Orthopaedic Handover

Hope that you are looking forward to this block, there are lots of learning opportunities and once you get used to the workload it can be quite a nice rotation.

Ward on call bleep 49989

SHO on call 49999

Reg on call 42022 — best to get their phone number and call them as it is more efficient and when they are NROC bleeps don't work that far away from the hospital

Ask to get an etrauma account from the trauma co-ordinators and then practice using it with them before your first on call shift. All admissions and any patient you see on call should be placed onto the system. If you are admitting the patient select the admit operation, if they will need an operation create a new theatre slot and put theatre 2 as the theatre. If patients are not admitted they will normally be triaged through the VFC (virtual fracture clinic) or brought back in person and the etrauma entry will be needed to track them.

If you are interested in surgery, there is lots of opportunity to go to theatre and develop your skills. If this is something that you are interested in, you can go to theatre at any point as long as the ward is okay and covered. I would recommend going at midday if all urgent jobs are completed then returning to finish the remaining jobs. Or just try and blast through everything and go after. Make sure you have handed over any important stuff to chase etc to your colleagues

There are multiple ways to approach the wards, but generally you should always be with one other person, so split Digby in half and Shuttleworth into Bays, A, B side room 27 and 28, and C, D side room 25, 26.

In the morning hopefully all the bloods for the day will have put out the day before, some people this rotation have prepped notes the day before to make the morning faster. Others prefer to grab an IPad first thing and use that whilst prepping the notes. Can access Web V on it.

Always check the blue sheets which are Dr Mathew patient reviews as there are normally jobs found on them, most of the jobs Dr Mathew completes himself but it is always worth checking. He will also include if he wants an outpatient follow up for the patient in his clinic.

Before the weekend make a weekend jobs list to give to the on call so that anything urgent over the weekend is completed and is not missed.

When discharging a patient you must also book any Orthopaedic follow up required using the internal ereferral system, otherwise thew patient will not have a follow up appointment made. To find this system go on ereferrals, then orthopaedics, outpatients and put in the clinic code for the consultant who operated as they will be the discharging consultant.

If you need to book them into a spinal clinic with Mr Paskou, who is a spinal surgeon who normally visits once a week, then book them into Mr Gales clinic on the selection menu.

All NOFs required 28 days Enoxaparin, and all ankle injuries require 6 weeks (trust guidance).

Standard dose is 40mg SC OD

body weight below 50kg requires 20mg SC OD

Body weight above 100kg is 40mg BD

United Lincolnshire Hospitals NHS Trust

Low Molecular Weight Heparins: product and dosing guidance for thromboprophylaxis

Dose for adult medical/surgical patients

Dalteparin 2500unit and 5000unit injections: Please reserve for use in patients with eGFR <20 and/or haematology advice

Body Weight (kg)	Renal Function (*eGFR*)*	LMWH product and dose (subcutaneous)
<50	<20	Contact haematology
	≥20	Enoxaparin 20mg (2000 units) OD
50 – 100	<20	Dalteparin 2500 units OD
	20 - 29	Enoxaparin 20mg (2000 units) OD
	≥30	Enoxaparin 40mg (4000 units) OD
101 - 150	<20	Dalteparin 2500 units OD
	20 - 29	Contact haematology
	≥30	Enoxaparin 40mg (4000 units) BD
>150	<20	Dalteparin 2500 units OD
	20 - 29	Contact haematology
	≥30	Enoxaparin 60mg (6000 units) BD

*If there is any doubt about the accuracy of the eGFR measurement (e.g. very small or large patients) then the creatinine clearance should be calculated using the Cockcroft-Gault formula

Renal Impairment
For patients with eGFR<20, anti-Xa level at 3 hrs post dose if continuing for more than 3 days. Contact haematology for interpretation. Ensure the request form for anti-Xa level specifies dalteparin.

Body weight <50kg or >150kg or patient at increased risk of bleeding
Anti-Xa level at 3 hrs post dose if continuing for more than 3 days. Contact haematology for interpretation. Ensure the request form for anti-Xa level specifies dalteparin or enoxaparin.

Dose for obstetric patients

Body Weight (kg)	Enoxaparin Dose (subcutaneous) (Creatinine Clearance* ≥30)
<50	20mg (2000 units) OD

The trauma co-ordinators are really friendly and super helpful so go to them if you need any advice or support.

All check the post op notes, lots of info, including follow-up will be there. You can normally find it in the notes because the top right corner will be highlighted in red.

All hemis and total hip replacements will require check X-rays after the operation.

DHS and Gamma nail do not as there should be intra-operative imaging.

Most patients will require post op bloods including U&E and FBC (Dr Mathew will sometimes request LFTs post op so check his documentation)

SAL will constantly be annoying you with jobs and EDDs, they are not afraid to escalate to the consultants and the business units so cannot be ignored all day

Rainforest will commonly ask for EDDs as well, these do not take much time and can often wait to do a larger number in one go

Technically Shuttleworth Drs cover SAL and outliers, and Digby Drs cover Rainforest although it works better if you all just split jobs evenly. Technically the regs are supposed to write the EDDs for any daycase (including paeds) but this rarely happens

For the on calls:

Always check the drugs on Summary Care Record, can be accessed by putting your smartcard into the pc and clicking on the NHS portal shortcut on the desktop.

