

TERM DESCRIPTION

Term descriptions are designed to provide important information to prevocational junior medical officers (JMOs) regarding a particular rotation. They are best regarded as a clinical job description and should contain information regarding the:

- Casemix and workload,
- Roles & Responsibilities,
- Supervision arrangements,
- Contact Details,
- Weekly timetable, and
- Learning objectives.

The term description may be supplemented by additional information such as Clinical Protocols which are term specific. Term supervisors should have considerable input into the content of the term description and they are responsible for approving the content. In determining learning objectives, supervisors should refer to the Australian Curriculum Framework for Junior Doctors (ACFJD). The term description is a crucial component of orientation to the term, however it should also be referred to during the mid-term appraisal and end-of-term assessment processes with the JMO.

Submissions of Term Descriptions are required to be current and as precise as possible. When submitting a Term Description for endorsement, please provide a cover sheet outlining the changes from the previous Term Description. To ensure the Term description is endorsed please provide a current date on the Term Description document so the version control can be monitored for auditing purposes, additionally please ensure the document is reviewed for content and accuracy and signed by the current supervisor.

DOCUMENT VERSION: Nov 17															
FACILITY: The Canberra Hospital															
TERM NAME: Neurosurgery															
TERM SUPERVISOR: Dr Peter Mews															
CLINICAL TEAM:	A/Prof David McDowell, Staff Specialist - 6244 4080 Dr Stephen Halcrow, Staff Specialist - 62444080 Dr Peter Mews, Staff Specialist - 62444080														
ACCREDITED TERM FOR :	<table border="1"> <thead> <tr> <th></th> <th>Number</th> <th>Core/Elective</th> <th>Duration</th> </tr> </thead> <tbody> <tr> <td>PGY1</td> <td>1</td> <td>Core Surgery</td> <td>12-14 weeks</td> </tr> <tr> <td>PGY2+</td> <td>2</td> <td>Core Surgery</td> <td>12-14 weeks</td> </tr> </tbody> </table> <p>Total positions available: 3 maximum</p>				Number	Core/Elective	Duration	PGY1	1	Core Surgery	12-14 weeks	PGY2+	2	Core Surgery	12-14 weeks
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<p>OVERVIEW OF UNIT OR SERVICE</p>	<p>Introduction</p> <p>Welcome to the Neurosurgical team. We are committed to your educational experience.</p> <p>As a member of the Neurosurgery Department at The Canberra Hospital you will help manage a wide range of common disorders affecting the nervous system. We hope that you find this experience both interesting and rewarding, which has been the experience of our JMOs.</p> <p>The care of neurosurgical patients requires meticulous attention to pre- and post-operative management. Some of our patients will be desperately ill. Any change in a patient's condition must be carefully assessed and managed, as deterioration may be rapid and life-threatening.</p> <p>A neurosurgical registrar is on-call at all times to help with patient care. You should not hesitate to seek advice from the registrar at any time. If none of the registrars can be contacted, in an emergency the consultant should be called directly, without hesitation.</p> <p>Role of the Neurosurgical Unit</p> <ul style="list-style-type: none"> • Treatment of inpatients with proven or suspected neurosurgical conditions • To consult on inpatients and patients in the Accident & Emergency Department with proven or suspected neurosurgical conditions, including trauma • To provide advice on the management of neurosurgical conditions • To provide advice on neurosurgical patients referred from the regional hospitals and surrounding areas • To provide advice and management on neurotrauma in Canberra as well as the surrounding area • To train medical students, medical graduates and neurosurgical registrars in the management of neurosurgical conditions • To teach nursing and ancillary medical staff on neurosurgical topics • To actively liaise with the neurological unit in the management of diseases of the nervous system of mutual interest and in particular management of stroke and non-traumatic intracranial haemorrhage patients • To promote preventative measures in neurotrauma and education of the public in such issues. <p>This term forms part of Surgical Pod 2 which includes the following units:</p> <ul style="list-style-type: none"> • ENT/Max Fac/Dental • Neurosurgery • Plastics • Ophthalmology • Vascular Surgery • Relief positions. <p>General information about Surgical Pod 2</p> <ul style="list-style-type: none"> • Each pod works as a functional unit allowing all JMOs within it to attend the teaching sessions provided by each of the sub specialties when able as well as your own specialties' teaching programme. All JMOs, particularly PGY 1 are expected to attend general intern teaching sessions held every Tuesday afternoon. • Whilst in a pod you will have a direct term supervisor as outlined by the individual term description as well as an over-riding pod supervisor to facilitate the co-ordination of the working unit. The weekday rostered hours are 0700 – 1630 hrs unless otherwise indicated in the term description or roster. • Within your pod, some of you will have one week of evening shifts from 1330 –
