PORTFOLIO EXPORT

# 3 Feb 2026 - 3 May 2026

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**12 entries in period**

## Formative Rotation Appraisal

APPRAISAL

Period: 26 Apr 2026 - 2 May 2026

### Self appraisal

Mixed week - MAU nights plus some surgical days stuck together by rota rather than design.

What went ok: escalated the post-op wound same day rather than sitting on it; clerking for ACS felt structured; consent clinic went better when I slowed down and drew a picture; tap went smoothly with senior nearby.

What still needs work: small-closure knots under fatigue, ringing radiology with a cleaner one-line indication overnight, and not arriving at clinic still mentally on ward adrenaline.

Spoke up once about missing antibiotic allergy on pre-op checklist - anaesthetist fixed before patient slept.

Attached narratives cover medicine + surgery + acute bits - matches how the week actually felt rather than neat specialties.

### Development plan

Next few months:
* USS access / drainage workshop then aim for a couple more supervised taps - log them properly after each.
* Two more minor-ops lists bias toward closing - practice ties outside theatre once a week like actually doing it not intending to.
* Short teaching (~10min) for juniors on AKI causes incl drugs/obstruction - use anonymised MAU case.
* Mini-CEX-style observed consent with ES - focus on pacing + teach-back.
* Ask supervisor if daft to run tiny audit on frailty documented in pre-assessment notes - bail if pointless admin.

Catch up in ~12 weeks; ping clinical fellow mid-way if drowning.

### Supervisor review (countersigned)

| | |
|---|---|
| Reviewer: | Dr Morgan Reilly (Educational Supervisor) |
| Email: | m.reilly@deanery.example |
| Rating: | Great |
| Request sent: | 2 May 2026 |
| Countersigned: | 2 May 2026 |

#### Comments

Readable bundle - acute + surgical + teaching hooks isn't forced. Reflections sound like you rather than boilerplate.

Self-review names actual behaviours not buzzwords. PDP is doable without sounding like a LinkedIn post.

Optional nice-to-have later: one-line outcomes ("HbA1c down at follow-up") when you've got them - not critical now.

Happy to countersign - keep doing short reflections when tired rather than saving six months of waffle for ARCP.

## Inguinal hernia - consent clinic

ENCOUNTER

Date: 2 May 2026

Pre-assessment for open inguinal hernia + mesh. Fit-ish aside from BP on meds.

Talked through what op involves, GA vs alternatives mentioned briefly (anaesthetist note on file). Risks: bleeding, infection, chronic/groin pain, recurrence, seroma, DVT prophylaxis, mesh-specific chronic pain stuff - tried not to sound like reading a textbook; paused halfway when I realised I was rattling.

Drew a rough sketch + gave leaflet - patient relaxed more after that.

Driving/heavy lifting rough timelines. Mesh questions answered in general terms.

Capacity fine - quick teach-back at end. Partner sat in but patient led.

## MAU night shift

SESSION

Date: 1 May 2026

MAU nights - got busy from ~9pm. Few sick ones from ED (neutropenic sepsis pathway), fast AF with bad EF, plus usual elderly falls / ?UTI crop.

Nothing flashy - mostly investigations, sensible fluids, knowing when to wake the reg. One chest pain with ok-ish HEART - kept for tropes + repeat ECGs, wrote on notes who to call if pain came back.

USS booked morning for someone where obstruction might explain AKI - documented why we weren't CT-ing at 3am.

Shift dragged after 5am. Handover stressed who still needed scans / renal review.

Rang renal twice when K wouldn't shift - helped both times.

## AKI overnight - mixed picture

ENCOUNTER

Date: 30 Apr 2026

Elderly patient sent in by GP - knackered, not eating much, creatinine jumped (was ~85, now 210 - timing fuzzy, notes messy after transfer).

Story fits dehydration after a cold week + loose stools stopped a couple of days ago. History bit muddy - mild baseline cognitive stuff.

Exam: hard to say wet vs dry - mouth dry, JVP not gross. Abdomen soft. Bladder unclear - agreed small catheter trial to rule out retention (had a reason, wasn't routine).

Urines bland-ish initially. Bloods repeated, VBG, renal tract USS booked AM - flagged because relatives mentioned single kidney halfway through clerking.

Thinking was dehydration vs obstruction vs drugs - stopped NSAIDs, reviewed ACE hold with seniors. Fluid cautiously - rubbish EF on old echo so didn't free-fluid them blindly.

OT referral - lives alone, will need discharge thinking.

