Date:

Subject title: Suspected Ectopic Pregnancy

What happened?

Patient presented 7 weeks pregnant with lower left sided abdominal pain and some mild vaginal bleeding. The patient was admitted to the ward and examination revealed mild LIF pain on deep palpation and speculum examination revealed blood in the vagina with a closed cervical os, VE was unremarkable.

What, if anything, happened subsequently?

There was no early pregnancy assessment unit scanning facilities available and so the patient would need to come back either the next morning, or remain an inpatient until ultrasound had been performed. From my limited obstetric and gynaecology experience I thought the lady was likely to be having a miscarriage.

What did you learn?

Having limited gynaecological experience I found it difficult to illicit whether this lady was having a miscarriage or could potentially have an ectopic pregnancy, with the symptoms being similar in both. There were no specific risk factors for ectopic pregnancy in the history. I felt uneasy about my knowledge relating to management of miscarriage/ suspected ectopic pregnancy and this made me feel that I couldn't give the patient appropriate advice about whether to remain an inpatient or discharge her as she was haemodynamically stable. Whilst waiting for blood results I contacted the registrar for advice regarding management - he advised that as the patient had abdominal tenderness she would be suitable to remain an inpatient overnight for a scan in the morning.

Later that evening I asked the registrar which suspected ectopics were suitable for discharging home with follow up early pregnancy assessment unit USS. He advised that if there are no ectopic risk factors (previous ectopic/ previous abdo or pelvic surgery/ PID/ fertility treatment / COCP or POP or coil use) and no clinical signs (shoulder tip pain/ collapse/ abdo tenderness/ cervical excitation/ adnexal tenderness) and stable HB. This was helpful in giving me a baseline for establishing which patients could be safely discharged home with appropriate safety netting.

Overall this experience made me realised my gap of knowledge regarding management of suspected ectopic and subsequent management of confirmed ectopic and implications for fertility.

From this experience I feel I need to read around the common presenting gynaecological problems that can present to hospital as at present my knowledge is limited to primary care management e.g. suspecting a miscarriage and booking for EPAC, but I need to learn about the types of miscarriage and associated clinical features with each. Also I need to learn which patients require Anti-D.

What will you do differently in future?

Until I am confident in my management of patients I will discuss with registrar before discharging patients from either obstetric or gynaecology ward.

What further learning needs did you identify?

Read around the common gynaecology topics e.g. miscarriage, ectopic pregnancy, hyperemesis, complications following abortion etc.

How and when will you address these?

During the next week read Obstetrics and Gynaecology (L.Impey & T. Childs) and complete learning modules on these topics.

Date:

What happened?

It was the end of my colleagues shift, she had finished clerking in a patient, had sent bloods and a CXR and had asked me to review the patient CXR and then send either to the medics or the gynae team depending on results. The patient had presented with hypoxia and initially abdominal pain, however on examination of the patient by my colleague she could find no abdominal pain and just found that the patient was hypoxic with some creps on the chest. Given these findings my colleague thought that it was likely a chest infection. The patient had recently had laparoscopic surgery under the gynaecology team.

When checking the CXR, i could see no focus of consolidation, however given the raised inflammatory markers, I went in to review the patient. The patient complained of no abdominal pain but did have a noticiblly productive cough.

I decided to refer the patient to the medical team and continued with my referral.

What issues were raised by this significant event?

I later heard from an A&E consultant that the patient did not have a chest infection but had a slow leaking small bowel perforation, likely to have been caused by the gynecology surgery carried out the week before. The A&E consultant had been alarmed to this by a consultant in the medical team, who flagged up the inappropriate referral.

Fortunatley the patient was well and had been operated upon.

What was done well?

I am glad that this lady was admitted into hospital and am also pleased that the patient had enough analgesia to make her comfortable. However this completely masked the symptoms and therefore made the diagnosis difficult.

What could be done differently in future?

