Registrar's Information Page

Guidelines for the John Hunter Hospital Emergency Department Term

- There is always 1 general orthopaedic consultant on call
- There is always 1 hand consultant on call, and registrar
- There are 3 orthopaedic trauma trainees on site 0700-1530 Monday to Friday.
- There is 1 orthopaedic trainee rostered on site 1530-2300 Monday to Friday evenings (usually in JHH OT9)
- There is 1 weekend orthopaedic trainee rostered each day 0730-2300 (Saturday and Sunday) in JHH OT9 and an additional orthopaedic trainee rostered from 0700-1100 (they do the shift till 2300 the day prior to admit anything that came in overnight), they cover ED consults/calls in the morning while the unaccredited rounds on all the trauma inpatients.
- Day unaccredited is rostered from 0600 till 1630
    - tasked with running handover each morning with the on-call consultant at 0700 in allocated handover/meeting room
    - required to present their weeks trauma meetings (Thursday at 1700, and Monday at 0700)
- Evening unaccredited is rostered from 1530 till 0100
    - Tasked with admitting patients during evenings
    - Working with Training registrar ion evening to create an ordered OT list for theatre the next day
- During some week evening shifts (Monday, Thursday and Friday) there is an SRMO who has a 'tag along' role with you.
    - They are to be supervised during procedures and taking referrals.
    - Their role is to learn about the responsibilities of the registrar and are not expected to work independently or unsupervised.
- The General Orthopaedic consultant roster is 1800-1800 in usual hours, and 0800-0800 in the Christmas shut down period.

- The Hands consultant roster hours is 0800-0800.
- Consultants on for Friday usually do the weekend as well.

Sick Leave:

- If you are sick, you need to contact:
    - Ange Keers - 49223510
    - Senior Registrar – as per roster
- If you are unable to attend a rostered overtime shift due to sickness:
    - The default cover will be the person who is rostered two nights in advance on the oncall roster. If that person is unable to fill the shift then a general request will be made for cover.
    - When the shift is covered, the person who has been unwell will be rostered to cover the next shift of the registrar who has filled the gap in the roster

Organisation:

WHEN YOU FRIST SART WORKING WITH A CONSULTANT IT IS WISE TO ASK ABOUT THEIR PREFERED WAY OF MANAGING PATIENTS, BOOKINGS, WARD ROUNDS ETC. EVERYONE IS SLIGHTLY DIFFERENT. UNTIL YOU KNOW HOW EACH CONSULTANT LIKES TO ORGANISE THEIR ON CALL, ASKING FIRST CAN SAVE A GREAT DEAL OF HEARTACHE.

Carry a folder/organiser. It means you can do things on the run (important for rounding with consultants, where you don't want to come back to the ward twice, and where you may not have a resident).

- The folder should contain:
    - x-ray forms
    - theatre booking slips
    - consent forms (kid, adult, substitute)
    - admission booklets (RFA)
    - letter heads and envelopes, script pads, and know your provider number for referring to private rooms

Use a proforma sheet to document important details on with a box large enough to put a sticker on the sheet which can be used to create a handover document.
Keep all consults, every patient you make clinical decisions, and of course admit, notated. If you are junior, run it all by the orthopaedic trainee (always one around) or the boss at some time (the sooner the better) before making clinical decisions.

Handover:

Due to the shift-work nature of the job, this is one of the most crucial components.

Write down all the relevant details AT THE TIME the referral is first made. This will not only ensure the patient is not missed in ED/ward rounds, but also means the important information is already there when it comes to doing the handover sheet.

Every handover MUST contain details of all referrals and include:

- Patient details including name, age, MRN (patient sticker preferable)
- A brief history of injury, mechanism etc.
- Relevant co-morbidities (including anticoagulants)
- Location of peripheral centre traveling from if being transferred
- Outcome e.g. admitted, discharged, fracture clinic, GP etc
- If the patient is admitted, then:
    - Under which consultant?
    - Is the consultant aware?
- If the patient is for theatre, then:
    - Is the case booked?
    - Has the patient been consented?
- Also include any info relevant to the case e.g. blood/aspirate results, other specialty reviews etc

Any outstanding jobs – highlight them so that it's obvious to the next person (This is particularly helpful for the morning team. A courtesy phone call between 7-7:30am will also be greatly appreciated by them for the more complex cases)

Tick off the completed jobs – that way things will not be forgotten

Make time for a handover at 3pm when the evening person starts their shift and give them a handover sheet of the admissions from that day. This is handy when the consultant wants to do a late afternoon round. It is also crucial for the day unaccredited runner to update the training registrar in Theatre 9 about the patients admitted during the day before going home. Giving them a photocopy of the handover sheet is helpful. It is also equally important to leave a copy of the handover sheet in "The Cave" on F1, or in the office prior to morning formal handover meeting.

