T&O QMC Junior Doctor Guide March 2022

Context

Welcome to Trauma & Orthopaedics at QMC – our major trauma centre opened in April 2012 and is the busiest and one of the best major trauma units in the country, with 4 million patients in the catchment area. Expertise in trauma, neurosurgery, spinal surgery, cardiothoracic surgery, intensive care and resources are concentrated in this hub, and ambulance crews are trained to bring the most seriously injured patients here rather than to their local emergency departments. We are active in clinical work, research and service development. Our consultants are trainers in trauma and orthopaedic surgery across the globe.

The team are approachable and there is an active T&O social element to the job. You will get to know your colleagues well through daily meetings.

Firm Structure

- There are ~20 consultants in T&O (12 adult, 5 Paediatric & 4 Hands).
- The 12 adult consultants are divided into 4 teams which dictate which day of the week they are on call (weekends rotate);
    - Monday – Prof OIlivere (BJO), Mr Badhe (NPB) & Mr Coughlin (TAC), Mr Hahn (DMH)
    - Tuesday – Mr Deakin (DD), Mr Geoghegan (JMG), Mr Westbrook (APW), Prof Moran
    - Wednesday – Mr Taylor (AMT), Miss Myint (YM), Mr Manning (WAM)
    - Thursday – Mr Forward (DPF), Mr Hatton (MH7) & Mr Sehat (KRS)

- The Paeds consultants are Mr Hunter (JBH), Ms Price (KP), Mr Chell (JC) & Mr Lawniczak (DL), Mr Bryson (DJB).
- The Hands consultants are Mr Downing (NDD), Mr Oni (JAO), Prof Davies (TRCD), Ms Karantana (AK), Mr Das (AD)
- Hands on-call is split between T&O and Plastics, with T&O covering Mondays & Tuesdays and alternating weekends. Plastic always cover Wed and Thurs.

- Core Surgical Trainees (along with the junior & Nottingham Fellows) are allocated to either a weekday 'team' or the combined paediatric & hand team and are therefore responsible for all patients under the named consultants (i.e.- the Monday team CT will look after all patients under Messrs Ollivere, Badhe & Hahn).
- Each team will usually comprise one CT and one Fellow.
- Registrars are assigned to one or two specific consultants, which may not necessarily be within the same team (i.e.- Mr Ollivere's registrar will not be responsible for Mr Badhe or Mr Hahn patients, unless covering).
- Foundation doctors are not allocated to a specific firm, but cover the patients from all of the firms

Ward/Patient Locations

- The three main orthopaedic wards are F18 (28 beds), F19 (28 beds) & F20 (27 beds) all located on F floor in West block.
- Each ward is staffed daily by 1-2 foundation doctors and physician associates
- New hip fracture patients are seen on the ward on day of admission by the orthogeriatrics team (specialist geriatricians) to optimise patients' medical care. They are then followed up a week after admission by orthogeriatrics, and this team are available to troubleshoot problems with sick patients on the wards.
- At times the wards may be short-staffed, owing to Annual Leave or on-calls (FY2 doctors are on the same on-call rota as CTs); when this is the case, the LD2 doctor (see below) or doctors from neighbouring F wards are expected to make up for the shortfall, but all available CTs should pitch in, see their patients and make sure patient safety is not compromised.
- Orthopaedic outliers may often be found on C30 (major trauma), D8 (spinal), C24/C25 (ENT), and other wards. It is the responsibility of the CT/TGs to ensure these outlier patients are seen daily.

