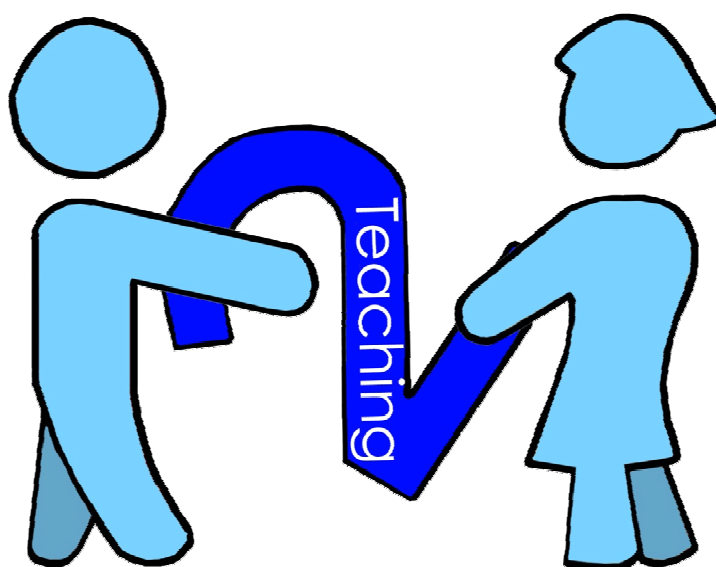


Phase 1A ICE

Clinical Peer Teaching

(Formerly the PEP Programme)



PEER

TEACHING

HANDBOOK

By Jonathan Brooke

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Introduction

The Intensive Clinical Experience (ICE) placements have been designed to give you a taster of the hospital environment. Spending two weeks on the wards allows you to understand the roles of different healthcare professionals, and provides a basic understanding of how patients are managed to ensure they are correctly diagnosed and treated. It is hoped that you will also appreciate what it is like to be admitted to hospital.

Starting an ICE placement can be a daunting prospect, as many of you will not have spent much time in a hospital setting before. The Clinical Peer Teaching (CPT) programme has been designed to help you adjust to ward life and bring some structure to your placement. It will also provide you with a friendly face to talk to about your experiences, as you will be assigned a tutor each week to help you with key learning points. The tutors are all students from phases 3a, 3b and 4 who have kindly volunteered to provide teaching sessions each week to go over areas that will help you make the most of your ICE placements.

Your tutor may ask you to fill in feedback forms to assess their teaching sessions. This will allow teachers to improve their techniques for future sessions, so please be honest. At the end of the programme you will be asked to complete a questionnaire on Minerva to evaluate the quality of your experience. Any responses you make will be anonymous, so again, please tell us the truth! You will receive "Professional Behaviour Credits" for completing this survey, so it's well worth taking a few minutes to do.

At the end of your two weeks, you don't need to be experts in taking histories and vital signs. These resources are here to give you an idea of things to come, and to help you get the most out of your placements.

Have fun on ICE!

Jonny Brooke – Clinical Peer Teaching Co-ordinator

Acknowledgements:

The 2011 edition of this booklet was re-written and edited by Jonathan Brooke. Thanks go to Andy Walker, Farhad Peerally and James Connors for previous versions of this handbook. Thanks to Hayley Colton and Stephen Hook for proof reading through this!

