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|  | FY1 | SHO |
| Trauma meeting | 07:45 – 17:00\*  Document trauma meeting on CRS and collate list of patients to be post-taken by the consultant and their locations. | 07:45 – 17:00\*  If no FY1s present then document trauma meeting on CRS and collate list of patients to be post-taken by the consultant and their locations.  Drive PACS on main computer for review of imaging during the meeting. |
| Ward cover | 07:45 – 17:00\* (trauma meeting)  Direct consultant to patients they need to review including post-takes and post-op day 1 patients/patients needing review.  Complete ward round of all remaining patients with the SHO/SpR covering the wards. Complete jobs arising from PTWR/ward round. Keep ward list up to date on Etrauma. Manage issues arising from the wards and escalate to SHO/SpR covering wards or to trauma team if not available. Orthogeriatric team will provide medical support if needed and you will need to complete wound/XR reviews for them. Carry bleep 611. Handover urgent jobs to on-call SHO from 17:00. | 07:45 – 17:00\* (trauma meeting)  Direct consultant to patients they need to review including post-takes and post-op day 1 patients/patients needing review.  Complete ward round of all remaining patients with the FY1/SpR covering the wards. Complete jobs arising from PTWR/ward round. Keep ward list up to date on Etrauma. Manage issues arising from the wards and escalate to SpR covering wards or to trauma team if not available. Orthogeriatric team will provide medical support if needed and you will need to complete wound/XR reviews for them. Carry bleep 611. Handover urgent jobs to on-call SHO from 17:00. |
| Trauma theatres | 07:45 – 17:00\* (trauma meeting)  Responsible for being a 3rd assistant if required to the SpR/SHO and consultant in trauma and for completing any additional jobs generated in theatres i.e. requesting operations on CRS, requesting blood products etc. | 07:45 – 17:00\* (trauma meeting)  Responsible for being a 2nd assistant if required and for completing any additional jobs generated in theatres i.e. requesting operations on CRS, requesting blood products etc. If able, then consent patients who have not already been consented for theatre. |
| Theatre assistant | 08:00/13:00 – 17:00 (DSU or AOD)  Act as the assistant for one of the consultants in either main theatres or DSU, complete documentation at their direction and any other jobs generated by the operating list. Review patients prior to list so that you can discuss them. | 08:00/13:00 – 17:00 (DSU or AOD)  act as the assistant for one of the consultants in either main theatres or DSU, complete documentation at their direction and any other jobs generated by the operating list. Review patients prior to list so that you can discuss them and consent them if you are competent. |
| Clinic | 08:30/13:30 – 17:00  No need to attend trauma meeting. Act as directed by the consultant/registrars i.e. observe or review patients and discuss cases. | 08:30/13:30 – 1700  No need to attend trauma meeting. Act as directed by the consultant/registrars i.e. observe or review patients and discuss cases. |
| On call | 07:45 – 20:00\*  The on-call team is comprised of an SpR with SHO +/- FY1. When an FY1 is on-call (does not happen with every on-call team) then they are responsible for helping the SHO with reviewing patients, completing the documentation arising from clerking, requesting, and vetting urgent imaging, requesting operations. At weekends, as there is no ward team, the on-call team must manage the ward patients with the help of the orthogeriatric team as well. This would involve responding to bleeps from the ward (Cambridge generally), reviewing patients that have been requested to be reviewed by ortho and any other patients that the on-call consultant wants to review. The on-call FY1 does not carry a bleep. | 07:45 – 20:00\*  During the day the on-call SHO is responsible for managing the 630 bleep and for taking acute orthopaedic referrals. The bleep is collected in the trauma meeting. These may come via ED, UTC, GPs, wards or from the fracture clinic. There is a referral guide in the T&O handbook which is sent out at the start of the rotation which has a general guide to the conditions that are accepted for admission under T&O and which will come under medicine/plastics/vascular/general surgery etc. In addition to taking the referrals, there will often be a list of scans/reviews generated from the virtual fracture clinic which are phoned through to you via the bleep at around 11am. The on-call SHO is also responsible for the patients admitted overnight which have yet to be moved to the wards/reviewed by a consultant. You may have an FY1 with you on the on-call who can help with the admin generated/reviewing patients. In terms of escalation there will be an on-call SpR until 5pm who will be in trauma theatres and they are best contacted by physically going to theatres and either going into theatre 5 (trauma theatre) or by meeting in the corridor opposite theatre 5 where the trauma team tend to congregate. After 5pm there will be another SpR who will take over the on-call and will be around normally until handover at 7:30pm at which point they normally go home and will be non-resident overnight but contactable via phone. After 5pm the on-call SHO is also responsible for the orthopaedic inpatients and any jobs handed over by the day team (these are normally just phoned through). Over the weekend, there is an orthogeriatric team who will help with reviewing routine bloods on the wards for our patients but if an in person review is required then this must be completed by the on-call orthopaedic team. Additionally, the SpR and consultant run a half day trauma list over the weekend compared to full-day lists during the week. |
| Nights | N/A | 19:30 – 07:45\*  Handover at 7:30pm, usually in the mess. Again, manage the acute orthopaedic referrals – usually just via ED overnight. Additionally, you are responsible for the orthopaedic inpatients. The overnight SHO is responsible for making sure the trauma list patients for the following day are starved, with consent forms/marking and have fluids/blood products requested as appropriate. The on-call SpR overnight will usually leave after handover and will be contactable via phone. Situations which must be escalated include but are not limited to displaced supracondylar fractures in children, fractures with neurovascular compromise, compartment syndrome, dislocations which require reduction which you/ED are not comfortable performing etc. If you have any concerns overnight please escalate, the SpRs would rather be woken up and know about a problem than be kept in the dark! Junior SHOs must call the on-call SpR to update them about every case being admitted, this can be done after multiple cases rather than each one. The night SpR will usually come in early (around 6:30am) to review all the admissions and consent as needed. |

\*except Fridays which start at 07:30am to include metalwork presentation