I have learnt alot of lessons from this case,

1. From now on, I am writing everything that I do down. It is not as easy to just document now that there are computers involved. However I have learnt that this is paramount and therefore will document everything.
2. If I am having a handover from a colleague, I need to make sure that i make notes and the patient plan is clear, however equally I need to understand that if I am involved in the patient care then this brings another doctor into it with fresh ideas and therefore I should properly review the patient.

What further (personal) learning needs did you identify?

I need to make sure that I am not too quick to complete the history and examination

It is also important that I take time to complete everything on the computer.

I need to get into a habit of taking the history, examination, bloods and then ordering all of the meds and investigations so that I can then sit at the computer and document everything together so that this time is uninterrupted.

How and when will you address these?

I will make a conscious effort to complete all of these points immediately.

What was not done well?

From this case there are many learning points.

1. Firtstly the handover between colleagues should be done with time and not quickly, as in A&E there are always time pressures, but it is important that the patient comes first and so time to listen is paramount.
2. I think that unless there is a clear management plan at the handover, then the patient should probably be handed over to a registrar aswell so that they are aware of the diemma.
3. I failed to document anywhere that I had reviewed the patient again, or even that I had looked at the CXR. This therefore does not look like it happened and so it can not be relied upon.
4. As the patient had been given significant analgesia before the admission, it is extremely important to read the ambulance sheet, If I had read this, it may have changed my management plan, I would have been able get a picture for how the paitent initially presented.
5. Finally, I think it is an important lesson to not pick up a patient too close to the time of ending the shift.

Date:

Subject title: Teaching VTS Death& Bereavement

What was the subject and aims of the lecture/seminar?

Our cluster decided to teach at the VTS half day release on the topic of Death & Bereavement. We felt that this was a topic that had not previosuly been covered on our curriculum and something which we encounter on a near daily basis. It is vitally important to be able to understand the intricacies relating to death and bereavement so that we can help our patients and the relatives of the deceased. As a group we decided to teach on 5 areas including the a presentation on the stages of bereavement followed by 4 small group sessions. The small group sessions were based on paper work & the coroner; cultures & religions; bereavement CSA case; ethical discussion cases. We then completed our teaching afternoon with the chaplain as an external speaker regarding death & bereavement.

What did you learn?

I was teaching on the subject of paperwork relating to death and the role of the coroner. As part of my small group teaching session I discussed the practicalities of what happens after a patient dies (either in hospital or in the community), and then talked about some specific points relating to completing the medical certificate of cause of death. I then explained that once the registrar decides that the death does not need reporting to the coroner he/ she will issue 1.) certificate for burial/ cremation 2.) certificate of registration of death (for social security purposes) and 3.) if requested copies of the death register (for bank/ insurance companies etc). I then went on to talk through 16 different case examples and asked the group to give their comments on whether they needed referral to the coroner or not and provided feedback based on each of these examples. From teaching this session I feel that I have learnt about the practicalities of dealing with the paperwork following death and how to explain this in a clearer manner to relatives. I now feel that I would be confident in explaining the process to family/ friends whereas before this role was often taken over by the staff nurse and left me feeling out of my comfort zone relating to these questions.

Furthermore, from watching the presentations given by other members of my cluster I have learnt about formal models of bereavement. Models that we discussed included Kubler Ross (1969) and Worden (1991). These models were useful to see how grieving patients who I have encountered would fit into certain stages of these models.

A key learning point raised was the importance of the GP practices role when being notified of a death. It is vitally important that the practice can think ahead and cancel any anticipated outpatient reviews/ nurse appointments etc, to try and reduce any further distress that may be caused to the family.

Furthermore, a key learning point was avoiding certain phrases around children e.g. "long sleep" in relation to death as this can have psychological implications in children and often results in sleep avoidance due to a fear that a similar fate may occur to them.

