keeping the end cap on, then close the roller clamp.
* Remove the cap from the end of the giving set and connect to the venous access device.
* Adjust the roller clamp to set the infusion to the prescribed rate - by calculating then timing the drops per minute required. Check this with a qualified colleague.
* Secure the infusion line as required to prevent movement & mechanical phlebitis
* Remove gloves and dispose of all used equipment safely and appropriately.
* Clean hands.
* Complete documentation for the procedure, including the prescription chart (along with a signature of the supervising qualified colleague) and fluid balance chart.

**Setting up an Infusion**

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# **Venepuncture**

**🚑 Danger 🚑 Health and Safety Blackspot! 🚑**

**More student’s at Imperial suffer needlestick injuries than   
any other clinical accident**

* **Practice in skills lab (including safety aspects) before venesecting patients**
* **Concentrate on what you are doing**
* **Keep Sharps bin handy**
* **Don’t resheathe needles**
* **Don’t take blood from known high risk patients (Hepatitis B & C & HIV)**

Before and after each patient contact and procedure clean hands as appropriate with soap and water or alcohol gel.

* Gather the required equipment, including a clean tray and sharps bin.
* Introduce yourself to the patient and check their identity (name, DoB, Hosp No.)
* If you are using a lab form completed by someone else, ensure the details match.
* Discuss the procedure with the patient and obtain verbal consent.
* Prepare the patient as necessary e.g. sitting or lying down
* Clean hands and apply non-sterile gloves.
* Select the most suitable site for venepuncture.
* Apply a disposable tourniquet 5-10cm above the site, to gently constrict venous return
* If necessary encourage venous distension by hanging limb downwards
* Clean the site by 70% isopropyl alcohol for 30 seconds and allow to dry for 30 seconds. Do not then repalpate or touch the skin.
* Connect needle or butterfly to holder.
* Stabilising the vein with one hand, insert the needle with the other; with bevel upwards at approx. 15 – 30 degree angle.
* Introduce the sample tubes following the recommended ‘order of draw’ and invert tubes upon removal following the recommended mixing guidelines.
* Release tourniquet
* Withdraw the needle, disposing of it directly into a sharps bin.
* With sterile gauze apply mild pressure over the puncture site until bleeding ceases; if capable the patient may be able to do this.
* Check for any complications e.g. haematoma, and apply dressing.
* Label all blood specimens and complete the laboratory form at the bedside (reduces risk of error).
* Place blood specimens and laboratory form into a plastic specimen bag ready for collection.
* Remove gloves and dispose of all used equipment safely and appropriately.
* Clean hands.

# **Venepuncture**

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| **Assessors please note: More Imperial students suffer needlestick injuries than any other clinical accident. Please take special care that students competence includes sharps handling** | | | | | | | | |

**Managing blood samples**

**Complete request form**

* Fill in relevant patient details including name, hospital number and DoB. (Use a sticker if available and if details on it are up to date)
* Fill in details of requesting doctor or team: e.g. Consultant / GP name, location for results
* Give brief relevant clinical summary
  + What clinical question is this test to help answer?
  + Record any hazards to lab staff (e.g. HbsAg risk)
  + Indicate urgency (urgent requests may additionally require discussion with the lab)
* Sign form indicating status (i.e. medical student) (some trusts will let you do this others require it to be done by qualified staff only – ensure you check first)
* Print your name and bleep number
* Get countersignature of clinical supervisor

**Label specimen container**

* use sticker if up to date or
* write adequate identification details (e.g. name , DoB, hospital number)
* date and location (eg ward name)

**Dispatch to lab in sealed plastic bag**

* URGENT samples
  + You may need to take them to the lab personally,
  + you may need to contact lab staff to discuss request

**Managing Blood samples**

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**Male catheterisation**

**Equipment:**

|  |  |
| --- | --- |
| * Procedure Trolley | * Sterile gloves x2 |
| * Disposal plastic apron | * Sterile Water |
| * Sachet of sterile sodium chloride | * 10ml syringe & needle |
| * Sterile anaesthetic lubricating gel | * Clinical waste bag |
| * Catheter drainage device | * Catheter stand |
| * Waterproof protection sheet | * Fixation device or tape |
| * Appropriate type, size & length of urinary catheter | |
| * Sterile catheterisation pack – e.g. gauze, cotton wool, galipot, drape (fenestrated), receiver dish | |