Normal Working Day

Trauma meeting and post-take ward round

- Shift pattern: 0800 – 1700 Monday to Friday.
- Day starts with the trauma meeting at 0800 where all admissions from the past 24hrs are presented & discussed. This is currently being held in the screens room / seminar room in the academic orthopaedic department, (C floor West Block). You'll see a huge volume of complex cases and this is a great educational opportunity. It is also the business part of the day when the day's activities and problems are sorted out. Ward doctors, your patients will be discussed during this meeting and it is important you are present to action any treatment decisions made. **ATTENDANCE IS MANDATORY FOR ALL JUNIOR DOCTORS**.
- Every Wednesday morning after trauma meeting, the microbiology MDT is held in the same room; if you have any patients with on-going infections (excl. simple e.g. – UTI, HAP etc), please ensure you know all the relevant details and be prepared to discuss the patients progress / plan. A CT will be allocated to record the minutes of the meeting for each patient discussed and then make sure a copy is put in individual patient notes.
- After the meeting, all on-call team should attend PTWR with the consultant. Ward FY doctors should accompany the round when it reaches their ward so they are aware of any outstanding jobs for new patients etc.
  - CTs & Fellows are expected to attend their team's PTWRs also, regardless of whether they have been on call or not.

Ward expectations

- Ward doctors are expected to see every orthopaedic patient on their ward every day, or to ensure that all have been reviewed by a more experienced member of

the orthopaedic team (i.e. CT/fellow/registrar/consultant) each day. Their ward round should follow a structured entry and thorough review of the patient daily.

- Sick patients, Day 1 postoperative patients and patients at point of discharge should be seen first so early discharges can be prioritised. These can be identified by doing a walkthrough of the ward first thing in the morning and obtaining a brief handover from the nurses. The discharge coordinator will also alert you to pending discharges in the next 1-2 days so letters can be prepared in advance.
- To avoid duplication of effort, it is advisable to track who the CT doctors and fellows have seen as they come around the wards so you can first see patients which they have not seen
- Ward doctors can scribe for CT/ fellows/ registrars/ consultants when they perform ward rounds.
- If there are any problems that are beyond the scope of the ward doctors or if there is an acutely unwell patient, the ward doctor should perform initial management and then escalate this to the appropriate team CT/Fellow e.g. acutely unwell patient under the care of Mr. Ollivere -> escalate to Monday team CT/Fellow.
- CTs & Fellows are expected to see their team's patients daily and to troubleshoot any problems the ward doctors may have.

Detailed tasks on ward

- If a patient is booked to go to theatre, request postoperative bloods for the following day in advance (FBC, U&E) and ensure patients have IVI if nil by mouth.
- On postoperative day 1 a thorough medical assessment of the patient in addition to a focused wound assessment (discharge/erythema/crepitus)
- Check X-rays should be promptly organised postoperatively for patients who have had THR, hemiarthroplasty, and for all patients whose postop notes indicate a check X-ray is required.
- Jobs may be recorded in the blue A4 diaries which are available at the doctor's station on each ward. Nurses/discharge coordinators will write TTO/eDischarge letter requests, and tasks relating to patients in these books – ensure these have been completed before leaving or hand these over to the evening on-call team.
- Nurses and pharmacists will leave drug cards with post-it tasks on them in your doctor's tray and by the bays – query anything unclear before action
- Handover notes for each patient are maintained on NerveCentre. These are typically maintained by the firms, but foundation doctors should update these as capacity allows.
- VTE assessments need to be completed for all patients, and you will be prompted to complete these on Notis at point of discharge.
- Generate a list of jobs that is ready to hand over to the LD2 doctor at 1600-1630 so you can ensure jobs do not get forgotten.