Missed trimethoprim on first drug pass - relative had actual list. Annoying but useful reminder to grab pharmacy rec when numbers don't fit.

## Grand round - peri-op medicine / frailty

EVENT

Date: 30 Apr 2026

Grand round ~2h - peri-op medicine in frail older adults having 'medium-sized' GA surgery. Actually useful rather than abstract stats.

Bits I wrote down: practical frailty screening pre-op, when people fuss about holding ACE/ARB vs beta-blocker, don't bridge anticoag unless someone convinces you you need to, anaemia isn't an automatic transfuse, simple delirium prevention stuff (glasses/hearing aids, mobilise, sleep).

Small group discussed a hypothetical similar to an AKI patient I'd seen - helped join dots on fluids before elective stuff.

Personal to-do: add a frailty prompt to my clerking stub; maybe suggest a tiny audit on pre-assessment docs mentioning frailty - need to ask supervisor if worth bothering.

Slides OK - will nick the references list if they email them.

## Skin lesion excision (assisted closure)

PROCEDURE

Date: 29 Apr 2026

Minor ops - ellipse excision pigmented lesion upper arm. Consultant marked along RSTL lines.

LA went in ok - patient jumped once then settled.

I helped with retractors/suction. Closed partly myself - absorbable deep, nylon skin. Kept rotating needle awkwardly until Miss Shah corrected grip again - same issue as last list.

Specimen to histology with stitch marking orientation however they like it here.

Pressure dressing + nurse clinic follow-up.

Should practise ties at home - I rush when the list runs long.

### Supervisor review (countersigned)

| | |
|---|---|
| Reviewer: | Miss Priya Shah |
| Email: | p.shah@hospital.example |
| Rating: | Satisfactory |
| Request sent: | 29 Apr 2026 |
| Countersigned: | 28 Apr 2026 |

#### Comments

Closing improving - you took grip feedback mid-case which matters.

Still tightening knots faster than needed toward list-end fatigue - watch it.

Specimen orientation convention varies by consultant - double-check until boring.

More reps before claiming independence - depth judgement still ours not yours yet.

Satisfactory with momentum.

## Orthopaedic trauma list

SESSION

Date: 28 Apr 2026

Trauma ortho list. First case NOF for DHS - anaemia sorted pre-op with anaesthetics/physio. Actually did the checklist properly this time (said it out loud).

Scrubbed - suction and retraction mainly. Reg talked through Carm and screw position between shots.

Second case ankle ORIF - more exposure than I'm used to; useful to hear how fussy they are about reduction on X-ray.

Third case dropped - sugars chaotic, anaesthetist wanted ward sliding scale first. Quick chat with pharmacist.

Wrote op notes before leaving; told recovery to watch foot pulses on ankle patient.

## Post-op laparotomy wound review

ENCOUNTER

Date: 28 Apr 2026

Ward nurse asked me to see POD2 laparotomy - patient says wound more sore, redness creeping under dressing.

Dressing off carefully - erythema ~4cm around wound, warm, no obvious pus yet. Photo taken (consent + sticker). Bloods for WCC/CRP/U&E.

Bleeped reg - upgraded antibiotics per surgical bundle rather than "wait for ward round tomorrow". Senior reviewed later and tweaked ABx after speaking to micro - USS backup if worse in a day or two.

Relative was anxious - they'd had a wound infection years ago on a different op. Tried not to hand-wave it; explained what we're watching for (spreading redness, fever, smell, worse pain).

Takeaway for me: if it looks dodgy post-lap, escalate early even if they're "fine" on obs.

### Supervisor review (countersigned)

| | |
|---|---|
| Reviewer: | Miss Priya Shah |
| Email: | p.shah@hospital.example |
| Rating: | Great |
| Request sent: | 28 Apr 2026 |
| Countersigned: | 27 Apr 2026 |

#### Comments

Good instinct on the wound - photo + bloods + senior loop closed properly. Relative handled honestly without drama.

When you describe redness put a rough cm from wound edge - photos help but numbers help remotely overnight.

Otherwise exactly what you want from an SHO review - not dismissed, not catastrophised.

## Diabetes clinic - starting basal insulin

ENCOUNTER

Date: 27 Apr 2026

Diabetes clinic - 50s, shift worker, overweight, BP from GP. HbA1c still above target on metformin + SGLT2 despite trying with diet.

BM diary: fasting highs overnight, post-meals less awful - talked about basal insulin being the next step rather than stacking more orals.

