Southern Health and Social Care Trust

Specialty Induction

Trauma & Orthopaedics

Craigavon Area Hospital

February 2023

Mr P Magill, Consultant T&O
30/01/2023

Revised:
1

Department staff

Consultants

Mr R McKeown

(Upper limb and clinical director)

Mr J Bunn (Lower limb)

Ms L Wilson (Upper limb)

Mr S Patton (Lower limb)

Mr M Murnaghan (Lower limb)

Mr D McMurray (Lower limb)

Mr T Doyle (Upper limb)

Mr B Watson (Lower limb)

Ms V Roberts (Foot & Ankle)

Mr G McLean (Lower limb)

Mr P Magill (Lower limb)

Staff Grades

Mr N Gibson

Mr G Rainey

Mr M Connolly

Mr Riad Al-Harfoushi

Ms Rachael MacAuley

Mr John Graham

Mr Ethan Toner

Registrars

3 Specialist Registrars

House officers

7 SHOs

1 FY2

2 FY1s

Orthogeriatrics

Dr K Kirk

Pam

Trauma Co-ordinators

Pamela Chambers

Eimear Hughes

Caroline Toland

Terri Eastwood

Trauma Ward Sister

Rachael

Orthopaedic Ward Sister

Stephanie Doherty

Fracture clinic sister

Laura Murphy

Managerial Head of Service

Brigeen Kelly

General Information

- All doctors need to obtain

1. A key fob/card to access wards/theatres (available from the trauma co-ordinator)
2. IT access, specifically requesting access to the 'T&O Docs' and "safeq" to enable access to printing facilities

- Annual / Study Leave

  Leave must be requested giving minimum 6 weeks' notice. Study leave requests must be signed by Mr McKeown

  Request only valid by emailing all of the following
  David.McMurray@southerntrust.hscni.net
  Niall.gibson@southerntrust.hscni.net
  Ronan.mckeown@southerntrust.hscni.net
  Brigeen.kelly@southerntrust.hscni.net
  And notify whatever consultants you work with

  Only 4 middle grades are allowed off at any one time
  Only 2 FY1s or FY2s are allowed of at any one time

  Mr Gibson will let you know at the time of your request if you can take it

- Sick Leave
  Please inform Mr Gibson 07793552078 and Ms Kelly 07825250793 immediately.
  If off for longer than 1 week, a GPs certificate is necessary, in line with Trust Policy

- If at any stage you are concerned about clinical or nonclinical issues, please feel free to discuss these with either your clinical or educational supervisor of indeed the clinical lead of the unit who is currently Mr R McKeown. Issues can also be discussed with our head of service Brigeen Kelly.

- You should expect to have a formal meeting with your educational supervisor within the first few weeks of attachment, at the mid-point and again before departure.

Formal Educational Opportunities

- There is a daily trauma meeting at 8am. Medical Education Centre on a Monday. Seminar room on the orthopaedic ward Tuesday to Friday. Trauma ward at the weekend.
- There is a weekly review of the preceding week operative trauma cases at 8.30am every Monday, after the trauma meeting. Run by the Trauma Registrar.
- There is a teaching session in the Medical education centre from 7am to 8am every alternate Monday morning. You will be expected to contribute to this. A rota will be made by one of the specialist registrars.
- There is a weekly arthroplasty meeting on Thursday at 7.30am held in the seminar room on the orthopaedic ward (organised by the Orthopaedic Registrar).
- There is a weekly joint T&O/MSK radiology meeting at 13.00 on Mondays; cases to be entered in the T&O MDM folder on PACS.

Trauma ward

28 bed trauma ward. Sister is Rachael. All trauma patients should be admitted to the Trauma ward. When there are not enough beds for the trauma admissions then the middle grade doctor follows the outlier protocol (on the trauma ward) to outlie patients to the orthopaedic ward. Before patients are out-lied to the Orthopaedic ward, the on-call Consultant must be informed. If Ortho 2 and subsequently Ortho 1 ring fencing is breached, all elective surgery requiring implants will be cancelled until a deep clean is performed and the ring fence is reinstated.

