Prevocational Training Term Description: Neurosurgery

Date of term description version	April 2024
Date term last accredited	March 2021

Term Details

Facility	Canberra Health Services				
Term name*	Neurosurgery				
Term specialty*	Surgery				
Term location	The Canberra Hospital				
Classification of clinical experience in term* (Highlight a maximum of 2)	Un-differentiated illness patient care	Chronic illness patient care	Acute critical illness patient care	Peri-operative/ procedural patient care	Non-direct clinical experience (PGY2 only)
Is this a service term? Service term is a term with discontinuous learning experiences including limited access to education program or limited access to regular within-unit learning activities or less/ discontinuous overarching supervision (e.g., relief term or nights with limited staff).				Yes	**No**

Term duration (weeks)*	12-14 weeks		
Term accredited for	PGY1 and PGY2		PGY2 Only
Total number of prevocational training places	**4**	**Limitations/conditions** In some terms, the CRMEC will make limitations (e.g. skills mix or minimum numbers)	The CRMEC has not placed any limitations or conditions on this training term

Term Supervision

Term Supervisor (name and position) Term supervisor is responsible for conducting term orientation, discussing the PGY1/2's learning needs with them, and conducting and documenting a midterm and end-of-term assessment. Term supervisors must complete mandatory training and commit to a code of conduct outlining their responsibilities.		Dr Sudipto Pal
Clinical team supervision	**Primary/Immediate Clinical Supervisor (name and position)** Clinical supervisor is a consultant or senior medical practitioner (PGY3+) with experience in managing patients in the relevant discipline. They are readily accessible for support, provide education, conduct EPAs, and contribute to assessment.	Two senior (SET trainee) registrars and two junior (unaccredited) neurosurgical registrars on day shift.

	Additional Clinical Supervisors (positions) Position of others (PGY3+) responsible for day-day clinical supervision, including after-hours supervisors.	Dr Hari Bandi, Staff Specialist Dr Rebecca Webb-Myers, Staff Specialist Dr Peter Mews, Staff Specialist Dr Zakier Hussain		
	EPA Assessors Name and position of others (PGY3+) who have completed training to undertake EPA assessments.	All Clinical supervisors in this term can undertake EPAs including registrars who have undertaken EPA training.		
Clinical Team Structure* Highlight the team model, identify and describe the clinical team structure including how PGY1/2s are distributed amongst the team.	Ward Based	Team Based	Other	
	The work is distributed amongst the team following handover. Typically, work is divided amongst the team based on the priorities. This may be during a paper round. This is revisited during the day to check progress and reallocate to team members.			

Commencing the Term

Requirements for commencing the term* If there are any specific requirements (e.g., courses, procedural skills, or e-learning requirements) provide details of how the prevocational doctor will receive this training/will be assessed.	Basic Clinical Training.
Orientation Include detail regarding the arrangements for orientation to the term, including who is responsible for workplace orientation and any additional resource documents such as clinical policies and guidelines required as reference material. **The term supervisor is responsible for orienting the JMO to the term requirements and clinical expectations within the first week of starting the term**	An orientation booklet has been prepared and will be made available to JMOs upon commencement of the term. In addition, JMOs should be familiar with the hospital policies on hand hygiene, pre-operative assessments, DVT prophylaxis regimens, and pain management.

Overview of the Unit

The role of the unit and range of clinical services provided, including an outline of the patient case mix, turnover and how acutely ill the patients generally are	**Introduction** Welcome to the Neurosurgical team. We are committed to your educational experience. 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.

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.

A neurosurgical registrar is always on-call 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. If this is not possible then the on-call consultant should be called directly, failing this, the head of department or any other consultant neurosurgeon.

Role of the Neurosurgical Unit

- 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.

