ISC Comments
[redacted] I was the only [redacted]r in the department. There was no SHO on call, and no other F1/equivalent on call in the department. This is below Christmas day (minimum) staffing and is an immediate safety concern.
I didn't have access to Allocate so submitting late.
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I had a shift in [redacted]. [redacted] has 4 bays (5 patients each bay) with 4 cubicles, making it a total of 24 patients. In these are new patients needing to be post taken, and old patients which needs reviewing and following the different management plans. I was all alone, having no senior supervision, besides, too many patients makes it very challenging and difficult to manage patients and give them the time and attention that they deserve. I barely had a break of 10 minutes, as it was really difficult to manage. seeing so many patients, and being expected to follow all jobs of those patients is extremely overwhelming, which leads to us making errors hence making it unsafe for the patients.
I have raised a similar concern recently while on weekend shifts, and experienced something similar today. [redacted] has a total of 40+ patients at any given time, on weekends there are 2 junior doctors and one registrar. All patients are divided between the junior doctors and the registrar reviews sick patients, who has high news score. While reviewing so many post take patients and old patients, I had 2 acutely sick patients, who were NEWS'ing above 10. The registrar came to help with both the patients, but almost 3 - 4 hours were spent on managing these 2 patients who eventually improved clinically. I had to leave all my post take jobs and reviews of old patients as I had to tend to the sick patients. By the time I got free many of my patients were shifted to other wards, and I had done none of their post take jobs and discharges as I was occupied at that time with the sick patients. there is no option on OOH that I can ask someone to follow post take jobs so I had to trace those patients to their wards, and do their jobs. many of which needed urgent scans and investigations etc. I am therefore raising the same concern that i raised previously, too many patients makes it very challenging and difficult to manage patients and give them the time and attention that they deserve, and is extremely overwhelming, tiring and mainly unsafe. not to mention that I didn't even get 2 mins to get a break, neither did my registrar.
It was very unsafe during my [redacted] as i had to see over 26 patients. Most of the patients were requiring alot of time as they had to be thoroughly assessed and managed. I had the bare minimum help available, On top of the 22 patients already present on [redacted], many new patients were shifted mid day, which i had to manage as well. As i have mentioned each time, i request again to please take notice regarding staffing levels on weekends.

Less than minimal staffing for wards (2 juniors instead of three). The immediate safety concerns comprise of two different things, 1) Firstly, patient safety issues due to lack of staff. e.g., I was informed that by midnight there were still 30 or so jobs on the system still pending reviews, for each doctor. This is not entirely safe. We prioritized the ones which needed immediate patient reviews and dealt with the others later. 2) More importantly, lack of communication has led to inability to plan the workload effectively. Yesterday when we were told that we were one doctor short, we had assumed that this was a single isolated event. However, when we were informed that this was again the case tonight, we were frustrated about the lack of prior information and plan. Please could we establish a standard of practice on how this information is communicated to the doctors working the shifts. Beginning a shift by trying to work out how many doctors we have, and if anyone is aware of this gap, trying to see if they have gone to [redacted] by mistake etc., is difficult when you are also having to review deteriorating patients. It would be much better to have a clear plan at the outset. I completely understand that lack of adequate staffing is entrenched in the NHS, however, the way these rota gaps are managed need to be looked at to establish a standard of practice. I suggest as a simple first step, to ensure that if a shift is understaffed, all the doctors and the HOOH coordinators working the shift get an email informing them of the situation. [redacted] I felt this might help the next set of doctors.
No registrar for [redacted] from 3pm-5pm and on leaving at 6pm no [redacted] registrar available so had case had to be discussed with Resus registrar meaning minimal staffing. From 4pm-5pm no other junior doctors for [redacted] only clerking doctors.
Not enough stuffing, patient safety at risk
On call F1 left at 5pm, no on-call F1's present in the hospital from 5pm-8pm. I was the only [redacted] in the hospital from 5pm on my twilight shift doing the work of the on-call F1 alongside. The agreed Christmas day cover was not correctly arranged this is a patient safety risk.
Only one registrar on a night shift led to a heavy and unsafe burden if work causing delays in reviews.
Patient safety as without a break, I am not in best of my ability
Second night in a row that we are a doctor down for sickness. Currently there is an F1, myself and the reg covering the HOOH hospital. Inadequate members of staff to safely cover the wards. Patient safety at risk.
Too many patients to see, Minimum senior support available during weekends, making it very unsafe for the patients.
Working extra hours