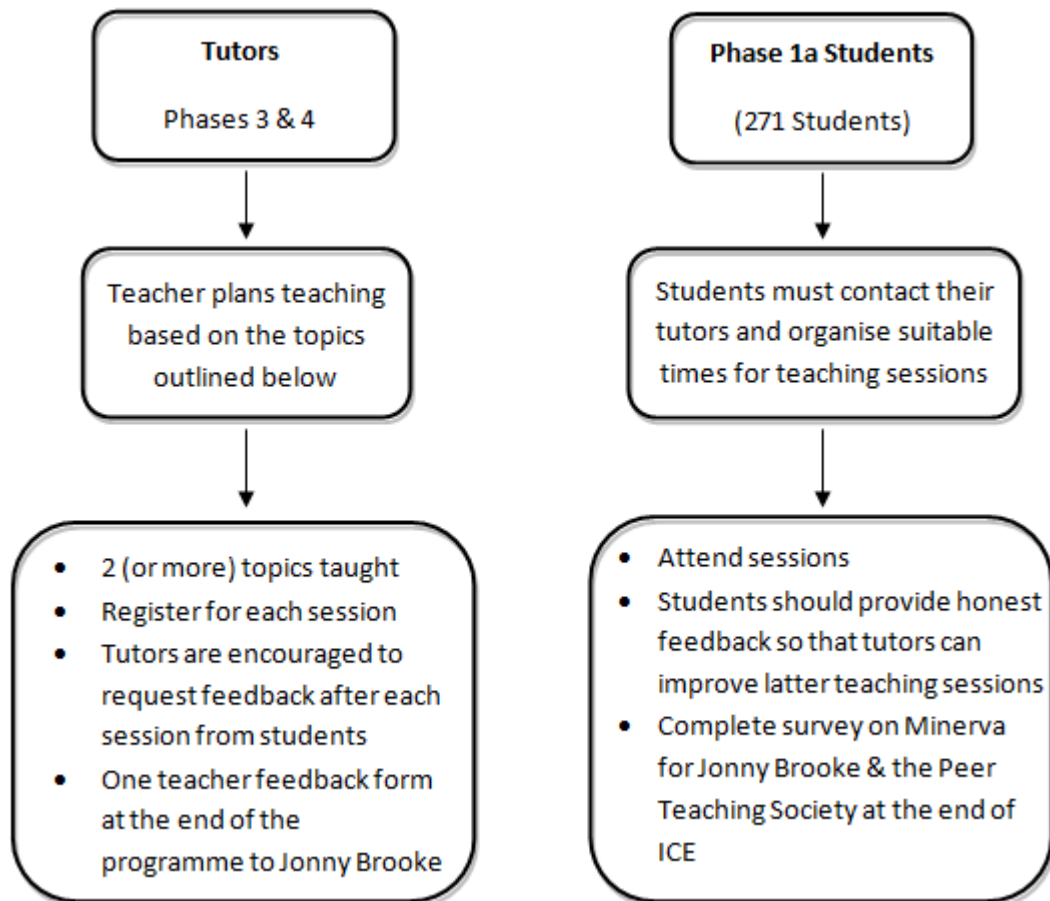
Clinical Peer Teaching – Phase 1a

What it is and why

The Phase 1a Clinical Peer Teaching (CPT) programme has been set up for two main reasons. Firstly, the Clinical Peer Teaching programme aims to support Phase 1a students on their clinical placements, and reinforce the teaching they receive from the medical school. Phase 1a can be very daunting for students as they often feel they are “thrown in at the deep end”. With doctors often very busy on the wards, CPT offers a friendly face for guidance when others are not around.

Secondly, it gives students in phases 3 and 4 the opportunity to experience, practice and refine their teaching skills by being a Student Teacher for a group of phase 1a students. It is hoped this will be the beginning of a career as a teacher.

Clinical Peer Teaching Outline:



The programme will run during the 2 weeks of ICE, which run from 14th Feb – 25rd Feb 2011. The programme aims to allow flexibility for the tutors and the students, with a minimum of 2 topics being taught over this period.

The first topic for tutors to cover is history taking & presentation. How they teach this is up to them, but it is recommended that you encourage your tutors to involve real patients on the wards (with the consent of patients!).

The second topic to cover is vital signs. You will have been taught these skills already in phase 1a, but there is no better place to practice than on the wards! Take along your own stethoscope if you have one to this tutorial so that you can take blood pressure manually.

Following ICE, you will be required to submit 2 history write-ups and a significant event write-up. Your tutors have been asked to give you advice and assistance with these assignments, so please do ask your tutor for help! Your tutors have all completed these tasks and are therefore well-placed to help you! Make the most of them!

This is not part of the curriculum and thus it is not appropriate to take time out of your placement or use these sessions as an excuse to miss any of your formal teaching.

Therefore you will need to co-ordinate when you can attend teaching sessions. Again we recognise this may mean you have to give up your own time, but these sessions have been found to be worthwhile by students in the past.

Aims and Objectives for the Student

- To provide a structure with learning objectives within the placement.
- To provide a support mechanism during a period that can be very daunting and unfamiliar.

Aims and Objectives for the Student Teacher

- To provide the opportunity for senior Student Doctors to teach students in phase 1a and to allow them to experience, develop and refine their teaching skills.
- To provide opportunities for feedback on the teachers' performance to help them develop and reflect on their own teaching skills.
- To ensure graduates from Sheffield Medical School have experience of teaching and recognise the importance of the teaching.

I hope you enjoy your ICE placements and I hope the Clinical Peer Teaching Programme is useful for you all! The rest of this handbook will hopefully be useful to help you get the most out of your time on the wards! Enjoy! 😊 Jonny – clinicalpeerteaching@gmail.com

Suggested Activities

Below is a list of activities which can be used as a guide to ensure that you're getting the most out of your time on ICE. The nursing staff and junior doctors will be your best point of call in finding suitable patients. You will also be able to ask your ICE tutor from Phase 3 or 4 for guidance.