* Hand hygiene
* Identify the patient.
* Discuss the procedure with the patient and obtain consent.
* Prepare the patient, laying them down supine with legs extended. Avoid exposing the patient at this stage to maintain dignity.
* Clean hands and put on a disposable plastic apron.
* Open dressing pack and empty out other required equipment onto the sterile field using an aseptic technique.
* Remove patients’ cover and place a disposable waterproof protection sheet under the patients’ buttocks.
* Clean hands & put on sterile gloves
* Organise items on your sterile field
* Place sterile towel across the patient’s thighs surrounding the penis
* Wrap a sterile gauze swab around the penis & retract the foreskin.
* Clean the glans penis with 0.9% sodium chloride, working away from the meatus.
* Insert the nozzle of the lubricating anaesthetic gel into the urethra and squeeze gel slowly in. Wait the recommended time for it to take effect.
* Apply gentle pressure to prevent the gel from escaping.
* Remove gloves, clean hands & put on the second pair of sterile gloves.
* With sterile gauze grasp the penis behind the glans, raising it until almost totally extended. Maintain grasp until procedure is completed.
* Place the receiver between the patient’s legs.
* Insert the catheter for 15-25cm until urine flows.
* If resistance is felt at the external sphincter, increase the traction on the penis slightly and apply steady, gentle pressure on the catheter. Ask the patient to strain gently as if passing urine.
* Advance the catheter almost to its bifurcation.
* Gently inflate the balloon with the required amount of sterile water, observing patient throughout.
* Withdraw the catheter slightly.
* Connect the catheter to a sterile closed urinary drainage system.
* Fix the bag below the level of the bladder using a urinary stand as appropriate.
* Ensure the glans penis is clean and then reposition the foreskin to avoid paraphimosis.
* Ensure that the patient is comfortable and dignified, and the area is dry.
* Measure the amount of urine in the receiver as required.
* Remove gloves and dispose of equipment safely and appropriately
* Wash hands
* Document the procedure appropriately. The sticky label from the catheter packaging should be included in the patients’ notes if available.

**Male Catheterisation**

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**Administer a local anaesthetic injection**

* Select local anaesthetic – usually lignocaine 1% (discuss with your supervisor whether to use a preparation containing adrenaline\*)
* Check with qualified staff member (usually this will be your assessor)
  + Drug name
  + with/without epinephrine
  + expiry date
  + calculation for maximum safe dose.
* Use wide-bore needle (green) to draw up the LA.
* Change to narrow-bore (blue or smaller) needle to inject.
* Clean the site with saline (as for suturing)
* Slowly inject the anaesthetic along the edges of the laceration
* Make sure you remember to start superficially, and infiltrate the deeper areas as the superficial anaesthetic takes effect.
* Always aspirate (pull-back) on the syringe to check that there is no blood (that you aren't in a vessel) before pushing down on the plunger.
* Document details of the anaesthetic in the notes.

\*Local anaesthetics frequently contain adrenaline. The purpose of this is to cause vasoconstriction to prevent systemic absorption which increases the duration of action of the anaesthetic and reduces risk of systemic side effects.

Adrenaline is **dangerous** if injected into end arteries such as the penis and ring blocks of fingers as the vasoconstriction can cause ischemia and necrosis.

**Administer a local anaesthetic injection**

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**Suture a wound or laceration**

**Equipment:**

|  |  |
| --- | --- |
| Suture material | 0.9% Sodium Chloride |
| Eye protection | Clean trolley |
| Dressing(s) | Non sterile absorbent field |
| Sterile gloves |  |
| Dressing pack – galipot, gauze, sterile drape, plastic tray | |
| Suture instruments – needle holder, scissors, toothed forceps, dressing forceps. | |