KEEPING THE CURRENT CONSULTANT'S INPATIENT LIST UP TO DATE IS ESSENTIAL. YOU/TRAINING REGISTRAR SHOULD CALL ADMISSIONS DIRECTLY AFTER THE EVENING HANDOVER TO ENSURE THE LIST IS UP TO DATE.

THE LAST THING TO DO BEFORE THE EVENING REGISTRAR GOES HOME IS TO CONTACT BED ALLOCATIONS AND ENSURE THE CURRENT ON CALL CONSULTANT'S INPATIENT LIST IS UP TO DATE! THIS IS PARAMOUNT, SO THAT PATIENTS ARE NOT MISSED ON THE FOLLOWING MORNING'S WARD ROUND.

DURING DAYLIGHT HOURS – ADMISSIONS PH (49213641)

AFTER HOURS INC. WEEKENDS – BED ALLOCATIONS (EX 13045) 11:30PM-12:00AM HANDOVER – MAYBE UN-AVAILABLE BUT WILL BE DOWN NEAR TRIAGE IN ED FOR HANDOVER AT THIS TIME.

JHH Emergency Department:

Being aware of patients and the situation in JHH ED and keeping your ear to the ground is the best way of approaching the job. Knowing what is coming is the key to organising things. Also hanging out in ED will allow you to intercept trauma calls that we are not alerted about.

All referrals must be seen and documented in the paper ED notes and/or logged on the CAP correspondence file. This is vital for phone consults (from GP's or other hospitals) it gives you the opportunity to track patient care and to have all imaging reviewed by a senior registrar or consultant. Furthermore, it is often the only document available to correlate the phone advice given to off-site hospitals.

The role requires you to triage all referrals with regards to:

- Clinical urgency
- Time of referral
- Optimise flow of theatres

The most important aspect is clear verbal and written communication with staff and patients. Legible written documentation will help you out in this regard, and potentially save many more phone calls.

All notes must clearly delineate basic admission clerking, which includes:

- Date/ Time
- Name/ Team
- Presentation
- History
- Medications/ Allergies
- Examination
- Imaging and lab results
- Plan

Take clinical photos of soft tissue injuries with a patients consent. This is to share them with the registrar creating and presenting the meeting. Take a couple if you need to in order to get the wound and put it into anatomical perspective. A limb shot and a close-up is the best way.

THE TEAM PLAN needs to clearly list **ALL** steps pending:

- Admission status and under which surgeon this has been discussed, or to follow up
    - If they are returning for admission the next day, they require an RFA with completed consent section. The RFA placed in the appropriate folder in ED, and a slip into theatre, otherwise the patient is not booked.

- Further Investigations
  - Imaging/ CT or USS investigations etc.
  - Bloods/ MSU/ Micro result pending
- Fasting status and planned theatre day
- Neurovascular obs, Elevation of limb, Weight bearing status
- Medications should be charted
  - Antibiotics
  - Usual medications
  - Analgesia/ Anti-emetics/ Aperients
  - DVT prophylaxis
- Consent (If you know the patient will need OT, fill the consent form and booking slip before talking to the patient – you can always rip it up).
  - Document risks and benefits discussed with patient
  - If not consented why not and who to contact for consent
- NFR status (if appropriate)
- Consults
  - You must liaise with these other medical/surgical teams
  - Document referral made, and with what team responsible
  - This includes those with likely ASA>3, who will need anaesthetic review pre-op

When admitting a patient the people that need to be informed are:

- Admitting Consultant (contact by phone, catch them in theatre or clinic)
- Training Registrar if case is for the same day
- ED
  - Medical Officer/ ED Nurse in Charge (red shirt)
  - Nurse caring for patient
- Theatre Staff (see further detail below)
- Patient and family members

Trauma in JHH ED

- The 55944 phone is the primary point of contact and is most important in terms of how our service is judged. If you are busy and having trouble, then simply take their

number down and call them back. This phone is a contact point for those outside the service. It is therefore paramount that whoever has this phone at the time provides a service which reflects well on all who work in the department.