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	<p>2200 hrs to facilitate handover with the day staff and handover with the night staff. Handover will be conducted at a nominated site where all JMOs for the pod must meet to handover relevant information.</p> <ul style="list-style-type: none"> For some of you, a week of night shifts will also occur during your term from 2100 hrs – 0730 hrs next day. On weekends the night shift is 2030 -0730 hrs. Following 7 night shifts, you will have 3 days off, 1 rostered ADO, another day off and then on call for the sat/Sun. Alternatively arrangements can be made to allow for leave provided adequate warning is given. Note: The rostering of a routine JMO (SP 2.1) and an extra (SP 2.2 A&D) on Saturdays is different to the rest of the after-hours rostering for Surg Pod 2. SP 2.1 will cover <i>all</i> SP2 units and SP 2.2 will be responsible for all admissions and discharges for both SP2 and SP1. On Sundays, the SP1 and SP2 will cover their respective units (without an extra, as is currently the case). By allocating sets of evening, night and relief weeks you will be part of a team providing twenty-four hour care for patients within your pod with whom you will be familiar. You will also be more aware of the specialist and registrar plans as you will be working in a small unit of specialties on a day-to-day basis. You will participate in more focused handover and utilise relevant electronic discharge/Casemix information more efficiently and you will be able to follow up relevant investigations and consultations more closely with a working knowledge of the various plans for each patient from their respective day teams. <p>In Neurosurgery team:</p> <ul style="list-style-type: none"> PGY1 (Intern) works day shifts only but may participate in the Surg Pod 2 overtime roster at times The two PGY2s are rostered alternate weeks of day shifts and evening shifts to allow for in-house cover over the afternoon/evening Handover may occur once the evening JMO has arrived or when time is appropriate. <p>As a working unit you will be expected to make additions to the discharge summaries of patients within a pod as important events take place over a twenty-four hour period to provide better communication with general practitioners and other external care givers. You will be able to provide up to date information to staff specialists during evening/afternoon ward rounds as required and participate in any bed side teaching conducted by the other specialties within your pod where possible. All JMOs are required to work weekends as dictated by the roster.</p>
REQUIREMENTS FOR COMMENCING THE TERM:	<p>Basic Clinical Training such as:</p> <ul style="list-style-type: none"> Ability to take history and carry out general physical examination Ability to document clearly in the patients' notes, to do ward rounds and to carry out decisions made Skills with venous cannulation.
ORIENTATION:	<p>An orientation booklet has been prepared, and will be made available to JMOs upon commencement of the term.</p> <p>In addition, JMOs should be familiar with the hospital policies on hand hygiene, pre-operative assessments, DVT prophylaxis regimens, and pain management.</p>
JMOs CLINICAL RESPONSIBILITIES AND TASKS:	<p>Daily Duties</p> <ul style="list-style-type: none"> Participate in the morning ward round and afternoon handover with registrars; Ensure that every patient's progress is documented in the notes daily and whenever there are changes in condition or management;

- Book and organise pre- and post-operative tests, consultations and follow-up;
- Ensure pre-operative patients have had the appropriate tests and that the results are available, particularly that the patient has with them all their X-rays, CTs and MRIs (although PACS has largely superseded the hard copies);
- Follow-up results of all investigations;
- Write high quality discharge summaries. Contact the GP on discharge if they are expected to continue active management;
- Hand-over any significant changes, results pending or remaining tasks to the team and covering resident before going home. Ensure drug charts and IV fluids are up to date; and
- "Jobs-to-do" are noted on the list at the nurses' station as they arise. Please check this regularly.

Theatre Lists

Most neurosurgery is carried out in **Theatre 7**. You are encouraged to attend to observe or assist, and our registrars can help you plan attendance.

