The Little book of Useful Information

Caboolture Hospital Junior Doctor Handbook
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Abbreviations

Try to avoid abbreviations as much as possible! These are a few you may see in the District:

ACAT: Aged Care Assessment Team that makes decisions about appropriate placement options

AHPRA: Australian Health Practitioner Regulation Agency

ATSI: Aboriginal or Torres Strait Islander

CKN: Clinician’s Knowledge Network

DCT: Director of Clinical Training

EAP: Employee Assistance Program

EDS: Enterprise Discharge Summary

GPD: General Practice Directory

HBCIS: Hospital Based Corporate Information System – the patient information database

HITH: Hospital in the Home

HIU: Health Information Unit – also known as Medical Records

MEO: Medical Education Officer

MET: Medical Emergency Team

NUM: Nurse Unit Manager

PBS: Pharmaceutical Benefits Scheme funded by the Commonwealth Government

PFF: Patient Flow Facilitator

PRIME: Clinical Incident Management

QHEPS: Queensland Health Electronic Publishing Service

MNHHS: Redcliffe – Caboolture-Kilcoy, The Prince Charles and Royal Brisbane and Women’s Hospital (Metro North Hospital and Health Service)

RMO: Resident Medical Officer

SDL: The Queensland Hospitals Standard Drug List governs the drugs available within public hospitals in Queensland

SMO: Senior Medical Officer, generally a specialist or doctor approaching specialist level in experience

TREND: The Medical Handover feature in Trend Care enables doctors to identify those patients who require review on future shifts

URN: Unit Record Number – a unique number for each patient at each hospital

VMO: Visiting Medical Officer – a part-time specialist with private practice responsibilities
Introduction

Welcome to Caboolture Hospital

Hello and welcome to Caboolture Hospital.

This book is not intended to be a clinical handbook, nor is it a guide on how to survive ward call or how to admit a patient. We realise you were not reading it anyway!

So we have instead put together a compact pocket book with useful links to online resources, essential contact numbers and some policies and guidelines that will help you do your job efficiently in the context of Caboolture hospital. Information and advice on how to perform on the wards should be covered during your unit specific orientation, however, if you are unsure of anything, don't hesitate to ask, either your clinical supervisor, or any of the Medical Education team.

We wish you well in your medical career, and hope that your time at Caboolture hospital will be a positive working and learning experience!

If you have any suggestions or feedback, please contact the medical education team.

Good luck!

The Medical Education Unit

Support for Doctors

Although internship is an exciting, challenging and rewarding first year in your medical life, it can also be a stressful and busy time.

Doctors, like everyone else, can get sick, and have a tendency to put their patients’ health ahead of their own. We have higher rates of alcoholism and drug abuse, marital discord, suicide and admission to psychiatric units compared to matched controls or the general population.

It is therefore important that you not only look after yourself but keep a friendly eye on your colleagues.

These are the warning signs to look out for:

- Increased reliance on alcohol for relaxation.
- Use of other drugs (legal or otherwise) to help unwind.
- Relaxation time receiving low priority.
- Family time receiving low priority.
- Symptoms suggestive of depression or other psychiatric conditions.

Although it may be difficult to confront a colleague, if you have suspicions about their health, a supportive and understanding but firm approach should ensure that the affected doctor obtains help.
If you do recognise any of the warning signs in yourself or in a colleague, please contact the Director of Clinical Training, Deputy Director of Clinical Training, Medical Education Officer/s or Director of Medical Services. These are all caring people who can help.

**SOURCE OF HELP**

Even though the Clinical Directors and the DCTs are happy to help with your problems, you may find it difficult to seek advice from your supervisor.

There are many other caring people at Caboolture. You will find Clinical Nurse Consultants, senior medical staff and Allied Health professionals that are easily approachable, and available for confidential advice. The Medical Education Officer/s are always willing to act as an advocate for you if you feel it difficult to discuss problems with others.

Caboolture Hospital has also made provision for individuals to obtain help outside of the organisation for confidential counselling. Information about the *Employee Assistance Program* service can be obtained from the Human Resources Department, the Director of Medical Services or the Medical Education Officers. Direct contact can be made with EAP -1800 604 640.

You can also contact the *Queensland Doctors’ Health Programme (QDHP)*. QDHP is a free, independent, confidential, colleague-to-colleague advisory service for doctors and medical students. **Telephone: (07) 3833 4352**

**And of Course……Get Your Own GP!**

**Acknowledgments**

Many thanks to the Medical Workforce Unit, and Medical Education Unit for their ongoing efforts and contributions in updating and revising the content of the handbook. This book has been adapted and edited from the 2015 “Red Book”, the contributors to which we gratefully acknowledge.

My Prescriber Number  ______________________
My Provider Number    ______________________
My Employee Number    ______________________
## Frequently Used Phone Numbers

### All Emergencies Dial 666

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Number</th>
<th>Description</th>
</tr>
</thead>
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<tr>
<td>SWITCHBOARD</td>
<td>9</td>
<td>Allied Health</td>
</tr>
<tr>
<td>Caboolture Hospital</td>
<td>07 5433 8888</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Caboolture Private</td>
<td>07 5495 9400</td>
<td>Social Work</td>
</tr>
<tr>
<td>Director of Medical Services</td>
<td>8608</td>
<td>Dietetics</td>
</tr>
<tr>
<td>Director of Medicine</td>
<td>8154</td>
<td>Occupational therapy</td>
</tr>
<tr>
<td>Director of Paediatrics</td>
<td>8292</td>
<td>Physiotherapy</td>
</tr>
<tr>
<td>Director of Surgery</td>
<td>8621</td>
<td>Aboriginal and Torres Strait Islander</td>
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<tr>
<td>Director of O&amp;G</td>
<td>8476</td>
<td>Liaison Service</td>
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<tr>
<td>Director of Anaesthetics</td>
<td>7110</td>
<td>Consumer Liaison Officer</td>
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<tr>
<td>Director of Clinical Training</td>
<td>8169</td>
<td>Infection Control Coordinator</td>
</tr>
<tr>
<td>Deputy DCT</td>
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<td>Psychiatric Acute Care and</td>
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<td>Medical Education Officer/s</td>
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<td>Assessment Team</td>
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<td>Medical Ed. Admin Officer</td>
<td>8243</td>
<td>Wards</td>
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<td>Medical Typing (Winscribe)</td>
<td>7400</td>
<td>Pharmacy</td>
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<td>Payroll</td>
<td>3170 4200</td>
<td>Reception</td>
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<td>Outpatients Bookings</td>
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<td>Antenatal</td>
<td>8679</td>
<td>Medical (Ward 4A)</td>
</tr>
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<td>Paediatrics</td>
<td>8643</td>
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<td>Emergency Department</td>
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<td>Doctors' Station</td>
<td>8685</td>
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<td>Team Leader</td>
<td>8208</td>
<td>Paediatrics</td>
</tr>
<tr>
<td>Director</td>
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<td>Maternity</td>
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<td>Bookings</td>
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<td>Birthning Suite</td>
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<td>8857</td>
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<td>Supervising Scientist</td>
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<tr>
<td>Patient Safety Officer</td>
<td>6280</td>
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<tr>
<td>Patient Flow Facilitator NUM</td>
<td>8975</td>
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<td>PFF ED</td>
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<td>Redcliffe Switch</td>
</tr>
<tr>
<td>PFF 2A (covers 2A, Day Surg, CCU and Paediatrics)</td>
<td>8248</td>
<td>Mater</td>
</tr>
<tr>
<td>PFF 3A</td>
<td>8246</td>
<td>RBWH</td>
</tr>
<tr>
<td>PFF 4A</td>
<td>8351</td>
<td>PAH</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TPCH</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kilcoy</td>
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*Speed Dials*:
- PFF ED: 7777
- Mater: 2301
- RBWH: 2306
- PAH: 2303
- TPCH: 2304
- Kilcoy: 2342
District Community Phone Numbers

Community Health Main Switch
Caboolture 8300

Child Protection and Liaison Officers:
Di Smout, CNC (Redcliffe-Caboolture)
CN CPLO (Caboolture) 5433 8204
CN CPLO (Redcliffe-Caboolture) 5433 8574

Child Protection Advisor:
Dr John Waugh & Dr Caroline Hughes– Caboolture
Dr Marlon Radcliffe – Redcliffe

Children’s Therapy Services
Referrals can be made through Central Referral Unit
Fax 3049 1260
Telephone 1300 658 252

Common External Numbers
QML 3121 4444
Sullivan and Nicolaides 3377 8555
The Prince Charles Hospital
Microbiology results 3139 4357
Serology 3139 4357
Histopathology 3139 4379
Adult Guardian (Healthcare Decisions) 1300 753 624
Interpreting Service 3139 5360
After hours or emergency session 3115 6999

IT Help Desk 1800 198 175
Speed Dial *2000

DECT Phones

DECT phones will only work within the hospital perimeter due to their low signal range.

The batteries supplied with phones have a useable capacity of around 2-3 days before needing a re-charge. The batteries will give a longer life if they are not placed in and out of the charger continually, but rather kept in use and then placed in the charger when the battery indicates.

Switch can provide you with charged batteries.
## Basic Operating Instructions:

<table>
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<tr>
<td>Turn phone on</td>
<td>Press and hold ⊕</td>
</tr>
<tr>
<td>Turn phone off</td>
<td>Press and hold ⊕</td>
</tr>
<tr>
<td>To answer a call</td>
<td>Press green button</td>
</tr>
<tr>
<td>To hang up</td>
<td>Press red button</td>
</tr>
<tr>
<td>To make internal call</td>
<td>Dial required number, and wait for ring</td>
</tr>
<tr>
<td>To obtain a busy number</td>
<td>Call number and if engaged, press OK button and number will call back when free</td>
</tr>
<tr>
<td>To transfer a call</td>
<td>Dial the extension number the caller requires, press the green button and either speak to the third party before hanging up, or just hang up</td>
</tr>
<tr>
<td>To forward calls</td>
<td>Press *01 and the number of the phone where your calls are to be forwarded to then the green button and then hang up</td>
</tr>
<tr>
<td>To remove call forward</td>
<td>Press *00 then the green button and then hang up</td>
</tr>
<tr>
<td>To remote call forward</td>
<td>If you are attending a meeting, you can forward your phone to another extension by pressing *08 and the extension number you require your calls to go to. When you have a call, your phone will ring 4 times, giving you the chance to answer it before going to the forwarded number</td>
</tr>
<tr>
<td>To remove remote call forward</td>
<td>Press *08 and then your DECT number</td>
</tr>
<tr>
<td>To answer a code/page</td>
<td>Press the green button to answer the call</td>
</tr>
<tr>
<td></td>
<td>Press the left side of the line bar (the wide key under the screen)</td>
</tr>
<tr>
<td></td>
<td>Scroll using the right arrow on the oval pad to read the message – the time and date will appear first, continue scrolling through the message until the time and date appears. You have now read the entire message. Press OK button after having read the entire message. Hang up to clear the message from the screen. PLEASE NOTE – If you receive a code/page during a call, the phone must be hung-up to read the code/page. If you stay on the phone, your phone will 'beep' until you hang-up.</td>
</tr>
<tr>
<td>To answer a flashing 2 symbol</td>
<td>Press and hold the ⊕ button until ‘1 new message’ appears (there may be more than one)</td>
</tr>
<tr>
<td></td>
<td>Press the OK button twice</td>
</tr>
<tr>
<td></td>
<td>A phone number will appear on the screen – this is a number left by a caller when your DECT was unanswered or tuned off. If the OK button is pressed the number will be rung. If the red button is pressed the number will be deleted.</td>
</tr>
</tbody>
</table>

All external calls are time costed, even local calls.

When calling another extension within Caboolture Hospital, but outside the hospital, only dial the four-digit extension number and this will cost nothing. If you dial the entire number, for example 5433 8888 rather than 8888, the call incurs a charge depending on the call duration. Please avoid making personal calls.
Medical Education Unit

The DCTs and the MEOs coordinate supervise and assist with Intern training through:
- Career Guidance
- Access to professional development activities
- Monitoring of performance / support for improving performance if needed
- Fostering & improving teaching and learning
- Pastoral care and advocacy.

Each term, the Unit Supervisor will assess your performance. The DCT reports on intern progress to the AHPRA at the end of the Intern year. You will have feedback as to your progress during each of your terms and an opportunity to comment on these reports. The DCT and MEOs supervise this process.

If you would like career advice or to arrange a tailored education program for current and future years, or training in specific techniques, the Medical Education Unit is there specifically to assist.

Our recently built and modern Education and Skills Centre includes a state of the art lecture theatre, and fully equipped simulation training rooms.

Junior Doctor Education Program

At Caboolture we place a high priority on training during your Intern and Junior House Officer years. There is a regular education program for all junior doctors at Caboolture Hospital. Each unit also has its own meetings. It is compulsory for Interns to attend these meetings and JHOs are highly encouraged to attend as many as possible. If you are having difficulties attending due to roster clashes, please notify the Director of Clinical Training (DCT), the Deputy Director of Clinical Training (D/DCT) or Medical Education Officers (MEOs) 8937.

You are expected to contribute to the course content and actual presentations. Each of the clinical units presents in turn and your unit Director will ask you to contribute. There are also weekly lunch-time clinical meetings. Details are on noticeboards near the lecture rooms and library, outside the stairwells, or are available from the MEOs.

Patient and Family Centred Care (PFCC)

In 2015, we entered a partnership with the Australian Institute for Patient and Family Centred Care (AIPFCC) to become the first hospital in Australia to be accredited as patient and family centred. Over the next two years, we will be working with the AIPFCC to develop an accreditation standard and accreditation process for PFCC for all of Australia. The PFCC model involves a multidisciplinary team approach, where the patient and the patient’s family are recognised as part of the team, and are included in decision-making and management planning.
ISoBAR Communication Tool

ISoBAR is a communication tool used for routine or emergency communication with other health professionals.