- Talk to as many patients/members of staff as possible,
- Gain a basic understanding of reading drug charts and patients notes and begin to familiarise yourself with the abbreviations used.
 - Try to follow a patient through a 'typical' day for them so that you see what it is like to be a patient, how they and medical/nursing staff and others interact, and the procedures carried out. Also consider their feelings, concerns and hopes during their stay.

Try to do something to help a patient e.g. feeding them, reading a newspaper to them or making a bed with other staff.

Attend a ward round.

Observe practical procedures e.g. taking blood, insertion of an intravenous cannula, administration of drugs.

- Ask to accompany a patient for procedures including an ECG or endoscopy.
- Use your tutorials with your Phase 3 or 4 ICE tutor as an opportunity to take histories, examine, and check the vital signs of patients on the ward.

Usually patients are very willing to speak to students; in particular the older patients are extremely appreciative of the time you spend with them. Taking advantage of this is one of the best ways to learn and gain experience.

Even if you don't feel confident speaking to a patient on your own, see if anyone else in your year group would like to come along with you. Having another person with you may help you to feel more relaxed when talking to patients.

FAQs & Useful Information

Where will I be sent to?

Sheffield Medical Students can be sent to the following, although not all of these are used during the Phase 1a ICE programme:

- Royal Hallamshire Hospital (Glossop Road, Sheffield, S10 2JF)
- Jessop Wing (Tree Root Walk, Sheffield, S10 2SF)
- Weston Park Hospital (Whitham Road, Sheffield, S10 2SJ)
- Northern General Hospital (Herries Road, Sheffield, S5 7AU)
- Doncaster Royal Infirmary (Armthorpe Road, DN2 5LT)
- Bassetlaw Hospital (Blyth Road, S81 0BD)
- Rotherham General Hospital (Moorgate Road, S60 2UD)
- Barnsley District General Hospital (Gawber Road, S75 2EP)
- Chesterfield Royal Hospital (Chesterfield Road, S44 5BL)

Commonly used terms:

- **Bleeping:**
Doctors carry bleeps around to make it easier for them to be contacted by internal phones within the hospital. Usually, the sequence used to bleep a Doctor is “code, bleep number, extension number of phone you are using” – in this particular order.
- **Firm:**
A team of doctors who work together to look after a specific list of patients. Different firms within the same hospital can be colour-coded or numerated for instance. A firm is usually made up of the consultant, Registrar, SHO and Foundation Year doctor (F1).
- **Ward round:**
This is when a firm goes from patient to patient on the ward, usually in the morning to see how they are progressing. During a ward round, the junior doctors usually present the cases and the results so far to the more senior members of staff and decisions are taken as to what is the next line of action for the patient’s management. Do not hesitate to ask questions at ward rounds.
- **Clerking in:**
Taking a full history, examination, along with formulating the differential diagnosis and a management plan. This is usually done by the first doctor who sees the patient in hospital (could be in A&E, clinic).
- **On take/On call:**
A doctor is said to be on call or on take when they are the ones who are responsible to see any presenting patient. A doctor can be on call for different hours. E.g. some do 9am-5pm. Others are on call for the night shift. Shadowing a doctor who is on take is a good way of knowing the bread and butter of the job of a doctor. Being on take at night is an especially good way of getting quite a bit of hands on experience and teaching as doctors are usually less busy at night.
- **Multidisciplinary Team (MDT) Meeting:**
This is where consultants from the same (or different) specialty meet up, along with some juniors to discuss interesting cases. Radiologists are usually present and they project the imaging findings. This is a great learning opportunity and it will no doubt boost your enthusiasm about medicine. It is also interesting to see that consultants don’t know everything about medicine – and do need to work in a team to efficiently manage a patient.
- **Handover**
This occurs at a shift change when one doctor will update the next on the progress and current condition of the patients on a ward.
- **Grades of doctor**
By assigning each doctor to a grade, they can be classified according to their level of training. Some grades are referred to by more than one name due to a change in the training system.