* Identify the patient.
* Discuss the procedure with the patient and obtain consent.
* Clean the trolley and gather equipment.
* Prepare the patient, lying the patient down whenever possible.
* Prepare the wound area and check that the area is anaesthetised.
* Clean hands.
* Open dressing pack and empty out other required equipment onto the sterile field.
* Open sterile gloves avoiding contamination of the sterile field.
* Use eye protection as necessary
* Wash your hands, including wrists and distal third of forearms
* Put on sterile gloves
* Organise layout of items on sterile field.
* Begin to clean tissues with normal saline; starting from the wound edges in an outwards motion away from the wound.
* Apply a sterile paper drape with an appropriate window cut into it.
* Map out where you plan to insert your sutures, noting the position of wound edges and skin folds.
* Insert the first suture in the middle of the wound and then continue dividing into equal sections – approximately 5-10mm apart.
* Grasp the needle two thirds of the way from the needle’s point with the needle holder.
* Holding the skin with toothed forceps, pierce the skin at a 90° angle not closer than 5mm from the wound edge, following the curvature line of the needle as it passes through the tissue, into the middle of the wound.
* Remove the needle and remount it in the needle holder before taking a corresponding bite on the other side of the wound. Do not touch with fingers to avoid needle stick injury. Hold the needle with toothed forceps while repositioning it in the needle holder.
* Pull the suture through until approximately 15cm remains.
* Tie a surgical knot – ensuring that all knots end up on the same side.
* Cut both ends of the suture to an appropriate length e.g. 5-10mm.
* Clean the wound and apply gentle pressure to ensure bleeding ceases.
* Take note of the number of sutures before applying a non-adherent dressing.
* Instruct the patient appropriately, including precautions and aftercare.
* Dispose of equipment safely and appropriately and remove gloves.
* Clean hands.
* Document the procedure in the patient notes including anaesthetic effect, suture material, number of sutures and follow up information given.

**Suture a wound or laceration**

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**Sharps handling & disposal**

* Have a sharps bin ready at the place you are working
* Ensure it is less than 2/3 full
* Take the bin to the sharps, not the sharps to the bin
* Clear up your own sharps
* Do not re-sheath needles
* Beware of sharps hidden by swabs, sheets etc.
* Handle sharps as little as possible
* Never put broken glass, sharps & needles in plastic bags or laundry bags.   
  Use sharps bins.

**Sharps handling and disposal**

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**Obtain written informed consent for a procedure**

**Legally, only a person qualified to carry out a procedure may obtain informed consent from a patient for that procedure. This DOPS is a way for you to practice consenting a patient, but the actual consent is gained by your supervising doctor.**

* Your supervisor should introduce you to the patient
* Let you explain the procedure as below
* Your supervisor may want to discuss things further with the patient at the end of which they will sign the form and get the patients signature.

**Gaining consent for a procedure**

Introduce yourself to the patient with your name and status

Explain the procedure to be undertaken using straightforward non-technical language

Include

* The procedure itself
* The benefits of the procedure
* The significant, unavoidable and/or frequent risks, including any particular to the patient themselves
* Any extra procedures that may be necessary (eg blood transfusion, )
* Anaesthesia to be used (if any)
* Offer leaflet to explain details to patient (where available)

Deal with the patients questions (seek advice if you don’t know the answer)

Check that the patient has understood (“Is there anything you would like me to go over again?” “do you need time to gather your thoughts/read the leaflet”).   
N.B. making the patient repeat back to you what they have been told is patronising, although there are times when you will want to check very carefully that the patient has properly understood if (for example) their capacity is borderline.

**Your supervisor must be present throughout the discussion and must sign the consent form themselves once they are satisfied that the patient has properly understood for consent to be legal.**

**Obtain written informed consent for a procedure**

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**Teach patient to use a peak flow meter**

**NB Explaining and teaching skills.** Student often assume this is all about what they say, but it is a 2 way communication, the second part is listening to the patient to check they have understood

**Introductions**

* Introduce yourself – name, and status
* Check patient’s identity (name, DoB, Hosp No.)

**Explain Task**

What you want to do

* “the doctor has asked me to teach you to use a peak flow meter”

Why you want to do it

* e.g. “this will help us to discover whether you have asthma”
* Or “this will help monitor your asthma to see if your treatment is working satisfactorily”
* Or other reason

Gain verbal or written consent (verbal fine here) –

* “is that OK?”