- Dr. Mews: Monday 0800 – 1700 hrs alternate weeks
- A/Prof McDowell: Wednesday 0800 – 1700 hrs
- Dr. Halcrow: Thursday 0800 – 1700 hrs

Assisting In Theatre

The JMOs are encouraged to attend theatre, assist or observe surgical procedures as part of the training. However, it should be ensured that the ward round had been done and there is someone on the ward to cover - usually the second JMO.

The JMO should be accessible at all times, either through the theatre telephone system or by page while in theatre.

Outpatients Clinics

There are 3 or 4 outpatient clinics in any given week.

JMOs are not expected to attend the outpatient clinic as a requirement; however should other duties allow, attendance will allow exposure to another facet of neurosurgical care, and will be encouraged.

Clinical Care of Patients - GENERAL

Pre-op:

- Every patient must have a full neurosurgical admission pre-operatively, usually in pre-admission clinic. The consent is the responsibility of the registrar or consultant;
- Most patients require at least a pre-operative FBC, EUC, Coags and G & H. Cross match vascular tumours, aneurysms, AVMs. If in doubt, ask the registrars;
- In general, cranial and intradural spinal cases must stop aspirin and NSAIDS 10 days pre-op, but discuss this with the registrar or consultant. Valproate (Epilim) use should be discussed with consultant/registrar, as it may need to be stopped; but this should not be undertaken lightly;
- Subcutaneous heparin is started routinely peri-operatively for most patients (see Surgeon's Preferences, pg 8);
- Prophylactic anticonvulsants may be commenced if the cerebral cortex is to be breached; and
- Dexamethasone is prescribed if cerebral or cerebellar swelling is expected. Ranitidine or a proton-pump inhibitor is prescribed for the duration of the steroid treatment.

Post-op:

- Every patient must be seen every day;
- A change in Glasgow coma score of 2 or more points is significant;
- Only saline is used as IV fluid for craniotomy patients; and
- Fever should be investigated by a full septic work up INCLUDING calf Dopplers.

Ward Patients:

- Under supervision of the registrar and consultant, the JMO is responsible for the day to day management of patients admitted under the neurosurgical unit. Most of the patients will be on **Ward 9B** but there will be a few outliers;
- All patients should be seen at least once a day and the patients in the Neurosurgery Acute Care Unit (NACU) at least twice a day if not more;
- The patients on the Intensive Care Unit will be looked after by the registrar and the staff of the neurosurgical unit. The JMO is expected to know about these patients and follow their progress as these patients will eventually be transferred to Ward 9B;
- If there is any deterioration of the condition of the patients, the JMO should take appropriate action as given in the guidelines and contact the neurosurgical registrar and if s/he is not available, the consultant in charge; and
- It is the responsibility of the JMO to follow up the results of all investigations and be conversant regarding the progress of the patient.

Discharges

Rehabilitation consults are arranged by:

- Making a referral to the Rehabilitation Registrar, and Informing the CNC as soon as possible so the patient can be added to the ward list for discussion at the Friday meeting. This allows the nursing and allied-health staff time to assess the patient;
- Planned discharge dates are written on the allied health white board;
- Every patient (including patients going to rehab) must have a completed "Discharge Referral" to take with them on discharge. Ideally this should be completed 24 hours beforehand. The "Discharge Referral" form can be started on admission and added to as events occur;
- Follow up is usually 6 weeks post-op in the consultant's rooms or outpatient clinic. Either give the patient the consultant's business card or call the rooms to make the appointment; and
- Notes are kept on the ward for 48 hours post discharge then can be accessed through CRIS on the intranet.

	Dr Mews	A/Prof McDowell	Dr Halcrow
Pre-op S/C Heparin	All	All	Not craniotomies
Post-op S/C Heparin	All	All Day 1 onwards	After CT brain for craniotomies, Day 1 for spine
Antibiotics	Only VP shunts and instrumented spine	No post-op antibiotics unless proven infection	24h IV post-op
Drain	Out Day 1	Out Day 1	Out Day 1

Consultations

The JMO is not directly responsible for patients on whom the Neurosurgical Unit is consulted by other units.