Common presentations that need management on ward

- Pain: paracetamol and opiate (zomorph + oramorph // oxycodone MR + oxycodone IR) are the mainstay of pain management on the wards, with drug selection based on renal function, side-effects and response.
- Constipation: an escalating pathway of docusate + senna + movicol + glycerin + micralax + phosphate enema

- Wounds: Serosanguinous wound discharge and wound infections
- Identifying if patients are at point of discharge: balancing input of premorbid state, acute medical issues, physio and occupational therapy input.
- Postoperative hypotension (especially post-spinal anaesthetic)
- Postoperative AKI
- Postoperative sepsis

LD1

- 0800 – 2030
- Bleep: 284-3401
- Covers ED admissions & attends trauma calls (Amber & Red always, Green when requested for orthopaedic injuries). You are expected to participate in Trauma calls as you will be part of the trauma team, performing primary/secondary surveys and bloods as directed. Green calls with NO orthopaedic injuries are the responsibility of the Major Trauma team to enter onto the database.
- Each patient should have a green QMC trauma admission assessment form completed in full on admission, including pages 1-5, 7-8, 10 prior to admission to the ward, plus drug card and consent form. A major trauma booklet can take its place if the patient has been red/amber trauma called.
- Make sure all patients seen & admitted during your on-call are recorded on the handover list in the trauma database (see below).
- As LD1, keep a sheet of paper with you and record name/ DOB/ hospital number/ PMx/ mobility status/ mechanism of injury/ blood results/ planned procedure/ AMT/ Nottingham hip fracture score so you can add this to the database later
- You will be expected to perform wrist manipulations which are performed primarily under Biers block, or haematoma block where this is contraindicated or cannulation of the injured limb is not feasible. A laminated cheat sheet is available in the plaster room to help. Registrars will demonstrate/supervise in the plaster room during your initial on-call shifts. You will be expected to perform wrist manipulations from early in your on-calls as your registrar will be busy.
- Read and understand: "Early Management of Polytrauma and severe musculoskeletal trauma. The role of the orthopaedic team. 2017 Guidelines for NUH" (available on the intranet) and "Early management of the severely injured major trauma patient" (British Journal of Anaesthesia 113 (2): 234–41 (2014)).
- **IF YOU ADMIT PATIENTS, IT IS YOUR RESPONSIBILITY TO ENSURE THAT THESE PATIENTS ARE SEEN ON THE POST-TAKE WARD ROUND BY THE ON-CALL CONSULTANT.**

LD2

- 0800 – 2030
- Bleep 284-1769
- Covers wards, principally from 1700 – 2030, but may be expected to attend F wards for emergencies.
- You will be expected to see & clerk any patients with Neck of Femur #s who are fast-tracked to an orthopaedic ward, which you must then ensure you enter onto the trauma database. The LD2 doctor will present these cases at screens the following day.
  - Current policy allows ED to fast-track patients with Neck of Femur fractures to orthopaedic wards without being seen in the department, as long as the patient is otherwise medically well and observations have remained stable. Read the specific eligibility criteria for fast tracking hip fractures. This does not apply to any other type of fracture.
- As a CT on LD2 you may still be able to get to theatre, but you will be expected to attend and help out on wards if required.
- At 1600-1630 please make sure you pass through the wards to collect and jobs the ward doctors need to hand over before leaving. This is crucial to ensure things do not get missed overnight.
- Weekend handovers need to be written on the electronic weekend handover list (available in registrar's room, on or on shared drive once access has been granted)
- **IF YOU ADMIT SOMEONE, IT IS YOUR RESPONSIBILITY TO ENSURE THAT THESE PATIENTS ARE SEEN ON THE POST-TAKE WARD ROUND BY THE ON-CALL CONSULTANT.**

Nights

- 2030 – 0900 (leaving at this point is encouraged – if you wish to stay longer for completion of the round this is a voluntary learning opportunity and should not be exception reported)
- Bleep: 284-3401
- At 2030, evening handover takes place in the orthopaedic registrars' office (C floor, West Block, turn right out of the lifts, head to end of corridor, first door on the left past the corner) between day & night teams
- Covers ED admissions, attends ALL trauma calls overnight (Amber and Red overnight. No green calls) & provides ward cover as required.
- It is your responsibility to print out handover lists for everyone for the morning trauma meeting. You need to print 13 copies.
- **IF YOU ADMIT SOMEONE, IT IS YOUR RESPONSIBILITY TO ENSURE THAT THESE PATIENTS ARE SEEN ON THE POST-TAKE WARD ROUND BY THE ON-CALL CONSULTANT.**

