Dartford and Gravesham NHS
NHS Trust

Orthopaedic Handbook for SHOs

CONTENTS

Introduction

We wish you a warm welcome to the Darent Valley Hospital Orthopaedic Department. This handbook is written to help you familiarize yourself with the workings of the department, the day to day job and the key people who you will be working with.

This handbook can be found on the Shared Drive . However, it will be best used by downloading the electronic .pdf version of this document to your smartphone. This will allow a searchable, way of finding the information you require.

This handbook is not intended to be a textbook of orthopaedics.. Instead it is designed to help you survive the day to day challenges you may encounter.

The department is friendly and supportive to its junior colleagues and skills learnt during your time with us will stay with you throughout your career.
It is our wish that you find this handbook useful and that you enjoy your time with the department.

Mr Charles Godavitarne
Mr Thilagarajah
February 2016

Acknowledgements

We would like to thank Dr Colin Weekes (Orthogeriatric Consultant) who provides the orthopaedic orthogeriatric service at DVH. He has ensured that the "orthogeriatric" section of the handbook (page 19) is up-to-date and concise.

We would also like to the thank Mr Nik Bakti (ST5) who is the designer and implementer of the Online Trauma Database. This section has been written exclusively by Nik and whilst at DVH, will be happy to answer any questions you may have.

We would like to finally thank Dr Raj Singavarapu, Dr Emma Hughes and Dr Poonam Kandel for reviewing the handbook and ensuring it is suitable for incoming orthopaedic team members.

Who 's Who ?

Consultants

Mr Norris	Clinical Director of Orthopaedics Surgical Site Infection Lead Hip and Knee Surgeon+ Foot and Ankle Surgeon
Mr Thilagarajah	CollegeTutor for Orthopaedics and NOF Lead Hip and Knee + Foot and Ankle Surgeon Trauma Lead
Mr Moftah	Hip and Knee
Mr Smith	Audit Lead Hip and Knee Surgeon
Mr Chettiar	Hip and Knee Surgeon Rota Coordinator
Mr Charles	Hip and Knee + Foot and Ankle Surgeon
Mr Singh	Upper Limb Surgeon
Mr Neen	Upper Limb Surgeon
Mr Anugraha	Locum Consultant
Mr Katchburian (Visiting)	Paediatric Orthopaedic Surgeon (based at Tunbridge and Maidstone Hospital)
Dr Colin Weekes	Orthogeriatrician

Secretaries	(Secretary to)
Jackie Acton	Mr Thilagarajah, Mr Norris
Anita Diggory	Mr Moftah
KellieBettell	Mr Smith, Mr Chettiar
Janette McCarthy	Mr Sait, Mr Neen
Jackie Nixon	Mr Katchburian, Mr Singh, Mr Charles

Others of note

Sandra Almeida	Ortho / POPS Clinical Nurse Specialist
Shainy Hillarious	Ortho / POPS Clinical Nurse Specialist
TBA	Ortho / POPS Clinical Nurse Specialist
Heidi Cooper	Rota Co-ordinator
Siva Kabalan	Surgical General Manager
Kim Pennington	Surgical Matron
Gerard Visser	Surgical Matron
Trish Bannister	Operation manager for surgery

Orthopaedic Department Contact Numbers

Secretaries	Consultant	Extension
Jackie Acton	Mr Thilagarajah Mr Norris	8463
Anita Diggory	Mr Moftah	8462
Helen Goode	Mr Smith Mr Chettiar	8465
Janette McCarthy	Mr Sait Mr Neen	8461
Wendy Lane	Mr Singh Mr Charles	8464
Jackie Nixon	Mr Katchburian (TWH Orthopaedic Paediatric Specialist)	8791

Role	Name	Extension
Ortho POPS nurse	TBA	8441
Rota coordinator	Heidi Cooper	4747
General Manager	Siva Kabalan	8615
Operation Manager	Trish Bannister	4339 (bleep 271)

Team – SHO	Mobile Number
Thilagarajah / Norris / Charles	07444 576 032
Moftah / Smith / Chettiar	07765 693 888
Singh / Sait / Neen	07776 285 357

Most of the above are friendly and approachable (we're not just saying that, its true!!)

You must familiarize yourself with your Consultant's timetables. The Secretaries although busy, will be more than happy to help you locate their respective consultants and pass on messages. They will also help you to book outpatient appointments at late notice if clinics are fully booked. Within your first couple of weeks, you should introduce yourself to the secretaries as you will be needing them more than you think!

Ortho / POPS CNSs are a fantastic point of contact for any questions. They can help liaise with other hospitals regarding patient transfer and follow up, identify which teams need to be contacted when "working up a patient" for theatre and can help locate notes for upcoming M+M meetings. They, along with Dr Weekes have a major role in dealing with the neck of femur admissions.

The Department

The Orthopaedic department is located on the 3rd floor. Here you will find all Consultant and Secretaries' offices, the Orthopaedic Registrar room and the location of the trauma meeting (held in the Orthopaedic Seminar Room, within the "Surgical Admissions Lounge" corridor.

The **main wards** for orthopaedics include:

Cherry	(Elective admissions)	3rd Floor
Maple	(Trauma admissions)	3rd Floor
ACER	(Daycare admissions)	2nd Floor (directly below Maple)

With patients sometimes being placed in other wards including the surgical wards:

Juniper	(Gen. Surgical admissions)	3rd Floor
Rowan	(Gen. Surgical admissions)	3rd Floor

Paediatric patients will be admitted to:

Willow	(Paediatric admissions)	1st Floor

There are 2 main sites for **orthopaedic surgical procedures**

Main Theatres	(Opposite Maple Ward)	3rd Floor
Daycase Theatres	(Via ACER ward)	2nd Floor

For the **outpatient clinics** and **plaster room**:

Fracture Clinic	(Fracture Clinic)	2nd Floor next to AE
Plaster Room	(Fracture Clinic)	2nd Floor next to AE
Orthopaedic Clinics	(Fracture clinic)	2nd Floor next to AE
	(Outpatients Blue Zone)	2nd Floor in front of main entrance

Contact numbers for all of the above can be found on page in *Appendix 1*.

Things to do on your first day

1. Get a valid swipe card allowing you access to:

   All Wards
   Theatres

   If you realise you have restricted access contact "Heidi Cooper" but ensure you have the serial code of the card. Alternatively, you can take your card down to security at the front desk (by the main entrance) and they should be able to help you.

2. Ensure you have your own access to logon to the computers. If you have not already been given one at the trust induction, you will need to contact the IT Helpdesk to assist you.

   Computers on the ward and in AE will often already be logged on such that you will not need to logoff the computer. However having your own logon details can be handy should computers need rebooting ie following a power cut.

   NB: Clinically relevant input activity should be done on your own logon. In this modern age of computerization and governance you should record and take responsibility for your own actions.

3. You will need your own unique access to:

Patient Centre	Accessing patient demographics, ordering investigations and looking up previous clinic letters
Telepath	Accessing patient blood and sample results
PACS	Accessing patient scans

   Without access to all of the above, you will struggle to do your job!

4. You will definitely need access to NHS mail. If you do not already, you must be at an NHS computer (any in the hospital) and contact the IT services helpdesk (ext 8368) who will prompt you through the process. This is mandatory for any email that is sent containing patient information.

5. Familiarise yourself with ADAGIO (trust intranet). It contains a wealth of information that various departments and teams will refer you to. The quicker you learn to navigate this, the easier it will be to find things.

6. Orientate yourself around the hospital, particularly with the locations of:

   Orthopaedic wards
   Orthopaedic Secretary Offices
   Theatres
   Fracture clinics/plaster room
   A&E
   Mess
   Canteen

Things To Do in Your First Week

1. On your first day you will have an induction meeting, usually with Mr Thilagarajah

2. Ensure you introduce yourself/make contact with your Educational Supervisor (if this is your first rotation of the academic year).

This is your supervisor for the year and you will be expected to be in regular contact with him/her

He or she will be responsible for overseeing your training and making sure that you are making the necessary clinical and educational progress. You should have/seek regular feedback from your Education Supervisor. It is YOUR RESPONSIBILITY to organize your meetings in a timely fashion to avoid problems with sign offs.

DO NOT LEAVE THIS UNTIL THE LAST MINUTE
LACK OF ENGAGEMENT WILL BE RECORDED IN YOUR SIGN OFF BY YOUR EDUCATIONS SUPERVISORS

3. Ensure you introduce yourself/make contact with your Clinical Supervisor.

This is your supervisor for the rotation. He/she (usually a consultant) is responsible for your progress within each placement and for your day to day clinical progress. You should have regular feedback from your clinical supervisor. The process by which information about your progress is collated, is based on direct liaison between your Clinical Supervisor and your Educational Supervisor

4. Ensure you are aware of your rota and plan your annual leave in ADVANCE.

Heidi Cooper (rota manager) will email out the rotas on a weekly basis and this is based on a rolling rota.

If you have dates in mind that you would like to take as annual leave you must email these dates to Heidi as soon as possible. The department and trust work on an 6 week notice period and where possible this should be adhered to. Obviously not all leave can be planned with this much notice but you must try to plan as far in advance as possible.

There will be limits on the maximum number of juniors allowed to be on leave at any one time as we would not want your remaining colleagues to be left with an over burdened workload.

You must be aware of your on call commitments. If you have booked leave over dates when you are on call, it is YOUR RESPONSIBILITY to swap these shifts with others.

Annual Leave, Study Leave and Sick Leave – all planned leave to be discussed with Mr Chettiar to ensure appropriate ward cover available.

Annual Leave

Annual leave must be officially requested. Annual Leave must be discussed and agreed with your Clinical Supervisor and Heidi Cooper before you make plans if you want to avoid disappointment.

As stated in the previous section you must look ahead when booking annual leave. This needs to be done in a timely fashion and any on call commitments over your intended period need to be swapped in advance. Inability to do so may result in your annual leave being cancelled.

It should also be considered that leave may not be granted if another SHO on your firm is also on leave during your chosen time. The aim is to ensure 3 SHOs are present daily on shift. This is simply due to the lack of SHO support remaining in the department which could directly impact on patient care.

The trust policy for booking leave is 6 weeks and as a general rule, leave not taken during a rotation cannot be carried forward into the next rotation.

Study Leave

Study Leave is now centrally controlled by the Deanery. Please liaise with Post Grad regarding the process.

As above, study leave must be submitted 6 weeks in advance. If there are too few SHOs left within the department on your chosen dates for leave, you may not be granted the time off that you desire, regardless of what this may be for. It is therefore you responsibility to swap shifts accordingly and in a timely fashion.

The quality of study leave requests is assessed prior to acceptance, by the Deanery and the Department.

Sick Leave

We all get sick from time to time. It is important however that you notify the correct people when this occurs.

1. Inform Heidi Cooper as soon as possible.

2. If you are due to be on call, notify the rota coordinator and the SHO/Registrar you are due to be on call with. If you are unable to contact these people, then you must let the site coordinator know (accessible via switchboard).

Forms that need to be completed upon your return can be founds in Appendix 7.

Usernames, Passwords and Access Codes

The trust has a very strict policy on NOT sharing passwords and access codes so do not be tempted to share your user specific details to others. For this reason generic logons have not been included in this handbook.

However, listed below are the systems you will be requiring access to along with who to contact should you need to enquire.

Logon Details	Contact
Windows Logon (generic)	IT Service Help Desk (ext 8368)
Windows Logon (orthopaedic seminar room	IT Service Help Desk (ext 8368)
Patient Centre	IT Service Help Desk (ext 8368)
Telepath	IT Service Help Desk (ext 8368)
PACS	IT Service Help Desk (ext 8368)
Trauma Database	Mr Thilagarajah
Theatre Man	Sue Bannister (via switchboard)
TRIPPS	Directly via website
Acute Neurosurgical Referral Service	Directly via website

Patient Centre

A key program allowing you to access patient demographics, clinic letters and referrals, as well as ordering investigations

Telepath

The program by which you can look up investigation results

PACS

The only program that allows you to see patient scans (Xrays, Ultrasounds, CTs, MRIs)

Trauma Database

An electronic version of the daily updated referrals/admissions as well as trauma/outstanding trauma lists. This is a VERY IMPORTANT piece of software that ALL MEMBERS OF THE DEPARTMENT should know how to use.

Theatre Man

The program that allows you to identify operating schedules

TRIPPS

The online referral system to the East Grinstead Plastics unit.

Acute Neurosugical Referral Service

The online referral system to the Kings College Hospital Neurosurgical Unit. Any spinal issue requiring more specialist input, must be referred via this system before being discussed with the On call Neurosurgical Registrar.