The talk by the chaplain was very inspiring as whilst not everyone will have a religious stance towards death it is important to be aware that as clinicians we need to be aware of our own feelings towards grief and be mindfulness towards how this can impact on our patients.

What will you do differently in future?

In future when discussing grief/ bereavement I will be aware of the appropriate sources of advice to signpost patients to, for example:-
www.adviceguide.org.uk (Citizens Advice Bureau)
www.gov.uk
CRUSE Bereavement Care
Edward' Trust (supporting children and families during serious illness & bereavement)

Furthermore, when discussing grief/ loss it is important to be mindful of your own personal feelings towards your own grief. This is particularly applicable during the current post of Obstetrics & Gynaecology when there are many early pregnancy losses and intrauterine deaths, being involved in these cases is obviously upsetting for all involved and so it is important to be mindful of your own feelings towards bereavement even if these are not specifically related to the cases you are seeing.

What further learning needs did you identify?

The topic of death and bereavement is clearly something that is encountered within clinical practice very frequently. Whilst having a basic understanding of the models of bereavement and practicalities of what happens after a death, there is obviously much more scope to be able to understand how to best help patients suffering from the effects of death and bereavement. Having previously referred patients to CRUSE the important point for me is to see how effective such interventions have been, and monitor feedback from patients to see what is the best way to help people.

How and when will you address these?

Read more around the topic of understanding death, dying and bereavement. Try to spend time with palliative care team to see how they address patients spiritual needs.

Date:

Subject title: Mental Capacity Act

What happened?

A young lady attended A&E department with a friend after she had disclosed that she had inserted a foreign body into her vagina. She had expressed that she did not want intervention to remove the object but was experiencing pain. She was refusing any examination but imaging confirmed the presence of a metal object. She was referred to gynaecology as an emergency for assessment and management due to concern about serious internal damage. She was unknown to the local area and her identity was uncertain. On further questioning during history taking she began to disclose information about the rationale for her action. She had deep concerns about her fertility and expressed thoughts that a famous serial killer was planning on sexually assaulting her. She had placed this object to protect herself and was therefore unwilling to allow for removal despite the pain. This was then related to several other bizarre thoughts including fertility of African woman.

A complete mental state examination was performed. She was casually dressed, carrying excess money and had evidence of previous self harm. Her speech was normal in tone and rate, mood was labile and confirmed evidence of psychotic symptoms. The mental health team were contacted urgently for assessment of her mental health and for further guidance regarding her capacity.

What, if anything, happened subsequently?

After review from both the gynaecology consultant and psychiatrist, she was deemed to not have capacity to consent for the removal of foreign body. Therefore the mental capacity act was applied and the team acted in her best interests. Consent was taken by two consultations to perform the necessary treatment under general anaesthesia.

The procedure was uneventful and she recovered well. She required significant support throughout her admission due to fears and delusional beliefs. She was placed under Section 2 of the Mental Health Act and transferred at discharge to a psychiatric hospital for further assessment.

What did you learn?

There are several learning points from this experience. Having previously completed a psychiatry placement and a course on Mental Capacity Act 2005 as amended by the Mental Health Act 2007 including Deprivation of Liberty Safeguards on 04-09-2012, I was able to have a good understanding and input into this case.

- Mental Capacity Act: The patient did not have capacity as she was unable to make a decision for herself in relation to the matter because of an impairment in the functioning of the mind. In addition she was unable to make a decision for herself as she was unable to understand the relevant information and weigh up as part of the process of making a decision.

- Treatment without consent: There are four broad areas where treatment may take place despite lack of consent: treatment undertaken under common law, treatment under the provisions of an incapacity act, treatment under the provisions of a mental health act and treatment authorized by a court. This case involved three of these areas.

- Ethical considerations: The decision to remove the foreign body was made in the best interests of the patient and the least restrictive intervention was chosen. It was a very difficult case and therefore required support from many healthcare professionals. Together the outcome was that she recieved input for her physical symptoms but was also directed to the appropriate services, however it is never an easy decision to treat without patient consent.