The Trauma Database

- The handover list is stored via a Microsoft Access database known as 'Trauma DB'.
- It is located in the T&O Shared Drive and requires a password (both of which you will be given access to when you start).
- Any patient you have admitted during your on-call must be recorded here for handover; this includes ED admissions seen by LD1 /Night SHO and any fast-track NOF#s seen by LD2.
- The Night SHO will need to save a copy of the database to the relevant folder in the T&O Shared Drive around 0715-0730 and print out 13 copies for the trauma meeting.
  IT IS YOUR RESPONSIBILITY TO HAVE WORKING ACCESS TO THE DATABASE BEFORE YOU BEGIN ON-CALLS. If you don't know, ask.

Teaching/Audit/M&M

- There is weekly junior-led teaching every Thursday at 1300 in the AO room; one CT is appointed as teaching co-ordinator and responsible for producing a teaching schedule of basic Orthopaedic topics and dividing these out amongst all the juniors (FY1 – CT2 and Fellow) and encouraging SpRs to attend and act as moderators for the discussion. **ATTENDANCE IS MANDATORY FOR ALL JUNIOR DOCTORS.**
- Every Friday at 1300, Mr Hatton will provide teaching in the AO room (when he is in). Questions are aimed at the appropriate knowledge level for individual trainees F1 – senior registrar (and sometimes consultant). **ATTENDANCE IS MANDATORY FOR ALL JUNIOR DOCTORS.**
- M&M meetings occur every 2-3 months, Mr Deakin will normally assign cases to CTs/Fellows/SpRs the week preceding – please ensure you attend and present.
- Audit meetings occur every few months; if you have a relevant audit you would like to present, get in touch with Jess Nightingale (Jessica.nightingale@nuh.nhs.uk) in the research & audit office.

Microbiology-MDT Meeting

- Takes place on Wednesday mornings, immediately after trauma conference. All to attend.
- Dr Susan Snape (Consultant Infectious Diseases) chairs the meeting where we discuss every MSK inpatient infection. Reachable on susan.snape@nuh.nhs.uk
- A list of cases is circulated the day before. Ward doctors should know their patients clinical status and current antibiotics. CT's and Fellows should know their patients clinical status.

Rota and Leave

- Please provide a contact number to the Admin CT within the first week (ideally the first day). This should ideally be a hospital iPhone number as this number will be next to your name and published on the Firm rota for all ward staff to see. If you are not comfortable with your personal number getting published it is your responsibility to get a hospital iPhone. It is important that you are always contactable when on duty.

F1s/F2s/TGs/CTs arrange AL and SL through Alannah Davis (alannah.davis@nuh.nhs.uk)

- You need to request leave early. Leaving it late may result in the request being declined.
- There is an allocated admin SpR and an admin CT in T&O who allocate SpRs / CTs & Fellows to theatres and clinics – wherever possible, they will allocate you with your team's consultants, but if you have any requests, please speak with them.
- The "admin CT" will allocate CT's to lists/clinics. Sometimes you will be first assistant and prompt attendance is essential. These are known as "red sessions" as your name will be in red on the rota. It is your responsibility to be in theatre ready for the brief at 0845 and be familiar with the patients on the list. If you are unsure, ask. If you just turn up, you are likely to be spectating.
- The "Teaching CT" will prepare a Wednesday lunchtime 1pm teaching program for F1's/2's/CT's/Junior Fellows/Trust Grades. Each registrar will be asked to present one session. The admin CT role is to coordinate the program.

You will be working in one of the busiest orthopaedic departments in the country, and your contribution is essential and valued to help our team successfully management our patients. You will also get out what you put in, whether from teaching, audit, theatre skills or satisfaction from the transformational outcomes for our patients. Make the most of it.