Bleeps

Each SHO is designated a bleep at the start of the rotation. This bleep should be with you at all times during your shift.

Each team also has a firm Mobile Phone – please ensure one member of the team carries it every day.

To Bleep: Dial 78
Await the automated message
Dial the bleep to contact
Followed immediately by the extension of the phone you are using

Team – SHO	**Mobile Number**
Thilagarajah / Norris / Charles	07444 576 032
Moftah / Smith / Chettiar	07765 693 888
Singh / Neen / Anugraha	07776 285 357

If you are unsure whether your bleep is working or not, you should first start by bleeping yourself.

Should you still have difficulties the bleep can be tested at the Switchboard located on Level 2 following signs for 'SERCO'.

If you highlight that there is a problem with the bleep you must notify Heidi Cooper immediately such that a replacement can be organized.

The same goes for a bleep that is damaged.

DO NOT FORGET: You have a duty and a responsibility to be contactable in order to fulfill your clinical duties

A Day in the Orthopaedic Department

A typical day (Monday to Friday) will consist of the following:

Time	Event
08.00 (Except Mr Sait – 8.30)	Trauma Meeting in the Orthopaedic Seminar Room
08.30-09.30	Ward Round WITH MIDDLE GRADES
09.00	Morning Clinics Start – Middle Grades attend at 9.30
09.00	Morning Theatre Lists Start
13.30	Afternoon Clinics Start
13.30	Afternoon Theatre Lists Start
17.00	Day Team informal hand over to day on call
20.30	Day On call handover to Night on call

During the weekend, the schedule is slightly different:

Time	Event
08.30	Trauma Meeting in the Orthopaedic ***Registrar Room***
08.30-09.00	Ward Round
Saturday	Scheduled Trauma List
Sunday	Scheduled Trauma List

Please ensure the Trauma List is considered and necessary arrangements made the day before, on Friday and Saturday evenings – Discuss with Registrar / Consultant.

DAILY SAL Admissions – every day elective lists run in main theatres – it is your responsibility to ensure you are aware of any patients that have arrived in SAL for your team. You should make sure their drug charts are completed appropriately. It is not the responsibility of the Anaesthetist, and you should NOT wait for the patient to arrive back on the ward for this to be done.

Trauma Meeting

This is a Consultant led meeting whereby all referrals over the previous 24 hours are discussed and their corresponding radiographs displayed.

Attendance at this meeting is mandatory for all SHOs and Registrars.

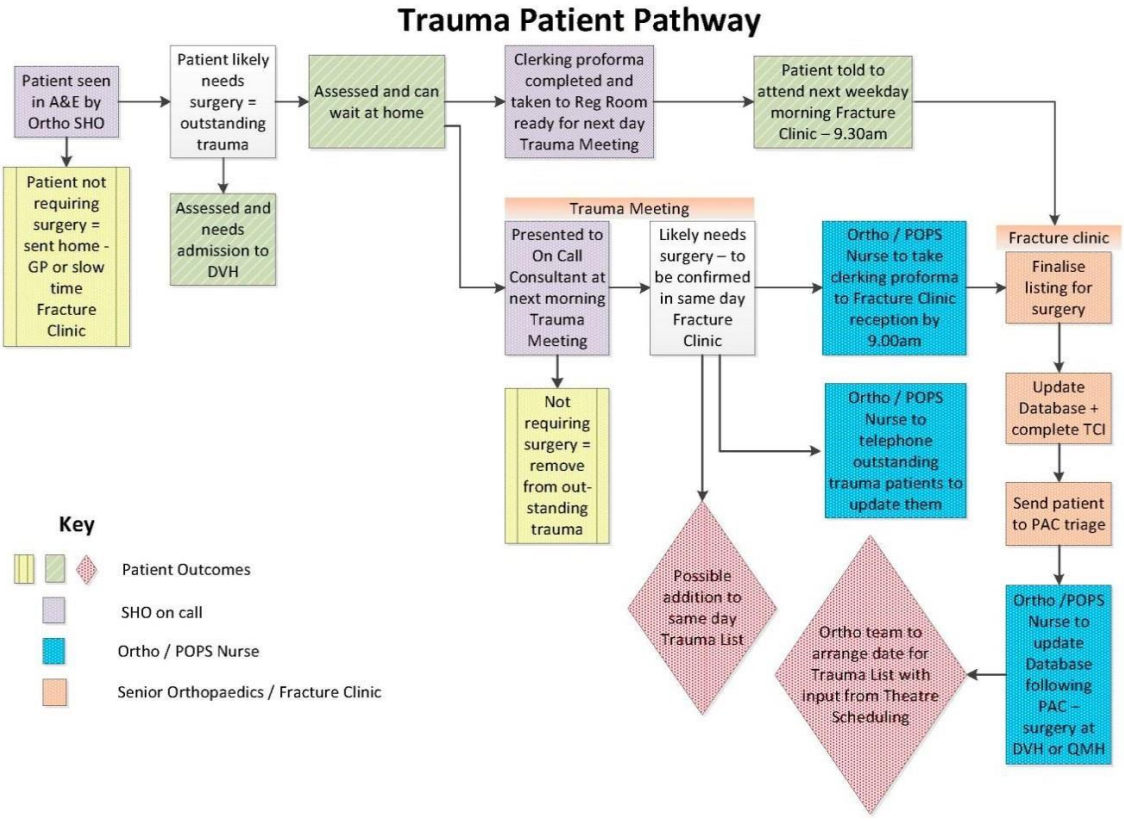
This is a very valuable teaching opportunity and discussion is actively encouraged.

This is also the time when the trauma list is finalised and outstanding trauma is provisionally scheduled. Therefore attendance by all is key to updating the wards regarding which patients will be for theatre that day and how much trauma is outstanding. Decisions are updated on the trauma database and the trauma list is printed out.

Patients will be discussed.

- Some will not be for surgery and would have had arrangements made for slow time fracture clinic or GP follow up.
- The rest will be for surgery at some point. All of these patients should be told when seen in A&E by the Ortho SHO, to attend the next weekday Fracture Clinic at 9.30
- All the above will be discussed, and plans made with the overview of the Consultant.

Trauma Patient Pathway



Ward Rounds

These ward rounds are often SHO led. Registrar and Consultant led ward rounds do occur during the week but timing is at the discretion of the senior involved, so contact them to find out when this will be.

Every patient under your Consultant's care must be seen every day, with documentation made in the notes for every patient seen.

Theatre Sessions

All SHOs are welcome to attend theatre sessions. It would be wise to ensure that you make yourself known to the surgeon prior to attending, such that there is no ambiguity in theatre as it can often be stressful enough. Ideally, you should attempt to attend the theatre briefing session before the list begins such that all members within a given theatre are aware of one another.

It is imperative however, that if you plan to attend a given theatre session, you make your whereabouts known to the other SHOs and ward staff. Your bleep should either be passed to a colleague to hold or left at the theatre reception main desk, such that should someone want to contact you or pass on a message, this can be done.

Tempers will run high, and you will gain a bad reputation if you are uncontactable whilst you spend your time in theatre. It is your DUTY and SOLE RESPONSIBILITY to ensure your patients are cared for/are being cared for before you attend theatre.

To this end the most reliable way to ensure your bleep is answered is to take your bleep into theatre and kindly ask a member of staff to answer it when you request.

Outpatient and Fracture Clinics

The same as goes for attending theatre, applies to clinics as well. This presents a valuable learning resource and is strongly encouraged.

It is also very useful to spend some time with the plaster room technicians. They have years of experience between them and can help shed light on questions you may have regarding immobilization techniques. You will also be able to learn techniques that you can use during your oncall.

The aim is for you to attend 5 clinics and 5 theatre sessions during your stay with us.

WARD SHO

A rota exists (run by Mr Chettiar) to provide morning and afternoon cover for the wards Cherry and Maple. One SHO is allocated for each session, to cross cover between the wards. That SHO is to hand over his / her bleep to a different SHO so they are not disturbed by other duties outside these wards. The work for the ward SHO is to facilitate a direct contact for the nurses, for any jobs which have not been done by the appropriate team. The teams are still expected to carry out all their duties on these wards, and the ward SHO is to be regarded as a back up.

Working on the Wards

Firms

SHOs are allocated to Consultant Firms:

Firm A	Firm B	Firm C
Thilagarajah, Norris, Charles	Moftah, Smith, Chettiar	Singh, Neen, Anugraha

SHOs are expected to familiarise themselves with their consultants respective management. Specifically:

DVT Prophylaxis	(post operative)
Choice of Antibiotic	(post operative)
Duration of Drain	(when necessary post operative ie hips and knees)
Outpatient clinic days	(post operative elective follow up)
Fracture clinic days	(on call/post operative trauma follow up)

Despite this allocation, SHOs are expected to SHARE the workload if other SHOs are on nights/post nights/leave.

Please note, each of your Consultants is paired with a single other Consultant based on their weekday on call, which alternates each week. If you have a query relating to a patient whose Consultant is away, you should approach his paired partner for an opinion.

You must remember that at any one time, 2 SHOs from the rota will not be present during the day (due to nights and post night leave) so the work load can be high.

If you are covering another SHO, you must not only carry your bleep, but also the SHO's bleep you are covering.

Try your best to establish a good relationship with the other members of staff on the ward. Although it may seem that their job is separate to yours, they can prove to be very helpful especially when you are busy so it's in your interest to maintain a close working relationship.

Note Keeping

Daily entries are required for all in-patients.

Although you will know this already you must ensure that all entries include:

1. The most senior person on the ward round
2. The date and time
3. A working diagnosis and plan
4. A signature, legible name (in block capitals) and bleep number

If on call/post take, all of the above apply including:

1. The name of the Consultant on call – as he takes responsibility for that patient.
2. Clear identification of the post take ward round (PTWR) and management plan.

Blank history sheets are now a thing of the past at Darent Valley and instead patient specific history sheets must be printed off using Patient Centre. This is the new trust protocol and must be adhered to.

Always check that the sheet you are writing on has the correct patient details at the top as failure to do so could result in incorrect management plans for patients and patient safety is thus at risk.

Remember, a lot of information exists on PACS and PatientCentre regarding previous admissions and clinic attendances, which will help with your clerking.

Integrated Care Pathways

Integrated Care Pathways (ICP) exist for Total Hip Replacements(THR), Total Knee Replacements (TKR) and Fractured Neck of Femurs (NOF). They are designed to follow the patient from the initial assessment through to discharge.

Like any other set of notes, they are multi-disciplinary with spaces allocated for other members of the multi-disciplinary team to document their findings.

The THR and TKR ICPs are typically found on Cherry ward. They are located within the flimsy/soft red folders. When documenting your ward round, it is the ICP that you document in, and NOT the larger card based folders.

Electronic Discharge Notifications (EDNs)

All inpatients when being discharged are required to have EDNs completed before the patient leaves the ward.

It is important that adequate information is provided regarding their hospital stay including any complications that are encountered, drugs on discharge and follow up arrangements.

Although this sounds obvious, ensure that the diagnosis and where necessary, operation as well as operation date is recorded.

Always ensure the patient is being followed up in the correct consultants clinic

REMEMBER: this is the only official way the GP knows what their patient underwent during their stay in hospital. Consultants and GPs READ the EDNS you write when their patients are followed up in their respective clinics, so make sure they are informative.

Weekend Handover

It is the SHO's responsibility to ensure that all of their firm's patients are placed onto the weekend handover list.

This template can be found in the "Firm Lists and Weekend handover lists" folder.

All fields must be completed to help compile a comprehensive Orthopaedic handover that the weekend SHO can use to review patients.

Be aware that you will have to do a weekend on call during your rotation and you will realise how much easier your ward duties become if this list is completed accurately. If you can help to make your colleagues' weekend on call easier, they will in turn help you.

The most important thing to stress, is that patients on this list have clear plans in place for the weekend, and if you are requesting a patient review be specific in what you want the on call to assess.

You will need to copy and paste your week day handover document to the weekend template and complete the weekend plan section.

You should note on the handover which patients are for potential discharge over the weekend, and complete their EDNs as much as possible.

The last thing your colleagues will want to do on a weekend is trawl through EDNs which should have been completed during the week.

Orthogeriatric Overview

The following section has been kindly written by Dr Colin Weekes.

The Orthogeriatric team will review all hip fractures aged 60 or over within 72 hours of admission. Patients admitted with other injuries who fall into this age group can also be discussed. However there is currently no dedicated service on bank holidays or weekends meaning that this is not always possible.