What will you do differently in future?

This case highlighted the importance of a multidisciplinary approach to patient care. From this experience I will take this important aspect to help me with such cases in the future. Support from colleagues and team work are essential to allow for a structured, legal and ethical approach to care. It is important to be aware that patient safety is the key factor and working together will ensure this is not compromised.

Date:

Subject title: Breaking Bad News

What happened?

Son of a lady with Dementia attended the ward asking for an explanation as to what was happening with his mother as he had been out of the country for the previous two weeks. The patient was an 87 year old lady who had presented with heavy 1L PV blood loss with a large palpable mass in the abdomen. She had been on Rivaroxiban for AF pre admission. This lady was under investigation relating to the abdominal mass.

What, if anything, happened subsequently?

Further investigation of this case included a CT Abdo Pelvis which showed a large mass but unable to comment on the origin. The Consultant therefore arranged for a biopsy which she had done that afternoon.

I therefore discussed with the son the above management so far, firstly trying to illicit how much he was aware of and what he thought could be going on. I tried to use the SPIKES six step protocol for breaking bad news as this is a tool that I have found beneficial in improving consultation skills.

What did you learn?

I explained to the son the events so far and that given the PV bleed and large mass, though not confirmed from imaging, the working diagnosis was that of endometrial cancer. This was a difficult consultation as the son was in the belief that the PV bleed had been caused by the Rivaroxiban and had not been informed about the mass. This therefore followed the discussion of explaining that the Rivaroxiban will have induced bleeding, but ultimately there was a large abdominal mass up to the level of the umbillicus, likely to be malignant.

This consultation was difficult in that there was no concrete information that I could give the patient from the investigations, other than the clinical suspicion and explaining the abnormal anatomy. However I felt that the consultation went well and by the end of the discussion he was fully informed and aware of the intended plan. The relative thanked me for taking the time to explain what was happening and whilst obviously being upset seemed less anxious. Whilst obviously being a naturally upsetting discussion to have with the patients relative, I felt happy that I had broke the bad news effectively and in a way that I would like bad news broken to me if I was a relative. Ultimately I feel that breaking bad news and palliative care is something that all GP's should be confident in managing as it is this perspective of the GP that the remaining family members will have and so if done correctly will give the bereaved family trust in their family doctor.

What will you do differently in future?

I will continue to break bad news using the SPIKES six step protocol as through experience I have found this to be a useful tool on previous consultations. I feel that my experience in elderly care has vastly improved my breaking bad news consultation skills, but overall in GP I didn't seem to come across as many cases where these skills were implemented.

What further learning needs did you identify?

I therefore need further exposure and experience to breaking bad news in a primary care setting as this is something which I have had limited exposure to.

Overall I would like to continue to develop my consultation style with breaking bad news and also develop my skills relating to palliative care.

How and when will you address these?

Look at improving palliative care knowledge and see if there are any palliative care courses that I can attend.

Date:

Subject title: Title

What happened?

Premature baby admitted to the neonatal ward requiring initial respiratory support. Baby was on intravenous antibiotics (Benzylpenicillin and Cefotaxime) and TPN. This baby subsequently developed an Extravasation injury resulting in a necrotic left thumb. This babies respiratory system deteriorated and so baby had to be transferred to a tertirary unit, with the ongoing issue of a newly noticed necrotic thumb.

This clinical incident prompted a review of the issues surrounding extravasation injuries. The management of extravasation injuries was rasied by junior doctors at the West Midlands Paediatric Deanery meeting.

What issues were raised by this significant event?

This incident raised concerns regarding the appropriate management of extravasation injuries. It prompted much discussion between what is distinguished as a "cannula tissuing" and an extravasation injury.

Further concerns were raised by registrars as they had worked at differing neonatal units where their policy was to promptly requestr plastics review following extravasation injuries.