The most commonly used terms are:

1. Consultant – the doctor who leads the firm.
2. Registrar – often shortened to ‘Reg’, these doctors have passed their membership exams and are specialists, waiting to accumulate the required number of years to become a consultant.
3. Trust or Staff Grade – often referred to as a registrar or SHO, these doctors hold non-training posts.
4. ST trainees – according to the new system, these doctors are equivalent to SHOs or Registrars in the old system. They have completed the 2 year foundation programme after medical school, and chosen a specialty to pursue
5. Senior House Officer – These doctors have completed their pre-registration years and are either preparing for their membership exams or have already done them. SHOs and Registrars are usually the ones who give teaching to students on the ward.
6. F2 doctor – these doctors are in the second year of the foundation programme after medical school.
7. F1 doctor – these doctors completed medical school less than a year ago. Do not hesitate to speak to them, they’re the ones who will understand you best and should be willing to teach.
8. Pre-registration House Officer – equivalent of an F1 doctor in the old system

Also you may come across the term “Locum”: A consultant, registrar or SHO who is employed on a short term basis to cover a doctor who is on leave.

Important scenarios

- **What should I do if a patient I’m talking to becomes angry?**

Whenever you are speaking to a patient, make sure you are closer to the exit than the patient is, whenever possible. If a patient becomes angry, try to calm him/her down by talking to him/her and if you are worried about your safety or that of the patient/other patients, inform a doctor/nurse.

- **What should I do if a patient starts crying?**

Try to comfort the patient, but if you feel out of your depth, inform a doctor/nurse. When you leave the patient to summon help tell the patient what you are doing.

- **What should I do if I feel left out on the ward?**

The ward can be a strange place if you don't open yourself to it. Familiarise yourself with the people on it and how the ward works and you shouldn't feel left out at all. Most importantly, introduce yourself to the nurses and doctors and make sure they know you are a first year medical student on ICE placement.

- **There's 'nothing happening' on the ward. What should I do?**

The ward is better than textbooks to learn medicine but it can be very boring if you are not pro-active. There is always plenty happening on the wards and you can always find something to do to aid your learning: e.g. read patients' notes and write down new things you haven't heard of before, shadow one of the nurses, health care assistants, or phlebotomists through their daily routine. Most importantly, speak to patients. You are doing your ICE placement to break the barrier that exists between you and patients. Once you manage to get over this, the patient will become your biggest learning tool...and to achieve this, you need to speak to lots of them!

History Taking Template

Here is a guide to taking a general medical history, including suggested questions to help you when taking histories during ICE. Recorded histories should have a clear structure (as shown in this template), with information divided into key sections such as presenting complaint and drug history.

In general, if you ask open questions and allow the patient to speak freely they will often cover most of the points below without being prompted. These questions are used to check for specific things that the patient might not mention.

Once again, you don't need to be an expert at history taking after ICE. You are not expected to remember every point in the template, but you may find it useful to refer to when speaking to patients.

The following format is by no means perfect, but it should be fairly comprehensive for the level of a phase 1a student. It is based on Phase 2 Clinical Examination Handbook (the green booklet) by Dr Caroline Woodley.

Remember to keep histories anonymous, and do not leave your notes anywhere that could compromise patient confidentiality.

Introduction

Wash your hands and introduce yourself (full name & designation)

Explain that you would like to take a history, and obtain consent

Confirm patient identity, and establish a rapport as you take the history

Patient Information

Name, Age & DOB

Marital Status / Living Circumstance

Occupation

Date & Time of admittance

Presenting complaint (PC)

What brought the patient into hospital? List the problems and their duration. This should be written in lay terms, e.g. a patient would complain of coughing blood, not haemoptysis!

e.g. Short of breath, 3 hrs duration

History of Presenting Complaint (HPC)

Include all the information you can get about the PC

Timeline of symptoms is important!

SOCRATES can be used to obtain information on most complaints:

Site – Where is the pain? Can you pin-point or is it spread out?

Onset – When? What doing? Fast/Slow onset?

Character – Sharp, burning, crushing, aching, dull, tearing etc

Radiation – Does the pain spread anywhere?

Associated Features – Any other symptoms at the same time as PC?

Timing – When does it come and go? For how long? Worse at any times?

Exacerbating/Relieving Factors – Activities, time of day, relief with drugs?

Severity – on a scale of 1 to 10, with 10 being the worst pain imaginable

Enquire about risk factors if they may be relevant to the PC!

Other useful questions:

- Have you had this complaint before?
- Have you ever been an inpatient before with this problem? If so what made it go away?
- Then ask questions about any other symptoms they mention.

Past Medical History (PMH)

Any previous significant illnesses? Or previous hospital admissions?

Any operations in the past?

If appropriate, list some diseases to check that the patient has not forgotten to mention them. The mnemonic MJTHREADS can be used:

Myocardial Infarction

Jaundice

Tuberculosis

Hypertension/High Cholesterol

Rheumatic Fever

Epilepsy

Asthma

Diabetes

Stroke

Drug History (Drugs and Allergies)

- All current medications/drugs (include doses & times per day)
- Any allergies (include food allergies) & if so, what happens?
- Any over-the-counter medicines, vitamins, etc.
- Is the patient compliant? / do they know how to use their medications?
- Does/Has the patient ever used recreational drugs?