Routine examples include:
- Nurse to Medical Officer re: patient condition/deterioration
- Ward Nurse to Pharmacy re: D/C medications
- Medical to Allied Health referral
- Hospital to community referral

Staff should have available when communicating using ISoBAR:
- The patient medical record and most recent vital signs
- List of current medications, allergies, IV fluids and pathology and
- Reporting pathology results: provide the date and time the test was done and results from previous tests for comparison

Identify
Yourself
Who you are talking to
Who you are talking about (at least name and date of birth)

Situation
What is the current situation or the concerns?
Are there any advanced directives?

Observations
What are the recent and latest vital signs and clinical assessment data?
What type of lines in/out does the patient have (e.g. IV, IDC)?

Background + History
What is the (brief) relevant background? This sets the context for the patient – History, Evaluation and Management

Agree to a plan
Given the situation, what needs to happen?
What are you wanting (e.g. advice, orders, transfer)?
What is the level of urgency? What is the plan?

Readback
Clarify and check for shared understanding – who is responsible for what and by when? Read-back, of critical information, especially in the situations where face-to-face handover is not possible.
Trend Medical Handover

The Caboolture Hospital is in the process of moving to TREND for medical handovers.

**Trend Medical Handover**

- **Night Reg** enters new admissions with any outstanding actions for follow up. **THIS IS ESSENTIAL**
- **Morning handover** updates Actions, Drs + Units. Handover + Patient Lists by Consultant printed after Handover.
- **Reg** to check Trend prior to all.

**Friday PM Trend updated for Weekend.**

Situation entered as W/E Reg review, Discharge Reg or W/E Resident review.

Actions added as required. If same action needed for both Sat + Sun then 2 actions need to be added e.g. Check INR SAT + **Check** INR SUN W/E JHO to print Handover sheet for Nursing staff.

Actions to be ticked on completion.
Non-clinical Emergencies (bomb threats and fires)

- Ring 666
- Follow the instructions of designated Area Emergency Officers
- Refer to Emergency Procedures Manual.
- Take note of the evacuation route maps and fire extinguishers located in prominent areas throughout the hospitals.

Emergencies

High Risk Patients

Seek Senior Advice According to the Following Guidelines

- Consult a senior about any patient requiring more than normal ward care.
- Acuity of illness, aetiology, co-morbidity, responsiveness to intervention, predicted duration of illness and interventional monitoring need determine individual priority for critical care management.

Recognition and Management of the Deteriorating Patient (RMDP)

Recognition and management of the deteriorating patient is a key strategic priority both nationally and locally. The need for enhanced systems to achieve this has been substantiated though several local clinical audits and reviews. These include improvements in undertaking and documentation of observations and recognition of observations which indicated a patients’ deterioration.

In line with the Patient Safety and Quality Improvement Centre, the Australian Commission on Safety and Quality in Healthcare and ILCOR; Caboolture Hospital has implemented the following strategies to improve the recognition and management of the deteriorating patient:

- Minimum standard of observations for all acute care adult patients – QID observations
- ISoBAR as the standardised communication tool
- An early warning score observation tool for charting observations
- A defined escalation process to support clinicians in seeking guidance and assistance
- Comprehensive education packages

The ISOBAR tool for communication is standardised across Caboolture Hospital. A copy is in the Ward call section of this book. The defined escalation process as detailed on the following page. Links to education for recognition and management of the deteriorating patient are available on the PC applications screen – double click on the “Compass” icon.
Q-ADDS Score Chart

Queensland Adult Deterioration Detection System is an observation chart that is colour-coded in such a way that medical staff can clearly detect vital signs that fall outside an acceptable range, or any change in trend, and respond appropriately.

There is a copy of the front page of the Q-ADDS form on the next page. (It is a double sided A3 document which is usually folded in half). There have been recent changes to the form; please note these under the headings “General Instructions” and “Temporary modifications”.

---

**ADDS Score**

- **ADDS 0**
  - Continue observations as per minimum standard or prescription.

- **ADDS 1-3**
  - 1. Record observations at least 4/24
  - 2. Carry out prescribed interventions
  - 3. Manage fever, pain or distress
  - 4. Review O2 delivery
  - 5. Inform Team Leader (ward)

- **ADDS 4-5**
  - 1. Ward doctor (JHO, Ward Call) to review patient within 30 minutes
  - 2. Team Leader notified
  - 3. Observations at least every 30 minutes

- **ADDS 6-7**
  - 1. Registrar to review patient within 30 minutes and ensure Consultant is notified
  - 2. Team Leader notified
  - 3. Observations at least every 30 minutes
  - 4. Ward doctor to attend
  - 5. Nurse + Medical escort

- **ADDS ≥ 8**
  - 1. Consider MET Call
  - 2. Registrar to review within 10 minutes and ensure Consultant is notified
  - 3. Nurse + Medical escort

If review delayed or score not decreased:

- Registrar (SHO) to review patient within 30 minutes.
- If > 60 minutes with no review and score not decreased:
  - Registrar and Consultant notified to review. Consider MET Call / ICU Consult.
Queensland Government

Queensland Adult Deterioration Detection System (Q-ADDS)
For tertiary and secondary facilities

General Instructions
- You must record all observations including Pain, Functional Activity Scale and Sedation scores (p4) at a frequency appropriate to the patient's clinical condition.
- You must calculate a Total Q-ADDS Score for each set of observations and record it in the Total Q-ADDS Score box, even if the score is zero. (Respiratory Rate + O₂ Saturation + O₂ Flow Rate + Blood Pressure + Heart Rate + Temperature + Consciousness)
- A Target systolic BP can be documented in the appropriate box on page 3 by the treating Registrar or SMO. The Target systolic BP will supersede the Usual systolic BP.
- If there is no Target systolic BP the nurse admitting the patient should determine the patient's Usual systolic BP and record it in the appropriate box on page 3. If the Nurse is unable to determine the patient's usual BP then the "Default systolic BP: 120mmHg" box on page 3.
- When graphing observations, place a dot (+) in the appropriate box and join to the preceding dot (e.g. ). For blood pressure, use the symbols indicated ( ). You must write any observation outside the range of the graph as a number.

Modifications for Patients with Chronic Abnormal Physiology
- Modifications can only be made on the basis of chronic abnormal physiology. That is, physiological parameters that are usual for the patient at home.
- Modifications must be authorised by a SMO / registrar / PHO (or equivalent).
- NB: document the letter 'M' in the row above the Total Q-ADDS Score on page 2 to indicate modifications in use.

Diagnosis which justifies modification (e.g. chronic obstructive pulmonary disease):

Authorised by (SMO / registrar / PHO):

Doctor's name (please print):

Designation: 
Signature: 

Date: 
Time: 

Temporary Modifications
- Temporary Modifications can only be made to ONE of the following - Blood Pressure, Heart Rate or Respiratory Rate.
- Must have explanation and detailed management plan documented by Medical Officer (MO) in the case notes (heading: "Temporary Modification Plan 1, 2 or 3").
- Caution should be exercised in prescribing Temporary Modifications for patients with suspected Sepsis.
- Temporary modifications must be authorised by the SMO accountable for the patient or after consultation between at least two members of the Medical Emergency Team.
- Each modification will last a maximum of 2 hours (1 box), sequential modifications are permitted for maximum 6 hours (all 3 boxes) but only 1 box can be completed for each MO review (i.e. MUST have MO review every 2 hours and modification prescribed into next box).
- A Total Q-ADDS Score must be documented at least every 30 minutes.
- Document the letter "M" in the row above the Total Q-ADDS Score on page 2 to indicate modifications in use.

Temporary Modification 1
Write the acceptable range (will score zero)

<table>
<thead>
<tr>
<th>Systolic BP</th>
<th>to mmHg</th>
<th>(can NOT be modified &lt;80 mmHg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Rate</td>
<td>to beats/ min</td>
<td>(can NOT be modified &gt;34 bpm)</td>
</tr>
<tr>
<td>Resp. Rate</td>
<td>to breaths/ min</td>
<td>(can NOT be modified &gt;34 bpm)</td>
</tr>
</tbody>
</table>

Modifying Doctor Name: 
Authorising Doctor Name: 

Start Date: 
End Date: 
Contact number: 

Temporary Modification 2
Write the acceptable range (will score zero)

<table>
<thead>
<tr>
<th>Systolic BP</th>
<th>to mmHg</th>
<th>(can NOT be modified &lt;80 mmHg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Rate</td>
<td>to beats/ min</td>
<td>(can NOT be modified &gt;34 bpm)</td>
</tr>
<tr>
<td>Resp. Rate</td>
<td>to breaths/ min</td>
<td>(can NOT be modified &gt;34 bpm)</td>
</tr>
</tbody>
</table>

Modifying Doctor Name: 
Authorising Doctor Name: 

Start Date: 
End Date: 
Contact number: 

Temporary Modification 3
Write the acceptable range (will score zero)

<table>
<thead>
<tr>
<th>Systolic BP</th>
<th>to mmHg</th>
<th>(can NOT be modified &lt;80 mmHg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Rate</td>
<td>to beats/ min</td>
<td>(can NOT be modified &gt;34 bpm)</td>
</tr>
<tr>
<td>Resp. Rate</td>
<td>to breaths/ min</td>
<td>(can NOT be modified &gt;34 bpm)</td>
</tr>
</tbody>
</table>

Modifying Doctor Name: 
Authorising Doctor Name: 

Start Date: 
End Date: 
Contact number: 

Page 1 of 4

The Little Book of Useful Information – V2017.02 Page 15 of 73
The Medical Emergency Team (MET)

**Aim:**
To provide an early and rapid response to seriously ill patients with life-threatening conditions, or to patients who are at risk of a cardiopulmonary arrest.

**Responsibilities:**
- Rapid attendance to the MET or notification of inability to attend.
- In the first instance, the CCU nurse will coordinate the MET until an appropriate clinical leader is identified.
- All team members need to remain at the MET until an appropriate clinical leader is identified.
- The clinical leader is accountable for coordination of clinical care, communication and documentation.
- The MET pager functions as a ‘baton’ and must remain on site at all times. The pager is passed from person to person each shift, and that person accepts the responsibilities associated with its carriage.
- Ensure the pager is set to an audible alert under SET ALERT and that the AUTO SLEEP mode is not set.
- If you leave the hospital while carrying the MET page, you must hand it over to a suitable Medical Officer before you depart.
- Ensure switch is notified of the hand-over.

**CALLING CRITERIA:**
The MET uses a standardised calling criteria that is found and used throughout the hospital. The criteria are applicable to patients and non-patients (i.e. visitors or staff of Caboolture Hospital).

**CRITERIA FOR CALLING MET TEAM**

<table>
<thead>
<tr>
<th>ACUTE CHANGES IN:</th>
<th>PHYSIOLOGY</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIRWAY</td>
<td>THREATENED</td>
</tr>
<tr>
<td>BREATHING</td>
<td>ALL RESPIRATORY ARRESTS</td>
</tr>
<tr>
<td></td>
<td>- Respiratory Rate &lt;8</td>
</tr>
<tr>
<td></td>
<td>- Respiratory Rate &gt;36</td>
</tr>
<tr>
<td></td>
<td>- New saturation drop to &lt;90%</td>
</tr>
<tr>
<td>CIRCULATION</td>
<td>ALL CARDIAC ARRESTS</td>
</tr>
<tr>
<td></td>
<td>- Pulse Rate &lt;40</td>
</tr>
<tr>
<td></td>
<td>- Pulse rate &gt;140</td>
</tr>
<tr>
<td></td>
<td>- Systolic Blood Pressure &lt;90</td>
</tr>
<tr>
<td>NEUROLOGY</td>
<td>SUDDEN FALL IN LEVEL OF CONSCIOUSNESS</td>
</tr>
<tr>
<td></td>
<td>- (Fall in GCS of &gt;2 points)</td>
</tr>
<tr>
<td></td>
<td>- Repeated or prolonged seizures</td>
</tr>
<tr>
<td>OTHER</td>
<td>Any patient who you are seriously worried about that does not fit the above criteria</td>
</tr>
</tbody>
</table>
Basic Life Support

D | Dangers?
DRS | Responsive?
S | Send for help
ASA | Open Airway
BA | Normal Breathing?
C | Start CPR
    | 30 compressions : 2 breaths
    | If unwilling/unable to perform rescue breaths continue chest compressions
ABCD | Attach Defibrillator (AED)
    | as soon as available and follow its prompts

Continue CPR until responsiveness or normal breathing return
Adult Cardiorespiratory Arrest Flowchart

Advanced Life Support for Adults

Start CPR
30 compressions : 2 breaths
Minimise Interruptions

Attach Defibrillator / Monitor

Assess Rhythm

Shockable

Non Shockable

Shock

CPR for 2 minutes

Return of Spontaneous Circulation ?

Post Resuscitation Care

During CPR
- Airway adjuncts (LMA / ETT)
- Oxygen
- Waveform capnography
- IV / IO access
- Plan actions before interrupting compressions (e.g. charge manual defibrillator)
- Drugs:
  - Shockable
    - Adrenaline 1 mg after 2nd shock
      (then every 2nd loop)
    - Amiodarone 300 mg after 3rd shock
  - Non Shockable
    - Adrenaline 1 mg immediately
      (then every 2nd loop)

Consider and Correct
- Hypoxia
- Hypovolaemia
- Hyper / hypokalaemia / metabolic disorders
- Hypothermia / hyperthermia
- Tension pneumothorax
- Tamponade
- Toxins
- Thrombosis (pulmonary / coronary)

Post Resuscitation Care
- Re-evaluate ABCDE
- 12 lead ECG
- Treat precipitating causes
- Re-evaluate oxygenation and ventilation
- Temperature control (cool)

December 2010
Advanced Life Support for Infants and Children Paediatric Cardiorespiratory Arrest

Advanced Life Support for Infants and Children

Start CPR
15 compressions : 2 breaths
Minimise Interruptions

Attach
Defibrillator / Monitor

Shockable
Assess
Rhythm

Non
Shockable

Shock (4 J/kg)

Adrenaline 10 mcg/kg
(immediately then every 2nd loop)

CPR for 2 minutes

Return of Spontaneous Circulation?