This term forms part of Surgical Pod 2 which includes the following units:

- ENT/Max Fac/Dental
- Neurosurgery
- Plastics
- Ophthalmology
- Vascular Surgery
- Paediatric Surgery
- Paediatric Sub-Specialty Surgery
- Relief positions

General information about Surgical Pod 2

- 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 interns are expected to attend mandatory general intern teaching sessions held every Tuesday afternoon. All RMOs are expected to attend mandatory RMO teaching held every Thursday afternoon.
- Whilst in a pod you will have a direct term supervisor as outlined by the individual term description as well as an overriding 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 or more weeks of evening shifts from 1330 – 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. • 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. The standard process is 7 nights rostered, followed by 7 days off – however the JMO is on call for days 6 and 7, unless taking annual leave after the days off. Alternatively, arrangements can be made to allow for leave provided adequate warning is given (e.g. generally before the start of term). • 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 *all* 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/Case mix 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. In the Neurosurgery team: • PGY1 (Intern) works day shifts but will participate in the Surg Pod 2 overtime roster • 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. • This may change from term to term depending on the number of JMOs and their seniority As a working unit you will be expected to make additions to the discharge summaries of patients within a pod as notable 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.
Clinical responsibilities and tasks of the prevocational doctor	**Daily Duties** • 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;

Provide an overview of the routine duties and responsibilities	• 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 all their imaging results accessible, either loaded onto PACS or on local radiology providers; • 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, pending results or remaining tasks to the team and evening resident before going home. Ensure drug charts and IV fluids are up to date; and • Non urgent tasks are documented in the medical tasks section in DHR. Please check and action these regularly. Preadmission Clinic (PAC) • These are elective case patients who have had an RFA submitted and need anaesthetic review. • The clinic review starts with a review by an anaesthetist or a registrar, bloods are taken. Then they will need to be seen by the neurosurgery team (an RMO/intern). • Every day, check to see if there are patients coming to PAC; this can be done after the ward round. In the event this is missed, PAC will contact you directly. • Usually by the time PAC pages the neurosurgery team, the patient(s) have already been seen by an anaesthetist and bloods taken (or the nurses may ask RMO/intern to book bloods first). After these are done, walk down to PAC to see the patients. • The review for the PAC patients consists of: 1. Checking consent (this may be on DHR or on CPF, so do some digging). 2. Checking the most recent imaging (especially MRI). This may be done at an external company. Get a date of the scan. 3. Have a look at the medication list, looking for antiplatelets/anticoagulants/diabetic medications. 4. Have a look at the anaesthetist note, particularly confirming medications looking for those noted above and any concerns for surgery 5. Talk to the patient and ask about recent symptoms. 6. Perform a full neurological exam which forms the patients baseline prior to surgery • May need to talk to neurosurgery registrar if: ◦ The symptoms have changed recently; ◦ The patient is on any of the medications listed above; ◦ The patient does not have consent (consent for surgery and the RFA can only be executed by registrar or above) ◦ The patient does not have any recent CT/MRI or if the imaging studies are old. The time-frame varies dependent on the pathology. The faster the likelihood of change the more recent the imaging will need to be ◦ Any neurological exam findings that are inconsistent with what the registrars found in their clinic (read their letters). ◦ Any questions.

Theatre Lists

Most neurosurgery is carried out in **Theatre 14**. You are encouraged to attend to observe or assist, and our registrars can help you plan attendance.

- Dr. Bandi: Monday 0800 – 1700
- Dr. Mews: Tuesday 0800 - 1700
- Dr Pal: Wednesday 0800 – 1700
- Dr. Webb-Myers: Thursday 0800 – 1700
- Dr. Hussain: one Wednesday per month

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 rounds have been done and there is someone on the ward to cover.

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

Outpatients Clinics

There are 4 consultant outpatient clinics in any given week.

JMOs are not expected to attend these outpatient clinics 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, Coagulation profile and Group & Hold. 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 on Ward Protocols provided on commencement);
- 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

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 an integral part 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

There are a few imaging requests performed during the neurosurgical term. They are typically ordered through DHR, but in the event you are unsure, or it is urgent please contact medical imaging. The imaging requests include CT, stereotactic planning (this may require "dots" (fiducial markers) which the registrar will need to apply), angiograms, spine XRAYs, shunt series XRAYs and MRIs.

It is imperative to also include the exact pictures. Such as AP, lateral skull, chest, and abdomen to image the entire length of shunt etc. To be sure that all the requisite images are performed it is best to contact the radiographers to discuss.