FH (Family History)

- Any diseases which run in the family?
- What did family members die of and at what age? (be tactful)
- Are parents/siblings fit and well?
- Constructing a family tree may be a good idea

SH (social history)

This must be tailored to individual patients. It may not be appropriate to ask all of the following to all patients!

- Home status – does the patient live with anyone? If so, whom?
- Does the patient have any dependents? (e.g. children)
- Smoking – pack years?
- Alcohol intake? CAGE screening tool can be used
- Recreational drug use?
- Occupational history – NOT just the most recent job!
- Social circumstances – Do they cope at home? / Any carers?
- Limitations of any disability on lifestyle
- Activities of Daily Living (ADLs) e.g. cooking, cleaning, shopping, washing?
- Recent overseas travel?
- Hobbies?
- Pets?
- Diet?

Systems Enquiry

Summarised in table below and example questions are provided overleaf.
Ask about systems that are relevant to PC/PMH!

<p style="text-align: center;"><u>Cardiovascular</u></p> <p>Chest pain Shortness of breath, at rest or on exertion Breathlessness on lying flat and how many pillows they use Breathlessness at night Palpitations Ankle swelling Poor circulation in the hands or feet Pain in the calves on walking</p>	<p style="text-align: center;"><u>Respiratory</u></p> <p>Cough Sputum Shortness of breath, wheeze Fever Night sweats Recent chest X-ray?</p> <p style="text-align: center;"><u>Breasts</u></p> <p>Lumps, change in shape, nipple discharge</p>
<p style="text-align: center;"><u>Gastrointestinal</u></p> <p>Change in weight Bowel habit Indigestion or acid reflux Problems swallowing Incontinence</p>	<p style="text-align: center;"><u>Neurological</u></p> <p>Headaches visual disturbance, hearing, speech difficulties Dizziness, vertigo Faints, fits, blackouts Weakness, numbness Sleep disturbances Unsteadiness, tremors Concentration, memory</p>
<p style="text-align: center;"><u>Genitourinary</u></p> <p>Incontinence Frequency, dysuria, nocturia Hesitancy, dribbling Change in quantity, colour Blood in urine Genital rashes, lumps Menstrual cycle, possibility of pregnancy</p>	<p style="text-align: center;"><u>Endocrine</u></p> <p>Heat or cold intolerance Sweating Fatigue Tremor Neck swelling Weight gain or loss</p>
<p style="text-align: center;"><u>Skin</u></p> <p>Itch, rash Bruising Swellings, lumps, ulcers Pigmentation changes</p>	<p style="text-align: center;"><u>Haematological</u></p> <p>Bruise easily Bleed excessively Lumps in axillae, neck, groins Previous thromboses, pulmonary embolism Fever, night sweats, weight loss</p>
<p style="text-align: center;"><u>Musculoskeletal</u></p> <p>Joint pain, stiffness, swelling Dry mouth Sore eyes Skin rash Back or neck pain</p>	<p style="text-align: center;"><u>Mental Health</u></p> <p>Worries, anxieties Mood Abnormal beliefs, hallucinations Memory problems</p>

Systems Enquiry (SENO)

This is a set of final screening questions to make sure you haven't missed anything at the end of the history. It runs through each body system and covers the key worrying symptoms which may be present. At this stage, you will probably only be familiar with the

Cardiovascular and Respiratory systems. As such, the rest of the questions are not too important at Phase 1a level and are here as a reference point. Patients often answer 'No' to most of these questions, but they are there in order to ensure you don't miss anything!

Cardiovascular System (CVS):

Chest pain:

Do you ever get any chest pain?

Palpitations? – Do you have any awareness of your heart beating?

Breathlessness:

Exertional- do you ever get breathless on walking/ going up stairs?

How far can you walk before you become breathless?

At night (Paroxysmal Nocturnal Dyspnoea, or PND)- Do you ever wake up breathless at night?

Lying flat (Orthopnoea)- How many pillows do you sleep on? This question gives an idea as to how severe the breathlessness is – some patients with heart failure need to sleep upright in a chair.

Intermittent claudication: Do you get pain in your legs when you walk? How far can you walk before this happens? What do you then do?

Peripheral Oedema: Any ankle swelling?

Respiratory System (RS):

Do you have any breathing problems?

Cough – do you have a cough? If yes, is this all the time?

Sputum – do you bring anything up when you cough? Colour? Amount?