However, the JMO should attend all rounds on consultations as this is part and parcel of the process of education:

- Complete relevant paperwork for Care-type as appropriate

- Document the change in Progress notes
- Prior to discharge from hospital complete Discharge referral letter and give a copy to the patient or responsible next of kin.

Common investigations and how to book them

CT scans

- Scanner ext 42017 Reporting: Room 2
- Contact the radiology registrar after having completed the on-line electronic request (Syngo Workflow) on any hospital computer
- The request should detail the requested study type (including contrast vs non-contrast, special reformat requests, etc) as well as the reason for the study (if not sure, check with neurosurgical registrar), and include all pertinent clinical information.

MRI

- Bookings: 42527
- Contact the radiology registrar (for inpatient cases) or booking clerk (outpatient cases) as well as placing a standard medical imaging request on-line, including the area to be scanned and the purpose of the scan
- A "Pre Procedure Patient Questionnaire" (available on the intranet, ward, or ED) must be completed for all cases. If the questionnaire identifies any risk (any "yes" answers) discuss with the radiology and/or neurosurgery registrar.

Stereotactic planning scan (Stealth™ MRI or CT)

- A scanning protocol which allows data from MRI or CT to be loaded into a computer in theatre
- For cranial procedures, the patient may need "dots" (fiducial markers) applied to the scalp prior to the scan. This should be done or supervised by a registrar – check if this is required for each patient
- Following the performance of the scan, the data CDROM should be collected from MRI/CT and delivered to the neurosurgery registrar, or placed in the registrar's office.

Angiogram

- Request made electronically after discussing with the interventional radiologist/registrar
- Each patient will also require an "interventional checklist" completed, available from the Radiology Day Ward staff station, ext 42018
- Most patients will require a "4 vessel cerebral angiogram" on the request, but check with the neurosurgery registrar
- **Consent is the responsibility of the radiologist**, unless you are an expert in angiography
- If in doubt, discuss with neurosurgery registrar **AND If urgent, discuss with Radiologist.**

Flexion-extension views Cervical Spine

Either:

- Plain films with patient holding the head in flexion then extension
- A doctor must be present to supervise removal of the collar
- Book like any X-ray.

Or:

- Video fluoroscopy with patient flexing and extending
- Must be supervised by a registrar
- Book in fluoroscopy or angio.