Once a patient has been reviewed, the Orthogeriatric team will decide whether to:

a) Wholly take over care of the patient (this will be written in the NOF Proforma, the consultant in charge changed on PatientCentre and updated on the VisiBoard).

b) Undertake joint care – Orthopaedics and Orthogeriatric teams to see daily; the patient will remain under the Orthopaedic Consultant on Patient Centre).

c) Give advice to the Orthopaedic team re: ongoing management with further review on verbal request.

Orthopaedic involvement with these patients will finish when check x-rays (if indicated) are satisfactory, the wound is healing, and the patient has achieved their documented weight bearing status.

There is a box to complete on the NOF Proforma covering these issues.

Orthogeriatric Referrals

Orthopaedic inpatients without hip fracture (either trauma or elective) can also be reviewed on verbal request. Written referrals are not required.

Who should be discussed?

As a general rule, patients with the following issues may benefit from discussion with the Orthogeriatric team +/- review:

- New onset delirium
- Inpatient fall
- Hypoxia pre-op *or* >=24hr post-op (sats <94% on air *OR* needing oxygen to maintain >94%)
- Hypotension at any time pre- or post-op (systolic BP<100)
- Bowels not opened ≥ 3 days
- Fever ≥ 38 more than 48 hrs post op
- Acute kidney injury
- Any medical illness causing transfer to Laurel or ITU
- Difficult capacity assessments
- Discharge planning hurdles (eg. Is the patient well enough to be discharged?)

Oncall

General Overview

One Consultant is oncall for a 24 hourperiod.

SHO Day on call: 08.00 - 20.30
SHO Night on call: 20.30 - 08.00

Registrar: 08.00 – 08.00

During the day the Registrar will usually be onsite and available to review patients when needed. However after late evening, the Registrar will be off site but accessible by phone. Should a problem arise during the night, have no hesitation to contact your registrar for advice/review if needed.

The duties of the on call SHO are:

1) To take ward referrals
2) To take AE referrals
3) To review and deal with patients on the ward
4) To keep your Registrar informed appropriately

The Day and Night SHOs will be responsible for presenting all patients referred and admitted at the trauma meeting the next morning. One of these SHOs will be responsible for navigating PACS such that radiographs can be displayed whilst the histories are being presented as well as updating the trauma database ***DURING THE MEETING***.

You must ensure that you know these patients and the histories well, as questions will be asked by the Consultant to ensure the appropriate management plans are employed.

REMEMBER: when seeing patients in A&E you are representing the Consultant on call. Therefore any advice given or decisions made will be the responsibility of that Consultant. **If you have instructed patients to return to fracture clinic they must be booked into the fracture clinic of the Consultant on call.**

If this cannot be done by A+E reception, ensure it is done by the Consultant's Secretary the next morning.

Ensure that all patients who are referred are entered onto the trauma database and discussed in the morning meeting ***without exception***. All patients having Orthopaedic opinion or input are discussed at Consultant level in the Trauma Meeting.

Day Oncall Overview

1) Collect the bleep from the Night SHO at the morning trauma meeting.

2) Aim to see all of your firms patients as quickly and thoroughly as possible before the on call starts to get busy.

   If you have another member of your team present, share the workload of ward patients to ensure the on call SHO is able to see referrals in a timely fashion.

3) REMEMBER: the patients referred during the on call are the priority particularly those referred from A&E. If you are struggling to balance the on call with ward commitments, **seek help from your fellow SHOs and Registrars.**

4) Try to update the Trauma Database through the day to avoid a long spell on the computer at the end of the shift.

5) At 17.00 try to make yourself available to the other SHOs such that they can hand over any outstanding jobs.

6) Refrain from seeing any more patients from 20.00-20.30 to allow yourself time to update the trauma database and prepare for handover.

7) Identify which patients have been operated on during the day such that you can update the Trauma Database and inform the Night SHO of which patients will need post operative review.

8) Ensure that when handing over, this is kept as a "bleep free" period and politely ask referrers to call back after handover.

9) Briefly discuss all admissions and inform the night SHO of any outstanding jobs or reviews that must be performed. If handing over to a locum, ensure your handover is robust.

10) Discuss with the Registrar oncall which patients should be made Nil by Mouth and from what time (00.00 vs 06.00) and provisionally prepare the trauma list for the following day.

11) If you have decided to make inpatients NBM it is your responsibility to inform the patient, the ward staff and to document this in the notes.

12) Don't throw away your handover sheet as this can serve as a memory jog whilst presenting in the trauma meeting the next day.

Night Oncall Overview

1. Before the start of your shift, ensure you know who the Registrar and oncall Consultant are for the shift.

2. Collect the on call bleep from the Day SHO.

3. Take a good handover from the Day SHO. You have a half hour overlap ofshifts.

4. Ensure you enquire as to which patients will require overnight review (especially post operative Day 0 NOFs).

5. It is your responsibility to ensure that the ward is aware of the patients who are to be NBM. **Ensure that patients who are at home awaiting surgery, are called to tell them when they are to be NBM from, as well as where and when to come in to hospital for the trauma list the following day.**

6. Should you have any queries or concerns about the management of patients do not hesitate to contact your registrar.

7. Prior to the morning trauma meeting, ensure that any NOF admissions are added to the Trauma Database and written on the white board in the orthopaedic seminar room as well as any other cases that will be requiring theatre.

8. Add all referrals made during your shift to the Trauma Database.

9. Print off 5-10 copies of the "Meeting List" and the "Trauma List" for the morningmeeting.

10. Ensure that the computer in the trauma meeting room is on and that PACS is loaded for a prompt start.

11. Inform your colleagues at the meeting of those that have been made NBM such that if plans have changed the patients can be notified accordingly.

This last point is very important as patients should NOT be expected to have to call the secretaries or the on call SHO to find out whether or not their proposed procedure is going ahead. This has been a highlighted problem within the department so ensure that patients under your Consultant's care are kept informed.

Weekend Day On call Overview

This is much the same as the weekday on call.

BUT the trauma meeting however, takes place in the Orthopaedic Registrar Room.

The weekend is the same as the weekday on call with the following additional points:

1) Review all admission from the previous take

2) See any patient who is post operative Day 1, Day 2 or Day 3 (elective and trauma)

3) See all other Orthopaedic patients at least once over the course of theweekend

Your registrar on call will almost inevitably be in theatre so it is worthwhile changing into scrubs before the start of your shift, such that should you want to discuss something with the registrar, you can freely walk into theatres (after changing into appropriate footwear).

You may also be required to assist in weekend orthopaedic trauma cases. As before, ensure the wards are aware of where you will be, and give them an indication as to when you will be returning to the wards to complete jobs.

> Some SHOs find it useful to ask the wards to make a list of jobs, so that you can come to the wards periodically and complete all jobs in one go.
>
> This is a good idea, especially if you are busy whilst on call, but don't forget to return to the ward!!!

The weekend on calls can get very busy. Doing ward rounds, assisting in theatre and seeing oncall patients can make it very difficult to do everything expected of you. To help with this:

> Make a list of jobs and PRIORITISE
>
> For A&E patients, complete your clerking in its entirety to prevent unnecessary bleeps from the ward to clarify plans
>
> Take regular breaks
>
> Bring food!!!

Admissions

For any patient that you admit, please ensure you have done the following:

1. Taken a thorough history and appropriately examined the patient.

2. A full clerking on a separate history sheet (not the A&E CAS card) as well as the name of the Consultant on call.

3. A completed drug chart, together with adequate analgesia.

   It is also essential that you complete the VTE assessment and prescribe thromboprophylaxis accordingly.

4. Ensure that admission bloods have been performed including a group and save if major surgery is to be planned.

5. Appropriate imaging has been performed. In particular:

   2 views of a fracture (AP and Lateral) – if not, ensure it is done before the patient is admitted to the ward.

6. Adequate immobilization has been applied (usually in the form of a cast). Ensure this is done before the patient leaves A&E. This is for 2 reasons

   i) It is a form of analgesia for the patient

   ii) Especially during the night it is significantly more work for you to achieve this once the patient is on the ward.

   Not only will the patient be in pain for longer than necessary, the A&E technicians are VERY UNLIKELY to come to the ward to cast a patient (although if its quiet and you can charm them, it is a slight possibility)

7. If the patient is to be made NBM, clearly document this in the plan and from what time.

8. Note down to which ward the patient will be transferred.

9. The admission is recorded on the trauma database.

Although this may seem like a lot, you will instinctively be doing all this without thinking after your first few oncalls.

During your day oncall you may also be called down to fracture clinic to clerk in patients who are in need of surgery. Some patients will require admission from clinic, whilst others can be discharged home, with surgery pending.

If the patient is to be admitted: Follow the steps as outlined above

If the patient is to be scheduled: Follow the steps as outlined above and ensure that the patient is discussed in the morning meeting. If the patient was told that they would be called following the trauma meeting, make sure someone is appointed to do this.

Neck of Femur Fractures THIS IS A PRIORITY IN THE DEPARTMENT

General Overview – Please familiarize yourself with the NOF PROFORMA

This is an important injury and one that the department takes very seriously.

Patients admitted with neck of femur fractures are worked up extensively such that they are ready for surgery as soon as possible.

If you are referred a case that is ambiguous for this type of fracture, you should discuss this with your registrar on call. It is recommended that an MRI is performed. If MRI is not available (ie over the weekend) or if it is contraindicated, then a CT scan is the next modality of imaging to be considered. This is in accordance with BOAST 1 Guidelines: Care of Patients with a fragility fracture.

If the patient you are admitting is on anticoagulation/antiplatelet medication, this needs to be highlighted clearly in the notes.

Warfarin: it is imperative that the INR is checked. Remember, for surgery the INR must be <1.5. It is therefore your responsibility to ensure that the patients INR is reversed in a timely fashion such that it will be in the correct range prior to surgery.

Vitamin K is the reversal agent of choice and can be given either orally or intravenously. Should you have any doubt about how much to give, this should be discussed with your registrar or the Consultant Haematologist on call. Once the decision to operate has been confirmed in the Trauma Meeting, a check INR should be taken, and consideration should be made to giving Beriplex pre-op.

Aspirin: Not reversed. Withold this medication and inform the anaesthetist

Clopidogrel: Not reversed. Withold this medication and inform the anaesthetist

Rivaroxaban: Irreversible and not detectable using INR
Withold this medication and inform the anaesthetist.

Apixaban: Irreversible and not detectable using INR
Withold this medication and inform the anaesthetist

To reiterate, should you have any queries or concerns about a patients anticoagulant medication, do not hesitate to discuss this either with your registrar on call, or the Consultant Haematologist on call.

Consent Forms

All patients undergoing surgery will require a consent form. Check with your clinical supervisor as to whether or not you are allowed to complete this form. Consent forms completed for these patients will either be a Consent Form 1 or Consent Form 4:

Consent Form 1: To be completed if the patient has capacity
Consent Form 4: If the patient lacks capacity
If you feel that the patient has scored highly on the AMTS but lacks capacity, then a form 4 must be filled out.

If there is any ambiguity, this must be discussed with your registrar/oncall consultant.

DNAR Forms

At the point of admission, you must consider the DNAR (Do Not Attempt Resuscitation) status for the patient. This can be a difficult subject to address but it is one that is essential should the patient have a complicated stay in hospital.

Unless a DNAR form is already in place prior to admission, any form to be signed must first be discussed with the registrar or Consultant on call. It is imperative that a discussion is had with the patient/patients family before the form is signed to avoid unnecessary litigation.

Neck of Femur Admissions

As patients with neck of femur fractures are worked up extensively prior to theatre a concise but detailed proforma is to be used for all admissions/referral (available in AE, found within the cabinet in Majors, by the main nursing station).

It is essential that this is completed in its entirety as this is heavily audited.

In the proforma when clerking, you are required to complete everything up to and including the capacity assessment.

Things to remember for neck of femur admissions:

1. Take a detailed history from the patient and appropriately examine them

2. Within the history, identify any co-morbidites that the anaesthetist may want to know about, that may influence the procedure itself or may impact the post operative period. Examples can be found below but this list is not exhaustive.

Anaesthetistic Concerns	**Procedural Concerns**	**Post Operative period**
Cardiac Pathology	Anticoagulation	Diabetes
Lung Pathology	Pacemakers	Conditions requiring steroids
Previous ischaemia	Malignancy	

3. Identify within the history, the pre morbid state of the patient.

   Previous mobility (independent, with walking aids, immobile)
   Ability to perform activities of daily living (independent, carers)
   Living situation (with partner, alone, sheltered accom. residential/nursing home resident)

4. If cancer is identified in the history, ensure that full length femur radiographs are ordered as this will help preoperative planning.