Furthermore as this child was transferred soon after the extravasation injury had occurred this meant that there was a lack of communication to the receiving hospital and so they were required to arrange for plastics review

What was done well?

Once the extravasation injury was noted this was quickly communicated to the family. However, it is likely there was subsequent delay in the nursing staff noticing that the extravasation injury had occurred, it was not until there was evidence skin changed that concern was raised.

In terms of addressing this as a significant event the concerns were discussed at the junior doctors meeting and at the West Midlands deanery meeting. This then highlighted this issue as a cause for concern with the paediatric consultants and so prompted a review of the process of managing extravasation injuries. A new policy was updated which specifically related to extravasation injuries. Furthermore specific charts have been created on the neonatal ward including a wound assessment chart and extravasation management chart.

Following on from this there was a presentation at the weekly educational meeting by a Consultant regarding the updated guidelines for management of extravasation injuries. This presentation focussed on the definitions of extravasation injury, prevention, management of extravasation injuries and the protocol for which all doctors and nurses are to follow.

Learning points from this presentation included
-Definition of Infiltration ("Tissueing") - Leakage of a non vesicant (non-irritant) fluid from a vein into the surrounding tissues.
-Definition of Extravasation injury - Inadvertent administration of a vesicant fluid or solution into the surrounding tissue.
-Vesicant fluids etc include Penicillin, Cefotaxime, Gentamicin, Dobutamine, TPN and many more.

We also covered factors to prevent/ minimise extravasation injuries e.g. avoiding scalp veins, avoiding mobile sites such as ankle, importance of securing well with tranparent dressings.

The management of extravasation injuries was explained in detail. It is important that doctors describe the injury anatomically, recording each cannula insertion into the medical notes. When injuries occur the wound is to be described using available charts and medical photography arranged. An incident form is to be completed detailing all persons involved in the injury.

What could be done differently in future?

Implemented changes include
-New guideline regarding management of extravasation injuries on neonatal unit and on the Russells Hall Hospital Hub.
-New Wound assessment and Extravasation management charts (aimed to improve documentation and communication between nurses and doctors).
-Presentation at educational meeting specifically relating to extravasation injuries.

Furthermore whilst there has been recent discussion and presentation relating to the management of extravasation injuries, this is something which will need to be regularly covered when new junior doctors are entering the neonatal ward.

Additionally, it would be useful for nursing staff to be updated on the new changes relating to extravasation injuries. Furthermore in future these injuries should be reported via Datix Incident form reporting sytstem.

What further (personal) learning needs did you identify?

From this case I learnt about how to go about instigating change alongside colleagues once a failure in the current systems had been identified.

Whilst I was not involved in the initial management of this child, I was involved in the ongoing care upon transfer back from the tertiary centre. In this case parents were understandably unhappy and so to help alleviate their concerns I tried to update them with how we were changing our practice as a result of the clinical incident.

I need to continue to be involved in the management of, and reporting of clinical incidents that occur both in secondary and primary care. I need to be proactive in identifying causes for concern via the datix reporting system where clinically necessary and raising these concerns with seniors if a significant even has occurred in order to help implement change.

How and when will you address these?

During ongoing clinical practice in hospital over the next 7 months.

What was not done well?

Prior to this case of an extravasation injury junior doctors had not been informed how to appropriately manage such cases. There is no training specifically relating to neonatal or paediatric cannula insertion, it is presumed that juniors will acquire these skills upon entering their paediatric rotation.

In this case there was no documentation by nursing or medical staff relating to the fact that the extravasation injury had occurred. It was only upon the thumb appearing necrotic that this was retrospectively reported. No incident report was completed at the time of the injury, this occurred only 4 weeks later.

Additionally, as this neonate required tertiary specialist input for the respiratory deterioration there was minimal communication to the receiving hospital which needs to be improved, this has been highlighted as an area of concern in both meetings.