- Major trauma transfers are always accepted. Any patient who meets the trauma team activation criteria from the Hunter Valley and Newcastle, should be managed at JHH. Any problems with interdisciplinary logistics should be communicated to the on-call trauma surgeon, who can help.
- In major trauma resuscitations consider ownership of the patient and lead decision making where the patients have musculo-skeletal injuries regardless of how many teams are involved. AGSU is the primary admitting team for all trauma call patients at least until completion of the tertiary survey but in practical terms 80% of these patients have orthopaedic injuries and require operative management or decision making from the orthopaedic trauma service.

Getting a CT/ USS/ MRI

The CT registrar is usually in the CT reporting room, same goes for the USS Reg, and if you're lucky the MRI consultant is in hospital. Talking face to face with the imaging team is much more likely to get you the test you need when you need it.

Procedures in ED

Closed reductions, open fracture/ dislocations, plasters/slabs are for you to organise and do in the ED. You need to liaise with the in charge and ED senior for appropriate sedation and to facilitate timeliness of the reductions.

Aspirates are almost always your responsibility and you need to chase the results.

Transfers

Outside Imaging – a lot of peripheral hospitals have imaging that we cannot immediately access. Speak to the transferring team to ask their radiology department about uploading the images to PACS prior to transferring patients.

Any transfer that is from anywhere other than the Mater or Belmont should be discussed with the on-call consultant prior to accepting them.

Spine transfers – An important component for referral is the neurological examination in addition to the imaging, so it is important that the referring doctor liaise directly with Dr Kuru/Dr Abson.
The general rule is that orthopaedic registrars at other sites talk to Dr Kuru/Dr. Abson after making an assessment. If the registrar at the peripheral site is unavailable for any reason (e.g. in theatre on the weekend and carrying an on-call phone) and the problem is urgent, then you should review the imaging, get a neurological assessment over the phone and call Kuru/Abson yourself. ANY decline in neurology is a surgical emergency, as is Cauda Equina or an epidural abscess. Unstable spines can be managed in traction, flat on back. Liaise early with the orthoapedic trainee and Dr Kuru/Abson about any spinal emergencies.

Other Transfers

- Patients to be transferred in from hospitals other than BDH and the Mater should be discussed as consultant-to-consultant referrals. If you are taking calls requesting these transfers, please respectfully ask that the managing consultant call the consultant who will be accepting the patient prior to accepting a patient-flow transfer.
- This includes Lake Macquarie emergency department. The ED physician at LMP should call the on-call surgeon. Registrars should not be advising on the management of patients who are not on site and under active management in a private Emergency Department without consulting with the consultant on call first.

Theatre:

No case can be taken to theatre without the consultant being aware.

Booking patients is the only way that the theatres know how much work we have, and what resources we need.

DO NOT HORD THEATRE BOOKING SLIPS. It is also paramount that you let the trainee/s running theatre know of any emergencies as soon as possible. They are often in charge of running the list and may need to wait before calling for another patient or starting a long case, if there is an emergency downstairs. Don't wait for the case in OT 9

to finish before letting the trainee or consultant operating know what the lie of the land is, and where any patient in extremus is up to.
When discussing it with the anaesthetist always know about the patient's past GAs, and if you think they'll need a consult, fill out a consult form and suggest it to the anaesthetist and place in the anaesthetic consult folder for overnight reviews.

Always ask for what equipment is needed from the consultant when booking a patient. This saves the red hat or the orthoapedic trainee making a repeat phone call.

Booking Slips

YOU NEED TO ENSURE THAT THE BOOKING SLIP REFLECTS THE PLAN DISCUSSED WITH THE CONSULTANT, IT IS ALSO PARAMOUNT THAT THE CONSENT REFLECTS THE PLAN AS OUTLINED BY THE TREATING CONSULTANT.

All booking slips must include:

- Patient information – preferably sticker
- Planned date for operation
- Procedure planned
- Equipment –
    - Position i.e. prone?
    - Usual equipment, anything extra? Does it need ordering in?
    - II needed
- Major co-morbidities
- Fasting status/ time
- Surgeon –
    - Consultant vs Operating surgeon, and public v's private classification.
- Triage Category
- All cases discussed with Nurse in Charge (55483) and Duty Anaesthetist (55051)
    - Slips for surgery that day are left with the In-Charge nurse
    - Slips for any other day go to Jayne's desk in the office (not on weekends)

Anaesthetic Referrals

Liaise directly with theatre 9 anaesthetist for all cases for theatre that day

As Ortho often run a number of theatres, it is best to liaise directly with the anaesthetist responsible for that list i.e. Theatre 4 hands list should be told about the disarticulated hand etc.