Post Resuscitation Care

During CPR
Airway adjuncts (LMA / ETT)
Oxygen
Waveform capnography
IV / IO access
Plan actions before interrupting compressions
(e.g. charge manual defibrillator to 4 J/kg)
Drugs
Shockable
* Adrenaline 10 mcg/kg after 2nd shock
(then every 2nd loop)
* Amiodarone 5mg/kg after 3rd shock
Non Shockable
* Adrenaline 10 mcg/kg immediately
(then every 2nd loop)

Consider and Correct
Hypoxia
Hyperkalaemia
Hyper / hypokalaemia / metabolic disorders
Hypothermia / hyperthermia
Tension pneumothorax
Tamponade
Toxins
Thrombosis (pulmonary / coronary)

Post Resuscitation Care
Re-evaluate ABCDE
12 lead ECG
Treat precipitating causes
Re-evaluate oxygenation and ventilation
Temperature control (cool)

December 2010
Neonatal Resuscitation Flowchart

Newborn Life Support

**At all stages ask: do you need help?**

- Term gestation? Breathing or crying? Good tone?
  - **YES** Maintain normal temperature, Ensure open airway, Stimulate
  - **NO** Stay with Mother

- HR below 100? Gasing or apnoea?
  - **YES** Positive pressure ventilation, SpO₂ monitoring
  - **NO** Laboured breathing or persistent cyanosis?
    - **YES** Ensure open airway, SpO₂ monitoring, Consider CPAP
    - **NO** Post-resuscitation care

- HR below 100?
  - **YES** Ensure open airway, Reduce leaks, Consider: Increase pressure & oxygen, Intubation or laryngeal mask
  - **NO** Targeted pre-ductal SpO₂ after birth
    - 1 min 60-70%
    - 2 min 65-85%
    - 3 min 70-90%
    - 4 min 75-90%
    - 5 min 80-90%
    - 10 min 85-90%

- HR below 60?
  - **YES** Three chest compressions to each breath, 100% oxygen, Intubation or laryngeal mask, Venous access
  - **NO** IV Adrenaline, Consider volume expansion

**IV Adrenaline 1:10,000 solution**

<table>
<thead>
<tr>
<th>Gestation (weeks)</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>23-26</td>
<td>0.1 mL</td>
</tr>
<tr>
<td>27-37</td>
<td>0.25 mL</td>
</tr>
<tr>
<td>38-43</td>
<td>0.5 mL</td>
</tr>
<tr>
<td>10-30 mcg/kg (0.1-0.3 mL/kg)</td>
<td></td>
</tr>
</tbody>
</table>

January 2016
MANAGEMENT OF FOREIGN BODY AIRWAY OBSTRUCTION (CHOKING)

Assess Severity

Ineffective Cough
  Severe airway obstruction
    Unconscious
      Call ambulance
      Commence CPR
    Conscious
      Call ambulance
      Give up to 5 back blows
      If not effective
      Give up to 5 chest thrusts

Effective Cough
  Mild airway obstruction
    Encourage coughing
      Continue to check casualty until recovery or deterioration
      Call ambulance

Guideline 4 Page 6 of 7
June 2014
Bradycardia Algorithm
(includes rates inappropriately slow for haemodynamic state)

If appropriate, give oxygen, cannulate a vein, and record a 12-lead ECG

Adverse signs?
- Systolic BP < 90 mmHg
- Heart rate < 40 beats min⁻¹
- Ventricular arrhythmias compromising BP
- Heart failure

YES

Atropine 500 mcg IV **

Satisfactory response?

YES

Risk of asystole?
- Recent asystole
- Møbitz II AV block
- Complete heart block with broad QRS
- Ventricular pause > 3s

NO

Interim measures:
- Atropine 500 mcg IV ** repeat to maximum of 3 mg
- Adrenaline 2-10 mcg min⁻¹
- Alternative drugs * OR
- Transcutaneous pacing

NO

Observe

Seek expert help
Arrange transvenous pacing

* Alternatives include:
  - Aminophylline
  - Isoprenaline
  - Dopamine
  - Glucagon (if beta-blocker or calcium-channel blocker overdose)
  - Glycopyrrrolate can be used instead of atropine

**500-600 mcg
Tachycardia Algorithm (with pulse) – Broad and Narrow

**Tachycardia Algorithm (with pulse)**

Synchronised DC Shock* Up to 3 attempts

- Amiodarone 300 mg IV over 10-20 min and repeat shock; followed by:
- Amiodarone 900 mg over 24 h **

Unstable

- Signs of instability include:
  1. Reduced conscious level
  2. Chest pain
  3. Systolic BP < 80 mmHg
  4. Heart failure

Is patient stable?

Stable

- Rate-related symptoms uncommon at e.g. than 150 beats min⁻¹

Broad

Broad QRS

Is QRS regular?

- Use vagal manoeuvres
- Adenosine 6 mg rapid IV bolus; if unsuccessful give 12 mg; if unsuccessful give further 12 mg.
- Monitor ECG continuously

Is QRS narrow (< 0.12 sec)?

Narrow

Narrow QRS

Is rhythm regular?

- Regular
  - Normal sinus rhythm restored?
    - Yes
      - Probable re-entry PSVT:
        - Record 12-lead ECG in sinus rhythm
        - If recurs, give adenosine again & consider choice of anti-arrhythmic prophylaxis
      - Seek expert help
      - Possible atrial flutter
      - Control rate (e.g. β-Blocker)
    - No
      - Irregular Narrow Complex Tachycardia
      - Probable atrial fibrillation
      - Control rate with:
        - β-Blocker IV or digoxin IV
        - If onset < 48 h consider:
          - Amiodarone 300 mg IV 20-60 min; then 900 mg over 24 h
          - Seek expert help

- Irregular

Probabilities include:

- AF with bundle branch block treat as for narrow complex
- Pre-excited AF consider amiodarone
- Polymorphic VT (e.g. torsades de pointes - give magnesium 2 g over 10 min)

- Attempted electrical cardioversion is always undertaken under sedation or general anaesthesia

Cardioversion of AF present for > 48 Hours has a risk of stroke

- Magnesium should be given rather than amiodarone if the rhythm is torsades.

* May be withheld if previous history of cardiac arrest. ** Magnesium should be given rather than amiodarone if the rhythm is torsades.
Recommended Clinical Resources

CLINICIANS’ CLINICAL NETWORK (CKN)

Click on the CKN link on the left hand side of the QHEPS toolbar
Includes links to:

- THERAPEUTIC GUIDELINES (eTG)
- MIMS ONLINE
- AUSTRALIAN MEDICINES HANDBOOK
- MICROMEDEX
- AUSTRALIAN INJECTABLE DRUGS HANDBOOK
- PBS Scheme
- BMJ best Practice

UPTODATE

Get clinical answers at the point of care with evidence-based clinical decision support

---

**UpToDate® Anywhere Access Tip Sheet**

1. Access UpToDate by going to the QH App Store, select UpToDate and “install”. This will download the link to your desktop.

2. Click the Log In/Register button in the upper right corner of the screen.

3. To register, complete all fields on the right side of the registration page and then click Submit Registration.

   Please note: You must first register from within the Metro North Network to gain access to the Mobile App and accrue CME credits.

4. If you already have an UpToDate User Name and Password, log in on the left side of the registration page.

You are now registered and able to download the Mobile App and earn CME credits!
MENTAL HEALTH ACT


Allied Health and Support Services

Allied Health is on the ground floor at Caboolture Hospital with an administrative officer at the location – 8625

Diabetes Education

Diabetes education is available triaged according to this table. Please send written referral forms to either the diabetes educator at Redcliffe or Caboolture Hospitals.

<table>
<thead>
<tr>
<th>Type 1 (IDDM)</th>
<th>Newly diagnosed</th>
<th>Urgent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unstable</td>
<td>Urgent</td>
</tr>
<tr>
<td></td>
<td>Stable</td>
<td>OPD review</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type 2 – (NIDDM)</th>
<th>Newly diagnosed</th>
<th>Survival Kit from allied health and book into education group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Needs Insulin for Discharge</td>
<td>Semi-urgent referral – review as inpatient</td>
</tr>
</tbody>
</table>
Medical Imaging

The Medical Imaging Department at Caboolture Hospital is run under a contractual basis by Southern X-ray Clinics.

Medical Imaging Office (Phone 8692)
0630 – 1730 Monday – Friday

General Radiography (Phone 8179 (DECT) / 8694 (dept))
24 hrs/7days for routine examinations.

Please be mindful that after 1630 Monday – Friday and at any time on weekends and public holidays there are a maximum of 2 Radiographers covering the whole hospital at any one time. At times there will only be 1 Radiographer covering the entire campus. There are no shifts allocated for Procedures, Theatre, CT or Ultrasound out of routine hours. For all urgent cases ring the DECT phone number 8179 or if no answer 8694).

Radiologists’ Hours
In general 2 Radiologists are rostered to the department between 0800 – 1800 Monday – Friday. On occasions only 1 Radiologist will be onsite with the 2nd Radiologist reporting remotely from offsite. There is a Medical Education session every Tuesday at 1200 – 1300 on the 3rd floor. (Except Tuesdays following a public holiday).

The Radiologists encourage teaching of Medical staff and are freely available for consultation but good manners should prevail.

Interventional Procedures (Phone 8692)
0900-1600 Monday - Friday. This is dictated by Radiologist coverage. Complex cases are booked by Medical Imaging Nursing Staff and direct discussion with the Radiologist is required for these cases.

For urgent cases please liaise directly with Medical Imaging Nursing staff

CT (Phone x-ray office 8692 for routine cases)
0800-1700 Monday - Friday for routine cases. An appointment system operates.

For urgent cases during routine hours liaise directly with staff in CT (8694).

For urgent cases out of hours contact the duty Radiographer (8179) to arrange these cases. Routine cases are reported by the Radiologist on duty on a daily basis. Out of hours CT cases are reported by the VRC (Virtual Reporting Centre). The VRC is based in Victoria and reports CT images for over 60 hospitals in Australia.
MRI (Phone x-ray office 8692 for routine cases)

0700 – 2130 Monday – Friday

For urgent cases during routine hours liaise directly with staff in MRI. Currently there is no after hours MRI service.

ALL EXAMINATIONS MUST HAVE A REQUEST SIGNED BY THE REFERRING CONSULTANT AND THE PATIENT SAFETY QUESTIONNAIRE MUST BE FILLED IN PRIOR TO ANY MRI BEING PERFORMED. (All Redcliffe inpatient examinations must be vetted by the District Director of Medical Imaging. Phone 7744)

Ultrasound (Phone x-ray office 8692 for routine cases)

0900 – 1630 Monday – Friday.
0900-1630 Saturday/Sunday

An appointment system operates. Please liaise directly with the Sonographers regarding urgent cases. Patients seen after hours who require an ultrasound done the next working please ask the patient to phone the department on 54983055 & ask for an appointment. (Please put the request in the Medical Imaging tray in ED.) On Call roster operates outside of these hours. Please see after hours protocols for applicable call in criteria.

Nuclear Medicine (Phone x-ray office 8692 for routine cases)

Routine hours 0900 - 1600 Monday – Friday. An appointment system operates. Cardiac Stress tests performed every Thursday.

Please liaise directly with the Nuclear Medicine Technician regarding any urgent cases.

No after hours on call service available.

PET scan Approvals

At Caboolture Hospital please note:

Requests for all in-patient PET scans must first be approved by:
   a) The Director of Surgery, Dr WG Premaratne followed by:
   b) The Director of Medical Services, (ph 8608 or fax 8700).

This also applies to outpatient PET scans for which there is no Medicare Item Number (Southernex can advise of these).

On Call

Call-in staff can be contacted by calling switch and asking for the appropriate staff. Please familiarise yourself with the afterhours protocols before calling Medical Imaging staff.
Electronic Image and Reports look up

I-MED Online is available on all Hospital computers to look at both images & reports. Log-ins & passwords will be issued by Southern X-ray.

Request forms

Request forms not completed accurately and completely including clinical details will be returned to the referring clinician, resulting in unnecessary delays. CT & MRI examinations must have the contrast questionnaire and renal function sections completed for all exams requiring contrast.

Separate referrals are required for each individual modality. The patients ward details and Doctor contact details, including dect phone and Consultant, are required for all examinations in legible writing.

Patient information may be provided by a patient sticker from their Medical record but care needs to be taken that the correct patient sticker is used as all Radiation incidents where the incorrect patient is irradiated need to be reported to Radiation Health.

Burning of Images onto CD

A request form is required for images to be burnt to CD for teaching purposes or to send to other Hospitals

Questions/Concerns

In the first instance please direct any concerns or questions to the duty Radiographer / Sonographer. Any concerns that the Imaging staff are not able to assist with please speak to the Site Manager, David Holmes or acting Deputy manager, Julie Weatherson. The Radiologist in charge of the Department is Dr Christine Campbell. Dr Paul Reidy is also available as second Radiologist. The X-ray Office Manager is Natasha Adams.

Disaster Plan

In the event of a Disaster contact the duty Radiographer. Additional Medical Imaging staff can be located by the phone list available at switch.

Chaplaincy

Part-time, trained chaplains endorsed by community churches serve the District in an honorary capacity. They provide spiritual, pastoral, emotional and sacramental support in an ecumenical non-denominational or non-religious basis. This means that the service offers pastoral care to all in hospital, patients, relatives or staff. It is appropriate to call the chaplain for the following reasons:

- on request of the patient or relative
- prior to the impending death of a patient
- when patients learn of the death of a relative or close friend
- where there is evidence of unresolved grief or guilt
- in terminal cases
• pre-discharge, when community or church support may be helpful where there are special problems related to religious background, including ethical and moral issues such as abortion, lack of faith, loss of meaning to life, inability to pray, feeling abandoned by God etc.

Health Information Management Service (HIMS)

The major areas of expertise provided by the Health Information Management Service include:

• Health Information Management;
• Clinical Records;
• Clinical Coding;
• Data Services; and
• Clinical Information Access

The Service also benefits from the incorporation of the following specialists:

• HBCIS – Patient Administrations System Manager
• Clinical Information Systems – Nurse Manager

For advice or education please visit the Health Information Management Service located on the ground floor or by contacting the Program Coordinator – Health Information Management on 8757.

For more specific information provided by this service please refer to the following headings listed in this book:

• Documentation
• Paperwork and forms
• Queensland Confidentiality Laws
• Medico-Legal Matters.