Orthopaedics ward

23 bed elective orthopaedic ward. Sister is Stephanie Doherty. No patients with infections are to be admitted to the orthopaedic ward under any circumstance. Follow ward based protocol for any outliers to be admitted to Orthopaedics.

Fracture clinics

Consultant led fracture clinics occur on a daily basis in CAH.

There are also two Specialty Doctor fracture review clinics held in CAH.

The consultants triage all ED referrals to the fracture clinic at the Fracture Hub.

If you take a referral from the ED and feel it requires fracture clinic, do not send it to the hub. Discuss it with your senior colleague and make a fracture clinic appointment. Do not use the Hub as a dumping ground. If you are not sure how best to manage a patient please discuss it with a senior colleague. You will never be criticised for asking for advice.

On-call

- Doctor on-call carries bleep 1777
- There is an on-call room in the nursing accommodation at the Beeches for the middle grade on call. (key available from the trauma co-ordinators office)
- Doctor on-call presents at the trauma meeting the following morning. The template for this presentation is an excel spreadsheet, found on the shared T+O folder on the computer. The file is named 'The Gospel'. The Gospel must be kept up-to-date and printed for the trauma meeting. Please dispose of the printed sheets after use in confidential waste.
- The presentation should include;

1. The patients who have been admitted over the last 24hr and the patients who are on the day's operating list. Note: the doctor presenting is expected to be aware of the patient's history and salient features pertinent to these cases.

2. Patients who require a consultant-level decision

Admissions

- Trauma patients who require admission should be admitted to the trauma ward
- Any patient with an infection or history of MRSA needs to be in a side ward
- Consideration should be given to the injury sustained, patients' general health and the general availability of operative lists prior to fasting all admissions.
- There is a specific proforma for patients with a fractured neck of femur. It is the responsibility of the **admitting doctor** to ensure this proforma is completed (admission packs are available from the trauma ward)
- Any patients who require trauma / orthopaedic surgery out of hours **must** be discussed with the consultant on call.
- Occasional patients may need to be referred to a tertiary unit for management of concomitant injuries not managed within this Trust. These patients **must** be discussed with the Consultant prior to referral.
- Details of any patient transferred out of the unit is to be added to "The Red Book", which is now stored electronically in the T+O file.
- Patients who are on the trauma ward and expecting to be on the trauma list the following day should have Enoxoparin prescribed at 1800hrs the night prior to surgery (not 2200hrs).
- Patients for surgery the next day should be marked and consented on admission. If you do not know the details of the surgery ask for advice and defer the consent process to a senior colleague if needed.

There are 5 subgroups of patients which require specific consideration. These are;

1. Children

- If the injury does not require admission or surgery it can be reviewed in fracture clinic, regardless of the patient age

- For children *requiring admission or surgery*:
    - Below 14yr – refer to RBHSC (Children's Hospital). If ED are confident they can do this without involving you.
    - 14yr and above – admit to Craigavon Area Hospital
    - **<u>If ED are unsure of the management of any injury they should in the first instance refer up the ladder in their own dept. If further advice is required then they ask you, the CAH T&O on call team. If the management plan remains unclear then ask the CAH T+O consultant on call. Normally this is done the next morning at the daily 0800 xray meeting.</u>**

2. Chest and head Injuries

Injury	Ward	Medical Responsibility
Significant chest injury + fractures	- General surgery ward. General surgeons may require joint care/input from T&O - If general surgeons ready to DC patient but they still require T&O input then patient to be referred to T&O for transfer to the trauma ward	General Surgeons
Minor head injury + fractures	- If GCS 12 or above admit to trauma ward. General surgeon of the week to be notified so that they can see the patient on the trauma ward if required - If T&O ready to DC but the general surgeons still need to monitor the patient then the patient is to be referred to the general surgeons for transfer to the surgical wards	T&O Surgeons General Surgeons
Head injury with GCS below 12 + fractures	- Admits to surgical ward - T&O consultant can see the patient there if required	General Surgeons
Head injury + Fractures that are for non-operative management	- Admit to surgical ward - T&O consultant will reviews x-rays at trauma meeting and take over care if a decision to operate is made	General Surgeons T&O Surgeons General Medicine/ Care of the Elderly

	- If patient is still not for operative management and the patients is not for DC then transfer to Care of the Elderly (if over 65yr)	

3. Spinal injuries

The management hinges on labelling the injury as either unstable or stable. This should be diagnosed by ED. If ED are unsure they can discuss with RVH or us. We do not have any spinal services in CAH so spines should only be admitted under us if they are definitely stable, if they do not require cast / brace, if they will not block our limited bed space….and thus only as a very last resort as per table below.