5. An AMTS has been completed.

6. An AP and lateral of the affected side has been taken.

7. An ECG and CXR have been done to help the anaesthetist.

8. Routine bloods including a Group and Save and INR (where appropriate) have been performed.

9. Adequate analgesia has been prescribed both on the regular and PRN sides of the drug chart along with laxatives.

10. That the patient has been fluid resuscitated.

11. The time from which the patient is to be made NBM is clearly documented.

12. You have notified the Anaesthetist such that they can assess the patient for theatre.

13. Add the admission to the trauma database and highlight the "NOF" selection.

14. Add this patient to the white board in the Orthopaedic Seminar Room.

On top of this, there are 2 very important things to remember:

- Ensure that the referring A&E doctor has completed page 1 of the proforma (blue border on the inside cover) – a new A&E audit tool will be in use soon, to consider fast tracking.
- You note the time of arrival in A&E and when 36 hours will have elapsed. Document this.
- The time of referral if the patient is already an inpatient.

This final point is imperative as you will be required to document this not only on the front page of the proforma, but more importantly on the white board in the Orthopaedic seminar room. This is how the Consultants will prioritise which patients require surgery first.

The proforma has been designed in accordance with:

NICE CG124 Hip Fracture: Management

This document can be found here:
https://www.nice.org.uk/guidance/cg124/resources/hip-fracture-management-35109449902789

It is a sizeable document, but a worthwhile read to update yourself with the standards of care we should be aiming to achieve for patients admitted with this type of fracture.

Paediatric Admissions

The same points as per adult admissions apply for children admitted to the hospital.

There are however a few extra points that need to be remembered:

1) When clerking in AE, ensure that paediatric doses of analgesia are prescribed

   A laminated chart can be found in the Paediatric A&E to help you prescribe correctly according to the patients ages and weight.

   Patients with fractures requiring traction, must have "Vallergan" (Alimemazine Tartrate) prescribed. This is classed as an antihistamine, but has an additional property of reducing muscular spasm. Correct dosage can be found in the BNF.

2) You must call ahead to Willow ward to handover your patient to the nursing staff such that they are aware of any incoming admissions.

3) If there is any suspicion of Non Accidental Injury, inform the nursing staff in A&E, as well as the paediatric doctors for further review. There is also a child safe guarding team that must be notified.

4) If you suspect that a child is at risk, but no acute injury has been identified you can admit the child for 'observation' (whilst notifying the relevant teams) allowing further investigations to take place, without raising suspicion.

The Trauma Database

The database was put in place to aide communication between all the members involved in the trauma department. It is vital that all patients referred to the trauma department are entered into this database.

This database is also used to minute the daily morning trauma meeting. Decisions made and plans discussed at the meeting are updated immediately on the database as the meeting takes place.

Where is the file?

The file can be found in the Shared (S:) drive in the folder:

- Trauma Orthopaedic Department List
- Trauma Database

Click on the file "***DVH Trauma Database***" to open the file.

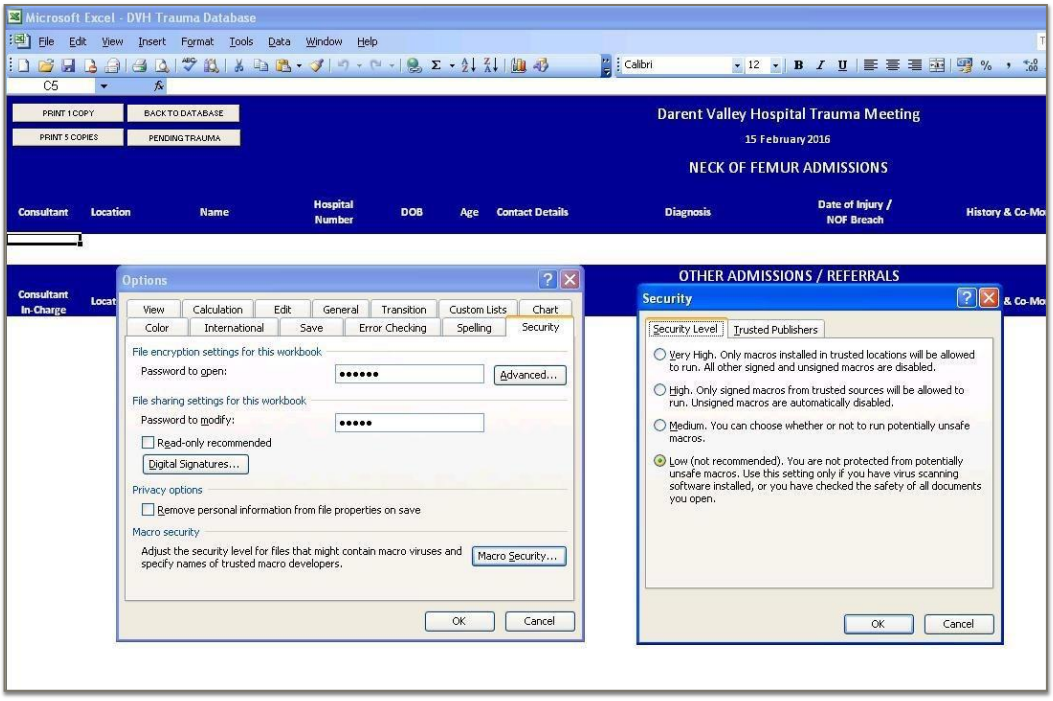
How to start using the database

Once you open the file, you will be prompted to enter a password. This password will be given to you on induction day. There are two passwords required. One to read, one to write.

In order to start using the database, the macro function must be enabled.

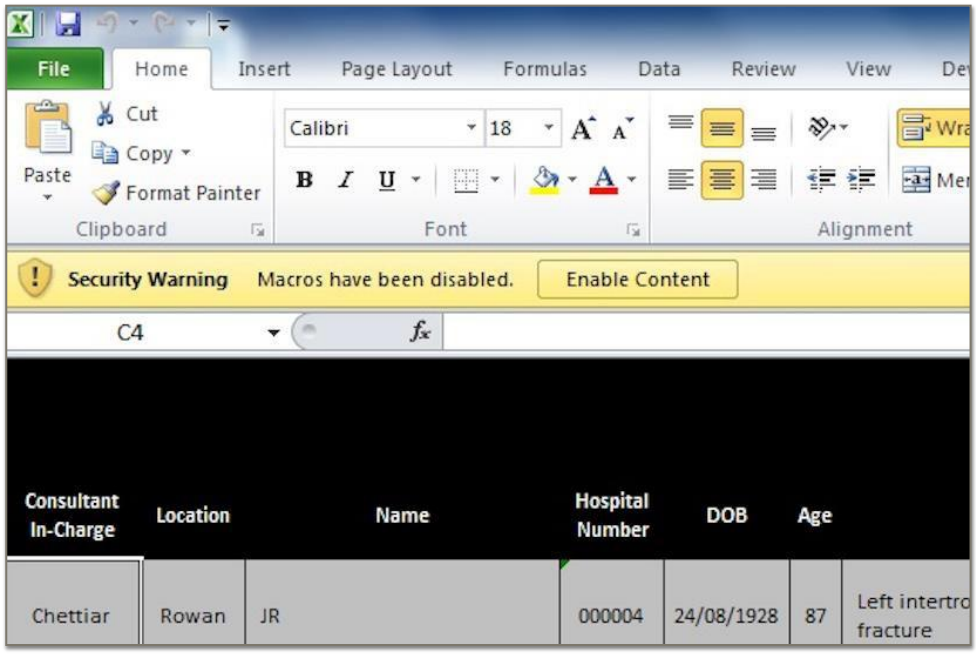
To do this in ***Excel 97*** or older: Go to Tools>Options>Security>Security Level

Choose the low security option for macro

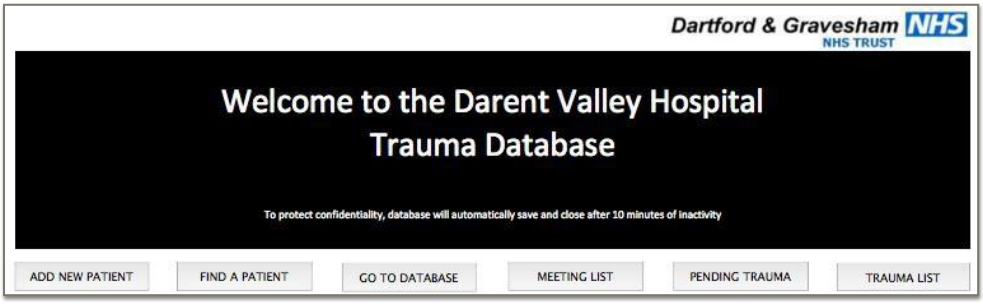


To do this in ***Excel 2000*** onwards:

When prompted, click on the yellow warning bar to enable macro

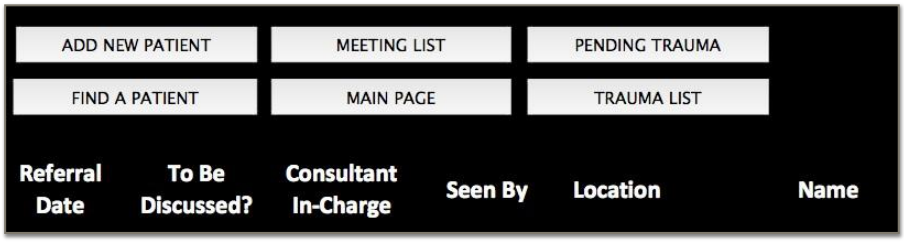


Database Main Page

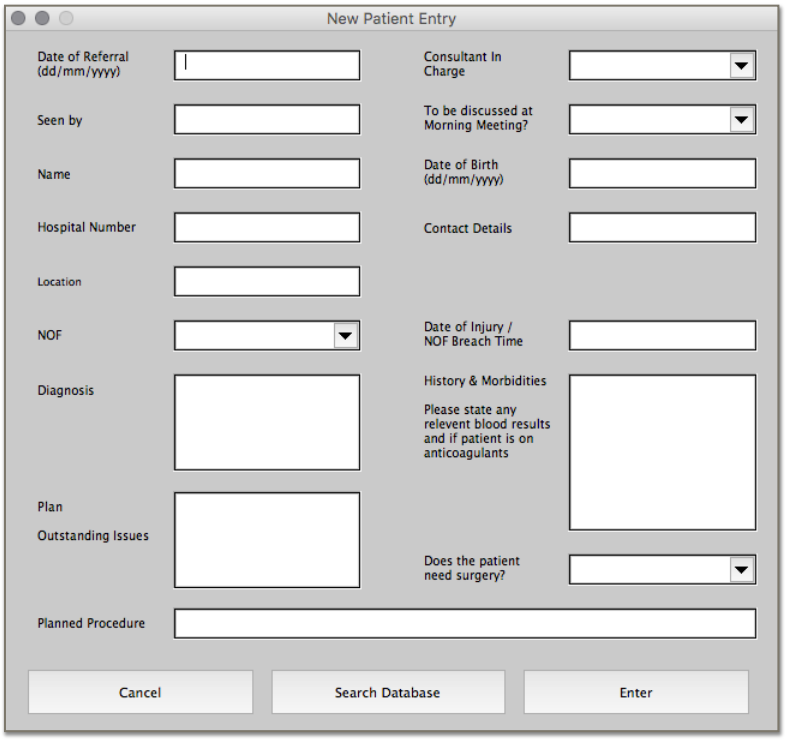


How to enter new patient details

To enter new data, simply click on the  button. This button can be found on the main page or the at the top left hand corner of the database page.



This will bring up a form which must be filled in as accurately as possible

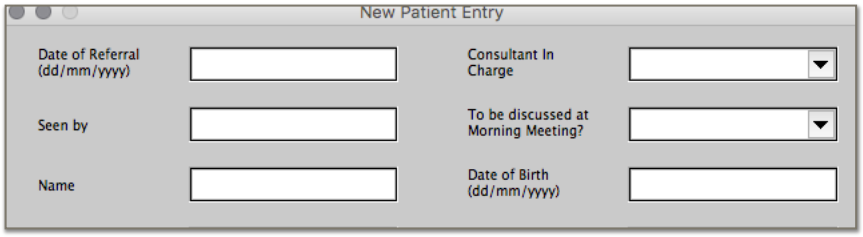


Once this has been done, patient's details will be entered into the main database. Based on information provided, the patient will be added into the trauma meeting printout or the pending trauma list.

To edit an entry, double click on the patient's hospital number and this will bring up the episode information. This can also be achieved by entering the patient's hospital number in the FIND A PATIENT function.

How to include a patient into the next trauma meeting printout?