Hospital in the Home (HITH) Subacute and Ambulatory Service (SaAS)

Hospital in The Home operates out of Northlakes Health Precinct and provides acute care at home for patients who would otherwise require admission to a hospital bed in the geographical boundaries of Metro North Hospital Health Services. Silverchain is a private organization who support the Northlakes team and can cover a larger demographic area.

• HITH provides acute care to patients who would otherwise require treatment in the traditional hospital inpatient setting. Patients are selected by the treating teams as suitable for treatment in a community setting based on the acuity of the condition and the treatment prescribed. These patients are still classified as inpatients but sit on a virtual ward in the community setting.
• HITH patients are transferred from the Emergency Department or from the hospital wards. A patient is to be transferred to the virtual ward HOME04 or HOMEPS (Silverchain) as per QHAPDC requirements at the time the patient leaves the acute facility.

• Referrals for HITH are made via HITH (SaAS) Intake on 0448626654. If the patient is for Silverchain HITH intake will transfer you to them.
• The hospital registrar consults with the HITH SaAS registrar for acceptance/clinical handover to the HITH Service.
• The HITH Team consists of a NUM, Registered Clinical Nurses, Registered Nurses, Physiotherapists, Occupational Therapists, Social Workers, Pharmacists, Assistance in Nursing and Administrative Officers. Our contact number is 3049 1414
• The HITH TEAM (SaAS & Silverchain) provides care between the hours of 0700 to 2130 hrs, with an on call service to support patients if an incident arises relating to their HITH treatment while on the programme.
• The HITH TEAM (SaAS & Silverchain) provides a service to patients in their own homes which include Residential Aged Care Facilities.
• The HITH patient is transferred to the Hospitals HOME (04 or PS) ward on HBCIS and the patient’s medical file is taken to Northlakes HITH team for staff working daily with these patients
• There is a procedure for retrieval of the medical file if the patient represents to hospital – In business hours 0700 – 2030 hrs this is through phoning the HITH unit on 3049 1414 and after hours via switchboard at Brighton on 3631 7400 who then takes the details and contacts security officer to retrieve the file and deliver it to the hospital.
• Clinical handover is to be verbal to the HITH (SaAS) Registrar and is to be documented with a clear clinical treatment plan to be developed by the referring Medical officer and other multidisciplinary team members on the medical management plan form.
• The minimum requirement for clinical handover includes past medical history, principle condition to be treated, secondary diagnosis, any alerts, allergies, evidence of consent, clinical treatment plan including investigations required, a medication list, nursing and allied health requirements (if applicable), to be placed on the medical management plan form on transfer.
• HITH referral will come on line early 2015.

Infection Control

Infectious Diseases Physician (Caboolture)

Dr Paul Chapman (Wed & Fri)
• Caboolture Hospital is committed to the principles of Standard and Transmission Based Precautions. All staff are responsible for maintaining high standards of infection control practice by complying with the Redcliffe Caboolture Infection Control Policy/Procedure Manual. The manual can be accessed on QHEPS. Please adhere to strict hand hygiene protocols and follow instructions for managing patients on transmission based precautions.
• Caboolture Hospital employs an Infection Control Clinical Nurse Consultant and Clinical Nurse who are contactable on phone 8220. Contact Dr Paul Chapman (Infectious Disease Physician – Caboolture Weds & Thurs – Contactable via Switch 9)
• The Infection Control Department provides Staff Vaccination Clinics on Tuesdays 2-4pm, follow-up for blood and body fluid exposures (staff) and provides training/education to all categories of staff.
• The Infection Control staff may assist you by counselling and informing patients or staff about infectious diseases. Infection Control staff are also able to provide
appropriate advice on managing patients who require transmission based precautions.

- You can assist infection control by contacting them if you suspect a patient has a hospital acquired infection or highly transmissible infectious diseases such as chicken pox, measles, mumps, TB, or multi-resistant organisms (MRSA, VRE, ESBL etc).
- The Infection Control staff are available to work with you to reduce hospital acquired infections to our patients. The Infection Control staff are happy to answer questions about the Infection Control Programme, staff vaccinations or infectious diseases.

**Sharps and avoiding needle-sticks**

Sharps (hypodermic needles, scalpel blades, lancets etc) are dangerous! HBV, HCV and to a lesser extent HIV are the main concerns, with needles being the most common cause of sharp injury.

- Always **personally** dispose of all sharps safely after use. Failure to handle sharps properly endangers not only you, but also other staff and the public.
- Regard all sharps as infectious and all patients as potential carriers.
- If a sharps handling practice seems unsafe report it to the infection control staff who can investigate and make recommendations.
- Do not recap or manipulate (bend or brake) needles after use.
- Needles are **NOT** to be removed from syringes by hand prior to disposal. Dispose of needles and syringes as a complete unit.
- Dispose of needles immediately after use in an approved sharps container.
- Never force sharps into an overfilled container.

**In the event of sharp injury or splash exposure**

Refer to the back of your emergency procedure codes badge and follow instructions in the “Kit” located in the Emergency Department.

**“Clean Hands Are Life Savers”**

Queensland Health has implemented the Hand Hygiene Australia’s 5 Moments for Hand Hygiene. It is aimed at improving hand hygiene among healthcare workers throughout Queensland’s hospitals.

HAI (health associated infections) pose a serious threat to all who are admitted to hospital. On average, infections complicate 7-10% of hospital admissions.

Hand hygiene guidelines are well established but evidence shows that compliance historically is fewer than 50%. Poor hand hygiene among healthcare workers is recognised as being the largest problem associated with HAI in hospitals.

**Ensure you are not placing your patients at risk, Comply with hand hygiene at appropriate times.**
**I-Care & Insertion & Management of Peripheral Intravascular Catheters Guideline**


**Moments of Hand Hygiene**


**ANTT Mandatory Training**


**PLEASE CONTACT INFECTION CONTROL Staff IF YOU HAVE ANY QUERIES phone 8220**

**Library**

Library is located in the Education and Skills Centre at Caboolture Hospital.

It is open during normal business hours, 8.30am – 4.30pm Monday to Friday excluding public holidays. After-hours access is available using your proximity ID card. You can contact the librarian on 7726.

The Libraries provide:
- Print journals and textbooks for the major specialties,
- a small reference collection
- on-line access to medical, nursing and evidence based databases as well as over 7200 electronic journal titles. Drug databases and online texts also available.
- a reading room for individual or small group bookings and
- study carrels, photocopier, newspaper, scanner, printer and computers for your use.

The librarian can assist you with literature searches, borrowing books, obtaining journal articles, and using the electronic resources

Please visit the library and register to become a borrower.

**Nutrition & Dietetics**

Any health professional may refer patients requiring clinical nutrition and dietetic services.

**Hours of business:** 8am - 4.30pm week days.
**Contact:** Allied Health Reception 5433 8193 or via switch
**Email:** CabH-Dietetics@health.qld.gov.au
**Referrals for inpatients:** via Patient Flow Manager (PFM) or via switch
**Referrals for outpatient:** fax a blue slip (Hospital Request Form) to allied health via 8730
SERVICES:

Inpatients:
- Clinical Areas :Surgical: Preadmission assessment and support for bowel surgery, ERAS Pathway (enhanced nutrition pre & post surgery) pre and post-operative, diet therapy for major bowel surgery,
- Medical : Stroke, patients with pressure injuries
- Intensive Care/ Critical care unit: Automatic referral for all ICU patients, refer as needed for coronary/critical care patients Paediatrics and Special Care Nursery, refer all
  - enteral nutrition support (nasogastric/PEG feeding)
  - malnutrition or failure to thrive/poor weight gain
  - food allergies or intolerances
  - poor feeding or decrease oral intake or fussy feeding
  - gastrointestinal surgery or children with an ileostomy or colostomy
  - Crohn’s disease or ulcerative colitis, post ENT surgery
  - inborn errors of metabolism
  - constipation
  - weight management
- iron deficiency
- Mental Health: Eating disorders (inpatient only)

Across all wards:
- Malnutrition identification and management
- Dietary and nutritional assessments and monitoring
- Consultation and organisation of Enteral and Parenteral Nutrition Support
- Dietary advice and education
- Provision of oral nutrition support such as high protein energy diets, snacks and supplements for patients with malnutrition
- Organisation and consultation on therapeutic diets such as high protein, fibre modified, texture modified diabetic, low sodium, fat modified, allergen and surgical,

Inpatient dietetic services are supported by Nutrition assistants who assist with organising high protein energy diets, snacks, supplements and other therapeutic diets under the direction of the dietician.

Outpatients:
- Referrals for chronic conditions should be made to CISS e.g. Type1 & II diabetes, gestational diabetes, weight reduction, cardiac rehabilitation, and hyperlipidemia.

Occupational Therapy

Occupational Therapy is available for Acute Adult Inpatients at Caboolture Hospital. OT does not have services in: ED, Mental Health (OT in SMHU and Community only), Maternity and inpatient Paediatrics.

Inpatient Services:
- General Medical such as falls, COPD, dementia and delirium, functional decline
• Neurological conditions such as CVA, MS, Parkinson’s disease
• Pressure care for patients
• Vascular conditions such as DVT.

How do I refer acute inpatients to Occupational Therapy?
OT Ward Dects: ICU&2A#5776, 3A#8105, 4A&GEM #8132, AH Reception #8625
For inpatient referrals, contact therapists directly via DECT phone, speak to the OT team at handover, or make a referral using the Patient Flow system (ask the Team Leader) or complete the Allied Health referral form and leave in the AH slot on each ward.

Outpatient Services:
• Hand injuries and post-surgery follow-up for fractures, tendon repairs, nerve injuries
• Management of vascular conditions including oedema & DVT
• Rheumatological and soft tissue conditions such as arthritis, nerve injuries.

How do I refer to outpatient Occupational Therapy service?
For outpatient referrals, forward a legible completed internal blue slip referral to Allied Health outpatients Reception on the ground floor of the hospital.

Referrals should include date, diagnosis, intervention required, precautions/contraindications (particularly for outpatients), your name and method of contacting you for further information if required.

You can contact Occupational Therapy Department on 5433 8625.

Assessments offered:
• Functional assessments, occupational performance and activities of daily living such as showering, toileting and meal preparation to establish if the patient will be able to manage at home can be assessed.
• Functional & formal cognitive and perceptual function assessments such as the MOCA or RUDAS or abbreviated PTA.
• Equipment needs assessment and prescription
• Home Visit assessments (with patient) or Home Access visits (without the patient) and home modifications recommendations for safe discharge
• Upper limb and hand function assessment

Treatment may include:
• Activities of daily living retraining & education for patients and carers
• Activities to improve upper limb function & splinting
• Perceptual, cognitive and memory retraining.
• Prescription and supply of compression garments

Paediatric Services

Child Development Program (CDP) (is a Children’s Health Queensland (CHQ) service)

Services include:
• Physiotherapy, Speech Pathology, Occupational Therapy, Psychology and Behaviour Management services are available at Caboolture Hospital, Redcliffe Hospital, North Lakes Health Precinct and Woody Point Special School.
- Developmental assessment and intervention.
- Paediatric and neonatal feeding difficulties
- Orthotics
- Equipment prescription
- Advice on appropriate special educational placement

Referrals:
- Outpatient referrals are accepted.
- Inpatients should be referred for follow up in the community after discharge.
- Referrals can be made through Central Referral Unit, preferably via email

Email: cdpacessservice@health.qld.gov.au
Fax: 3335 8700
Phone: 1300731805

Community Paediatrics – Family Care Program

Staff includes Child Health Nurses, Social Workers, Psychologists, school health nurses, Indigenous immunisation nurse and health worker and continence nurse.

Services include:
- The “Family CARE” home visiting initiative is operational in Caboolture.
- The Program is aimed at assisting vulnerable families with newborn babies, who are identified in the antenatal or postnatal period. A family may be eligible for the Program if risk factors such as postnatal depression, domestic violence, or significant financial disadvantage are present.
- Families enrolled in the Family CARE Program will be visited by a Child Health Nurse at regular intervals throughout the child’s first year of life.
- The progress of each family is monitored via a multi-disciplinary (Paediatrics, Senior Nursing, Psychology/ Social Work ) Case Conference, which meets weekly.
- The goal of the program is to optimise the child’s physical health and development, and to reduce the risk of child abuse and neglect.
- At risk families may present to the Emergency Department, to Antenatal clinic, Maternity, or Paediatrics.
- Medical Officers are strongly encouraged to discuss families who may be eligible with the ward’s Nurse Unit Manager or on-call Paediatrician.

Other Services:
- Child & Family Health Services are available for many issues relating to infants and children e.g. breast feeding management issues for infants. Services include groups for new parents and post natal wellbeing groups.
- Services are also offered out of the Early Years Centre at Caboolture for first time mothers with infants from birth to 18 months of age. This is a new service and provides universal services for families in the local catchment.

Referrals:
Phone Central Referral – 1300 658 252
FAX referrals to CRU on 5433 8488
Pain Management Team

To refer patients to the pain service, contact the Clinical Nurse Pain Management on Ext 8209, Tuesday-Friday. The Anaesthetic Registrar is available to assist with afterhours difficulties.

Routinely reviews non-insured patients with an epidural or PCA each morning.

Reviews privately insured patients when requested by the Consultant, a written referral is also required to be written in the patient chart.

Patient Flow Facilitator

The Patient Flow Facilitator has the role of facilitating the optimal journey for patients through Caboolture Hospital, from admission to discharge. This is achieved through close collaboration with the Patient Flow Managers, treating medical team, Nurse Unit Managers, ward staff and the wider interdisciplinary team and relevant service providers.

There are Patient Flow Facilitators on Wards 2A (ext.8248), 3A (ext.8246) and 4A (ext.8351) and Department of Emergency Medicine (ext.8247).

Nurse Navigator

Nikia Goldsmith is our Nurse Navigator at Caboolture Hospital. She manages those patients with Complex Chronic Diseases - those with Heart /Lung / Diabetes conditions that require holistic care / management of their conditions. She assists in the patients journey in the acute setting with navigating and understanding their health condition, medication and education and with the assistance of external providers and regular contact try and avoid re-presentations through self-management with primary health providers.