Needle worry - showed pen with practice dummy dose, booked nurse educator.

Safety stuff: hypos (including overnight), sick-day rules for SGLT2 if vomiting, feet hadn't been checked in ages - chiropody booked after nurse looked.

DVLA: drives for work - charted we discussed notifying them after insulin starts.

Plan: low-dose basal + phone titration review in a week, carry metformin for now. Patient wanted insulin now after bad nausea on GLP-1 before - documented that choice.

Quick teach-back at end - they could repeat what to do if sweaty/shaky at 3am.

## Diagnostic ascitic tap

PROCEDURE

Date: 27 Apr 2026

Diagnostic ascitic tap overnight - reg supervising, radiology SHO marked with handheld USS.

Known cirrhosis, tense ascites, LFTs creeping - tap mainly for SBP screen + SAAG.

Bloods/clotting checked - consultant ok'd despite not-perfect numbers. Consent again on ward - bleeding, hypotension, perforation mentioned briefly but honestly.

Sterile prep, lateral pocket away from midline vessels. Z-track - got straw fluid ~40ml without drama.

Bottles to lab properly (culture bottles at bedside like we're supposed to). Serum albumin paired.

Obs for an hour - BP fine. Patient wanted to shuffle to toilet - nurse walked with them.

Still feels awkward narrating steps out loud but reg says it stops silly skips - fair enough.

### Supervisor review (countersigned)

| | |
|---|---|
| Reviewer: | Dr Sam Okonkwo |
| Email: | s.okonkwo@hospital.example |
| Rating: | Satisfactory |
| Request sent: | 27 Apr 2026 |
| Countersigned: | 26 Apr 2026 |

#### Comments

Tap done safely - marking, sterile technique, samples including bottles, obs afterward - all there.

Satisfactory rather than glowing because I still want you rattling contraindications cold before needle without prompting, and explaining roughly what lab'll show before results ping - patients worry less.

Sharps discipline fine - don't get sloppy swapping syringes when knackered.

Keep writing these up same night memory fresh.

## Medical on-call (cardiology outreach)

SESSION

Date: 26 Apr 2026

Medical on-call with cardiology outreach - bouncing between wards and CCU queries.

Night handover left two jobs: hypoxic patient on ward 7 (CXR, reviewed diuretics with nurse), and an elderly patient on ward 3 with confusion + climbing NEWS where sepsis six wasn't finished. Did NEWS patient first - assessment in bay, cultures before antibiotics after speaking to reg.

Later helped FY1 clerk suspected ACS - hx together, ECG looked like anterolateral depression without STEMI. Troponins timed, cardiology aware. Afternoon was chasing echo, couple of discharges, fluid review on someone whose creatinine bumped after diuretics.

Post-take board then nights handover - flagged two who might go off (new oxygen need + tachycardia we hadn't sorted).

Note to self: should have photographed the nasty-looking wound on ward 9 earlier - would have saved a phone call to surgical SHO.

## NSTEMI - clerking & secondary prevention

ENCOUNTER

Date: 26 Apr 2026

68yo, independent at home. HTN, lipids, ex-smoker. Came in with ~90min exertional tight chest - radiates to jaw, nauseated, not pleuritic.

On CCU bay obs: OK in themself, BP 148/86, SR ~78, sats fine on air. Chest clear. ECG: ST dep V2-V5 + TW inv - repeat showed similar dynamic stuff, no STEMI pathway here.

Trops positive with rise/fall - ACS pathway: DAPT after bleed check, high-intensity statin, beta-blocker started gently (HR borderline), plan ACE once renal stable. Cardiology happy to angio inpatient.

Spent time on secondary prevention - statins (worried about muscle ache - talked through usual vs red flags), still off cigarettes, sensible return to activity. Rehab referral + DVLA/private driving advice documented.

They asked sensible "when do I panic" stuff - gave printed chest pain advice.

### Supervisor review (countersigned)

| | |
|---|---|
| Reviewer: | Dr Chris Cardwell |
| Email: | c.cardwell@hospital.example |
| Rating: | Great |
| Request sent: | 26 Apr 2026 |
| Countersigned: | 26 Apr 2026 |

#### Comments

Solid ACS clerking - reads clearly for whoever inherits the patient. Prevention bits actually documented (rehab, driving, what to do if pain returns) which plenty of people skip when busy.

Tiny tweak: first line after ECG paragraph could state trop trend/timepoints even quicker - busy readers skim for it.

Good job overall - keep that habit on every ACS not just this one.