You can prep the notes prior to seeing the patient using this, every patient will require a clerking booklet, respect form, drug chart, anaesthetic booklet, consent form and pre-op checklist. You might as well collect everything and take it to the patient.

Update etrauma as you go along— this is where the trauma list for theatres is generated from, so all operations/admissions and even referrals have to be put on there.

Sometimes the consultants would want a bit of physiological and functional baseline— so quick line or two regarding mobilisation status, comorbidities and AMT score would be very helpful.

RESPECT Form is required for all NOFs on admission. This DOES NOT mean that all patients admitted with a NOF is automatically DNACPR, but such an injury is often a sign of physiological and functional deterioration and it is good practice to assess the ceiling of care for such patients. At first this might be a bit uncomfortable, but eventually you will find your little spiel every time and this carries on to other specialties you will do in the future.

Osteomyelitis is bit of a tricky area— there is differing opinions from seniors so discuss with SpR before accepting the patient. Sometimes you might need the SpR to talk to EPIC in ED about best specialty for admission. Typically, that will require extended antibiotic treatment, often requiring OPAT input.

Simple cellulitis should be a medical admission but if you are referred such a patient, assess for any abscesses that is amenable to drainage.

Consent form 1 is for patients with capacity, form 4 is for those without.

Examine every patient for neurovascular status and document chest examination, heart sounds and GI clearly as the anaesthetists will call it out if it isn’t done.

Also copy the drugs on prior to admission properly in the clerking booklet, don't just write see prescription chart because drugs will change and things will be missed. Having the original medications to quickly reference back to is extremely important.

Always sign the AMTS section even if it isn't needed because it is a requirement and you will be chased if it is needed.

Don't accept a patient without scans and bloods being done. A&E will try this a lot or will DTA to you.

ECG for all patients in A&E

CXR for all NOFs - part of the protocol

Dr Mathew will review most NOF – he will always ask for the same set of bloods so you can just add these to the list taken by A&E:

FBC, U&E, LFT, INR, Coag

B12, Folate Ferritin

TSH and T4

Vitamin D

Myeloma screen can always be added but isn't always needed, if a previous or active cancer is present add the myeloma screen.

Always get a full-length femur XR of the side of the NOF if there is a history of cancer.

For a multiple myeloma screen, select Mr Rizwan Shahid on the consultant list and a premade screen option is available to select – to interpret just read the comments next to serum free light chains and protein electrophoresis.

Ensure that every patient has analgesia and laxatives prescribed as regular, then breakthrough analgesia and anti-emetic on the PRN.

All NOFs will need fluids prescribed for when they reach the wards due to blood loss from the fracture site.

If there is an intra-articular injury, then you can order a CT for operative planning and assessment.

All spinal patients will need to be referred to QMC, this can be done via the refer a patient website, selected QMC and then spinal surgery. All the alerts will ping to your email so make sure that you put the code in the etrauma entry so that it is easy for anyone to chase and find the patient rather than having to search manually through the website.

For any suspected cauda equina, A&E must perform the entire examination prior to referring to you, the most important aspect is urinary retention, so get a pre and post void bladder scan, recent guidance says that a DRE is not required.

Overnight (especially early on in the night) ?Cauda Equina Syndrome that require a MRI in the morning should be admitted to the ward as bed managers will attempt to clear out ED. It is practically overnight babysitting with analgesia (plus a lot of paperwork) but has to be done. Also for some reason Lincoln MRI only runs 8am-6pm and not overnight…

If you see a patient in ED who has been referred to you always ensure to either document in ED notes or leave the clerking booklet in ED and inform the nurse in charge to avoid any confusion between the two teams after.

Ward referrals go to the Reg on call during the day, so direct them as appropriate

If the plan is for VFC, UTC or ED need to make the referral as we do not have access to this list

Never aspirate a joint that has metalwork in situ. If you do aspirate a native joint, send two white top bottles to microbiology and one to cytology for crystals.

Aspiration samples need to go to Scunthorpe for microscopy and culture. These need to be labelled appropriately on the Microbiology form, with adequate clinical details as well as sample details (ie side, site). The box that contains these samples is available in path lab, rarely in ED and theatres. Labelled sample with form needs to be put in this box and dropped off at main reception where you will be asked to fill some details and it will be taxied to Scunthorpe. Call 03033303719 (Scunthorpe micro technician) to alert them of an incoming package (often reception will do this for you if you ask nicely)

If you are on call for Grantham or if any other hospital calls through to you, politely advise them to contact your reg on call. If there have been trying and cannot get through, apologise and advise then to keep trying or try the consultant on call through switchboard. Youa re not responsible for dealing with these patients and therefore should escalate to your seniors.

Don’t rush when are on call, most Orthopaedic issues can wait, excluding Septic Arthritis, Compartment Syndrome and Nec Fas.

The main two paediatric consultants are Mr Hafez and Mr Southorn.

Stay organised and calm, remember that there will always be someone to hand over to and that you can only get through a set amount of work. Don’t rush and try to enjoy it, good luck!!