Nikia can be contacted by phone: (07) 53165878
Email: nikia.goldsmith@health.qld.gov.au
or electronically via PFM.

Pharmacy

The pharmacy distributes, dispenses (inpatient and outpatient), and monitors administration of medication, and provides drug information.

Inpatient Prescribing Notes

The Medication Chart used at Caboolture Hospital is a QLD Health corporate chart. This generic National Inpatient Medication Chart (NIMC) is a major initiative of the Queensland Health Medication Management Service - Adverse Drug Event Prevention Project. It has now been implemented nationally to assist practitioners to safely prescribe, dispense and administer medications in order to minimize the risk of adverse medication events. To succeed, the following must happen:

- All Medical staff are to prescribe medications for inpatients in accordance with relevant legislative requirements according to the Health ‘Drugs and Poisons’ Regulation - 1996, available on QHEPS/Legislation/Health Legislation.
• The medication chart is to be completed for all admitted patients and placed at the foot of the bed unless ward/unit procedure states otherwise. Under no circumstances should it leave the ward unless accompanied by the patient.

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• Hard-copy training assistance can be found at - National Inpatient Medication Chart User Guide Including Paediatric Versions (PDF 2256 KB) and National terminology, abbreviations and symbols to be used in the prescribing and administering of medicines in Australian hospitals (PDF 132 KB)

• Web-based hands-on training in using the chart can be accessed at www.learningindustries.com/nps

• All medications should be reviewed regularly to identify potential drug interactions and to ensure medications no longer required are properly ceased in the chart.

Prescribing

• Write in ink and date all entries
• Print the generic name (Qld Health Policy), route, dose and frequency of the medication/s. Complete the “Indication” field as an additional safety measure.
• Include your PRINTED name, DECT phone number and signature
• Cease and rewrite items if the dose changes or the medication is discontinued: cross the medication order completely, write “cease”, sign and date the entry.
• It is a legislative requirement that any verbal orders given for a drug (in emergencies) must then be written on the medication chart by the Doctor within 24 hours of that verbal order being given.

• The Queensland Hospitals “List of Approved Medicines (LAM) regulates the medications you can prescribe within Queensland public hospitals. Other medications require specific Director of Medical Services (DMS) approval. Only brands on contract with Queensland Health are available.

Documentation of Adverse Drug Reactions (ADR’s)

The Medical Officer, Pharmacist or nurse must complete adverse drug reaction (ADR) details for all patients on the medication chart.

If the patient is not aware of any previous ADRs, tick NIL KNOWN.

If a previous ADR exists, tick YES and document the following information on the medication chart and in the patient’s medical notes:
• name of the drug, nature of the reaction, and date

SMALL ADR stickers are attached to the front, inside and the reverse pages of the medication chart in the appropriate section as an alert.

AVOIDING ERRORS

• Doses are to be ordered using metric and Arabic (1, 2, 3) numeric systems.
• Use ‘g’ for grams, and use ‘mg’ for milligrams
• Use ‘mcg’ for micrograms (never use ‘ug’ as it can be misread as ‘mg’); preferably write ‘micrograms’ in full.
• Decimal points are frequently missed in faxed documents. Always use zero (0) before a decimal point; e.g. ‘0.5g’. Failure to do so can lead to errors in
interpretation which may result in significant overdosing. *e.g. if possible, the prescriber should write ‘500 mcg’ instead of ‘.5mg or ‘0.5 mg’ or ‘125 microgram’ instead of ‘0.125 mg’.*

- Likewise, the use of trailing zeros after a decimal point is discouraged to avoid errors in interpretation *e.g: 5.0mg interpreted as 50mg.*
- Do not use ‘U’ for units as it be misread as ‘0’ – always write ‘units’ in full.
- In the case of liquid medications, the strength should always be specified and the dose stated in milligrams or micrograms NOT millilitres: *e.g. morphine mixture* - 10 mg/ml Take 10 mg - 8 hourly.
- **Do not** use Roman numerals (I, II, III)
- The **frequency** and **times** of drug administration must be written by the **Medical Officer** using the accepted abbreviations, as listed in the **Administration Times** table below.  If not completed, the medication should not be administered by nursing staff. Errors have been reported where nurses incorrectly interpret the frequency ordered by doctors, and write the times down incorrectly: (e.g. ordered QID times written down as TDS.)
- All dose times are to be entered using the **24-hour clock**.
- ‘OD’ is not an accepted abbreviation.
- Use ‘daily’ or ‘once daily’. Even better, specify ‘mane’ or ‘nocte’.

<table>
<thead>
<tr>
<th>Time</th>
<th>Mane</th>
<th>0800</th>
<th>Night time</th>
<th>Nocte</th>
<th>1800 or 2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Twice daily</td>
<td>BD</td>
<td>0800</td>
<td>Three times a day</td>
<td>TDS</td>
<td>0800</td>
</tr>
<tr>
<td>Antibiotics Q8H</td>
<td>Q8H</td>
<td>0600</td>
<td>1400</td>
<td>2000</td>
<td></td>
</tr>
<tr>
<td>Four times a day</td>
<td>QID</td>
<td>0600</td>
<td>1200</td>
<td>1800</td>
<td>2200</td>
</tr>
</tbody>
</table>

**Physiotherapy**

Physiotherapy is available for inpatients and outpatients.

Advice on referrals is available by contacting the Physiotherapy Department on 8625

**As a guide, refer patients with:**

- Movement disabilities or pain
- Soft tissue injury
- Nerve injury
- Muscle weakness
- Fractures and Dislocations
- Orthopaedic conditions or surgery, paediatric & adult
- Brain or spinal damage, including trauma and CVA
- Respiratory or cardiovascular disorders
- Falls related to balance problems or weakness
- Major Surgical procedures including pre-operatively where possible
- Obstetric or gynaecological problems

**Special Services**

- Acute Rehabilitation Services and referral to hospital based rehabilitation unit
- Continence Services
- Ante and post-natal classes
**Weekend Services**

On-call service for urgent chest and postoperative physiotherapy new referrals at request of treating Registrar only.

**External Community Services available via on-line referral system**

- Community Based Rehabilitation (CBRT)
- Heart Lung Team Pulmonary Rehabilitation team
- Cardiac Rehabilitation - education and exercise classes
- Primary Health Team

**OTHER via Chip Nurse**

- Home Based Acute Care
- Transition Care
- NGO’s

**Podiatry**

- No acute podiatry service is available within Caboolture Hospital for the care and management of foot ulceration / complications
- There is a community podiatry service available at Caboolture Community Health Centre for patients living within the catchment area, patients require a Health Professional referral.
- Podiatry Services within the district are directed towards the care and management of ‘at risk’ / ‘high risk’ clients.
- Clients identified as ‘low risk’ are no longer eligible for public health podiatry services.
- Routine nail care will not be provided.
- Eligibility criteria for Podiatry Services – see below:

**Category 1 – Acute Complications**

- Current foot ulceration +/- infection
- Acute Charcot Arthropathy
- Necrosis / Acute Ischaemia

**Category 2 – The High Risk Foot**

- Foot Deformity with Peripheral Neuropathy or Peripheral Vascular Disease
- Previous Foot Ulceration or
- History of Amputation

**Category 3 – The At Risk Foot**

- Peripheral Neuropathy or
- Peripheral vascular Disease or
- Foot Deformity

**Post Acute Care Service**

The Service provides a seven day per week post acute hospital support to people who present to emergency departments (and not requiring admission) or discharged from hospital. Short term care multidisciplinary interventions are provided to address immediate care needs. Services are provided in-home or clinic based.
Clinical Interventions provided by the Post Acute Care Nursing Service

- Wound management including stoma care; medication administration, education and supervision; pain management; heart failure and respiratory care; self-care education and support for diabetes; home oxygen support and education; catheter care; risk assessment in home setting
- Other nursing services can be undertaken following consultation with the Service

Post Acute Wound Management Nurses

- Post Acute Wound Management clinics are provided for patients who require complex wound management (for example negative pressure wound therapy).
- Wound clinics can accept patients within 2 weeks of discharge for Negative Pressure Wound Therapy (NPWT) or from OPD where there had been recent surgical interventions with wound complications.
- Chronic wound management consultancy for subacute residential facilities of Subacute and Ambulatory Services.

Physiotherapy

- Physiotherapy – Assessment and management for falls risk, post fracture, respiratory/heart failure care and post orthopaedic surgery

Occupational Therapy

- Home Assessment and intervention for safety and promoting independence with ADL including personal care and falls prevention.

Dietetics

- Nutrition assessment and management

Social work

- Acute carer stress; coordination of services; acute stress disorder/stress management; assessment of psychosocial risk in relation to cognitive decline and sustainability of care arrangements

Speech Pathology

- Swallowing and high risk communication

Personal Care

- Hygiene assistance with up to two to three sessions per week

Domestic support (including shopping and laundry)

- Services provided if clinically indicated
Referring to Post Acute Care Service

Central Referral Unit (CRU) accepts referrals Monday to Friday by facsimile, electronic transfer, or telephone.

Contact details for the CRU:
- Phone: 1300-658-252
- Fax: (07) 3146-2412

For the geographical areas of Moreton Bay Regional Council
- Fax: (07) 3049 1260

Referrals for weekend or public holiday 0800 hours to 1630 hours contact the Intake Officer:
- Phone: 0437-934-426

Social Work

Social Work Services are provided at Caboolture Hospital from Monday to Friday 0800 – 1630.

Social Workers provide psychosocial assessments and a range of interventions to inpatients and their families at the request of the patient, family and staff.

A limited service is provided to the outpatient services. Social Workers can provide counselling, support, advocacy and community referrals.

Referrals for patients are accepted for the following:
- Trauma & other significant life events
- Grief and loss; adjustment to illness
- Critical illness: diagnosis, poor prognosis and limited treatment
- Domestic and family violence (children at risk)
- Parenting issues and parenting support
- Alternative decision making (QCAT)
- Disability assessment and referral

Caboolture Hospital Emergency Department is staffed by a social worker during the following hours:
- Monday to Thursday 0800 – 2100
- Friday to Sunday 1300 – 2100

Further advice on referrals is available by contacting the reception of Social Work Services on extension 8625.

Speech Pathology

Services are provided to Caboolture Hospital inpatients between 8am and 4:30 pm on weekdays.

Adult Services

*Referrals: phone 8226 or 8149*
- Refer all TIA and CVA patients
- Other neurological (PD, MND, etc)
• Respiratory (COPD), oncology, ENT

**Services may include:**
• Assessment and treatment of swallowing, speech, language and voice disorders
• Modified Barium Swallows (please refer to Speech Pathology first, who will then coordinate the MBS procedure)

**Community:**
Once patients have been discharged back to community, please refer to community services through the Central Referral Unit (CRU), using CRU referral form, fax 8488

**Paediatric/Neonatal Services**

*Referrals: phone 8149*
• Premature infants - when establishing oral intake
• Breast feeding difficulties
• Difficulties transitioning to solids
• Oral-facial abnormalities (e.g., cleft lip and cleft palate, tongue-tie)

**Services may include:**
• Assessment and management of paediatric feeding
• Assessment of speech and language

**Community:**
Once patients have been discharged back to the community, please refer to Children’s Therapy Services (CTS), using a CTS referral form, fax 8730

**Specialist Outpatients Department**

**Referrals**
• All patients requiring consultation at Specialist Clinics will have a referral documented on the standard referral form, available throughout the district on QHEPS / District Forms.
• All referrals received in Specialist Clinics are categorised according to clinical urgency by the appropriate Clinical Director.
• Referrals for Specialist Clinics remain valid for the single course of treatment for a period of twelve months. The presentation of an unrelated illness or condition would require a new referral.

**Urgent Referrals**

Medical Officers should contact the appropriate Registrar for patients requiring urgent referral to Specialist Clinics, in the first instance.

**Overbooking**

When clinics are required to be overbooked, advice from the Consultant / Registrar will be required as to whether any other patients booked into the clinic need to be rescheduled to prevent over-run clinics and increased waiting times.
Clinical Urgency Categories

The following clinical urgency categories have been defined for use in specialist clinics:

**Category One (Urgent): Appointment desirable within 30 days**
Appointment within 30 days desirable for a condition that has the potential to require increased complex care if delayed or have significant impact on quality of life.

**Category Two (Semi-urgent): Appointment desirable within 90 days.**
Appointment within 90 days desirable for a condition that is not likely to deteriorate quickly or require increased complex care if delayed.

**Category Three (Routine): Appointment not required within 90 days**
Appointment not required within 90 days for a condition that is not likely to deteriorate quickly or require increased complex care if delayed.

Allocation of appointments is based on prioritisation according to clinical need.

Intra-District Referrals from Emergency Department

When referring ED patients to specialist clinics, only category one patients should be referred directly. Category 2 and 3 patients should be referred back to their GP, unless they do not have one.

Discharge

When a patient is discharged from clinics, this must be documented in the chart or, preferably, in a letter to their GP.

Failure to attend

Hospital staff will educate patients in order to minimise the occurrence of missed Specialist Clinic appointments. The Medical Officer will review all clinical records of patients that fail to attend their appointment at the end of each clinic, and advise if another appointment is required. If another appointment is not required, the patient will be discharged from the clinic, and a new referral will be required to access the service.

Medical Officer Leave

All Medical Officers involved with the delivery of Specialist Clinics must provide at least four weeks in advance of planned leave, to enable appropriate re-booking of patients, or to coordinate backfill of the affected clinic.

Elective Surgery

Booking Elective Surgery Patients

- All patients referred to the elective surgery waiting list must have an Elective Admission Request form completed, in consultation and agreement with the appropriate Consultant / Staff Specialist.
- The Elective Admission Request form must be legible, complete and contains a clearly indicated clinical urgency category. Incomplete forms will be returned to the requesting Medical Officer, and will delay the booking process.
• Surgery should not be booked until the need for surgery is established, i.e.: all investigations are completed. This makes the process fairer for all patients.
• Please do not advise patients of approximate waiting times for elective surgery / gastroenterology procedures. Bookings office will do this via a letter.

Clinical Urgency Categories

Clinical urgency categories have been adopted for use in all elective surgery undertaken in Queensland public hospitals.

The clinical urgency categories are:

Category 1
Admission within 30 days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency.