Haemoptysis – have you ever coughed up blood?

Wheeze – do you have a wheeze/noisy breathing?

Gastrointestinal System (GI):

How have your bowels been? Any changes in bowel habit? Diarrhoea/constipation?

Change in stool colour?

Melaena (blood in the stool) – have you noticed any blood in stool? Stools dark and smelly?

Any slime/mucus in stool?

Do you get any heartburn?

Have you noticed any weight loss?

How has your appetite been?

Dysphagia- have you had any difficulties swallowing?

Any abdominal pain?

Have you had any nausea/vomiting? If yes does vomit contain blood? (Haematemesis)

Rectal bleeding – have you noticed any blood in your underwear or on the toilet paper?

Genitourinary System (GU)

Have you noticed any problems with your waterworks?

Frequency – Are you passing water more or less than usual?

Dysuria – Any pain on passing water?

Haematuria – Colour of the urine? Any blood in the urine?

Prostatism – Do you need to pass urine more often than you used to? When you pass water do you get a good stream? Any dribbling afterwards?

Incontinence – Have you ever had any leaks/accidents/been incontinent?

Neurological System (NS)

Have you had any fits, faints or funny turns?

Headaches?

Dizziness or vertigo- room spinning?

Hearing problems- has anyone commented on your hearing recently? Tinnitus – any ringing in your ears?

Eye problems – Any change in your eyesight?

Weakness- Are your arms or legs weaker than normal?

Altered sensation- paraesthesia, Have you noticed any pins and needles?

Locomotor System (LS)

Any pain in your joints?

Any Stiffness or swelling?

How far can you walk? What limits distance? Joint pain or shortness of breath?

Skin

Any problems with your skin? Rashes etc?

To finish

Ask the patient “Is there anything else I need to know?”

To conclude:

- Thank the patient
- Leave the bedside
- Wash your hands
- Document and report findings

Sample History

Please note that 0 means “no”, but this is dated and you should now write the word “no”

Patient Identity: Mr XX

Date: 15/01/09
Time: 16.00
Name: Mr AN Other
Age: 65
DOB: 29/10/1942
Marital Status: Married
Occupation: Builder (Retired)
Date admitted: 14/01/09

PC:

1. Chest Pain, 3hr Hx
2. Shortness of breath, 3hr Hx

HPC:

1. Chest Pain

Mr AN Other was at home when he experienced a sudden onset of central chest pain

Site: Central Chest

Onset: The pain came on suddenly, within a few seconds. It began while the patient was at rest, sitting eating lunch.

Character: Crushing, "Like a vice around my chest". This has been constant for 3hrs and was not precipitated by exercise.

Radiation: Spreads up into jaw and into the left arm

Associated Symptoms: Sweating, SOB, ^oVomiting (^o means a negative finding, i.e. no vomiting), ^oNausea

Timing: The pain has been more or less constant since it began

Exacerbating/Relieving factors: ^oExacerbating/relieving factors,

Severity: 9/10

^oRecent Long-haul flights

^oTime Spent Bed-Bound

Pt does not normally suffer with indigestion, but says the pain is different from indigestion pain he had experienced in the past.

2. SOB

- Pt has been SOB since shortly after the onset of the chest pain.

- The breathlessness has got steadily worse over the past 3 hours.
- It has not improved with Salbutamol (pt has had a total of 8 puffs)
- The patient has mentioned that they are more comfortable sitting upright

◦Cough

◦Wheeze

◦Sputum

PMH:

1999-Present: Hypertension diagnosed by GP

- Now takes Ramipril, Aspirin and Bendroflumethiazide.

2001: Asthma diagnosed by GP

- Now takes Beclametasone and Salbutamol

2005: Hypercholesterolaemia diagnosed by GP

- Now takes Atorvastatin

◦Previous hospital admissions

◦Previous surgery

◦ MI previously

◦ Jaundice

◦ TB

HT diagnosed 1999, see above

◦ RF

◦ Epilepsy

Asthma diagnosed 2001, see above

◦ Diabetes Mellitus

◦ Stroke/TIA

DH

Ramipril	2.5mg		OD
Bendroflumethiazide	2.5mg		OD mane
Aspirin	75mg		OD
Lansoprazole	15mg		OD
Atorvastatin	10mg		OD
Salbutamol	100mcg	two puffs	PRN
Beclometasone Dipropionate	100mcg	two puffs	BD

NKDA

FH

Father: Died aged 59 of MI. Had two MIs before his death, first aged 47

Mother: Died aged 84, "of old age". No known medical problems apart from "arthritis" in hands.