Subject title:
Epilepsy

What happened?
An 87 year old gentleman presented from sheltered accommodation with increased falls and seizures. He was treated for a urinary tract infection and seemed to be improving both clinically and biochemically. Then when I reviewed him one morning he stated he did not feel too well, he felt dizzy. On clinical examination there was little to find apart from intermittent very mild twitching but I was unconvinced at that time that it was significant.
He was known to have quite generalised seizures. He was already on lamotrigine three times a day.
Later on the day he was aided to the bathroom where the emergency buzzer was called as he had a vacant episode. His observations remained stable and the nursing staff did not seem concerned. However, prior to leaving I reviewed the patient and noticed he was vacant and his upper limbs were shaking more frequently which the nursing staff later mentioned they too noticed. The was no obvious focal neurology but I felt he was likely having another seizure and wondered if in fact they had been going on for much longer and possibly intermittently through the day.

What, if anything, happened subsequently?
I immediately called my registrar as it was the end of the day and I knew I needed some senior input as something was not right with this patient.
We both reviewed the patient and he agreed that he seemed to be having a prolonged seizure. We performed a full septic screen, ABG (normal lactate) started IV phenytoin and intravenous fluids and after looking through the medical notes/letters found that he had recently been seen by a neurology consultant and a management regime had been advised. Therefore we also started levetericitam twice a day.
I asked the on call team to review the patient in the evening.
The following morning he had made some clinical improvement and had normal electrolytes and ECG. However, his chest x-ray showed basal consolidation and so was started on IV antibiotics. We arranged for an EEG to exclude non-convulsive status and weaned down his amitriptyline.

What did you learn?
As a GP if one suspects a seizure there are particular questions that can help to clarify this and types which can be very useful especially with the timing constraints of a consultation.
Was any warning noted before the spell? If so, what kind of warning occurred?
What did the patient do during the spell?
Was the patient able to relate to the environment during the spell and/or does the patient have recollection of the spell?
How did the patient feel after the spell? How long did it take for the patient to get back to baseline condition?
How long did the spell last?
How frequent do the spells occur?
Are any precipitants associated with the spells?
Has the patient shown any response to therapy for the spells?
The main imaging studies are MRI and EEG (NB. negative findings do not exclude seizures).

History is very important because not all episodes are seizures. Differentials include syncope, electrolyte disturbance, migraine, TIA, movement disorders, febrile seizures. There are various causes including alcohol, drugs and genetic syndromes. But in many cases no cause is found. There is a classification system 1. focal-onset seizures (simple or complex-conciousness impaired) and generalized-onset seizures. Focal-onset seizures begin in a focal area of the cerebral cortex, whereas generalized-onset seizures have an onset recorded simultaneously in both cerebral hemispheres.
In elderly people presenting with seizures for the first time it is important to exclude a space occupying lesion.

Management is mainly pharmacological. For a single unprovoked seizure, no treatment is required. There are various anti-convulsants targeted at the type of seizure but it is important to note that the threshold for seizure activity may be lowered due to drug interactions with ciprofloxacin, anti-psychotics, electrolyte disturbance, infection.
The FDA has recently approved another oral once-daily extended-release formulation of topiramate (Qudexy XR) for initial monotherapy in patients aged 10 years and older with focal-onset or primary generalized tonic-clonic seizures,

What will you do differently in future?
I feel that I should have assessed the patient earlier and investigated the patient's symptoms sooner or at least gained a senior review. I regret to think that the patient may have been feeling unwell all day before we managed him.
It is important to listen to patients. Most of the assessment was by observing the patient as he revealed clear abnormal findings.
I had not previously read through the patients letters until that point, with any new patient it should be made a habit to read through their background and understand their medical history and the reasons for any current management.