Category 2
Admission within 90 days desirable for a condition causing some pain, dysfunction, or disability but which is not likely to deteriorate quickly or become an emergency.

Category 3
Admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency.

Informed Consent

• In addition to completion of an Elective Admission Request form, and prior to being registered on the waiting list, all elective surgery patients (particularly Category 1 and 2 patients) must have a signed informed consent form.
• Informed Consent forms are available in Specialist Clinics.
• Informed consent should be obtained by the registrar or PHO. It is not suitable for interns to obtain consent, they should observe and learn the procedure.
• For more information, please see website: http://www.health.qld.gov.au/informedconsent/formsindex.asp

Emergency Surgery

Phone and inform theatre Team Leader on 8652
• Phone anaesthetist on 8212 to inform them
• Complete an emergency booking form including the name of the anaesthetist you spoke to, and hand in to theatre

Enterprise Discharge Summary (icon found on desktops)

Discharge summaries are to be completed in the Enterprise Discharge Summary system for all units with the exception of Emergency Department (EDIS) and Mental Health (CIMHA).
On completion of the discharge summary by the treating Medical Officer, the Ward Receptionist from the discharging ward is responsible for:

- Completing the distribution report
- Forwarding discharge summaries not electronically distributed to the GP / referring doctor / other care provider as advised by the Medical Officer
- Filing the original in the clinical record

The discharge summary should be the basis of communication with referring or subsequent health care providers, such as the Local Medical Officer, rehabilitation service or home nursing service. It also serves as a ready source of information to hospital staff if the patient has subsequent admissions. Consequently it is essential for the continuity and quality of patient care.

The discharge summary should be the basis of communication with referring or subsequent health care providers, such as the Local Medical Officer, rehabilitation service or home nursing service. It also serves as a ready source of information to hospital staff if the patient has subsequent admissions. Consequently it is essential for the continuity and quality of patient care.

For further support / education please research any of the references listed below.

References:

- National Centre for Classification in Health – Australia. 2007. The Good Clinical Documentation Guide (2nd ed). The University of Sydney: NSW.

**Advanced Care Planning**

Advance Care Planning is giving patients the opportunity to document their wishes regarding future health choices and who should make them on their behalf. There are three documents that form the core of this information in the community and one that is hospital only.

**Enduring Power of Attorney (EPOA)**

This document is completed by a person who still has the capacity for decision making and informs whom they wish to make health and or financial decisions on their behalf if they lose the capacity to do this for themselves. This is a legal document, available as a PDF from the Queensland Justice website and can be downloaded and completed by any person over the age of 18 in Queensland. This document needs to be witnessed by a Justice of the Peace/Commissioner of Declarations for it to be legal. It can be done by a Solicitor but this is not necessary.
Advance Health Directive (AHD)

This document is completed by a person who still has the capacity for decision making and informs substitute decision makers and medical staff of their health care wishes if they lose the capacity to do this for themselves. This is a legal document, available as a PDF from the Queensland Justice website and can be downloaded and completed by any person over the age of 18 in Queensland. It is known in some jurisdictions as a “Living Will”. This document is the highest level of decision making for the patient and an EPOA cannot override a decision on an AHD. This document needs to be taken to the patients General Practitioner to be discussed and signed, it is then to be witnessed by a Justice of the Peace/Commissioner of Declarations for it to be legal. It can be done by a Solicitor but this is not necessary. The law only requires you to comply with an AHD if it is consistent with good medical practice and you are comfortable that it would still represent the intentions of the adult.

Statement of Choices

This document is a values based decision making tool that can be completed by a patient who has capacity (Form A) or completed on the patients behalf, by their family or EPOA, for those who have lost capacity (Form B). The Statement of Choices requests patients to document their values and things they enjoy about life and to also identify what health states they would find unacceptable. They can if they wish, also express their wishes regarding CPR and life prolonging treatments. The document is then signed by the patients GP. This document is available on the Viewer and is filed in the front of the patients charts behind the Alerts page.

Acute Resuscitation Plan (ARP) (Hospital only)

An ARP in a non-legal medical decision making tool used within the hospital setting to identify that where possible a discussion has taken place with the patient and/or their family regarding medical treatments to be initiated in the event of a medical emergency within the hospital. Where other ACP documents have been completed these document should be used to inform and ARP but not to the exclusion of discussion with the patient and/or family if possible.

The ARP form applies to adult patients only
• The ARP replaces ‘not for resuscitation’ (NFR) orders and aims to improve documentation of resuscitation planning.
• Information is supplied on the form as well as links for additional information.
• Any changes made to an existing ARP render the ARP invalid even if signed
• Changes to ARP orders require a new ARP
**Advance Care Planning**

*Plan now, Peace of Mind Later*

Attention ALL Members of the Treating Team

**IDENTIFY**

Is your patient appropriate for Advance Care Planning (ACP)? Do any of the following criteria apply?

- Resident of RACF
- Patient has a progressive Chronic Disease (eg COPD, Heart Failure)
- Patient has a progressive Life Limiting Disease (eg Cancer, MND)
- Patient is frail or largely dependant on others for physical support

**DISCUSS**

Discuss ACP

With the patient and/or family members and ask them if they would like a referral for further discussions with the ACP Facilitator

ACP Documents:
- Enduring Power of Attorney
- Advanced Health Directive
- Statement of Choices

**REFER**

Refer to ACP Facilitator Desré 5316 5946 or myacp@health.qld.gov.au

Stating patient’s name, UR, and ward.

The ACP Facilitator will talk to the patient and family about ACP and provide documents for them to consider completing post discharge.

**POST D/C**

ACP Facilitator will follow up with the patient and family in their home, RACF or OPD appointment to assist with completion. The patient and family will talk to their GP. All completed documents will be copied and filed. The Statement of Choices will be uploaded onto The Viewer with copies sent to the patient, their family, their GP and their local hospital.

For referrals phone Desré  x5946
Please also consider the following:

**Medical Officer Responsibilities**

| 1. Medical Officer responsible for the patient’s care | Must respect the patient’s wishes for end of life care. Medical officers are required to adhere to the standards of good medical practice in all decision-making about end of life planning and care. The most senior clinician involved in a patient’s care is responsible for initiating advance care planning, such as an Acute Resuscitation Plan, and ensuring any decisions about advanced care planning and care with the patient and/or their substitute decision-maker are kept current. The medical officer is also required to ensure that the communication channels between themselves and patient, their substitute decision-maker and the health care team remain open. The medical officer is also responsible for ensuring that the choices of the patient are respected and that all decision-making reflects their best interests. | Carries the medicolegal responsibility for that patient while under their care. |

| 2. Medical Officers | Are required to adhere to the standards of good medical practice for their profession. There is a responsibility to ensure any treatments are provided in ways that promote quality of life for the patient and are in their best interests. Medical professionals have a duty of care to discuss with the most senior medical officer involved when the active treatments become burdensome for the patient and those closest to them. Junior medical officers should not be excluded when end of life decisions are considered, although they should be supervised in any discussions about end of life decisions with patients and/or their families. Junior Registrars are not advised to authorise a patient’s Acute Resuscitation Plan form. |

**Enduring Health Attorneys and Appointed Guardians**

Some adults without capacity may have formally appointed substitute decision makers. The adult, before they lost capacity, may have appointed an ‘attorney for health matters’ themselves in an AHD or Enduring Health Attorney document. In some cases the Guardianship and Administration Tribunal may have appointed a guardian. It is good practice to ask to see the appointing document and make a copy for the notes. (In some cases the appointed substitute decision maker may have limits to their authority specified in the appointing document.)
**Statutory Health Attorneys**

In the more common situation, where there is no formally appointed substitute decision maker, a Statutory Health Attorney gives consent for adults without capacity. The Statutory Health Attorney is the first of the following list **who is readily available and culturally appropriate**: the spouse, if the relationship is close and continuing, or if not suitable, an unpaid carer who is 18 years or more, or if not suitable, a close friend or relation, who is 18 years or more and not a paid carer.

**Adult Guardian**

For adults who lack capacity, and have no appointed decision makers or potential Statutory Health Attorneys, contact the “Adult Guardian” to obtain consent. The Adult Guardian also has significant powers to intervene to protect the rights of adults with impaired capacity. The Adult Guardian is on call 24 hours per day.

**Emergencies**

- When treatment is urgent because of **imminent** risk to health you do not need consent.
- “Imminent risk” implies there is a significant threat to the patient’s health if treatment is delayed while consent is obtained. You cannot treat without consent merely because it is convenient to proceed without delay in circumstances where the delay would not otherwise seriously compromise the patient.
- If the patient cannot consent and treatment is urgent, but could wait for you to make a phone call, for example to the Adult Guardian, you need to make the call.

**Deaths**

All wards/units throughout the hospital have a “black box” which has copies of the required forms.

When asked to declare the death of an inpatient:

1. See the patient and confirm life extinct. When confirming life extinct check the following:
   - Rousable / responsive?
   - Lung & heart sounds?
   - Pupils: Dilated? Fixed? Non-responsive to light?
   Try to do this as soon as possible.

2. Record that life is extinct and the time seen in the patient’s notes. Also record the time the nurses inform you the patient died, especially if the delay includes midnight.

3. Fill in the appropriate form declaring life extinct.
   - Decide if death is coronial. If so **notify the police immediately**.
   - Ensure relatives are informed.
   - The resident primarily looking after the patient completes the death certificate at the earliest opportunity if the death is non-coronial.
   - Indicate on the Form 9 COD if the patient is a cremation risk.
Form 1A may be used where:

- The medical practitioner seeks advice from the coroner about whether a death is/is not reportable (see Categories of Reportable Death below).
- The death is reportable and the medical practitioner seeks the coroner’s authority to issue a death certificate because the cause of death is known and no autopsy or investigation appears necessary.

Please email (preferred method) or fax this completed form along with:

- Discharge summary
- Recent admission notes, and
- Draft Cause of Death Certificate (Form 9) to coroner.
- Section B to be returned by the coroner prior to certification

Dead on Arrival

- Patients who are dead on arrival are not brought into ED.
- You should complete the forms kept in ED to pronounce life extinct and give it the police.
- If the police are not in attendance, check that they have been notified.

Deaths within ED

- If the patient has only been seen by the emergency medicine resident and there is no doubt as to the cause of death (for example, known terminal cancer with severe pneumonia at presentation), then the emergency department resident should sign the death certificate.
- Otherwise, if no hospital doctor is able to sign the death certificate notify the police.

Autopsies

- Ask relatives for permission for a post-mortem if the death is non-Coronial. If done sensitively with the explanation that a post-mortem (a) helps to learn more about disease and (b) identifies the precise cause of death, relatives will often give permission.
- It is helpful to explain that the autopsy can detect infectious or hereditary disease with subsequent risk to family members.
- If consent is obtained make sure this is recorded in the history with the name of the person giving permission. Autopsies are performed at Caboolture Hospital by The Prince Charles Hospital pathology staff. Make arrangements directly with the pathologists at Prince Charles.
- Autopsies are performed at Redcliffe Hospital by The Prince Charles Hospital pathology staff. Make arrangements directly with the pathologists at Prince Charles.
- Under the Transplantation and Anatomy Act, someone must consent for non-Coronial autopsies.
- There is an autopsy consent section on the back of the standard consent forms. These can be found on line or in the “Black Box”
- Patients can consent to their own autopsy prior to death! More commonly the ‘senior available next of kin’ gives consent after death. The hierarchy of senior next of kin is:
For children: child’s spouse (if they are married), a parent, a sibling over 18, or a guardian.

For adults: a spouse, a child over 18, a parent, a sibling over 18,

- Consent then needs to be approved by a Designated Officer, usually the Medical Superintendent.
- Patients may also consent to bequest their bodies to UQ or QUT. Both facilities need to be advised of death ASAP. This needs to be arranged prior to hospitalisation.

**Coroners Act**

**What is a Reportable Death**

The *Coroners Act 2003* (http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/C/CoronersA03.pdf) provides for the investigation of reportable deaths. Reportable deaths are defined as deaths where:

- the identity of the person is unknown
- the death was violent or unnatural
- the death happened in suspicious circumstances
- a ‘cause of death’ certificate has not been issued and is not likely to be issued
- the death was a health care related death
- the death occurred in care
- the death occurred in custody
- the death occurred as a result of police operations.

**The Identity of the Person is Unknown**

Even if there is nothing suspicious about the death, unless the identity of the deceased can be established with sufficient certainty to enable the death to be registered, the death must be reported to a coroner. Fingerprints, photographs, dental examinations or DNA can be used to identify the person.

**Violent or Unnatural Deaths**

A death is violent or unnatural if it is not the result of the natural progression of a disease but is caused by accident, suicide or homicide. Car accidents, falls, drowning, electrocutions, drug overdoses, and industrial and domestic accidents are all reported to coroners under this category. A death is reportable under this category even if there is a delay between the incident causing injury and the death, as long as the injury caused or contributed to the death and without the injury the person would not have died.

**Suspicious Deaths**

Suspicious deaths are reported to coroners to enable their circumstances to be further investigated. If police consider there is sufficient evidence to prefer criminal charges in connection with the death they may do so. In these cases, the coronial investigation is postponed until those charges are resolved.

**A ‘cause of death’ certificate has not been issued and is not likely to be issued**

Medical practitioners are obliged to issue a cause of death certificate if they can ascertain the probable cause of death. If this is not possible the death is reported to
the coroner so that an autopsy can be ordered to determine the medical cause of death.

**Health Care Related Deaths**

‘Health care’ means a health procedure or any care, treatment, advice, service or goods provided for the benefit of human health. A health procedure includes any dental, medical, surgical, diagnostic or other health related procedure, including giving an anaesthetic or other drug. Health care related deaths include deaths that result from a failure to treat or diagnose, and clinical or medication incidents and errors. A death will be health care related if health care or a failure to provide health care caused or contributed to the death and, before the health care was provided, an independent person (who is qualified in the area of health care) would not have expected the health care to cause or contribute to the death or for the death to occur at that time.

The independent person can look at all of the circumstances including:

- the person’s known state of health before the health care was provided, for example, whether they had any underlying disease, condition or injury
- the clinically accepted range of risk associated with the health care.