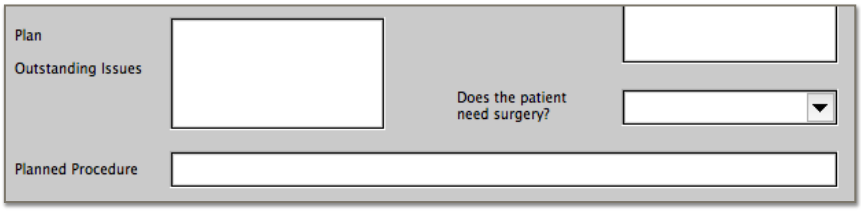
Simply select option "**Yes**" in the box "**To be discussed at the morning meeting?**"



The converse is true. Once that patient has been discussed or does not need to be discussed at the next trauma meeting, please change this to "**No**"

How to provisionally put a patient on the trauma list?

To put patients on the next trauma list, choose the option "**On Trauma List**" in the box circled below on the data entry form.



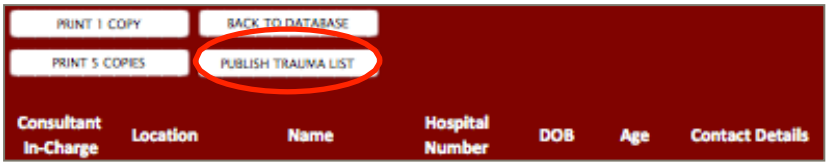
If the patient requires surgery but is not for the next available trauma list, choose the option "**Awaiting Surgery**".

How to order the trauma list?

On the *pending trauma tab*, double click on the patient in question. This will bring up a specific form with an additional ability to order the trauma list. This box is unlabelled and is on the right hand side of the "Planned Procedure" text box.

Please ensure ***each*** patient on the trauma list is given an order.

Once an order has been agreed, publish the finalised trauma list by clicking the button on the top left hand corner of the *pending trauma tab*. Printing this page is done by clicking the appropriate button at the top of the *trauma list tab* and this will come out of the printer in the nurses desk at the Surgical Admissions Lounge (SAL).



Please hand the published trauma list to:

- Surgeons in charge of trauma list (consultant & registrar)
- Trauma theatre nurse in charge
- One copy to each of the wards with the patients on the trauma list
    - If patients are coming from home, please give a copy the list to the nurses at the Surgical Admissions Lounge (SAL).

Trauma Calls

Trauma Calls are not common at Darent Valley. However on the occasions that they do present, they are specifically run by the A&E Seniors and the Surgical Registrar with help from Anaesthetics.

To reiterate: Orthopaedics are not involved in the primary survey. The registrar is off site on call.

Orthopaedic involvement is only required for the secondary survey, by the on call SHO.

You are however expected to attend the trauma call and must liaise quickly with the registrar on call to inform them of what trauma has come in, and what Orthopaedic injuries are present.

If you feel you have been placed in a position of responsibility beyond your capabilities you must highlight this immediately to your Registrar/Consultant on call.

Consenting

Only CT1 trainees and above are allowed to consent patients for procedures. If you are unsure whether you are allowed to consent or not, discuss this with your clinical supervisor.

You must only consent for a procedure if you feel you are able to perform the operation in full or you have observed the procedure on a number of occasions such that you know the steps in detail and feel you can answer questions on all topics relating to it, including the associated complications.

Do not consent for a procedure if you have not seen it or know enough about it. If you are asked by a senior to do so, politely explain that you are not able to consent the patient, for the above reason.

When marking the patient ensure that you confirm the limb to be marked based on the history, examination AND radiographic evidence. FY doctors are not allowed to mark .

Use a permanent marker pen (not a whiteboard/washable marker).

Image Linking

During the day, image linking is done by the PACS secretaries who can be found in the Xray Department.

You will be required to fill out a form which highlights to where the images are being linked, patient identifiable information, the scans required and the urgency.
Ensure you have all such details to hand before attempting to fill out the form to avoid errors. If image linking is urgent, there is an option to “blue light” the images which will then be received by the accepting hospital much quicker.
During the night, the PACS secretaries are not around and therefore image linking is done by the oncall radiographer. They will usually be found either in the xray department or in the CT control room. They can also be contacted by bleeping #505.

Repatriations

You may receive a call from another unit, requesting permission to repatriate patients back to Darent Valley Hospital.

Be very careful when taking this referral.

The following information must be sought when taking such a referral:

1) The patient details

2) The date and type of injury

3) Surgery performed thus far

4) A clear post operative plan

5) Any plans for further surgery +/- follow up plans

6) The general condition of the patient including comorbidities

7) Images taken from the referring unit have been linked to our hospital

8) The name of the referring clinician and contact details

9) The name of the Consultant in charge of the patient's care.

If in any doubt whatsoever, inform the referrer that you cannot accept this patient yet and politely suggest that you will discuss this case in the morning trauma meeting.

There have been numerous occasions whereby inappropriate repatriations have been accepted.

If you have done all of the above, and you and your on call team are happy to accept the patient, this must be updated on both the Trauma Database and the white board in the Orthopaedic seminar room.

NOTE: the Consultant from DVH in charge of this patients care, will be the consultant who is on call when the request for repatriation was made, NOT the consultant on call when the patient arrives on the ward.

CEPOD

CEPOD or NCEPOD as it is correctly known stands for:
National Confidential Enquiry into Patient Outcome and Death.

Within the hospital, CEPOD is the recognized term for the emergency theatre.

Typically Orthopaedic procedures will be performed within designated elective or trauma lists. However, at times, certain admission will require patients to be booked onto CEPOD.

Examples include:

- Reduction of a dislocated joint after 17.00
- Fractures with neurovascular compromise
- Septic patients secondary to a septic arthritis requiring urgent aspiration +/- washout
- Septic patients secondary to an infected prosthetic joint requiring urgent aspiration in theatre

This list is by no means exhaustive.
Also be aware that certain procedures will need to be performed on CEPOD on a Saturday as there is no designated trauma theatre.

If you are at all unsure, your registrar will inform you if a patient is required to be put on CEPOD so don't worry about making this decision.

The CEPOD theatre technically runs until 00.00 after which only diagnoses that are life or limb threatening will be performed. Realistically, CEPOD theatres tend to close down by 22.00. This should be considered when attempting to book a CEPOD case. If you and your registrar think a case needs to be that night, you must present your case with confidence to the oncall anaesthetist and theatre staff.

When booking a patient on CEPOD:

1) This must be done electronically via patient centre. There is no other way to do this.

2) You must notify the oncall anaesthetist BEFORE you book the patient.

3) Ensure that the ward and patient are aware of their imminent surgery.

4) Be aware that emergency surgeries scheduled before yours could go on for longer than expected. It is therefore important that should there be any delays, both the ward and patient are informed.

5) If you are informed that your CEPOD case is going to be cancelled, you MUST INFORM THE WARD AND PATIENT and consider when the surgery may next be performed.

Spinal Referrals

It is important to remember that the Orthopaedic Department at DVH does not have a spinal unit nor does it have Consultant Spinal Specialists. Therefore our unit acts as a middle man, liaising directly with Kings Neurosurgery for management plans.

Whilst on call you will receive referrals for spinal pathology. This can be a minefield. This section will hopefully shed some light on which referrals to accept.

Referrals from AE

Generally the referrals that we would accept without too much questioning are:

1) Suspected Cauda Equina
2) Lumbar vertebral fractures

Referrals from A&E for cauda equina syndrome is one the golden tickets into the Orthopaedic Department. Some will seem questionable whilst others, very concerning. These referrals should be taken seriously as a true cauda equina has devastating consequences.

These patients require the standard clerking as described in section……. as well as a detailed neurological examination and an online submission to the Acute Neurosurgical Referral System (See below).

Any other vertebral fractures should be discussed with Kings by the A&E clinician first. Only once a plan has been received and clearly documented in both the notes and the online neurosurgical system, can we then accept and clerk in the patient.

There is no specialist Spinal services available at DVH.

Ward Referrals

Any clinician making a ***ward referral*** to you for spinal pathology should be politely instructed to liaise directly with Kings. As the patient already has an allocated inpatient bed, it is the responsibility of the team looking after that patient to seek a management plan from Kings. This may seem harsh, but as stated earlier, the orthopaedic department does not have specialist spinal expertise and therefore is not able to make decisions regarding a patient's management plan.

To make a Neurosurgical referral:

1) Open the website

2) Log on (having already set up your account as outlined in Section…..)

3) Complete all sections with as much detail as possible

4) Ensure you have linked all relevant scans to Kings

5) Phone 02032994207 once you have completed steps 1-4

This can be a very challenging task.

Ideally if you have clerked in a patient requiring discussion with Kings, it is your responsibility to discuss this case with the Neurosurgical Registrar, so plan your time accordingly.

It is not fair to let your on call colleague discuss this patient on your behalf as they will not know the patient nearly as well as you do.

As Kings accept referrals from the entire South East Region, the phone will often be engaged or you will be placed on hold. There is no way around this, and persistence is a useful and necessary attribute.

You will be asked various questions so make sure you know your patient well.

Updates to the management of your patient can be found by accessing the "journal" section of the online referral.

Once you have a management plan, you should ideally print out the journal entry and place this in the patients notes OR you should hand write the plan that has been detailed clearly and concisely.

Once a patient is to be discharged, Kings should inform you of any required follow up. Once again, it is your responsibility to ensure that this is arranged and that the relevant secretary has been contacted to book the patient for a follow up clinic.

May we take this opportunity to remind you again, that DVH does not have spinal specialists and therefore, spinal patients will NOT be followed up at DVH.

Plastics Referrals

Patients will often be referred from A&E with various soft tissue injuries. DVH does not have a Specialist Plastic Surgeon and we therefore liaise directly with East Grinstead for our management plans. This should be considered for most hand fractures also.

If AE refer you a patient with extensive soft tissue damage, you must ensure that they have discussed this with East Grinstead, before you accept the patient. If you do not…. It will become your responsibility to chase this up.

Ensure that the referring clinician has verbally informed you of the plan and has clearly documented this in the notes.

If you find yourself in the situation that this has not been done, you must do the following:

1) Take a thorough history and appropriately examine the patient

2) Using the A&E camera, take pictures of the injury

3) Submit your findings with the appropriate images via the online TRIPPS referral system (as described on page 12

An alternative method, is to call East Grinstead directly and ask for the plastics trauma coordinator. They may well accept referrals via NHS Email (confidentiality maintained) providing steps 1 and 2 have been completed, but this is very rare.

Complex Trauma

Occasionally complex trauma will be admitted to the unit. At times these cases will require more specialist input.

The two centres we commonly refer to include:

Kings College Hospital Orthopaedic Department
Ashford and St Peters Hospital, Chertsey

To refer to Kings College Hospital Orthopaedic Department:

1) Ensure you have taken a detailed history and thoroughly examined the patient

2) Have adequate imaging of the fracture (AP and Lateral radiographs +/- CT scans)

3) Link the images to the department as described on page 34

4) Contact either the Oncall SHO or Registrar such that the case can be discussed in their morning trauma meeting

5) Provide correct contact details such that following discussion at their morning meeting, you can be easily contacted with the outcome.

To refer to Ashford and St Peters Hospital (Chertsey):

1) Ensure you have taken a detailed history and thoroughly examined the patient

2) Have adequate imaging of the fracture (AP and Lateral radiographs +/- CT scans)

3) Link the images to the department as described on page 34

4) Contact the trauma coordinator (Hazel – via switchboard and bleep 5204) and inform her of steps 1-3

5) Provide correct contact details such that following discussion at their morning meeting, you can be easily contacted with the outcome.

Training Roles (FYs and CSTs)

This section is in reference to SHOs allocated to training posts.

Foundation Year Trainees (FYs)

You should speak with your educational and clinical supervisors early in the rotation and identify what your learning objectives are.

As per your e-portfolio you should structure your role to ensure you are achieving these targets. This will include:

Getting to grips with the ward management of patients

Learning to deal with the on call

Ensuring you are liaising with the seniors in your team

You will have regular weekly teaching sessions organized by the Post Graduate Department. They will tell you exactly when this is and what the minimum attendance will be. You are expected to attend this teaching, but it is your responsibility to organize cover whilst you attend. If there is no cover available, you should not attend teaching as this will put your patients at risk if you are uncontactable. It is also worthwhile notifying the post graduate department of your absence and stating the reason why.

It is important to realise that other SHOs will have different learning objectives during their placement. The Core Trainees (CTs) for example will be spending more time in theatre as this is part of their curriculum and they have a minimum number of cases to achieve to ensure they pass the year. They will still provide you with support when needed and will help with the review of ward patients. If this is not the case, you must highlight this to them. If you continue to feel unsupported, then you must highlight this to your clinical supervisors.