MRIs are the most important imaging requests during neurosurgery, and it is imperative that they occur in a smooth and efficient manner. Please see the process under MRI below.

MRI

- It is best to get a full list of MRIs to be ordered and to prioritise them with the registrar.
- Order the MRIs using DHR
- Kindly request the nursing staff or team leader on 9B if they can assist the patient complete the MRI safety checklist. If there are any risks, please discuss with the radiology registrar and/or neurosurgery registrar
- Contact the radiology registrar (MRI), ideally in person, to discuss the cases and using the prioritisation from the neurosurgery registrar decide which MRIs must be completed in the morning or the same day and which can be delayed dependent on MRI bookings
- Update the neurosurgery team about which MRIs will occur that day and which have been delayed
- Ensure you monitor the progress of MRIs using the DHR status board and chase the radiographers if there are delays
- Bookings: ext. 42527

Neurophysiology
EEG, Nerve conduction studies, EMG.

- Request these tests on a Department of Clinical Neurophysiology request form (leave in the notes) (or) Order on DHR, along with a referral to the Neurology consultant as indicated; then phone neurology on extension 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.

Neuroradiology Investigations

- A good relationship should be maintained with the imaging unit for continued cooperation to and expedite urgent investigations
- Urgent CT scans and MRI Scans form an important part of the management of these patients.

Ward Rounds

- 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 patients
- It should be ensured that all current results or relevant investigations are available at the time of the Ward Round Meetings.

Ward Meeting
A multidisciplinary meeting is held each week:

	• Monday morning 0900 hrs - Attended by JMOS, CNC, Allied Health Professionals AND by Registrars and Consultants in Ward 9B Tutorial room; ➢ *Summary of all neurosurgical patients given by JMOs on Monday.* **Medication Charts** • 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 timely as advised by the senior staff • The medical charts should be reviewed twice a week to ensure that drugs are not continued unnecessarily. **Handover** • At the end of term, ensure you contact the incoming JMO and orientate him/her to the ward(s)/clinics and any current inpatients. ***Please note the Unit Timetable.***
Work Routine Provide an overview of the work routine	Work routine and tasks are outlined above and in more detail in the JMO Handbook.
Clinical handover procedure Provide an overview of the handover procedure and expectations in this training term	Morning handovers happen with the night staff handing over to the day team, followed by a team handover with the Registrars prior to ward rounds. The registrars typically also like a handover at the end of the day to keep them updated about the events on the ward during the day. Please also update them on the progress of jobs and clinical reviews during the day. Night handover is at the Auditorium between the evening JMO and Surg Pod 2 JMO at 2100 hrs
Safety	**Occupational Violence** While rare, occupational violence is a risk in all departments. JMOs should: • Always maintain a clear exit path from the bedspace when seeing patients. • Know how to call a code black (either through dialling '2222' from a ward phone or pressing a Code Black button). **Pregnancy** JMOs who are pregnant or trying to conceive should be aware of the following: • Where possible, ensure immunisations are up to date prior to conception. • Always follow precautions indicated for specific patients and apply precautions for patients with suspected but not yet confirmed infections. • Be aware of blood borne viruses and report any needlestick injuries immediately to the Occupational Medicine Unit. • Avoid collateral exposure to radiation (e.g. step out of the room for mobile X-ray and do not enter radiology rooms/angiography suite during scans). • Avoid drawing blood from patients who have recently had nuclear medicine scans (e.g. PET scans, MAG 3) and maintain a distance of 3-6 metres from these patients for 6 hours after the scan.

	• Be alert around patients who are delirious, confused or known to have previously engaged in violence. The Neurosurgery Department supports Speaking Up for Safety of patients and staff.
Opportunities for Indigenous Health	Aboriginal and Torres Strait islander peoples may present as patients within this term and JMOs will be able to engage the support of the Aboriginal Liaison Officer as required for patients and their families and improve their knowledge, and skills around cultural safety.