A death is reportable under this category if:

A. **the health care caused or contributed to the death**

OR

a failure to provide health care caused or contributed to the death

AND

B. **death was an unexpected outcome of the health care being provided.**

**Deaths in Care**

A death will be a death in care if the person who died:

- had a disability under the [Disability Services Act 2006](http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/D/DisabServA06.pdf) and lived in either a level three accredited residential service (commonly referred to as a hostel) or a government funded or provided residential service
- was subject to involuntary assessment or treatment under the [Mental Health Act 2000](http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/M/MentalHealA00.pdf) and was either being taken to or detained in an authorised mental health service, detained because of a court order, or undertaking limited community treatment
- was a child awaiting adoption under the [Adoption of Children Act 1964](http://www.legislation.qld.gov.au/LEGISLTN/REPEALED/A/AdoptChildA64_05B_091201.pdf) and was living away from their parents as a result of action by the [Department of Child Safety](http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/C/ChildProtectA99.pdf) under the [Child Protection Act 1999](http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/C/ChildProtectA99.pdf)

An inquest must be held for deaths in care if the circumstances of the case raise issues about the care provided to the deceased person.
Deaths in Custody

A death will be a death in custody if the person died while in custody, escaping from custody or trying to avoid being put into custody. ‘Custody’ is broadly defined to capture detention under any state or Commonwealth legislation (with some limited exceptions) whether or not by police. Deaths in custody must be reported to the state coroner or deputy state coroner and an inquest must be held.

Deaths Occurring as a Result of Police Operations

Deaths occurring in the course of or as a result of police operations include the death of an innocent bystander while police are attempting to detain a suspect. These deaths can only be reported to the state coroner or deputy state coroner and an inquest must be held unless the coroner is satisfied that the circumstances do not require an inquest.

Who Reports the Death to the Coroner?

The Coroners Act 2003 (http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/C/CoronersA03.pdf) imposes a duty on people to report reportable deaths if they are aware of a reportable death and do not think that it has already been reported.

If the person who died had a disability and lived in a level three accredited residential service (local or a government funded or provided residential service, then the service provider must report the death even if the person died elsewhere (for example, in hospital) and the death may have been reported by another person. A higher obligation is placed on these service providers because the services are provided to particularly vulnerable members of society.

Usually a police officer or medical practitioner will report a death to the coroner. If they are unsure whether a death should be reported they will contact their local coroner to discuss the matter.

NOTIFICATION OF THE CORONER

- It is your responsibility to notify the police in Coroner’s cases, usually after discussion with the Consultant. Although the nurses may notify them on your behalf, you remain accountable. The police usually attend to make inquiries and arrange relocation of the body.
- If you are unsure, talk to the Director of Medical Services or the duty police sergeant.
- For further information on the Coroners Act, please refer to the QHEPS website: http://www.legislation.qld.gov.au/OQPChome.htm
Death Certification, Coronal Notification / Investigation & Non Coronal Autopsy

Death Certification, Coronal Notification / Investigation & Non Coronal Autopsy

A death is reportable under the Coroner’s Act 2003 (Section 12(2)(a)) if:
1. It is not known who the person is, OR
2. The death was violent or otherwise unnatural, OR
3. The death happened in suspicious circumstances, OR
4. The death was a healthcare related death, OR
5. A cause of death certificate has been issued, and is not likely to be issued, OR
6. The death was a death in care, OR
7. The death was a death in custody, OR
8. The death happened in the course of or as a result of police operations.

For decision support, contact the coroner on 3243 2424 hours a day.

CONSIDER: Is the death reportable to the Coroner?

YES

Ensure that the signed copy of the Form 1A Coroner’s actions section (part 1B) is filed in the patient’s medical record in accordance with the Act’s requirements. Communicate to the patient’s family, and in writing to the deceased’s family if they request. Refer to Quick Reference Certification Guide in the Decedent Patients’ Package.

NO

Has the deceased patient’s family been notified and/or consulted to a Non-Coronial Hospital Autopsy to verify the Cause of Death?

YES

Complete the Cause of Death Certificate (form 5) and death certificate (form 8A) in the case of a child who was still born or necropsy (morgue).

The deceased patient’s body is transferred to the coroner for further investigation.

Complete the Cause of Death Certificate (form 5) and death certificate (form 8A) in the case of a child who was still born or necropsy (morgue).

Ensure that a copy of the Death Certificate is:
1. Sent to the Registry of Births, Deaths & Marriages (White)
2. Sent to the person arranging for the disposal of the body (Blue)
3. Kept in the medical record (Yellow)

NO

Further investigation by the Coroner is necessary, and it is recommended that:

1. Ensure that any medical equipment attached or inserted to the patient remains in place as evidence of treatment provided
2. Complete a Form 1A Coroner’s Action section (part 1B)
3. Copies are available in the Decedent Patient Pack in each ward or electronically at http://www.health.wa.gov.au/1700.mnu ensure that a copy of a completed Form 1A is:
   a. Faxed to the coroner’s office on 3243 2424
   b. Kept in the patient’s medical record

1. Ensure that the signed Coroner’s Actions section is kept in the patient’s medical record
2. Ensure that the patient’s medical record is copied by:
   a. The Senior Health Information Manager on ext 8757 OR
   b. Results Information Unit counter after hours on ext 5226
3. Contact the Cadaverine Police on 5428 6444 and inform them that:
   a. There has been a reportable death,
   b. The Coroner has been notified
4. The Police will attend and start the investigation by:
   a. Arranging for the deceased patient’s body and medical record to be sent to the Coroner
   b. Questioning staff to obtain information relevant to the investigation
5. For decision making support please refer to the Coroner’s Investigation Guide in the Decedent Patient Pack on each ward, and at http://www.health.wa.gov.au/1700.mnu...
Black Box Standard Table of Contents

This coloured coded table of contents will be placed on the front of the box as the folders dividers are coloured as an additional prompt for staff.

<table>
<thead>
<tr>
<th>Contents</th>
<th>Number required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notification of death pad</td>
<td>One</td>
</tr>
<tr>
<td>Cause of death certificate pad</td>
<td>One</td>
</tr>
<tr>
<td>Autopsy information for staff</td>
<td>One original in plastic sleeve Fifteen copies</td>
</tr>
<tr>
<td>Autopsy consent and information for families</td>
<td>One original in plastic sleeve Fifteen copies</td>
</tr>
<tr>
<td>Form 1A coronial notification version four</td>
<td>One original in plastic sleeve Fifteen copies</td>
</tr>
<tr>
<td>Reference guide for COD death certificates</td>
<td>One original in plastic sleeve Fifteen copies</td>
</tr>
<tr>
<td>Life extinct form</td>
<td>One original in plastic sleeve Fifteen copies</td>
</tr>
<tr>
<td>Sudden death summary for QPS</td>
<td>Only one original is kept as document is 24 pages and is rarely used</td>
</tr>
<tr>
<td>Coroners investigation guide</td>
<td>One</td>
</tr>
</tbody>
</table>

Black boxes are located in:

- Critical Care Unit
- Paediatrics
- Maternity
- Mental Health Unit
- Ward 2A Surgical
- Ward 3A Medical
- Ward 4A Medical

ED department have their own ‘Kit for death in ED’
Death Certificates

Please ensure you have the following information completed on the Death Certificate:

- Your name
- Deceased name
- Date of birth
- Date of death
- Time of death
- Does the body of the deceased pose a cremation risk under the Cremations Act 2003? (please specify eg pacemaker).

These certificates are designed to enable the government statisticians to select the underlying cause of death.

The underlying cause is the complaint that initiated the train of events leading to death, or the circumstances of the injury that produced the fatal injury.

The quality of the statistics depends on you supplying the right information.

If you do not give the Bureau of Statistics enough information they write back to the hospital to demand more, so it saves time if you give enough the first time!

Detail required on certificates:

- type of infective organism (bacterial, viral).
- cause of cardiac or renal failure, for example, IHD, idiopathic,
- primary site and morphology of a neoplasm (state ‘unknown primary site’ if necessary)
- part of an organ or system diseased or injured.
- a description of the severity, nature, stage or degree of a morbid condition, for example: acute or chronic, congenital or acquired, benign or malignant, primary or secondary
- nature of hypertensive (for example, essential) and rheumatic conditions associated with circulatory disease
- nature of physical conditions associated with mental disorders.
- complications which were associated with pregnancy, childbirth, or the puerperium.

No entry is necessary in lines (b) and (c) of part 1 if line (a) completely describes the train of events.

“Due to (or as a consequence of)” includes aetiology or pathological sequences and where you think an antecedent condition prepared the way for the direct cause by damage to tissues or impairment of function, even after a long interval.

If more than one causal sequence is involved indicate which probably made the greatest contribution to death.

If you list pneumonia or bronchopneumonia as the underlying cause of death in part 1, together with serious conditions which could have predisposed to the pneumonia in part 2, describe the pneumonia as ‘primary’. Alternatively enter the condition predisposing to the pneumonia, as the underlying cause in part 1.
Quick Reference – Completing the Medical Certificate of COD

QUICK REFERENCE - COMPLETING THE MEDICAL CERTIFICATE OF CAUSE OF DEATH (COD)

Part One of the Certificate:

<table>
<thead>
<tr>
<th>Direct Cause of death</th>
<th>Example of Completed Medical Certificate of COD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Line 1a The direct cause of death</td>
<td>Part 1a Klebsiella pneumoniae 1 week</td>
</tr>
<tr>
<td>Antecedent causes Line 1b The cause of Line 1a</td>
<td>Part 1b Inactivity 2 months</td>
</tr>
<tr>
<td>Line 1c The cause of Line 1b</td>
<td>Part 1c Cerebral Infarction 2 months</td>
</tr>
<tr>
<td>Line 1d The cause of Line 1c</td>
<td>Part 1d Atherosclerosis years</td>
</tr>
</tbody>
</table>

Part Two of the Certificate:

<table>
<thead>
<tr>
<th>Other significant conditions contributing to death but not related to the disease or condition causing it</th>
<th>Part 1i Ischaemic Heart Disease 10 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholism and Smoking 20 years</td>
<td></td>
</tr>
</tbody>
</table>

Where two independent diseases have contributed equally to the fatal sequence they may be entered on the same line.

Duration between onset and death: Enter the duration of time, between onset of each condition and the date of death. Note: The shortest duration should be on Line 1a and increase sequentially to the last entry in part one. See example above.

If you have any questions regarding Cause of Death Certification Freecall the ABS on 1800 620 963

QUICK REFERENCE CERTIFICATION GUIDE - GENERAL CONDITIONS AND DISEASES

Please provide the required detail for the conditions and diseases listed below.

Where your best medical opinion does not permit you to document the required detail, please document this detail as UNKNOWN.

Note: This principle applies to ALL conditions and diseases that are documented on the Medical Certificate of Cause of Death, not only those listed below and overleaf. For information on the required detail for other conditions, not listed below, refer to the booklet “Cause of Death Certification, Australia, 2008 (1205.55.001)” pages 14 - 27.

Pneumonia
Primary, hypostatic or aspiration.
Cause of any underlying condition
Causative organism
If due to inactivity/debility - condition leading to inactivity/debility

Infection
Primary or secondary
Causative organism
If primary - bacterial or viral
If secondary - details of primary infection

UTI
Site within urinary tract
Causative organism
Underlying cause
If due to inactivity/debility - condition leading to inactivity.

Renal Failure
Acute, chronic or end stage, Underlying cause. eg hypertension, arteriosclerosis, pregnancy or heart disease.
If due to immobility - condition leading to inactivity/debility.

Hepatitis
Acute or chronic
Due to alcohol
Of new born
Of pregnancy, childbirth, puerperium
If viral - type (A,B,C,D OR E)

Pregnancy
Document pregnancy on certificate even if unrelated to COD.
- If pregnant at time of death or within 42 weeks
- If pregnant between 6 weeks and 12 months of death

If ANY of the detail requested above is UNKNOWN, please document this on the certificate.
Quick Reference Certificate Guide – Malignant Neoplasms

Medical Certification of Cause of Death should, at all times, be your BEST MEDICAL OPINION. If your best medical opinion does not permit you to document the required detailed outlined on this guide, please identify this by documenting the required detail as UNKNOWN.

QUICK REFERENCE CERTIFICATION GUIDE - MALIGNANT NEOPLASMS

Clearly identify the malignancy, exact site and behaviour of all neoplasms.

**Tumor/Growth** - Identify site and as benign, malignant primary, malignant secondary or unknown behaviour

**Neoplasm** - Identify the malignancy, exact site and behaviour

**Metastatic** - Identify whether metastatic TO (Secondary) or metastatic FROM (Primary)

**Secondary** - Identify whether primary site or document Primary as Unknown

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### HOW SPECIFIC SHOULD YOUR RECORDING OF A NEOPLASM SITE BE?

If the site of any primary neoplasm is unknown, "Primary unknown" MUST be documented on the Medical Certificate of Cause of Death.

The principles of site specificity, and primary unknown, apply to all malignant neoplasms, not just those listed below.

The primary neoplasm sites listed below require one of the subset qualifying terms, to provide necessary detail for identification of the underlying cause of death.