What further learning needs did you identify?
Become confident in diagnosing and assessing patients with 'episodes'. I have already seen a few patients in TIA clinic who have been referred by GPs but on further questioning have been sent for EEGs and suubsequent neurology assessment due to abnormal features in their history making a vascular cause unlikely.
On-going out-patient clinic patient reviews.

Date:
20/02/2014

Subject title:
Ambiguous documentation

What happened?
An elderly gentleman was being treated for a lower respiratory tract infection. He had multiple co-morbidities and his condition deteriorated. During this particular week I had to cover the whole ward and was unfamiliar with the patient. I was called to assess him due to low oxygen saturations and blood pressure. When I assessed him he was very hypotensive, tachypnoeic with no verbal response but eyes open. I was unsure if he was cheyne stoke breathing.
When I consulted the notes it stated he was medically fit for discharge, awaiting 24 hour care and not for escalation of care (NB. this does not exclude ward based care). He had actually been seen overnight and was started on antibiotics for possible aspiration pneumonia due to his worsening condition. I felt that the ceiling of care was not clear at all and no anticipatory medication or palliative care input was evident. Hence I contacted my registrar, who also did not know the patient. He advised following assessment of the patient to give bolus fluids and change of antibiotics until the afternoon. If there was no improvement in a few hours time for treatment to be stopped.

What, if anything, happened subsequently?
Thereafter the consultant and registrar for the patient came to the ward and made it quite clear that they were not happy with the management. The patient had a DNAR in place and they did not want further treatment if he deteriorated. However, I informed them that I acted as there was no clear plan for the limit of treatment and therefore I had contacted the registrar. I did not feel I had done anything extreme and felt that if the patient was not for further treatment anticipatory medication and palliative care should have been initiated and clear documentation of the management of the patient should have taken place.
I was quite upset by the whole situation as I acted based on the information I had and I did seek senior help early on. In some respects I felt I had done a disservice to the patient, his family and my team due to poor management.
The patient actually started to have seizures the next day and passed away. The family approached me thereafter and thanked me stating I kept them informed and put them at ease and they were very happy with his care. After feeling so despondent this made me feel like there was a positive outcome from this case i.e. patient/family satisfaction.

What did you learn?
Clear documentation is vital in all aspects of medicine. This helps to ensure the correct management of patients and also covers doctors from a legal perspective. There is great difficulty in trying to manage unfamiliar patients and lack of direction from the regular team/GP makes it al the more difficult. When on-call or working out of hours as a GP this is obviously unavoidable to an extent.
There is a lot of literature and debate surrounding DNAR's and end of life care and sometimes recognising exactly what this means creates confusion. Just because a DNAR is in place does not mean one should not treat a patient which is why there is need of clarity.

I think it is always important for a more senior doctor to support juniors. We all make mistakes but learning from them is so important and helps to shape future actions.

What will you do differently in future?
If I am covering any unwell patients I will be sure to inform other healthcare professionals of the management plan (both verbally and in documentation) and I would expect the same in return. I now generally ask consultants if the patient is to deteriorate at what level should treatment stop. Clearly it is not so black and white, patients fluctuate and often medical advise may contradict what the family or patient want, hence it is vital to come to an agreement/understanding.

What further learning needs did you identify?
Be able to recognise and manage palliative patients in regards to the psycho-social aspects as well as the medical side (anticipatory medication, symptom control) in a timely manner. Liaise with palliative care teams and learn how to manage them in the community and how to arrange such care.
Become confident in recognising when DNAR's are appropriate, the family based discussions and the ethical/legal aspects involved.
Be able to sensitively break bad news (different methods) and also manage difficult subsequent situations e.g. anger and my own coping methods in such an emotional situation.

How and when will you address these?
Mainly in my current rotation where the general cohort of patients are elderly with many co-morbidities and often deteriorate requiring end of life care.
Supervised discussions with relatives on the wards who may want updates or where DNAR discussions need to be had.
Read about the ethical/legal scenarios and cases of DNAR/capacity/futile treatment.