	<p>Shunt Series X-rays</p> <ul style="list-style-type: none"> • Plain X-rays, AP and lateral of the skull, chest and abdomen to show the whole length of shunt tubing • Booked as “shunt series XR” electronically. <p>Shunt function Study</p> <ul style="list-style-type: none"> • A nuclear med (ext 42439) scan involving injection of radioactive tracer into the shunt valve (performed by a neurosurgical registrar) • Request in the standard manner, after discussing with the nuclear medicine physician. <p>Neurophysiology EEG, Nerve conduction studies, EMG.</p> <ul style="list-style-type: none"> • Request on a Department of Clinical Neurophysiology request form (leave in the notes) then phone neurology on ext 42950 and tell them the patient details and test required • For EEGs, the technician, can be paged directly (pager 50140) • Patients for nerve conduction studies or EMG also require a neurology consult. <p>Neuroradiology Investigations</p> <ul style="list-style-type: none"> • A good relationship should be maintained with the imaging unit in order to obtain their cooperation and expedite such investigations • Urgent CT Scans and MRI Scans form an important part of the management of these patients. <p>Ward Rounds</p> <ul style="list-style-type: none"> • JMOs are responsible for presenting all new patients admitted to the unit and along with the registrar updating the consultant on the progress of all the patients • It should be ensured that all current results or relevant investigations are available at the time of the Ward Round Meetings. <p>Educational/Teaching Presentations</p> <ul style="list-style-type: none"> • The JMO is expected to present at least once during the term, either a case presentation or review a relevant topic. <p>Ward Meeting Two multidisciplinary meetings are held each week:</p> <ul style="list-style-type: none"> • Tuesday afternoon 1330 hrs - Attended by JMOS, CNC, Allied Health Professionals; <ul style="list-style-type: none"> ➤ <i>Summary of all neurosurgical patients given by JMOs on Tuesday.</i> • Friday morning 0830 hrs - Attended by JMOS, CNC, Allied Health Professionals AND by Registrars and Consultants in Ward 9B tutorial room <ul style="list-style-type: none"> ➤ <i>Summary of all neurosurgical patients given by Registrars on Friday.</i> <p>Radiology Meeting</p> <ul style="list-style-type: none"> • The JMO must submit a list of patients to the registrar of the radiology unit before noon on Thursday for the meeting on the next day • The question of interest should also be communicated to the radiology registrar in this list. <p>Grand Rounds</p> <ul style="list-style-type: none"> • The JMO may be asked to present at a Grand Round during the term or may have to assist the registrar in such a presentation • The case will be discussed further by the registrar or the consultant; • The presentations must be well rehearsed
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	<ul style="list-style-type: none"> If PowerPoint slides are used, there should be a maximum of 7 lines per page, suitable font. <p>Medication Charts</p> <ul style="list-style-type: none"> These charts should be properly maintained and any alterations should be also entered on the clinical notes and the reason given It is essential in the case of Phenytoin, Warfarin, Gentamicin and Vancomycin to monitor their blood levels as advised by the senior staff The medical charts should be reviewed twice a week to ensure that drugs are not continued unnecessarily. <p>Handover</p> <ul style="list-style-type: none"> At the end of term, ensure you contact the incoming JMO and orientate him/her to the ward(s)/clinics and any current inpatients. <p>Please note the Unit Timetable.</p>
<p>SUPERVISION: <i>Identify staff members with responsibility for JMO supervision and the mechanisms for contacting them, including after hours. Contact details</i></p>	<p>IN HOURS</p> <p>Consultant Roster</p> <ul style="list-style-type: none"> The neurosurgical consultants run an emergency for both emergencies as well as referrals within the hospital. Where a specific consultant is requested, the referral will be directed to that person rather than the one on-call The roster is available on the ward and with the hospital switchboard The consultants may cover for each other for brief periods as and when required, even if not on the roster. The registrar and the hospital switchboard will be notified of any such changes Even when not on call, the consultant is always responsible for his own patients. They will be available through their paging system, mobile phone or during working hours through their consulting rooms. The consulting rooms should be contacted during work hours before paging.
	<p>AFTER HOURS Neurosurgery JMOs participate in the Pod system of afterhours cover within Surgical Pod 2.</p>
<p>STANDARD TERM OBJECTIVES: <i>The term supervisor should identify the knowledge, skills and experience that the JMO should expect to acquire during the term. This should include reference to the ACFJD. The term objectives should be used as a basis of the mid and end of Term assessments.</i></p>	<p>CLINICAL MANAGEMENT</p> <p>Goals By the end of the term you should:</p> <ul style="list-style-type: none"> Be confident in assessing a neurosurgical patient and making a reasonable working diagnosis Be comfortable with the peri-operative management of neurosurgical patients Be aware of the presentation and early management of neurosurgical emergencies Have observed and assisted at some neurosurgical operations Be confident in diagnosis and management of the following conditions: <ul style="list-style-type: none"> ➤ Head and spinal injuries ➤ Cerebral Tumours and other space occupying lesions ➤ Subarachnoid haemorrhage from intracranial aneurysms, arterio-venous malformations etc ➤ Cerebrospinal fluid diversions – shunts & external ventricular drains ➤ Degenerative conditions of the spine ➤ Peripheral nerve entrapment and injuries ➤ Pre-operative and post-operative management of these patients in our Acute Care (“Staging”) Unit and the general ward.

