Trainee update – what’s happening in AIM

Nick Smallwood

SAM trainee representative
Some acronym busting

- **AIM**
  - Acute Internal Medicine

- **TPD**
  - Training programme director

- **Deanery/LETB**
  - Local Education and Training Board

- **STC**
  - Specialty training committee

- **SAC**
  - Specialty advisory committee

- **JRCPTB**
  - Joint Royal College of Physicians Training Board
STC or SAC...or SAM?

• Each LETB/Deanery has it’s own STC
  – Trust Acute medicine leads, TPDs, trainee reps, LETB
    • Discuss regional training issues

• The SAC sits 3 x per year
  – TPDs, SAM trainee reps, various JRCPTB representatives
    • Discuss national training issues

• Society for Acute Medicine Council
  – Elected Council members (inc SAM trainee reps)
    • Discuss Acute Medicine issues
What’s new?

• Tweaks to the AIM curriculum

• #takeAIM and increasing awareness

• AIM trainee survey

• Specialist skills
Tweaks to the AIM curriculum

• Primarily centre around timings of practical procedures
  – CVC, knee aspiration, DC cardioversion, abdominal paracentesis by St3
  – Chest drain (PTx and effusion) by AIM year 3

• SCE taken by year 3; passed by CCT
#takeAIM and increasing awareness

- November 2015 conference
- RCP specialty of the month (Nov 2014)
- #takeAIM fellowships
AIM trainee survey

• Sent out via SAM/TPDs this Feb/March for the first time
• Presented to SAC March
• Results collated (poster to view here)
• Write up in Acute Medicine soon

• Aim to become a regular feature
Specialist skills

• Constantly under review, esp as trainees propose new skills
• Diploma or higher in (relevant) postgraduate qualification
• Stroke, critical care, inpatient diabetes, palliative care, maternal medicine all undertaken successfully

• Recent change has been in practical skills
Practical skills

• Bronchoscopy
• Gastroscopy
• Tilt table testing
• Echocardiography
• Ultrasound
Echocardiography

• Old standard
  – Full BSE accreditation required

• New standard
  – FICE with ongoing logbook and 5 reflective case studies
Ultrasound

• Old standard
  – Limited definition; level 2 thoracic ultrasound acceptable

• New standard
  – Level 2 in an RCR focussed ultrasound standard
  – Four or more Level 1 RCR focussed standards
  – Postgraduate medical ultrasound qualification
  – Ongoing logbook
Focused ultrasound training standards

Board of the Faculty of Clinical Radiology
The Royal College of Radiologists

Ultrasound training recommendations for medical and surgical specialties
Second edition

Board of the Faculty of Clinical Radiology
The Royal College of Radiologists
Ultrasound

• Ultimate aim is to create AIM specific standards
Specialist skills

• SAM website section now back online!
Other AIM updates

• Database of regional trainee reps produced to feed into national reps

• Acute Medicine awareness week (likely Nov ‘15)

• AIM conference planned for Nov ‘15

• NICE guideline development group in Acute Medical Emergencies (NC and MJ)
Questions?

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#takeAIM
Fellowships and Conference

Nerys Conway
Launched last November
Then came...
Part of #takeAIM campaign

- Fellowships
- Conference
- Funding from HEE
Fellowships

• 6 trainees
• Each region
• Promote specialty 1 session per week
• Supported by TPD, mentor and Ed Sup
Fellowships

• Identify positive aspects of a career in AIM

• Develop a variety of media to publicise the benefits of a career in acute internal medicine

• Highlight the importance of AIM to patient care in the NHS

• Assist trainee reps hold trainee-led conference to encourage promotion of AIM
Fellowships

• CV and cover letter to Mike Jones
• Selection process- interview
• To start from July/August 2015 for 1 year
Conference

- November 2015
- Manchester
- 1 day
- F2s-CMTs
- Run by AIM trainees
- Supported by SAM
Conference

• Lectures
• Workshops
• Tutorials
• SIM/ Practical
Conference

• Keen for trainees to get involved
• We need **you** to encourage and promote AIM
• Thank you for supporting AIM

• Please continue to promote AIM locally within your region

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nick.smallwood@gmail.com
Safety in numbers
A collaborative project to improve PTWR safety in the Severn Deanery

Dr Z Jones, Dr A Stevenson, Dr N Conway, Dr C Williams and Acute Medicine Registrars in Severn Deanery
Key Aims

• Review the current nature of the Post Take Ward Round in Severn Deanery.
• Asses the performance of those PTWR in compliance with key safety issues.
• Question current practice/training in PTWR
• Collaborative effort across Deanery for AIM registrars.
Background

- Post take ward rounds (PTWRs) are:
  - the core of Acute Medicine
  - a large part of acute physician’s workload
  - increasingly done by AIM rather than GIM physicians
Why does our approach to PWTR need to change?