ST trainees can see spine patients in CAH **on behalf of the Belfast Spinal team**. This applies to ST trainees only. This is an agreement between the ST trainees and Belfast and does not involve the CAH consultant.

Injury	**Ward**	**Medical Responsibility**
Unstable spinal injury	Transfer to RVH - ED CAH transfer to RVH	RVH
Stable spinal injury	- Options in order of preference: 1. Transfer to RVH 2. CDU with trauma input 3. Trauma ward (only if there are 3 beds available) 4. Surgical ward - CAH options will depend on bed capacity	RVH ED Team T&O Surgeons General Surgeons

4. Foot referrals

Charcot: Check HbA1C

Ensure diabetologist involved in care

Prescribe calcium and Vit D (if not on already them)

Ensure has WB'ing Lat/DP/Obl views

Doppler pulses for waveform on ward: if monophasic needs CT angio and vasc input

Advise NWBing (an air cast boot may be required if no appointments soon)

Ulcer: Diabetic – refer to vascular surgeons

Not diabetic - Check HbA1C

Ensure has Lat/Obl/DP radiographs (WBing if possible)

Concern of Osteomyelitis – consider MRI scan

Doppler pulse for waveform: if mono, needs CT angio and vascular

Ensure ulcer has been swabbed and note any antibiotics pt is on

Email Miss Veronica Roberts with information of patient and results to book into Ortho OPD

5. Soft tissue injuries

1. Adult Soft Tissue	Referral from ED to a specialist team will be accepted by that specialty ie General Surgery (GS) or Trauma & Orthopaedics (T&O), patient to be seen and assessed – Refusal to attend ED to assess injury is unacceptable. If additional advice required from the other specialty GS will contact T&O or visa versa ***At no stage is the patient returned to ED for management***. **General Surgery** will accept the following injuries as requested by ED. • Abdomen • Chest • Head & Neck • Most soft tissues injuries without bone involvement **Trauma & Orthopaedics** will accept the following injuries as requested by ED. • Knee Injury • Obvious Tendon Injury • Severe Contamination Injuries • Crush injury requiring compartment measurements.
	Local Management of soft tissue injury is the best outcome for the child.

2. Paediatric Soft Tissue Injury	**<u>General Surgery</u>** All soft tissues injuries **<u>T&O</u>** Bone Joint Tendon Severe Contamination Injuries If child is brought to Theatre by General Surgeons and they request advice/assistance from T&O it will be given.

<u>Foundation year doctor duties</u>

(i) Attend unit admission handover / theatre planning meeting every morning at 8 am.

(ii) Attend morning trauma ward round with consultant in charge

(iii) Attend daily ward round with Trauma Registrar or Sp doctor.

(iv) Entries into patients charts must include
Date, Name of doctor in legible block capitals, GMC number and signature.

(v) Arrange regular meetings with their Supervisors.

(vi) All leave must be requested in line with unit policy.

(vii) Clerk patients in, in a timely manner.

(viii) Complete discharges in a timely manner.

(ix) Attend trauma / elective theatre when time allows – they should produce a logbook to their supervisor at the end of attachment before they can get signed off.

(x) Participate in a unit audit, either solo or in partnership with other member of team.

(xi) Be familiar and compliant with all trust policies in relation to the wards, e.g. antibiotic prescribing, DVT prophylaxis, hand washing.

(xii) Electronic Discharge:
All sections of electronic discharge letter should be completed correctly.
e.g. Diagnosis - the must be the condition the patient was admitted with
- e.g. Left Hip Arthritis / Right Wrist Fracture

Operation - This must accurately reflect the procedure as per the operation note

e.g. Left cemented total hip replacement / Open reduction and internal fixation right distal radius.