Education, Learning and Assessment

Term Learning Objectives List the term-specific learning objectives*	**CLINICAL MANAGEMENT** By the end of the term, you should: • Be confident in assessing a neurosurgical patient and making a reasonable working diagnosis of the localisation of any lesion • 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 in conjunction with the registrars: ➢ Head and spinal injuries ➢ Cerebral Tumours and other space occupying lesions ➢ Subarachnoid haemorrhage from intracranial aneurysms, arterio-venous malformations ➢ 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. **Procedural** • Develop an approach to assist with Lumbar puncture • Become comfortable with removal of EVDs or subdural drains (responsibility of the RMO, and a reg will show and teach the RMO this). **Interpretative** By the end of the term the JMO should be able to: • Develop an approach to taking a detailed clinical history, examine the nervous system and other systems and organise investigations of neurosurgical patients • Interpret the routine blood tests and in particular the neuroradiological investigations and lumbar puncture results.
Detail education and research opportunities and resources specific to this training term	**General Mandatory Education** • All interns are expected to attend the mandatory Tuesday afternoon teaching program. This is a requirement of CRMEC. The period from 1430-1600 on Tuesdays is protected time for PGY1.

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<tr><td>that will be available to the JMO during the term.
Formal education opportunities should also be included in the unit timetable</td><td colspan="4">

Mandatory RMO (PGY2) teaching is Thursdays from 1300-1400. This time is protected for PGY2 JMOs.
Non mandated, non-protected JMO teaching also occurs at 1300 on Mondays as part of the ‘Monday Shorts’ teaching program.
Venue and topics are confirmed by email earlier in the day.
Other team members, including registrars or JMOs are to continue the clinical work required in the absence of the attending JMO to prevent delay from completion of their clinical shift due to attending teaching.

All JMOS are encouraged to attend Grand Rounds 1200 Wednesdays in hospital auditorium

<u>Term-Specific Training</u>

NS & Allied health ward meeting with Registrar and consultant: Monday 0900 hrs, Ward 9B Tutorial room
Morbidity & Mortality Meeting held first Friday of each month;
Journal Club held the third Friday of each month;
Talks/tutorials by registrars on the other weeks, 0730 hrs Ward 9B Reg’s Office, or by Dr Pal on Tuesday or Wednesday afternoon depending on the clinical load
Radiology: Friday 1200 hrs (list must be submitted Thursday), Radiology Conference room;
Pathology: First Friday of each month 1330 hrs (Lunch 1300 hrs on 9B) Pathology Building 10, Level 2/3 Meeting room
Neurosciences case presentation: 1330 hrs Friday (if no pathology meeting), Ward 9B tutorial room. Lunch at 1300 hrs.

Educational resources
A comprehensive range of reference material is held in the hospital library and is available on the Intranet.

Handbook of Neurosurgery by Professor Andrew Kaye
Neurology & Neurosurgery Illustrated by Lindsay, Bone, Callander (3 copies in ANUMS library)

AMO Teaching
Dr. Bandi, Dr. Mews, Dr Pal, Dr Webb-Myers, Dr Hussain

Registrar Teaching:
Rotating registrars.
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<tr><td>During this term prevocational doctors should expect to complete the following EPAs* (Highlight all that apply)</td><td>EPA 1
Clinical Assessment</td><td>EPA 2
Recognition and care of the acutely unwell patient</td><td>EPA 3
Prescribing</td><td>EPA 4
Team communication – documentation, handover, and referrals</td></tr>
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Term/Unit Timetable and Indicative Duty Roster*