Anaesthetic Consult Forms (55051)

Private Patients

All patients that you have given an opinion on need to be discussed with the consultant on call. Consultants will manage private patients in a variety of ways. Individual surgeons may elect to follow up private patients in private rooms and it is very important that you discuss with the on-call surgeon where they want the patients followed up.

– Please, when private patients are referred out into the private system provide a referral letter and a copy of relevant imaging.

Wards:

Attendance on the daily ward round is ideal if there are no urgent cases in the ED awaiting review, as you will often be the point of contact for JMOs and other teams.

Weekend ward rounds at the JHH including general ortho trauma, paediatric, and any orthopaedic spine trauma patients are run by the unaccredited trainee and best attended early in the morning to minimise conflicting interests during the day. The previous night's trainee is to hold the phone for 4 hours while you complete the ward round.

If part of the ward round cannot be completed it is best dealt with when the evening unaccredited trainee arrives at 2pm.

Suspected orthopaedic emergencies (most commonly "?compartment syndrome?") in the JHH wards will often be referred to you and should always be treated as an emergency until proven otherwise.

X-ray Meeting

The day unaccredited runner is responsible for the Thursday X-Ray Meeting at 5pm and for the Monday Trauma Handover Meeting at 7am.

The Monday meeting should be attended by each unaccredited registrar working in the lead-up week. Runners are now rostered Monday 7-11am to attend the meeting and handover ward round if you worked the week leading up to it. It is very important to handover and assist with ward round on patients from the weekend

- A good way of doing the meetings is updating at the end of every day.
- Get the list off CAP. Search by the day of all orthopaedic cases at the JHH and RNC (trauma patients are shifted there occasionally) in both Orthopaedics and Paediatric Orthopaedics.

X-Ray Meeting format:

- Theatre availability
  - (E.g. "OT9 all day; OT5 half day….15 cases outstanding: 10 general, 5 hands" etc. in a clear bullet point form)
- Pending cases (present before the day trainees leave the meeting for OT at 0730)
- Discussion cases / anything a consultant has asked you to present to the department for opinion or interest. This will often be led by the person who knows the patient most.
- Cases completed since last meeting (all relevant imaging, slices, clinical photos etc.)

Save meeting to the orthopaedic file share / computer. You can view previous meetings there. It is best to label them by the date. This means that the person following you can also pull the 'pending' x-rays for the next meeting to save time.

When formatting, it is best to keep the x-rays as big as possible on the screen, and show standard views in correct orientation unless they weren't taken.

It is important to know, that for both Monday and Thursday meetings, the hand team are very particular about their photos. A large quantity of their work is soft tissue only and thus they occasionally feel that their work is not being critiqued to the same level as the general orthopaedic surgeons. It is imperative that you take photos of any hand soft tissue injury that comes through. It is also worth your while to ask the trainee covering

hands for the weekend for any photos taken intra-op. The hand registrars are also useful for photos during the week. It is also important to include a picture of the X-ray with the picture of the soft tissue injury.

The Value of the John Hunter Job:

-As an unaccredited trainee, this is the one job where you encounter all of the Newcastle-based orthopaedic surgeons.

-The job is busy and involves lots of high-end trauma. The evenings, can be quite challenging.

-On the plus side, in regard to time management, there are no clinics or theatres to run simultaneously with your on-call commitments.

-It is a brilliant term to gain the trust of the bosses and earn valuable references for an accredited application, provided you are honest, hard-working, and show good time management by getting the slips in efficiently and ensuring the trauma service is run well.

Social Media:

- There are several social media platforms used in the JHH. There is one for training issues, one for registrar discussion.
- For the most part these have been used in a positive manner – jokes about consultants etc. – I'm sure!!!
    - Things to consider
        - You are bound be the HNE code of conduct when using these site
        - In particular – Discussion of work colleagues in a way that intimidates, offends, degrades or humiliates an employee, is a breach of the NSW Health Policy Directive
        - Used well these sites are additive to the registrar experience.

Other Bits and Pieces:

- If you’re not in scrubs you’re doing it wrong.
- There is nothing to eat that does not come out of vending machines after 9pm
- The coffee shop does not open until 9 on a weekend – smash the ward round and then grab a quick cup on the way to ED
- You catch more flies with honey

If you don’t know… Ask…