Sister: Aged 71 suffers with type II DM and hypertension

◦Other familial illnesses

So: +ve family history of CHD, HT and Type II DM

SH

- Pt lives with wife at home (also 65), who is a retired secretary.
- She suffers from hypertension, but is otherwise fit and well
- Pt is fully independent: can dress himself, get in and out of bath, use stairs, cook, clean and walk to the shops

Smoking: Pt smokes 15 cigarettes daily and has done since the age of 15.
(15 cigarettes X 50 years)/20 = 37.5 pack years
Pt's wife also smokes

Alcohol: Pt is teetotal and has been all his life.

Drugs: Pt denies ever having taken any illicit drugs

◦Pets

◦Recent Travel

SENQ

CVS

Chest pain present, see above

SOB present, see above

?Orthopnoea as SOB better on sitting upright, none usually – 2 pillows

◦PND

◦Intermittent Claudication

◦Peripheral Oedema usually

◦Palpitations

RS

SOB currently, see above

Asthmatic, see above

- Cough
- Wheeze
- Sputum
- Haemoptysis

GI/GU

- Change in bowel habit
- Diarrhoea/Constipation
- Change in stool colour/form/smell
- Slime in stool
- Blood in stool
- Change in urinary habit/colour
- Blood in urine
- Dysuria
- Terminal dribbling/hesitancy
- Weight Loss
- Change in appetite
- Nausea/vomiting

Fully continent of urine and faeces

NS

- Blackouts
- Fits
- Faints
- Headaches
- Dizziness/vertigo
- Hearing problems inc tinnitus
- Eye problems – although does wear glasses for reading
- Problems with Smell and taste
- Weakness
- Paraesthesia

LS

- Pain in joints
- Stiffness in joints
- Swelling in joints
- Problems walking or with stairs

Skin

- Rashes
- Moles

Summary

Patient presented with a 3 hour H_x of crushing central chest pain, radiating to the jaw and left arm. He has also experienced progressive SOB, which improves when he sits upright. He has not been on any recent long haul flights or been bed-bound and has never had any surgery.

Mr XX has a previous medical history of hypertension, for which he takes Ramipril, Bendroflumethiazide and aspirin. He also takes Atorvastatin for Hypercholesterolaemia and salbutamol and Beclametasone for asthma. Additionally, he is on Lansoprazole.

He has a positive family history of CHD and lives at home with his wife, and is fully independent. He has smoked 15 cigarettes per day for 50 years (37.5 pack years) and is teetotal.

Management Plan

Impression: Myocardial Infarction

1. High Flow O₂ via face mask
2. ECG
3. Morphine 5mg IV + Metoclopramide 10mg IV
4. Aspirin 300mg chewed
5. GTN 2 puffs sl
6. Bloods for FBC, U&E, glucose, lipids, cardiac enzymes, d-dimers
7. Consider thrombolysis
8. CXR

Comments

This sample history and examination should give you an idea of how things will be set out when you read patient notes. You can learn more by taking histories yourselves, although as we've already said, don't expect to be an expert by the end of your 2 week placement. Repeated and regular practice over many years is needed to perfect history taking.

You can learn a lot from patient notes, and you may wish to go and read up about what you find within them. Kumar and Clark is quite useful for most things, and the British National Formulary (BNF) is handy for learning about drugs. You can often go to a pharmacy and request an old copy of a BNF and they are usually willing to let you keep them!

Glossary of terms you may come across

Abbreviations

∅	None, e.g. ∅pain would mean no pain
♀	Female
♂	Male
AMTS	Abbreviated mental test score (10 point test)
BM	Blood sugar level (bedside pinprick test)
BP	Blood Pressure
Bpm	Beats per minute
BS	Bowel sounds
CABG	Coronary artery bypass graft
CPR	Cardiopulmonary resuscitation
CVS	Cardiovascular system
DNA	Did not attend
D/N+V	Diarrhoea/nausea + vomiting
EBM	Evidence-based medicine
ESM	Ejection systolic murmur
GA	General anaesthetic
GCS	Glasgow Coma Scale
GIT	Gastrointestinal tract
GUT	Genitourinary tract
HS I+II+?	Heart sounds 1 and 2 (=added sounds)
ICP	Intracranial pressure
IVDU	Intravenous drug user
JACCOL	Jaundice, anaemia, clubbing, cyanosis, oedema, lymphadenopathy
JVP	Jugular venous pressure
LA	Local anaesthetic
LIF/RIF	Left/right iliac fossa
LMN/UMN	Lower/upper motor neurone
MAU	Medical admissions unit
MMSE	Mini-mental test exam (30 point test)
NAD	Nothing abnormal detected
NG(T)	Nasogastric (tube)
NBM	Nil by mouth
OT	Occupational therapist
OPD	Outpatient department
PERLA	Pupils equal and reactive to light and accommodation
PND	Paroxysmal nocturnal dyspnoea
PR	<i>per rectum</i> i.e. rectal examination
PSM	Pan systolic murmur
Pt	Patient
PV	<i>per vaginam</i> i.e. vaginal examination
R/L U/LQ	Right/left upper/lower quadrant (of abdomen)