	<p>Procedural</p> <ul style="list-style-type: none"> • Lumbar puncture • Assisting in theatre. <p>Educational</p> <ul style="list-style-type: none"> • Attend ward rounds regularly. Our consultants and registrars are keen to teach, and regular opportunities for tutorials will arise during term • Attend the combined meeting with Allied Health and Nursing Friday 0830 hrs • Attend the neurosurgery educational meeting (once a month an M&M meeting) with the consultants and registrars Friday morning 0730 hrs • Attend neuroradiology conference in the Medical Imaging Department at 1200 hrs (Midday) Friday • Attend the combined meeting with Neurology occurring 3 Fridays a month at 1315 hrs on Ward 9B • Attend neuropathology meeting once a month at 1315 hrs on the 1st Friday of a month; meeting in the Pathology Department • Attend Grand Rounds on Wednesday at 1200 hrs (Midday). <p>Interpretative</p> <p>By the end of the term the JMO should be able to:</p> <ul style="list-style-type: none"> • Take a detailed clinical history, examine the nervous system and other systems and organise investigations of neurosurgical patients • Interpret the routine blood tests and also in particular the neuroradiological investigations and lumbar puncture results.
	<p>COMMUNICATION</p> <p>By the end of term, JMOs should be comfortable with discussion of neurosurgical disorders and pathology in both professional communications (written and verbal) and in communication with patients and their relatives.</p>
	<p>PROFESSIONALISM – a high standard is expected</p> <p>By the end of term, JMOs should have gained experience in working with a closely-coordinated multi-disciplinary team. They will be comfortable discussing and coordinating patient care with other health professionals, including physiotherapists, occupational therapists, dieticians, and Neuropsychiatrists, Neurologists, Neuroradiologists, and General Practitioners. They will gain further experience in the social and ethical responsibilities of dealing with patients who have a reduced capacity to care for themselves.</p>

INSERT TIMETABLE

	Monday	Tuesday	Wednesday	Thursday	Friday	Sat	Sun
AM	0700-0800 hrs Morning handover rounds	0700-0800 Hrs Morning handover rounds	0700-0800 hrs Morning handover rounds	0700-0800 hrs Morning handover rounds	0730-0830 hrs M&M Meeting/Tutorials/ Journal Club (Registrar's Room 9B)		
	0800-1700 hrs Dr Mews all day OT (OT14)		0800-1700 hrs A/Prof McDowell all day OT (OT14)	0800-1700 hrs Dr Halcrow all day OT (OT14)	0830-0930 hrs Allied Health Meeting (Level 9 Tutorial Room)		

			0830-1200 hrs Outpatient Clinic Dr Mews	0800-1100 hrs Preadmission Clinic (Building 12, Level 2)	0930-1000 hrs Ward Round		
				0830-1200 hrs Outpatient Clinic Dr Mews (Week 3 and 4)			
PM		1300-1700 hrs Outpatient Clinic A/Prof McDowell	1200-1330 hrs Grand Rounds (TCH Auditorium)		1200-1300 hrs Neuroradiology Meeting (Xray Conference Room)		
	1300-1700 hrs Outpatient Clinic Dr Halcrow	1330-1400 hrs Ward Meeting		RMO teaching 2-3pm Conf Rm 1, Lev1 3, Bld 2	1300 – 1315 hrs Lunch (Level 9 Tutorial Room)		
		1500-1630 hrs Intern teaching sessions			13-15-1415 hrs Neuropath – Path Dept or Clinical presentation by Neurology or Neurosurgery Units (Level 9 Tutorial Room)		
PATIENT LOAD: <i>Average number of patients looked after by the JMO per day</i>			15-30 patients, shared between 3 JMOs (1x PGY1 and 2x PGY2s)				
OVERTIME <i>Average hours per week</i>							
		ROSTERED: 8		UNROSTERED: 0			
EDUCATION: <i>Detail education opportunities and resources available to the JMO during the term. Formal education opportunities should also be included in the unit timetable.</i>			Teaching & Other Meetings (as per timetable) <ul style="list-style-type: none">NS & Allied health ward meeting: Tuesday 1330 hrs and Friday 0830 hrs, Ward 9B Tutorial roomIntern protected teaching time Tue 1500-1630 hrs Building 2 Lecture TheatrePGY2+ teaching on Wednesday afternoons 1300-1400 hrsGrand Rounds (whole hospital) : 1200-1330 hrs Wednesday Hospital Auditorium, Level 2Neurosurgery Teaching Meeting: Friday 0730 hrs, Tutorial Room Ward 9BMorbidity & Mortality 1st Friday of month, Journal Club 3rd Friday, Talks/tutorials by registrars on the other weeks, 0730 hrs Ward 9B Reg’s OfficeRadiology : Friday 1200 hrs (list must be submitted Thursday), Radiology Conference room;Pathology: 1st Friday of month 1330 hrs (Lunch 1300 hrs on 9B) Pathology Building 10, Level 2/3 Meeting room				