Include the **start time** and **finish times** of the shifts the prevocational doctor will be rostered to. Show the activities that the prevocational doctor is expected/rostered to attend – these include all **education opportunities** (both training facility-wide and term specific), ward rounds, theatre sessions, inpatient time, outpatient clinics, shift handover, morning handover from hospital night team, afternoon handover to hospital's after-hours team. Please include the approximate times of activities wherever possible. If there are extended shifts or evening shifts attach four weeks of rosters for the whole team.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7.00-8.00 Morning handover rounds 8.00-17.00 Dr Bandi all day OT (OT14) 13.00-14.00 Monday shorts JMO teaching session 13.00-17.00 Outpatient clinic Dr Webb-Myers	7.00-8.00 Morning handover rounds 8.00-17.00 Dr Mews all day OT (OT14) 13.00-17.00 Outpatient Clinic Dr Pal 13.30-14.00 Ward Meeting 14.30-16.00 Intern teaching sessions	7.00-7.30 Morning handover rounds 7.30-8.30 M&M Meeting/ Tutorials/ Journal Club (Registrar's Room 9B) 8.00-17.00 Dr Pal all day OT (OT14) 8.30-12.00 Outpatient Clinic Dr Mews 12.00-13.30 Grand Rounds (TCH Auditorium)	7.00-8.00 Morning handover rounds 8.00-17.00 Dr Webb-Myers all day OT (OT14) 8.00-11.00 Preadmission Clinic (Building 12, Level 2) 8.30-12.00 Outpatient Clinic Dr Mews (Week 3 and 4) 13.00-14.00 MEU teaching session	7.00-8.00 Morning handover rounds 8.30-9.30 Allied Health Meeting (Level 9 Tutorial Room) 9.30-12.00 Outpatient Clinic Dr Bandi 12.00-13.00 Neuroradiology Meeting (X-Ray conference room) 13.00-13.15 Lunch (Level 9 tutorial room) 13.15-14.15 Neuropath – Path Dept or Clinical Presentation by Neurology or Neurosurgery Units (Level 9 Tutorial Room)		

Patient Load Average Per Shift	15-30 patients, shared between 3 JMOs	
Overtime	Rostered overtime hours/week	5
	Unrostered overtime hours/week	2
After hours roster Does this term include participation in hospital-wide afterhours roster? If so advise: • Frequency of after-hours work, including evenings, nights, and weekends (hours/week and weekends/month) • Onsite supervision available after hours If the JMO will be working outside this term on afterhours roster, provide details of the after-hours work and a four-week roster. The designated after-hours supervisor should be listed in the supervisory team.	This term forms part of Surgical Pod 2 which includes the following units: • ENT/Maxfacs • Neurosurgery • Plastic Surgery • Ophthalmology • Vascular Surgery When you do an evening shift, you will cover most of these specialties except Neurosurgery (who have their own dedicated Evening cover) and Vascular (their JMOs are rostered until 6–6:30PM so you will only need to cover them after this time). When you do a weekend or night shift, you will cover all specialties. • In a pod you will have a direct term supervisor (see above) as well as an over-riding pod supervisor to facilitate the co-ordination of the working unit. The weekday day roster is from 0700 – 1630 hrs unless otherwise stated – the pod is responsible for patients outside these times. • Within your pod, some JMOs will have one week of evening shifts from 1330 – 2200 hrs to facilitate handover with day staff and handover with night staff. Handover will be conducted at a nominated site where all JMOs for the pod must meet to handover relevant information. • For some JMOs, a week of night shifts will be rostered during this term. On weekdays the night shift is from 2100 hrs – 0730 hrs next day. On weekends, the night shift is from 2030 – 0730 hrs. The standard process is 7 nights rostered, followed by 7 days off – however the JMO is on call for days 6 and 7, unless taking annual leave after the days off. Arrangements can be made to allow for leave following night shit week provided adequate warning is given (e.g. generally prior to the start of term). • The rostering of a routine JMO (SP 2.1) and an extra (SP 2.2) on Saturdays is different to the rest of the after-hours rostering for Surg Pod 2. SP 2.1 will cover *all* SP2 units and SP 2.2 (now called SP A&D) will be responsible for all admissions and discharges for both SP1 and SP2. 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, JMOs are part of a team providing 24-hour care for patients in the pod with whom they are familiar. JMOs will be more aware of the specialist and registrar plans as they are working in a small unit of specialties on a day-to-day basis. JMOs participate in more focused handover and utilise relevant electronic discharge/case mix information more efficiently and will be able to follow up relevant	

	investigations and consultations more closely with a working knowledge of the plans for each patient from their respective day teams. • As a working unit, JMOs are expected to make additions to discharge summaries of patients within a pod as notable events take place over a 24-hour period to provide better communication with general practitioners and other external carers. JMOs will be able to provide up to date information to staff specialists during evening/afternoon ward rounds as required and participate in bed side teaching conducted by other specialties within the pod.

List Other Relevant Documentation
Intern job description RMO job description JMO Handbook