If you are on top of all of the above, you are welcome to attend other teaching opportunities, such as clinics and theatre sessions. All members of the department are keen to teach and you should try to get as involved as possible.

Core Surgical Trainees (CSTs)

As a core trainee you should follow the curriculum as set out in the ISCP.

Make contact with your educational and clinical supervisors early in the rotation to highlight what is expected of you and what you should aim to achieve by the end of the rotation.

Having successfully completed 2 years of Foundation Training you should be fluent with the ward management of patients. Your key aim as a CST is to balance efficient ward management with clinic and theatre time.

You will be expected at the very least to have control on the wards and support your juniors. You should make yourself accessible to them and help them when needed. If you are not fulfilling this, you will find consultants will turn you away from clinics and theatre.

A good way to organize your time is to set out a timetable with your supervisor. This will give you structure to your week.

Getting into theatre can be difficult especially if your colleagues are on nights/post nights/leave. If this is the case, it is your responsibility to ensure important ward jobs are complete before you attend theatre. This should be done either by yourself, or with help from another firm.

CSTs are expected to attend two Trauma Lists per week, and are expected to see patients / review their consents / condition, PRIOR to coming to theatre. Attendance in theatre by CSTs is expected to be 1.30 prompt.

CSTs are expected to attend two clinics per week. It may not be necessary to stay for the whole clinic, but manage your time to ensure this happens.

Ward duties take precedence if patient safety is an issue, and you may not be able to attend theatre on that day.

There is no doubt, that being a ***GOOD CST*** is a difficult role to do well and it will require excellent organisational skills. You should speak to other CSTs in the hospital and indeed the deanery for ideas about how they achieve this task.

If you are consistently struggling to attend theatre, you must speak with your clinical supervisor and highlight this early on. There is no point getting to the end of the rotation or worse still your ARCP meeting and showing a logbook that lacks cases.

Teaching

There are a number of teaching opportunities within the department

1) Trauma Meeting

This occurs every morning and is a valuable resource. All patients referred are discussed with their histories and radiographs presented. It is an excellent opportunity to relate things you have heard/read about to real life cases. Consultants will quiz you and others on your knowledge.

You will soon realize that this is a very pleasant department and the environment is very conducive for learning unlike other departments you may have worked in. Our Consultants are keen to teach. They will push you, but don't feel intimidated.

If you are presenting in the morning this also offers you the opportunity to complete CBDs and CEXs with the Consultant on call. You must however discuss this with them, before you send out your requests.

2) Fracture Clinics

Again, an excellent opportunity to see "new" and "follow up" patients. Clinics run every day during the week in the morning and afternoon. They are consultant and registrar led and seniors would be more than happy to let you sit in.

Once you feel more confident, seniors will even let you see your own patients such that you can present the patients back to them. This is an excellent teaching opportunity not only for self improvement but also as a way to complete work based assessments (CEXs and CBDs)

3) Orthopaedic Departmental Teaching

A teaching programme is currently being organized specific to orthopaedics, led by Mr Chettiar. If you feel you would like more teaching on a particular topic, don't be afraid to add this to the list in the Registrar Room

4) Surgical Departmental Teaching

This is a weekly hour long teaching session set up by Mr Nastro (Surgery) and Mr Thilagarajah (Orthopaedics). It is surgical curriculum based, and the attendance of CTs and FY2s is mandatory. Please manage you morning duties to ensure you attend. Please complete the feedback forms and attendance register as this is passed on to Post Grad and can contribute to your mandatory training numbers. You will be found if you are not in attendance and few excuses will be accepted.

5) Morbidity and Mortality Meetings

These occur once a month and provide a valuable insight into complications that can occur, as well as acutely ill patients that have died. It is from these meetings that we can learn from our mistakes and ensure that we can improve our day to day practice.

Audit

There is a monthly Morbidity and Mortality Meeting. The details of this are explained below.

Within this meeting, is the opportunity for people to present audits and service improvement projects. Please ensure you meet with Mr Smith (Audit Lead) early to ensure you have a project or two. This is classed as a local presentation and is an excellent way of getting feedback for the projects you are involved in. Many people often go on to achieve poster and podium presentations following this as well as the occasional publication.

All SHOs are encouraged to take on at least one project and present it at this meeting during their time within the department.

It is also worth mentioning that Darent Valley Hospital holds a yearly audit competition and it is certainly worth submitting audit projects that have been presented at these meeting for this competition.

Morbidity and Mortality (M+M)

Over the course of your rotation you will inevitably come across complications of surgery and mortality of acutely unwell patients. Such patients provide a valuable learning experience such that we can learn to recognize these patients in future and try to improve our practice.

Any complications or deaths that occur within your firm, should be documented in the M+M Black Book located in the Registrar Room.

It is the SHOs responsibility to ensure that once a patient who has had a complication is discharged, that patients name is written in the book for the corresponding month. Equally, if a patient dies, the name of the patient should also be written in the corresponding month.

These cases are then presented at the monthly M+M meeting. It is the SHOs who present these cases, by firm, with the aid of the Registrars, who also review and contribute to the information.

M+M, make sure you adhere to the following steps:

1) Speak to your colleagues and ensure that they have added any Morbidity and mortality cases to that corresponding month

2) Gather the notes for all cases you are due to present (Sister Michelle Yeadon is a good point of contact if you are having difficulty with this)

3) Read the notes in their entirety for the admission in question and familiarize yourself with the case - discuss with your Registrar

4) Summarise each case on a couple of slides

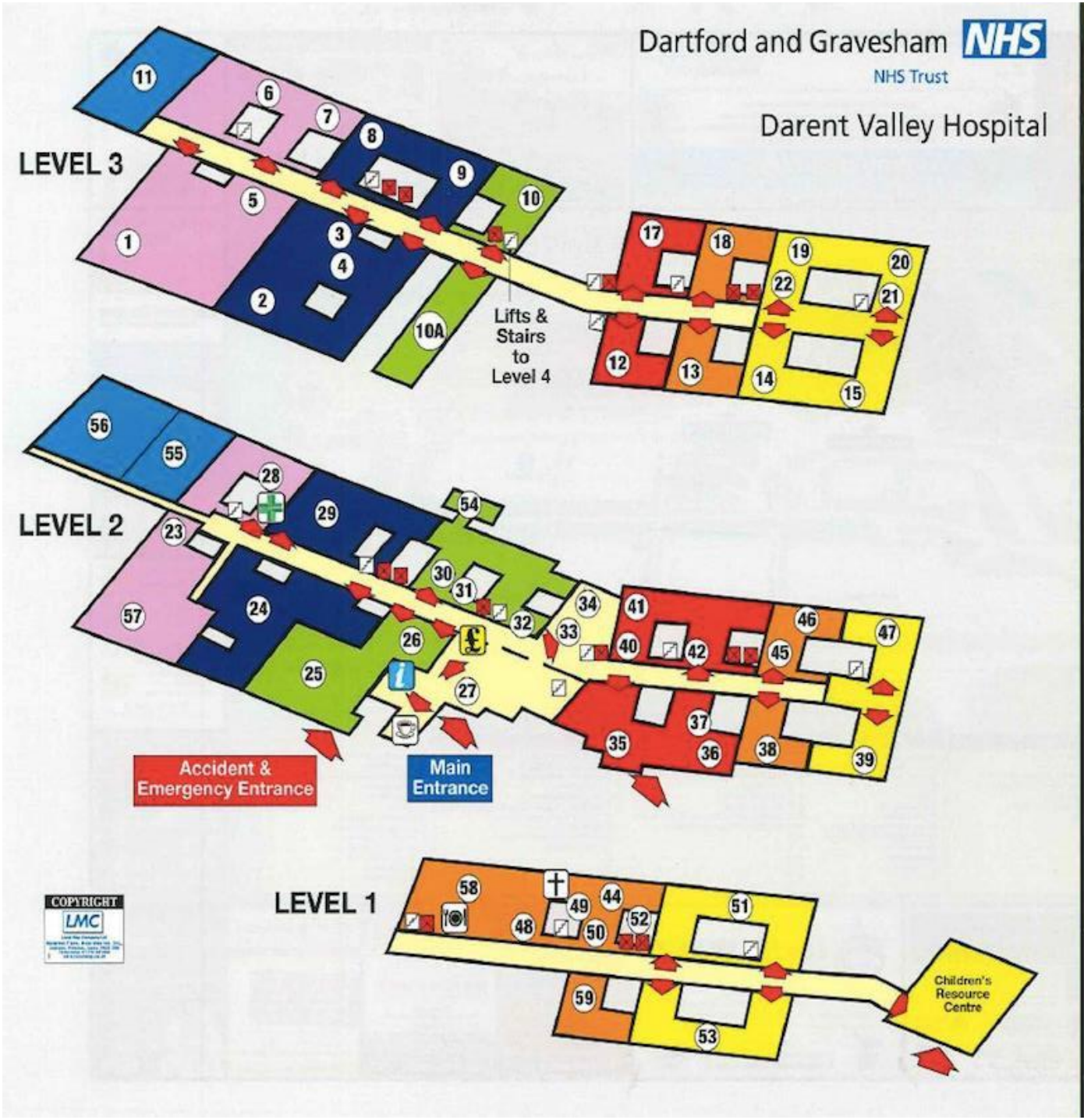
5) Involve your Registrars and Consultants in compiling this presentation as it is THEIR patients you are ultimately presenting, so details must be accurate.

6) Ensure that you have loaded the presentation onto the computer in the orthopaedic seminar room prior to the start of the meeting so you can ensure that your file is active.

7) If you are unable to get hold of any sets of notes, inform those at the meeting and carry that patients name forward into the next month, such that it can be discussed at the next meeting.

Appendix 1 : Useful Contact Numbers

AE Departments		Imaging	
AE Majors		CT Control Room	4958
AE Minors		MRI	4949
AE Resus		USS	8575
AE Paeds		Xray	4948 / 8568 / 8569
Medical Short Stay		Xray Bleep	505
Cypress Unit		Orthopaedic Specific	
Wards		Plaster Room	8872
Beech	8933 / 8670	# clinic reception	
CDU	8708 / 8701	# clinic nurse sta.	
Cherry	8874 / 8875 / 4994	Michelle Yeadon	8441
Dialysis Unit	8861	Specialties Bleeps	
Day Care (ACER)	8267 / 8268	Anaesthetic SHO	242
Elmcourt	01322 – 281744	Anaesthetic REG	230
Ebony	8675 / 8676	ITU SHO	242
ITU	8404 / 8405	ITU REG	230
Jasmine	1275 / 1287 / 1288	ITU Outreach	476
Juniper	8679 / 8680	Med REG	240
Laurel	5490	Med SHO	456
Linden	8683 / 8783	Neuro REG	101
Livingstone Hosp	01322 – 622374	Orthogeri SHO	105
Maple	4684 /	Orthoger. REG	283
Mulberry	8940 / 8677 / 4317	Surg SHO	561
Oak	8689 / 8688	Surg REG	232
Palm	8342 / 8970 / 8691	Other Bleeps	
Poplar	8107 / 8853	Pain Nurse	241
Recovery	8903	Pharmacy	115
Rowan	8695 / 4361 / 4362	Phlebotomists	228
Rosewood	8963 / 8972	Security	160
Redwood	8578 / 8577	Site Team	218 / 749
SAL	4699 / 4311	TVN	549
Spruce	8697 / 8105		
SSU	8152		
Theatres (Main)	8642		
Walnut	8936		
Willow	8702		
Departments			
Blood Bank	8501		
Pathology	8491		
Pharmacy	8491		
Social Services	8601		
Biochemistry	8478		