**Explain How**

Easiest done by demonstrating the machine to the patient and then observing them do it and helping them to correct their technique

Ensure that they:

* Check that the pointer is at zero.
* Stand (or if not possible to sit upright).
* hold the peak flow meter horizontally (and keep fingers away from the scale)
* Take a deep breath and close your lips firmly around the mouthpiece.
* Then blow as hard possible using a short sharp puff like “blowing out candles on a birthday cake”.
* Take the reading and write it down
* Reset the pointer back to zero.
* Ask them to repeat it three times and record the highest reading
* Show them how to fill in the peak flow chart (which comes in the package with the meter)

**Check for understanding**

“Is there anything you don’t understand?” “Have you any questions?”

**Wrapping up**

* Thank the patient
* Explain what happens next, e.g. follow up, etc.
* Hand hygiene
* Record what you have done in the patient’s notes and sign and date the entry.

**Teach patient to use a peak flow meter**

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| Student’s name: | | | | Student’s signature: | | | | |
| Examiner’s name: | | | | Examiner’s signature: | | | | |
| Examiner’s position (e.g. SpR, Consultant, etc.): | | | | | | Date: | | |

**Give a subcutaneous injection**

## (NB if you achieved this in year 5, you need not repeat it but may add you completed assessment form from last year’s portfolio to this)

* Introduce yourself and check the patient’s identity
* Discuss procedure with the patient and obtain consent

• Consult prescription and ascertain the following:

* + Drugs
  + Dose
  + Diluent (if appropriate)
  + Route of administration
  + Check allergies and intolerances
  + Date and time of administration
  + Validity of prescription
  + Signature of Doctor

• Select appropriate syringe, needles, injection and diluent vials, swab and plaster

• Select injection and diluent vials and check against prescription with assessor:

* + Correct drug
  + Correct strength and volume
  + Expiry date
  + Any warnings etc.
* Draw up correct volume of drug, expel air
  + - Remove needle used to draw up and replace with correct bore needle for administration

• Wash hands and put on a clean non-sterile pair of gloves

* Uncover injection site (upper arm, upper leg or abdomen)
* Clean the site with alcohol or dry swab as appropriate
* Pinch and hold a fold of the patient’s skin
* Insert needle in the base of the skin fold at an angle of 20-30 degrees
* Release hold on fold of skin
* Aspirate syringe to ensure needle is not placed in blood vessel
* Inject drug very slowly
* Withdraw needle quickly
* Wipe area with clean swab
* Dispose of sharps and remove glove and wash hands
* Ensure patient’s comfort
* Record details of injection given

**Give a subcutaneous injection**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | **Score** | | | | | | |
| **+++** | | **+** | | **+ / -** | **-** | |
| **Professionalism with patient**  Greeting and introduction to patient  Demonstrates concern for their welfare throughout  **Professionalism with assessor**  Discusses reason for procedure  Discusses outcome/findings/interpretation | |  | |  | |  |  | |
| **Consent**  Explains the purpose of the examination.  Checks for patients understanding  Asks permission in a way which permits refusal | |  | |  | |  |  | |
| **Performing procedure**  Prepares equipment  Performs procedure in a logical sequence, appears practiced  Explains what they are doing to the patient  Attends to the patient’s comfort and dignity.  Clears up, including disposal of sharps | |  | |  | |  |  | |
| **Patient safety**  Hand hygiene before and after  Checks patient identity  Aseptic / clean technique, as indicated  Labels specimen & forms legibly and accurately | |  | |  | |  |  | |
| **Communication**  Uses jargon free language,  Elicits and deals with patient’s concerns  Explains result of procedure (where appropriate) | |  | |  | |  |  | |
| **Overall competence & professionalism performing this skill** | |  | |  | |  |  | |
|  | |  | | | | | | |
| Anything especially good? | | | | Things to improve? | | | | |
| Student’s name: | | | | Student’s signature: | | | | |
| Examiner’s name: | | | | Examiner’s signature: | | | | |
| Examiner’s position (e.g. SpR, Consultant, etc.): | | | | | | Date: | | |