	<ul style="list-style-type: none"> Neurosciences case presentation: 1330 hrs Friday (if no pathology meeting), Ward 9B tutorial room. Lunch at 1300 hrs. <p>Educational resources A comprehensive range of reference material is held in the hospital library and is available on the Intranet.</p> <p>Handbook of Neurosurgery by Professor Andrew Kaye</p> <p>Neurology & Neurosurgery Illustrated by Lindsay, Bone, Callander (3 copies in ANUMS library)</p> <p>AMO Teaching Dr. Halcrow, Dr. Mews, A/Prof McDowell</p> <p>Registrar Teaching: Rotating registrars.</p>
<p>ASSESSMENT AND FEEDBACK:</p> <p><i>Detail arrangements for formal assessment and feedback provided to JMO during and at the end of the term. Specifically, a mid-term assessment must be scheduled to provide the JMO with the opportunity to address any short-comings prior to the end-of-term assessment.</i></p>	<p>Term Supervisors will provide formal assessment and feedback using the AMC approved formative and summative assessments at mid-term and at end of term respectively on the One45 website. In completing the assessments the Term Supervisors will consult with Consultants, Registrars, Nursing Staff and any other staff members, who have had extensive contact with you.</p>
<p>ADDITIONAL INFORMATION:</p>	<p>Ward organization</p> <ul style="list-style-type: none"> Ward 9B has 29 beds including a 6-bed neurosurgery acute care area (NACU). NACU is used specifically for close observation of acute Neuro patients and includes six monitored beds. NACU is staffed by 2 RNs. Nursing staff allocation can be found in the blue diary at the nurses' station and on the patient boards. There is always at least one RN on each side of the ward (as well as ENs) and they are responsible for administration of medications. Blood collection is done by the pathology nurse at 0800 hrs daily. Please leave the forms in the "Path request" clip at the nurses' station. Forms MUST have a barcoded label. Nurses may take blood on weekends, but this cannot be assumed and may be the responsibility of the after-hours JMO – think about which bloods are really needed. Thursday is the day for weekly tests eg anticonvulsant levels & progress X-rays on spinal fractures. For patients having drug levels please place a square over the appropriate box on the medication chart and write "level" so the drug can be withheld until the test is taken. ECGs: There is an ECG round at 0900 hrs weekdays. For emergency requests the ECG technician can be paged. There is an ECG machine on the ward for after hours; please ask the nursing staff. "Change Care Type" forms: to maximize government funding patients may progress through different episodes of care during one admission (eg "acute" immediately post op, "rehab", then "non-acute" whilst waiting for a nursing home). The form needs a diagnosis and a brief description of treatment which justifies the care type. <p>Clinical Management: specific conditions</p> <ul style="list-style-type: none"> These are general guidelines, not protocols. There are variations between consultants and between individual patients.

CRANIOTOMY/CRANIECTOMY

Pre-op:

- Group and hold, FBC/EUC/Coags/CXR/ECG
- X-match (2-4 units) for aneurysm/AVM/tumour close to venous sinuses
- TEDs
- Cease all anticoagulants/aspirin/NSAIDs at least 1 week pre-op
- Ensure imaging is available +/- stereotactic scan
- Check Consent signed
- Seizure prophylaxis if requested by consultant/registrar: Phenytoin 15mg/kg loading + 5 mg/kg nocte (eg ~1g loading [500mg po at 18:00 and 22:00hrs] the night before surgery then 300 mg nocte)
- Tumours: dexamethasone 0.25 mg/kg in divided doses (typically 4mg po/IV q6hr) + H2 antagonist or PPI.

Post-op:

- Head up 30 degrees
- GCS 1 hourly
- SBP <160 mmHg
- Normalize EUC, Coags, ABG
- PCA or oxycodone + paracetamol for analgesia. Avoid tramadol due to seizure risk;
- All patients should have regular aperients
- Check CT or MRI day 1 or 2 post-op +/- contrast for residual tumour
- Aneurysm and AVMs usually need a follow up angiogram or CTA.