• Nature of PTWR has changed greatly over past 10 years

• Introduction of standards
  • ‘Harm free’ care
  • NHS Safety thermometer
  • SAMBA

• Culture change to focus on patient safety
<table>
<thead>
<tr>
<th>Traditional PTWR</th>
<th>Current PTWR</th>
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<tbody>
<tr>
<td>Single team clerking</td>
<td>Large number of clerking doctors</td>
</tr>
<tr>
<td>One PTWR per day led by one GIM consultant</td>
<td>PTWR throughout day by multiple consultants</td>
</tr>
<tr>
<td>Stable team on PTWR SpR, SHO and house officer + nursing staff</td>
<td>Variable PWTR team</td>
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<tr>
<td>Clerking doctor on PWTR</td>
<td>Clerking doctors not always on PWTR</td>
</tr>
<tr>
<td>Ongoing care provided by clerking team</td>
<td>Ongoing care provided by other teams</td>
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</table>
Traditional PTWR

- Single team clerking
- One PTWR per day led by one GIM consultant
- Stable team on PTWR SpR, SHO and house officer + nursing staff
- Clerking doctor on PWTR
- Ongoing care provided by clerking team

Current PTWR

- Large number of clerking doctors
- PTWR throughout day by multiple consultants
- Variable PWTR team
- Clerking doctors not always on PWTR
- Ongoing care provided by other teams
Guidance on ward rounds: Royal College of Physicians

“All bedside reviews should address common safety aspects such as:

- thromboprophylaxis
- intravenous fluids
- drug chart review
- review of lines
- pain evaluation”
Guidance on ward rounds: RCP

• “An organised approach to ward rounds improves patient safety and experience”

• “Safety checklists reduce omissions and variation in practice, while strengthening team communication, performance and patient experience”
Safety checklists

- Safety checklists in high risk industries well established
- Role in medicine increasingly recognised
- WHO Surgical Safety checklist in use since 2008
  - reduction in mortality and inpatient complications
- Other specialties including Intensive Care Medicine, anaesthetics and obstetrics using checklists
- Several small studies show use improves ward round processes
Safety checklists: pros

- Proven to be useful (WHO surgical safety checklist)

- Easy tool to measure key safety elements

- Can be used as part of assessment tool for trainees carrying out ward rounds
Safety checklists: cons

• Need to be embedded as part of culture change
• Needs education, consultant buy in and training of staff in use
• Overcomplicates an already complex task
• Becomes a tickbox exercise
• Little data to show use improves patient safety
Aim of Safety in numbers

• Review PWTR practice across Severn Deanery

• Identify where and how safety checklists are used for PWTR in Severn Deanery

• Assess impact of PTWR checklists on key safety elements
### Consultant Review / PTWR

**Date:** / /  
**Time:** :  
**Consultant:**  

### Relevant history

### Relevant examination

### Checklist

<table>
<thead>
<tr>
<th>Trigger</th>
<th>n/a</th>
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<tbody>
<tr>
<td>Obs / NEWS</td>
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<tr>
<td>Fluid Balance</td>
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<tr>
<td>and IV fluids</td>
<td></td>
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<tr>
<td>Catheter / Cannulae</td>
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<tr>
<td>Drugs review</td>
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<tr>
<td>VTE</td>
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<td>ARD sticker</td>
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<td>Sepsis form</td>
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<td>Dementia form</td>
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<tr>
<td>DNAR / Ceiling</td>
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<tr>
<td>Explain to patient / relatives</td>
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### Relevant investigations or investigations not seen/awaited

- **Bleeds:**  
- **CXR:**  
- **ECG:**

### Problems/differential diagnosis

### Subsequent plan

### Discharge issues including destination

### Predicted date of discharge:

- **Signature:**  
- **Print name:**  
- **Grade and Specialty:**
### CONSULTANT REVIEW

<table>
<thead>
<tr>
<th>Date:</th>
<th>Time:</th>
<th>Consultant:</th>
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<table>
<thead>
<tr>
<th>History:</th>
<th>Examination:</th>
<th>AMTS: /10</th>
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Diagnosis: 

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<th>1. CXR:</th>
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<th>2. ECG:</th>
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<th>3. Blood tests:</th>
<th>Management:</th>
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<tr>
<th>Other results:</th>
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<table>
<thead>
<tr>
<th>Checklist:</th>
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<tbody>
<tr>
<td>10. VTE prophylaxis:</td>
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<table>
<thead>
<tr>
<th>Intended ward / destination:</th>
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<tbody>
<tr>
<td>(Can patient be managed in non-acute setting now?)</td>
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<tr>
<th>EDD:</th>
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<tr>
<td>or</td>
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<tr>
<td>Est. LOS: 1 – 2 days / 2 – 4 d / 4 – 7 d / &gt; 1 wk</td>
</tr>
</tbody>
</table>

| Is patient medically fit for discharge/transfer? | Y | N |

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<thead>
<tr>
<th>Signed:</th>
<th>Name:</th>
<th>Bleep:</th>
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Royal United Hospital Bath
PTWR Sheet

sambristol
7 - 8 May 2015
Bristol Marriott Hotel
City Centre
Elements included in PTWR checklist:

• Vary across trusts but key points...
• VTE Prophylaxis
• Oxygen
• Cannula plan
• Drug Charts/Antibiotics
• DNAR+/- escalation plan
PTWR practices: survey results

Survey conducted across Severn Deanery AIM registrars in February 2015

• Consultant leading PTWR:
  • 64% AIM only
  • 27% mix of AIM and specialities
  • 9% General Medicine Consultants (No dedicated AIM consultants in hospital or OOH)

• Who attends the PTWR?
  • 82% Consultant and 1 Junior Doctor
  • 18% Consultant+Junior+Nurse
“Scope to Improve”
Safety in Numbers audit results

• Data collected by AIM registrars

• 8 out of 9 available hospitals in Severn Deanery

• 114 patients notes reviewed
PTWR checklist in Severn Deanery

• PTWR checklist available in 5/8 hospitals

• When available, PTWR checklist completed in 54.3% cases

• Checklists only completed by AIM consultants, never by GIM consultants.
Checklist v Non Checklist

Percentage Individual Data

- VTE Assessment done
- Abx r/v date done
- Cannula Plan
- Catheter Plan
- DNAR filled in/escalation plan made

Legend:
- With Checklist Available
- Without Checklist Available
- With checklist available and actually used
Training for PTWR

Survey of Junior doctors regularly on PWTR

• Formal training in PTWR?
  • 85% doctors had no formal training
  • Those that had had training had been trained outside of Severn Deanery.

• Would formal training in PTWR be useful?
  • 95% doctors answered YES.
• What are junior doctors priorities on PTWR?

• “Review of differential diagnosis”
• “Safety aspects addressed eg. VTE”
• “Review escalation plan or discharge plan”

• “To have a clear plan”
Recommendations/ideas

• Acute physicians via SAM should lead in improving PTWR safety

• Local teams to decide on structure/timings of PWTR - needs consistency within Trusts

• Simulation-based ward round training in AIM curriculum including
  • Training tool developed in Surrey and Sussex Healthcare Trust for F1 doctors and final year medical students resulted in improved confidence and documentation

• Quality indicators for PTWR practice included in SAMBA
Recommendations/ideas

• Further research needed to assess whether safety checklists improve patient safety outcomes

• When checklist available, train and empower all members of PTWR team
  • Pre-briefing may help with this

• Develop national PWTR safety checklist (cf. NEWS chart)

• AIM Curriculum
Discussion

1. The nature of the PTWR has changed dramatically in a very short space of time. Now fewer staff involved in more regular rounds with little continuity of care.

2. The presence of a safety checklist should in theory ensure key priorities met despite lack of continuity, but in practice it is little used in Severn.

3. When checklists available and actually used, it did seem to make some differences in our findings so should this be focussed on as an area to improve or does the issue require more than a tick box to ensure patient safety?
Setting up a trainee led Research Collaborative

Dr Paarul Prinja
StR AIM/GIM
West Midlands Workforce Deanery
Getting to know each other

• June 2014 – Team-working and Leadership training day
• September 2014 – Dinner
• October 2014 – SAM Brighton – Whatsapp
• Similar frustrations....
Timeline – November 2014

• Research themed training day
• Trainee Surgical SpRs – Surgical research collaborative
• RCT - DREAMS
• Why can’t we do something similar?
Timeline – January 2015

• Setting up the collaborative – focus groups
• Structure of the collaborative
• Types of projects
• Idea Bank
• Authorship
• Project lead
• Timeline and aims
Structure of the Collaborative

Coordinator

- Deputy Coordinator
  - Project lead 1
  - Project lead 2
  - Project lead 3
- Deputy Coordinator (Trainee Rep)
Structure of the Collaborative

- Project lead 1
  - Local data collection leads
  - Data analysis
  - Ethical approval
  - Write up team
First Project

• Management of AKI on AMUs – A regional Audit
• 12 centres
• Over 3000 patients screened, over 200 AKIs
• SAM Manchester
• Second project......
What works for us...

• Twitter
• Whatsapp
• Monthly AIM Training days
• WAMC meetings - followed by Nandos
• ‘Film-credit” authorship
The future...

- Multi-centre RCTs/Clinical trial units
- Linking up with other trainee research collaboratives
- Share ideas/Teamworking
- Dedicated day with SAM support
- Boost the profile of our specialty
- Other collaborative work
Thank you for listening

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