LEVELS 3 & 4

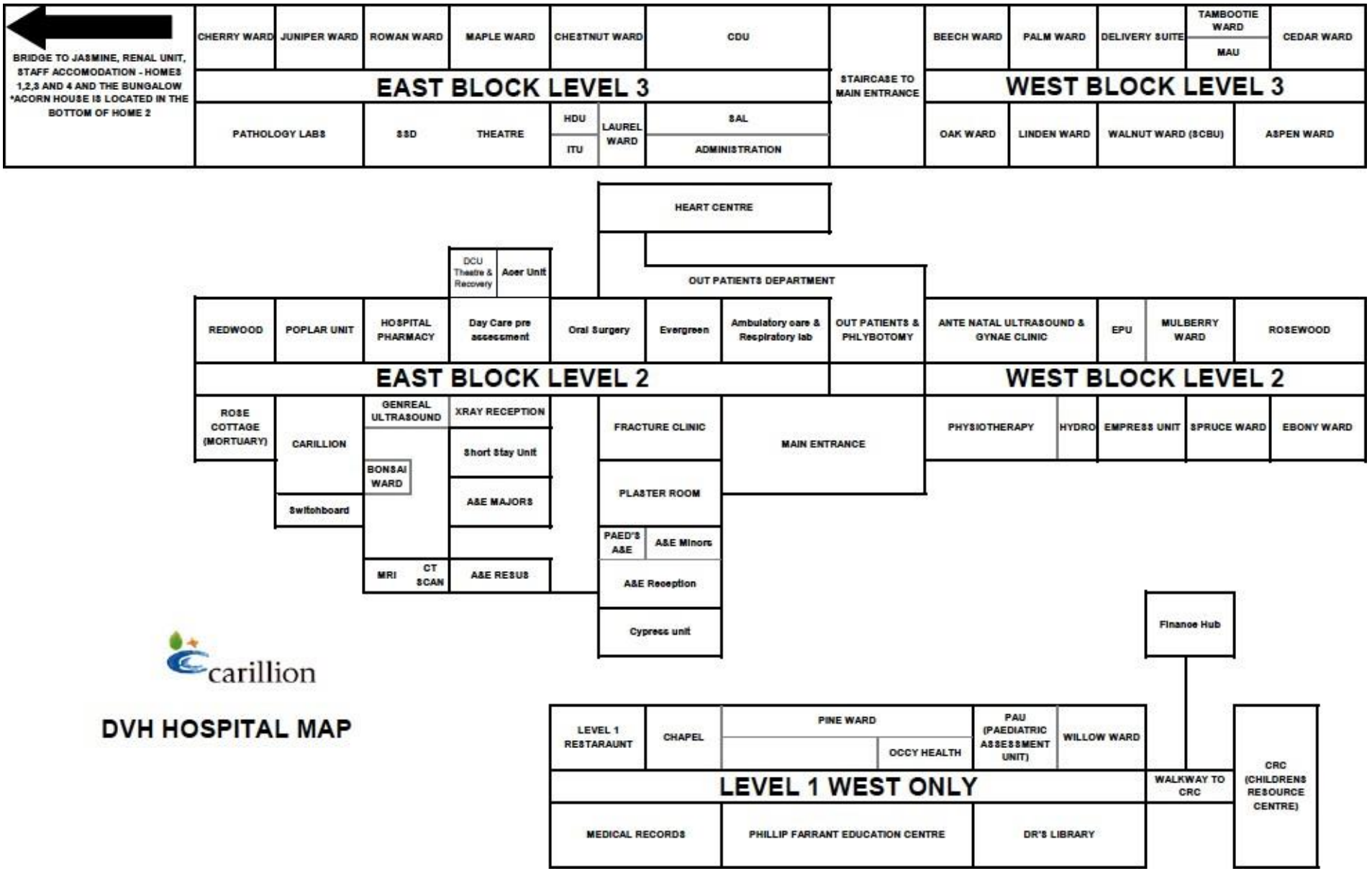
Aspen Ward (Midwifery Led Unit-MLU)	15
Beech Ward	17
Cedar Ward	20
Cherry Ward	11
Chestnut Ward	9
Clinical Decision Unit	10
Delivery Suite	22
Finance	(Level 4)
Information Management	(Level 4)
Intensive Thearpy Unit (ITU)	4
Juniper Ward	6
Laurel Ward (Coronary Care)	3
Linden Ward	13
Maple Ward	8
Oak Ward	12
Obstetric Theatres	19
Operating Theatres	2
Palm Ward	18
Pathology	1
Rowan Ward	7
Sterile Services (SSU)	5
Surgical Assessment Lounge	10A
Tambootie (Maternity Assessment Unit)	21
Trust HQ	(Level 4)
Walnut Ward	14

LEVEL 2

Accident & Emergency	25
Cardio-Respiratory Clinic	32
Cash Point	
Colposcopy	42
Day Care Unit	29
Ebony Ward	39
Endoscopy	29
Empress Unit	36
Evergreen	31
Fracture Clinic	26
Gynaecology Clinic	42
Heart Centre	54
Main Reception	
Mortuary	23
Mulberry Ward / Early Pregnancy Unit	46
Nutrition & Dietetics	40/41
Obstetrics / Gynaecology / Ultrasound	42
Ophthalmology	40
Oral & Maxillofacial Surgery	30
Orthodontist	30
Outpatients	34
Patient Services	27
Pharmacy	28
Phlebotomy	33
Physiotherapy	35
Popular Unit	55
Redwood Ward	56
Rehabilitation / Occupational Health	35
Rosewood Ward	47
Sapling Antenatal Clinic	45
Speech & Language Therapy	37
Spruce Ward	38
Support Services (Carillion)	57
X-ray	24

LEVEL 1

Chapel / Multi Faith Room	49
Children's Resource Centre	
Ellenor Foundation	50
Level One Restaurant	58
Library	53
Medical Records	48
Occupational Health	52
Outpatient Appointments	59
The Pine Therapy Unit	44
Willow Ward	51


BRIDGE TO JASMINE, RENAL UNIT, STAFF ACCOMODATION - HOMES 1,2,3 AND 4 AND THE BUNGALOW
*ACORN HOUSE IS LOCATED IN THE BOTTOM OF HOME 2
CHERRY WARD
JUNIPER WARD
ROWAN WARD
MAPLE WARD
CHESTNUT WARD
CDU
EAST BLOCK LEVEL 3
PATHOLOGY LABS
SSD
THEATRE
HDU
ITU
LAUREL WARD
SAL
ADMINISTRATION
STAIRCASE TO MAIN ENTRANCE
BEECH WARD
PALM WARD
DELIVERY SUITE
TAMBOOTIE WARD
MAU
CEDAR WARD
WEST BLOCK LEVEL 3
OAK WARD
LINDEN WARD
WALNUT WARD (SCBU)
ASPEN WARD
HEART CENTRE
DCU Theatre & Recovery
Acer Unit
OUT PATIENTS DEPARTMENT
REDWOOD
POPLAR UNIT
HOSPITAL PHARMACY
Day Care pre assessment
Oral Surgery
Evergreen
Ambulatory care & Respiratory lab
OUT PATIENTS & PHLYBOTOMY
ANTE NATAL ULTRASOUND & GYNAE CLINIC
EPU
MULBERRY WARD
ROSEWOOD
EAST BLOCK LEVEL 2
WEST BLOCK LEVEL 2
ROSE COTTAGE (MORTUARY)
CARILLION
Switchboard
GENREAL ULTRASOUND
XRAY RECEPTION
BONSAI WARD
Short Stay Unit
A&E MAJORS
MRI
CT SCAN
A&E RESUS
FRACTURE CLINIC
PLASTER ROOM
PAED'S A&E
A&E Minors
A&E Reception
Cypress unit
MAIN ENTRANCE
PHYSIOTHERAPY
HYDRO
EMPRESS UNIT
SPRUCE WARD
EBONY WARD
carillion
DVH HOSPITAL MAP
Finance Hub
LEVEL 1 RESTARAUNT
CHAPEL
PINE WARD
OCCY HEALTH
PAU (PAEDIATRIC ASSESSMENT UNIT)
WILLOW WARD
LEVEL 1 WEST ONLY
WALKWAY TO CRC
CRC (CHILDRENS RESOURCE CENTRE)
MEDICAL RECORDS
PHILLIP FARRANT EDUCATION CENTRE
DR'S LIBRARY

Appendix 3: Antibiotic Guidelines for Common Presentations in Orthopaedics

SKIN AND SOFT TISSUE INFECTIONS

Infection	First Line	Penicillin Allergic/2nd line
Cellulitis Organisms: Group A Streptococci, Staph. aureus	Benzylpenicillin IV 1.2g QDS +/- Flucloxacillin IV 1g QDS or Amoxicillin 1g TDS orally +/- Flucloxacillin 500mg QDS orally	Clindamycin IV 600mg - 1.2g QDS or Clindamycin orally 300mg QDS
	If MRSA carrier then give Vancomycin* IV as per Trust protocol * Vancomycin is dosed by actual body weight; see dosing table	
Wound Infections and Abscesses Organisms: Staph. aureus +/- Anaerobes	Flucloxacillin IV 1g QDS +/- Metronidazole IV 500mg TDS or Flucloxacillin orally 500mg QDS +/- Metronidazole orally 400mg TDS	Clindamycin IV 600mg - 1.2g QDS or Clindamycin orally 300mg QDS
	If MRSA carrier then give Vancomycin* IV as per Trust protocol * Vancomycin is dosed by actual body weight; see dosing table	
Superficial	Consider topical antiseptics e.g. povidone-iodine or chlorhexidine and seek specialist advice from Tissue Viability Nurse	
Animal and Human Bites Organisms: Pasteurella, Mixed gram positive organisms + Anaerobes	Co-amoxiclav 625mg TDS orally or Co-amoxiclav IV 1.2g TDS (if septic)	Doxycycline 200mg stat then 100mg OD orally (BD if severe infection) + Metronidazole 400mg TDS orally If contraindicated consult Microbiologist
Impetigo - Infected eczema Organisms: Staph. aureus, Group A Strep	Flucloxacillin 500mg QDS orally 7 days	Erythromycin 500mg QDS orally
	Topical Fusidic acid could be used for small discrete areas but resistance develops rapidly	
Herpes zoster (Shingles)	Aciclovir 800mg 5 times/day orally 7 days (10mg/kg TDS IV if patient is immuno-compromised)	
Herpes simplex Recurrent labial and genital herpes simplex	Aciclovir 200mg orally 5 times/day for 5 days (400mg if patient is immuno-compromised or absorption impaired) Aciclovir IV 5mg/kg TDS for immuno-compromised patients Aciclovir cream 5 times/day for 5-10 days	
Intravenous Catheter - related infection (+/- septicaemia) Organisms: Staph aureus, Coagulase negative staph.	Vancomycin* IV as per Trust protocol * Vancomycin is dosed by actual body weight; see dosing table	

URINARY TRACT INFECTIONS

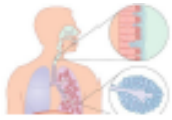
Send urine for Culture & Sensitivities a dips tick pos itive (leukocytes and/or nitrites).
If infection not severe await results before starting treatment. Always check preYious urine ct.ltures.
Amoxiciflin should nol boused ompirically for UTI's, only on basis ol results.

Infeetion	First Line	Penicillin Allergic/2nd line
Uncomplicated UTI	•Nitrofurantoin (1st line) 50-100mg orally ODS or Trimethoprim 200mg orally BD 3 days 1/Nomen) ' Nitrofurantoin (1st line) 50-100mg orally ODS or Trimothoprim 200mg orally BD 7 days (Mon) •Nitrofurantoin is contra-incfacated with an eGFA < 45mVmin'1.73m-2 tf oGFR is 30 to 44mVminl 1.73m2 discuss with Microbiologists Pharmacist If recent oourse of either Trirnethopri m or Nitro furantoin or oral route compromised then give Gentamicin• IV as per renal function and check MSU sensitivities	Consult Mia ob iologist
In Pregnancy	&CCXln 500mg orally 86 3 days	Consult Microbiologist
Pyolono ph ri ti s o r Bacteraa mia 2° to UTI **and** Cathelar asso ciated se psis	Ami kacin • IV as per renal function	Ciprofloxacin 500mg BD orally
	In sep6c shock add Amikacin· IV asper renal function If MRSA carrier plus sepsis w;t_h urinary catheter add Va.neomy cin • IV asper Trust protocol • Amikacin/Gentamicin is dosod by idoallcorroctod bodyweight and renalfunction; see dosing table • Vancomycin is dosed by actual body weight: soo dosing table	

UPPER RESPIRATORY TRACT INFECTION

Infeetion	First Line	Penicillin Allergic/2nd line
ons I Ib s Organisms: Most viral, Group **A** Stroptocccci	Penicillin 500mg QDS orally 7 days	Erythromycin 500mg QDS orally
Otitis media + Sinusitis Organisms: Pneumococci, Haemophilus inftuenzae (**NB** Most do not nood antibiota)	Amoxicillin 500mg TDSorally or Co-amoxiclav 625mg TDS orally	Erythromycin 500mg ODS orally
Epiglottili s Haemophilus inftuenzae (rare since Hib vaccination)	Celotaxime IV 1g TOS	**Anaphyfaxis -** Levoflox aci n IV 500mg BD

LOWER RESPIRATORY TRACT INFECTIONS



Send sputum and blood culture before starting treatment if possible.