TRANSPHENOIDAL RESECTION OF PITUITARY TUMOUR

Pre-op:

- TFTs, GH, LH, FSH, ACTH, Prolactin, UEC, LFT, G&H, Coags, FBC
- Endocrinology involved in all cases
- Eye review for fields
- Ensure imaging is available
- Stealth CT or MRI for some patients;

Post op:

- Endocrine review
- Strict fluid balance, at risk of diabetes insipidus
- Management of post-operative hormone problems to be discussed with registrar/consultant/endocrinologist.

SUBARACHNOID HAEMORRHAGE

- Hourly neuro obs
- Nimodipine (2mg/10mls/hour IV or 60 mg po q4h)
- SBP 120 –160 mmHg (may go higher post-clipping or coiling due to spasm);
- Euvolaemia
- Daily or 12 hourly UEC. Watch for hyponatraemia and discuss w Registrars
- Xmatch, coags pre-op.

BURRHOLE DRAINAGE OF CHRONIC SUBDURAL HAEMATOMA

Pre-op:

- Cease all anticoagulation/aspirin
- G & H, coags
- Ensure imaging is available.

Post-op:

- HDU or ward bed

- Nurse flat/5 degrees head down, strict bed rest for 24-72 hours.

LUMBAR LAMINECTOMY/DISCECTOMY

Pre-op:

- G & H, FBC, coags
- If over 40 yrs: UEC, ECG, CXR
- TEDs and sub-cut heparin
- Ensure imaging is available.

Post-op:

- Ward bed
- Monitor lower limb sensation and movement
- PCA / morphine for analgesia, change to oral as tolerated
- Must have aperients
- Check for ileus. Diet as tolerated
- IDC if no urine OP for > 8 hrs post-op (sit or stand up to go to toilet first). Check other neurological function
- Home when able to climb stairs.

LUMBAR FUSION

- As above plus:
 - Mobilise D1 post-op
 - Require post-op CT of fused segment.

ANTERIOR CERVICAL FUSION/DISC REPLACEMENT

Pre-op:

- G&H/FBC/UEC/Coags
- TEDs and subcut heparin
- Ensure imaging is available.

Post-op:

- Cx spine X-ray day 1 post-op to check graft position – Flexion/Extension if disc replacement
- Diet as tolerated; may have dysphagia and need soft diet
- Organise check X-ray prior to follow up.

Medical Record Documentation

All patients should have relevant notes written in their file following each review i.e. at least daily.

To maintain the integrity of the record and ensure the best optical disc image possible, the following must be adhered to:

- All entries must be legible, clear, relevant and objective
- Every entry must include date, time, signature, designation and printed name
- All entries must be written within the boundaries of the form. Do not write in the margins
- Only approved, bar-coded forms should be used
- Use black ballpoint pen only. Do not use blue pen, Pentel, rollerball, felt pens, highlighter pens or liquid paper
- Only approved hospital abbreviations should be used
- Student entries must be countersigned by their supervisor
- Entries written in error must have only one line ruled through the incorrect entry and must have "Written in Error" entered above or beside the incorrect entry must be dated, timed, signed and designated.

	<p>Care Type Change</p> <p>Care type change (also known as Change of Clinical Intent) is a change in the phase of treatment or change in acuity during a patient’s admission, for example from Acute Care to Rehab. In some situations a patient may have several Care Type changes during the course of their admission.</p> <p>For each Care Type change the JMO must:</p> <ul style="list-style-type: none">• Assess the patient• Document patient history, status and expected goals on the Notification of Care Type Change form• Document the new care type, the reason for care type change, and goals of current treatment and patient’s current status in the progress notes. <p>Once all sections of the form have been completed, it should then be signed and handed to the Ward Clerk for action on CareSys.</p> <p>Discharge Summary - Communication with General Practitioners</p> <ul style="list-style-type: none">• A Discharge Summary must be completed for all Inpatient discharges (usually by the JMO) within 48 hours of discharge/separation• All deceased patients must have a Discharge Summary completed• In either case, if you have never seen the patient please make a note of this on the Discharge Summary• Discharge Summaries not completed by the end of each financial quarter will be brought to the attention of the Unit Directors and, potentially, to Executive Directors• In accordance with relevant policies, the Medical Record Department will refuse to sign you out (for your final pay) unless you have completed all Discharge Summaries for which you are responsible.
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...23 Nov 17

Term Supervisor Signature

Date