SOB	Shortness of breath
SOBOE	Shortness of breath on exertion
RR	Respiratory rate
WR/PTWR	Ward round/post-take ward round

Diseases and Diagnoses

AAA	Abdominal aortic aneurysm
ACS	Acute coronary syndrome
AF	Atrial fibrillation
Ca	Carcinoma
CCF	Congestive cardiac failure
CHD/IHD	Coronary/ischaemic heart disease
COPD	Chronic obstructive pulmonary disease
CVA	Cerebrovascular accident
DM	Diabetes mellitus
DVT	Deep vein thrombosis
HT	Hypertension
LVF/RVF	Left/right ventricular failure
MI	Myocardial infarction
OA	Osteoarthritis
PE	Pulmonary embolism
PUO	Pyrexia of unknown origin
RF	Rheumatic fever
TB	Tuberculosis
TIA	Transient ischaemic attack
URTI	Upper respiratory tract infection
UTI	Urinary tract infection
VF	Ventricular fibrillation

Writing Notes

Hx	History
c/o	Complaining of
PC	Presenting complaint
HPC	History of presenting complaint
PMH	Past medical history
DH	Drug history
FH	Family history
SH	Social history
SE	Systems enquiry
CVS	Cardiovascular system
RS	Respiratory system
GI	Gastrointestinal (system)
GU	Genitourinary (system)

NS	Nervous system
LS	Locomotor system
o/e, Ex	On examination
Ddx	Differential diagnosis
Dx	Diagnosis
Mx	Management
Rx	Treatment
D/W	Discussion with
+ve/-ve	Positive/negative

Blood Tests

APTT	Activated partial prothrombin time
CRP	C-reactive protein
ESR	Erythrocyte sedimentation rate
FBC	Full blood count
Hb	Haemoglobin
INR(PT)	International normalised ratio (prothrombin time)
LFTs	Liver function tests
MCV	Mean corpuscular volume
U+E	Urea and electrolytes
TN	Troponin
WCC	White cell count
TFTs	Thyroid function tests

Investigations

ABG	Arterial blood gases
AXR	Abdominal X-ray
CT	Computerised tomography
CXR	Chest X-ray
ECG	Electrocardiogram
ECHO	Echocardiogram
EEG	Electroencephalogram
LP	Lumbar puncture
MCS	Microscopy, culture and sensitivity
OGD	Oesophagogastroduodenoscopy
USS	Ultrasound scan
V/Qscan	Ventilation perfusion scan

Drug Charts

OD	Once daily
BD	Twice daily
TDS	Three times daily

QDS	Four times daily
PRN	<i>pro re nata</i> – as required
nocte	At night
mane	In the morning
x/7	x days
x/52	x weeks
x/12	x months
CI	Contraindications
IM	Intramuscular
IV	Intravenous
NKDA /NKA	No known (drug) allergies
OD	Overdose
po	Orally
pr	Per rectum
SE	Side effects
sc	subcutaneous
sl	sublingual

Acronyms

Pain History:

SOCRATES

Site
Onset
Character
Radiation
Associated symptoms
Timing
Exacerbating/relieving factors
Severity

PMH conditions:

MJTHREADS

Myocardial infarction
Jaundice
Transient Ischaemic Attack
Hypertension
Rheumatic fever
Epilepsy
Asthma
Diabetes Mellitus
Stroke (CVA)



Phase 1a Clinical Peer Teaching



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Tutor/s:

Location:

Date:

Subject of teaching:

Please rate the tutor's performance below:

Score out of 5: (5 is best and 1 is worst)	5	4	3	2	1
					
Knowledge					
Organisation & Planning					
Enthusiasm					
Confidence					
Approachability					
Ability to answer questions					
Timekeeping					
Effort					
Opportunity to participate					
Overall tutoring ability					

Comments:

Highlights of the session:

Areas that could be improved:



Phase 1a Clinical Peer Teaching



The

Your tutor may request that you bring along this feedback form to a session
Jonathan Brooke clinicalpeerteaching@gmail.com

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d.

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