Infection	First Line	Penicillin Allergic/2nd line
Community-acquired pneumonia Organisms: Pneumococci, Legionella, Mycoplasma ***Record CRB-65 and evidence of chest x-ray consolidation.*** **C**onfusion (new onset) **R**espiratory rate ≥ 30/min **B**P < 90mmHg (systolic) or ≤60 (diastolic) Age ≥ **65** years	**NON SEVERE (CRB-65 score 0-2)** **Amoxicillin** PO 1g TDS +/- **Clarithromycin** PO 500mg BD If oral route compromised give **Benzylpenicillin** IV 1.2g QDS +/- **Clarithromycin** IV 500mg BD	**Clarithromycin** PO/IV 500mg BD or **Doxycycline** PO 200mg stat then 100mg OD
	Duration 7 days	
	SEVERE (CRB-65 score 3-4) **Benzylpenicillin** IV 1.2g QDS + **Levofloxacin** IV 500mg BD	**Cefuroxime** IV 1.5g TDS + **Clarithromycin** IV 500mg BD **Anaphylaxis** – **Levofloxacin** IV 500mg BD + **Gentamicin*** IV as per renal function
	In septic shock add **Gentamicin*** IV as per renal function ***Gentamicin** is dosed by ideal/corrected body weight and renal function; see dosing table	
Hospital acquired pneumonia (HAP) or Aspiration pneumonia Organisms: Pneumococci, Gram negative organisms, Staph. aureus, especially MRSA, Anaerobes Definition: Abnormal chest x-ray, High temperature, Increased sputum production	**< 5 days of admission** – **Amoxicillin** IV 1g TDS + **Metronidazole** IV 500mg TDS 5-7 days	**Levofloxacin** IV 500mg BD 5-7 days
	> 5 days of admission – **Piperacillin/Tazobactam** IV 4.5g TDS	**Levofloxacin** IV 500mg BD + **Metronidazole** IV 500mg TDS
	In septic shock add **Gentamicin*** IV as per renal function If MRSA carrier add **Vancomycin*** IV as per Trust protocol for aspiration pneumonia and ventilator associated pneumonia (VAP) * **Gentamicin** is dosed by ideal/corrected body weight and renal function; see dosing table * **Vancomycin** is dosed by actual body weight; see dosing table	
Exacerbation COPD **NB:** Most are viral Organisms: Haemophilus influenzae predominantly *Only give antibiotics if increased sputum volume, and/or sputum is purulent*	**Doxycycline** 200mg stat orally then 100mg OD 7 days	
Pulmonary Tuberculosis	**Rifampicin** + **Isoniazid** + **Pyrazinamide** + **Ethambutol** **NB** Visual testing required. Monitoring of LFTs required in all cases. Discuss with Chest Physician	

Appendix 4: Useful Orthopaedic References

Online

AO Surgical Reference	*https://www2.aofoundation.org/wps/portal/surgery*
Orthobullets	*http://www.orthobullets.com* *The best way to use this site is by typing into google the fracture you want more information about and following it with "orthobullets". This will link you straight to the relevant page.* *Ie: Distal radius fractures orthobullets*
Radiopaedia	*http://radiopaedia.org* *For the best way to use this site, see above*

Books

Apleys System of Orthopaedics and Fractures (9th Edition)
-Solomon, Warwick and Nayagam

Apley and Solomons Concise System of Orthopaedics and Trauma (4th Edition)
-Solomon, Warwick and Nayagam

Pocketbook of Orthopaedics and Fractures (2nd Edition)
-McRae

Practical Fracture Treatment (5th Edition)
- McRae

Appendix 5: Annual Leave Request

Dartford and Gravesham NHS Trust

APPLICATION FOR ANNUAL LEAVE

Postgraduate Doctors in Training (FY1/FY2/CT1/CT2) and SHO Level Specialty/Trust Grades

- Applications for leave must be submitted not less than 6 weeks before the first intended day of leave.
- This form should be **submitted to the Junior Doctor Rota Manager** after discussion/agreement with your Supervising Consultant and colleagues (you must ensure that arrangements are made for continuation of the clinical service during your absence).
- It is your responsibility to inform all relevant parties of your leave.
- Any cover or swaps that have been arranged, must be recorded on this leave form.

Name:	Grade:
Specialty you will be working in when this leave occurs:	
Date From:	Date To:
Total No. of Days:	

SCHEDULED ON CALL/SHIFT TIMES DURING LEAVE PERIOD				
DAY	**DATE**	**Day Shift ✓**	**Night Shift ✓**	**Name/Signature of Person Covering You**
MON				
TUE				
WED				
THU				
FRI				
SAT				
SUN				

I declare that I have made appropriate arrangements for cover of my On Call/Shift Times, and discussed this with the relevant individual(s) within my Directorate. Signed:	Date form submitted to Junior Doctor Rota Manager: Authorised by Junior Doctor Rota Manager:
Comments:	

Rota Updated	Leave Record Updated		File

Appendix 6: Study Leave Request Form

APPLICATION FOR STUDY LEAVE AND ASSOCIATED EXPENSES: POSTGRADUATE DOCTORS IN TRAINING

Dartford and Gravesham NHS Trust

Doctors must consider the following prior to arranging study leave:

- Study Leave application forms must be submitted at least SIX WEEKS prior to the educational activity.
- Doctors MUST discuss their request for study leave with the Rota Manager to ensure all clinical commitments are covered. Therefore doctors must gain signatures relevant to the time they wish to take the leave. LOCUMS CANNOT BE ARRANGED
- All claims for reimbursement of funds should be submitted no later than two calendar months following the month in which the expense is incurred (in line with Trust Policy)

PERSONAL DETAILS	
Full name:	Training Programme:
Grade: (please circle): Foundation/ Core/ Higher/ GP	Educational Supervisor:
Contact telephone/bleep:	Email Address:

EDUCATIONAL ACTIVITY DETAILS			
Study leave dates requested:	From:	To:	No of days:
Specialty in which you will be working during which study leave is being taken:			
Requesting time for: (please circle)	COURSE / EXAMINATION / MEETING OR CONFERENCE / PRIVATE STUDY PRIOR TO EXAM.		
Details of activity: Title			
Location			

DETAILS ON EXPENSES BEING REQUESTED FOR REIMBURSEMENT:		
All claims for reimbursement of funds should be submitted no later than two calendar months following the month in which the expense are incurred (in line with Trust Policy). Any receipts submitted after this time will not be reimbursed.		
1. Course/Meeting fee (examination fees cannot be claimed):		£
2. Travel:	Means of travel: (please circle): RAIL ROAD AIR	
	Cost of Travel:	£
If travelling by road, please declare total number of miles (including return journey). Please note mileage will be checked against AA Route Planner.		miles Total amount £
3. Subsistence (if not included in course/meeting fees). Provide details of subsistence.		£
TOTAL EXPENSES REQUESTED (funds will only be reimbursed on the submission of receipts to the Medical Education Department within two months of the date of the receipt)		£
COVER FOR CLINICAL DUTIES: Doctors MUST arrange cover for clinical commitments prior to submitting this form. LOCUMS CANNOT BE ARRANGED.		

SPONSORSHIP:	
Was support obtained from an external organisation for you to undertake this educational activity?	Yes / No
If so, which organisation(s) is providing support?	
Is there any conflict of interest between your clinical role and the sponsorship received?	Yes / No
Any external support for training also needs to be declared on the Trust's Gift, Hospitality and Sponsorship Form (see ADAGIO)	

PLEASE TURN OVERLEAF FOR APPROVAL SECTION (PTO) →

APPROVALS	
Doctors are responsible for gaining approval for their Study Leave in order for the educational activity to be undertaken. Forms submitted without the required approval will be returned to the doctor and Study Leave will not be authorised.	
Approval required from Educational Supervisor AND Rota Manager It is important that the educational activity is discussed with your Educational Supervisor. This is to ensure the request is relevant to your training and development.	
Educational Supervisor's name/signature:	
Date:	

Approval is subject to service commitments being covered and six weeks' notice given. You **MUST** discuss this request with the Rota Manager **FOR THE PERIOD THAT YOU ARE REQUESTING THE LEAVE**.	
Rota Manager's name/signature:	
Date:	

DOCTOR'S SIGNATURE	
Signature:	
Date:	Grade:
The signature of the Director of Medical Education or College Tutor will be obtained by the Medical Education Team. Should approval not be granted you will be contacted immediately.	

PLEASE SUBMIT YOUR COMPLETED APPLICATION FORM TO THE MEDICAL EDUCATION DEPARTMENT FOR PROCESSING.

For office use only:	
Director of Medical Education signature:	
Date:	
Days remaining:	Funds remaining: £
Finance to pay: £	Code: DG-537-000/3H380 (trainees)
Form Received:	Passed to Finance for payment:

Appendix 7: Sickness and Return to Work Form Part 1 (Part 2 must also be completed overleaf)

Return to Work following Sickness Absence Interview Form

Surname:		**Forenames:**	

Interviewing Supervisor/Consultant:	
Directorate:	

Sickness Absence:	**From:**	**To:**
Number of working days:		

Reasons for sickness absence:	
Details of discussion:	
Details of agreed action:	

Were you on-call during your absence?	**YES**	**NO**

For Postgraduate Doctors in Training Only	
Training opportunities missed:	

Reported to Rota Managers:	**Date reported and who to:**

Signatures:		
	Doctor	**Date**
	Supervisor	**Date**

Declaration

I declare that no secondary employment has been undertaken during the sickness period, and that the information provided is true and complete.

Please note to make a false declaration may result in disciplinary action.

Signed:..... Dated: .....

Appendix 7: Sickness and Return to Work Form (Must be completed with Part 1)

SICKNESS ABSENCE - SELF-CERTIFICATION FORM

This sickness absence self-certificate should be completed for any and all absences up to and including 7 days. Anything longer than this requires a GP certificate.

You should include weekends and other days not normally worked (Unless you notified your manager in advance that you were fit and would be returning to work as usual).

Personal Details

Surname .....

Forename .....

Date of Birth ..... / ..... / .....

Grade ..... Dept .....

Absence Details

Please give brief and accurate details about your sickness (Words like 'Sickness and 'Unwell' are not sufficient):

.....

.....

What date were you first absent from work: ..... / ..... / .....

What date did you become fit for or return to work (which ever date comes first): ..... / ..... / .....

How many days were you absent in total: ..... days.

Was this absence caused by an accident at work or by an industrial disease? Yes ☐ No ☐

I declare that no secondary employment has been undertaken during the sickness period, and that the information provided is true and complete.

Please note to make a false declaration may result in disciplinary action.

Signed ..... Date ..... / ..... / .....

Signed by Consultant .....

Name (Please Print) ..... Ext.....

When completed – please return this form to the Junior Doctor Rota Manager, c/o Medical Directorate, off Palm Ward.

Appendix 8: Special Leave Request

Special Leave Request

For the applicant to complete

Name:

Date:

Department/ Directorate:

Reason for request:

For the manager to complete

Manager's Name:

Signature:

Date:

Request granted/ not granted. (If not granted please give reasons below)

Copy sent to HR Date:

Appendix 9: Extra Duty Claim Form

DARTFORD & GRAVESHAM NHS TRUST
EXTRA DUTY CLAIM FORM

Week Commencing :		Locum Name :
Grade :	Specialty :	Site : DVH / QMH (please circle)
Person you are Covering :		Reason for Cover :

	DATE	START TIME	FINISH TIME	HOURS	SESSION	COVER	REASON
MONDAY							
TUESDAY							
WEDNESDAY							
THURSDAY							
FRIDAY							
SATURDAY							
SUNDAY							
			TOTAL				

1) I certify that this work does not breach the Contract Hours controls set out in paragraph 20 in the Terms and Conditions of Service.

2) I agree to disapply the limit on working hours in regulation 4(1) of the working time regulation 1998. I agree therefore that my working time will exceed 48 hours in this period of seven days as defined in the 1998 regulations.

Locum Signature :	Home Address :

TO BE AUTHORISED BY CONSULTANT OR MOST SENIOR MEMBER OF TEAM OR NURSE MANAGERS

Authorised by (Name):	Signed :

Please complete or delete as appropriate (This information is necessary for Pension/Superannuation purposes)

I am holding a Full time/Part Time appointment in the NHS on the above dates:

1) Trust/Hospital: .....

2) Grade : .....

3) If Part-time, number of sessions : .....

Payment is dependent on this time sheet reaching the Rota Management Office, Medical Directorate, Palm Ward, Level 3, Darent Valley Hospital, Dareeth Wood Road, Dartford, Kent DA2 8DA

Please pay the above named for ..... Hours/sessions at the rate of £.....ph

Signed ..... Date.....
Rota Manager

FOR OFFICE USE:

Signed.....Clinical Director Date.....

Print Name.....

COST CENTRE/EXPENSE CODEeptember 2013

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