**Site of Primary Neoplasm - Please be as specific as you are able.** (e.g. Primary carcinoma of inner aspect of lower lip)

<table>
<thead>
<tr>
<th>Lip</th>
<th>Mouth</th>
<th>Pharynx</th>
<th>Oral</th>
<th>Skin</th>
</tr>
</thead>
<tbody>
<tr>
<td>lower</td>
<td>cheek (mucosa)</td>
<td>nasopharynx</td>
<td>tongue</td>
<td>vulva</td>
</tr>
<tr>
<td>upper</td>
<td>vestibule</td>
<td>hypopharynx</td>
<td>salivary gland</td>
<td>vagina</td>
</tr>
<tr>
<td>commissure</td>
<td>retro molar</td>
<td>oropharynx</td>
<td>palate</td>
<td>penis</td>
</tr>
<tr>
<td>skin of lip</td>
<td>overlapping</td>
<td>tonsil</td>
<td>gum</td>
<td>scrotum</td>
</tr>
<tr>
<td>overlapping</td>
<td>unknown</td>
<td>pyriform sinus</td>
<td>overlapping</td>
<td>melanoma (by site)</td>
</tr>
<tr>
<td>unknown</td>
<td></td>
<td></td>
<td>unknown</td>
<td>other specified site (by site)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Liver</th>
<th>Bowel</th>
<th>Uterus</th>
<th>Endocrine Gland</th>
<th>Adrenal Gland</th>
</tr>
</thead>
<tbody>
<tr>
<td>sarcoma</td>
<td>large (colon)</td>
<td>cervix uteri</td>
<td>parathyroid</td>
<td>medulla</td>
</tr>
<tr>
<td>angiosarcoma</td>
<td>small</td>
<td>corpus uteri</td>
<td>pituitary</td>
<td>cortex</td>
</tr>
<tr>
<td>hepatoblastoma</td>
<td>colon with rectum</td>
<td>ligament</td>
<td>craniopharyngeal</td>
<td>unknown</td>
</tr>
<tr>
<td>hepatocellular</td>
<td>sigmoid colon</td>
<td>overlapping</td>
<td>pineal</td>
<td></td>
</tr>
<tr>
<td>intrahepatic duct</td>
<td>unknown</td>
<td>unknown</td>
<td>aortic body</td>
<td></td>
</tr>
<tr>
<td>unknown</td>
<td></td>
<td></td>
<td>pluri glandular</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respiratory</th>
<th>Lung</th>
<th>Breast</th>
<th>Urinary Organs</th>
<th>CNS</th>
</tr>
</thead>
<tbody>
<tr>
<td>nasal cavity</td>
<td>upper lobe</td>
<td>upper inner quadrant</td>
<td>kidney</td>
<td>meninges</td>
</tr>
<tr>
<td>middle ear</td>
<td>lower lobe</td>
<td>lower inner quadrant</td>
<td>ureter</td>
<td>brain</td>
</tr>
<tr>
<td>accessory sinus</td>
<td>middle lobe</td>
<td>lower outer quadrant</td>
<td>bladder</td>
<td>“specific” ventriculeterine</td>
</tr>
<tr>
<td>mediasinum</td>
<td>main bronchus</td>
<td>upper outer quadrant</td>
<td>urethra</td>
<td>brain stem</td>
</tr>
<tr>
<td>trachea</td>
<td>overlapping</td>
<td>lower outer quadrant</td>
<td>paraurethral gland</td>
<td>cranial nerve</td>
</tr>
<tr>
<td>thymus</td>
<td>unknown</td>
<td>axillary tail</td>
<td>overlapping</td>
<td>spinal cord</td>
</tr>
<tr>
<td>bronchus</td>
<td>primary</td>
<td>central portion</td>
<td>unknown</td>
<td>cauda equina</td>
</tr>
<tr>
<td>larynx</td>
<td>secondary</td>
<td>nipple and areola</td>
<td>primary</td>
<td>overlapping</td>
</tr>
<tr>
<td>overlapping</td>
<td>unknown</td>
<td>overlapping</td>
<td>secondary</td>
<td>unknown</td>
</tr>
</tbody>
</table>

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**Documentation**

The keeping of legible, logical, timely and comprehensive medical records is an important part of your job.

Your written word is potentially open to public scrutiny. The *Information Privacy Act, 2009* gives the public the right to see documents, including those concerning their personal affairs, held by government agencies such as Queensland Health. People can also request amendment of personal records if they contain inaccurate, incomplete, out of date or misleading statements.

Your documentation may be the only evidence that you have done your job completely and correctly:

- Be objective, relevant, complete and legible.
- Avoid subjective comments – especially disparaging ones.
- Ensure all your chart entries have the **date, time and your signature**.
- **Always print your name under your signature – use your stamp.**
- Do not leave gaps between entries.
- Never use pencil, highlighters or liquid paper.
- Black ink is better than blue. Do not use green or red.
- Ensure every page has a correct identification label.
- Take particular care when recording:
  - informed consent,
  - patient education, and
  - to display evidence that the patient understands their own responsibility.

If altering an entry, do not obliterate the inaccurate material. Draw a single line through the inaccurate record and indicate the reason for the alteration.

Refer requests for access to a patient’s information from someone other than the patient to Medical Administration.

Be especially careful with patient ID labels. Incorrect labels can easily become incorporated into charts. Handwriting specimen details do not overcome this if the incorrect details are copied from a label!

At any time you become aware that patient details are incorrect or pages within a chart are loose, let the Ward Receptionist know.

Once a patient has been discharged from the hospital specific codes are assigned to their episode of care that reflect the patient’s condition and care received. Coding is completed in accordance with international standards (ICD-10-AM). This data collection process informs resource utilisation, research and services planning. Each patient is categorised into a Diagnostic Related Group (DRG) based on the Medical Record. It is important that all relevant information is written clearly and concisely so that the Health Information Managers and Clinical Coders can ensure that the reimbursement is maximised for the treatment of each patient.
WINSCRIBE, the District’s dictation system will allow you to dictate and edit your current dictation from any DECT phone or table phone within the hospital.

A User ID is required to access WINSCRIBE, to obtain your User ID please contact the WINSCRIBE System Manager on ext. 7586.

The WINSCRIBE System Manager will also advise you of the appropriate job types to be used and will be able to assist you with templates to ensure your dictation is concise and contains all the essential information, which will ensure the Medical Typists complete your typing in a timely manner.

Guidelines to follow when dictating on Winscribe

Please advise the typist of the following information when dictating:

- State your name and the clinic where you are dictating
  - Note: There are different templates for different clinics
- Advise who the letter is to be addressed to – GP, Specialist, etc
- Please clearly state: Patient’s name, date of birth and UR Number
  - Note: In some cases the UR on Winscribe does not match the patient identified on the dictation
- Referrals: Advise the location of the Specialist including the address
- Copies – State extra copies required before starting your letter
- Please keep letters to a minimum (as short as possible)
- Avoid repetition of information
  - Note: In most cases the patient has returned for follow up, in which case only a brief update for the GP is required (Feedback from GP’s has indicated that they do not require long detailed letters).
- Speak clearly and at a normal pace into the microphone/DECT phone
- Avoid background noise as this affects the quality of the dictation

Following the above guidelines will help to ensure your letters are accurate and timely.

**Dictation:**

**Step 1**  Dial 7400.
**Step 2**  Press ## and then your User ID.
**Step 3**  Enter your Job Type ID.
**Step 4**  Enter the 6 digit patient UR number.
**Step 5**  Begin dictating

**To Pause** – Press ‘4’ to pause and to start dictating again press ‘2’

**To Rewind** -
Press ‘4’ to Pause;
Press ‘3’ to rewind
Press ‘1’ to listen to your dictation

**To Listen to your Dictation**
Press ‘4’ to Pause
Press ‘333’ to rewind back to the start of your dictation
Press ‘1’ to listen
Editing your dictation
Find location in dictation you wish to edit by rewinding dictation.
Press ‘4’ to pause
Press ‘2’ for your edit options
When editing finished, press ‘4’.
You can now listen to your edited dictation.

Step 6  Press ‘5’ to send letter to the typists.
Step 7  Press ** to disconnect

If you require assistance please contact the District WINSCRIBE System Manager on ext. 7586 or Module Experts on 8557 or 8548

Medical Administration
The Director of Medical Services has an open door policy. If you have a problem or need advice, please do not hesitate to speak to them.
The hospital MEO(s) are also here to be your advocate. Feel free to go to them if you are having any problems.
If you wish to stay on past the end of your contract, let Medical Workforce Unit know early. Conversely if you are applying elsewhere also let them know – they are well placed, and do advocate for your future careers.

Conflicts and Complaints
Queensland Health is very responsive to adverse publicity. Therefore the system places a big emphasis on avoiding and defusing conflicts with patients or relatives. All Queensland Health employees have a responsibility to assist consumers to resolve their concerns. If you are involved in conflict, try to defuse it. If you are unsuccessful, detach from the situation and report to your Consultant or to Medical Administration.

Employment Conditions

Sick Leave and Unplanned Absences
If you cannot work due to illness, or other extenuating reasons, it is vital that you immediately inform Switch ideally before the beginning of your shift and Switch will then notify the Director of your unit and Medical Workforce Unit –Let them know the reason and expected length of absence.
If you need to extend the leave, again advise both your Unit Director and Medical Workforce Unit as soon as possible.
You will need to complete a leave form when you return to work if your leave is greater than 3 days.
If you are sick for more than three days will need a doctor’s certificate or the pay office cannot pay you.
You must complete a leave form.
If a family member dies you may also receive bereavement leave to attend the funeral, however you must supply support (i.e. funeral notice)
Rosters

Rosters are published electronically 2 weeks prior of the start of every Term and then are continually revised and published every fortnight to optimise patient service and your working conditions.

Under the award, you are rostered for 76 hours per fortnight. Work on weekends is compensated by rostered weekdays off or, if this is not possible, it is paid at overtime rates.

You may also be rostered on-call and have rostered overtime shifts. The exact rosters will vary as staff numbers fluctuate.

Most rostered shifts are 8-10 hours in length and include a 30 minute meal break. You are paid overtime for work beyond rostered hours if this extra work is necessary to meet patient needs. Your Consultant and the Director of Medical Services must authorise unrostered overtime.

Shift Swapping

Swapping of shifts is acceptable if service is not compromised and no additional overtime cost occurs.

Email your request to the Medical Workforce Unit and wait for acknowledgement of this swap to be approved.

You must also notify the switchboard, your Clinical Director and anyone else likely to be affected by the change of shift.

Fatigue leave

If you have less than ten continuous hours off duty between shifts and you have worked more than two hours overtime call switch as you leave the hospital. Ask switch to contact your Registrar or Consultant for you in the morning informing them of your fatigue leave. Complete AVAC via the Medical Workforce Unit which is required to be sent to the Director of Medical Services for authorisation. This enables you to sleep in and return to work after your ten hour break unless you hear otherwise (you are entitled to be paid “fatigue leave” until you get ten hours off duty). If your Consultant instructs you to come in without having had ten hours off duty, the award entitles you to double pay until you are released from duty.

You must get your Consultant to authorise fatigue pay through the ESP e-mail exception reporter.

Recreation leave

You are entitled to five weeks leave every year providing internal relief is available. Holidays are negotiated with the Medical Workforce Unit (phone 8883).

Get your preferences in early, although sometimes leave will not be approved until staff numbers are known.

Leave not taken at the end of your service with Queensland Health is taken as a payout.

To ensure you receive your pay in advance, lodge your leave form at least four weeks beforehand. Leave must be booked form Monday to Sunday.

Code of Conduct and Conditions of Service

- If you change your telephone number, even temporarily, always inform the switchboard and Medical Workforce Unit.
- Be familiar with and abide by the Queensland Health Code of Conduct. If you do not have a copy yet please obtain one from the HRM Department.
- The Queensland Senior Medical Officer and Resident Medical Officer Award your conditions of service. You can get a copy from Medical Workforce Unit or on QHEPS.
• Please wear your identification badge at all times. Do not alter your badge.
• A meal allowance is paid with your fortnightly pay where appropriate.
• On-call rooms are available for staff on proximate call.
• When you leave us return all keys, ID badge, pager and DECT phone to the switchboard before you leave on your last shift.
• Notify the Medical Workforce Unit if you change home or postal address.
• If you smoke, now is a good time to quit. Smoking is no longer allowed within the grounds of Caboolture or Kilcoy Hospitals.
• You are provided with an e-mail account. You are allowed to use this for personal e-mails providing your use is infrequent and brief and it does not interfere with your work. Be very careful not to access pornographic or other offensive material and not to transmit large files or infringe copyright regulations. Queensland Health monitors all e-mail and internet traffic and misuse can lead to disciplinary action.

Workplace Health and Safety Responsibilities

You have legal responsibilities:
• Act in a manner that promotes your own health and safety and that of every other person in the workplace.
• Comply with safety instructions.
• Use protective clothing and equipment provided by the hospital in the manner you have been instructed.
• Do not recklessly interfere with or misuse anything provided for health and safety.

Immediately report all injuries, needle sticks or hazardous incidents to your supervisor and to complete an incident notification (Form 7) and forward to the Workplace Health and Safety Officer within 3 days. Incident report forms are a vital component of risk reduction strategies and early reporting facilitates workers compensation.

Equal Opportunity, Harassment and Grievance Procedures

The Caboolture Hospital is committed to eliminating all direct and indirect discriminatory practices. We will not tolerate you discriminating against or harassing other staff. We also do not expect you to tolerate this behaviour in others. Please let the right people know if you are experiencing difficulties or have any concerns regarding these matters.

Equal Employment Opportunity (EEO): The Hospital is an equal opportunity employer and all staff have equal rights to apply for positions within the organisation. We seek to eliminate all forms of discrimination based on gender, race, ethnic origin, age or disability. If you believe you are being unfairly treated please talk to your EEO Coordinator who is contactable through Human Resources.

Grievance Procedures: There are formal procedures to ensure that work related grievances are resolved justly. Ask Medical Workforce Unit or the Human Resource Manager to initiate them if you are unable to resolve a grievance personally.
**Sexual Harassment**: includes a wide range of unwelcome and unsolicited behaviours largely defined by the victims:

- Offensive comments or gestures
- Display of offensive pictures or books
- Persistent staring, touching, patting or pinching
- Repeated unwelcome requests for dates
- Demeaning comments about physical appearance or private life
- Implying that giving sexual favours is an acceptable way to gain promotions, avoid dismissal etc.

Sexual harassment can affect both genders and may cause distress, confusion and guilt. Sexual harassment lessens the integrity of the service we provide and our image within the community. Sexual harassment in any form is not acceptable and will lead to disciplinary action.

**Harassment Contact Officers**: There is a Workplace and Equity Harassment Officer (WEHO) network through the District. The WEHO’s listen, provide support, supply information and discuss options available. For a list of WEHO’s contact Human Resources.

Caboolture Hospital has also made provision for individuals to obtain help outside of the organisation for confidential counselling. Information about the Employee Assistance Program service can be obtained from the Human Resources Department, the Director of Medical Services or the Medical Education Officers. Direct contact can be made with EAP - 1800 604 640.

**Staff Workplace Rehabilitation**

If you are injured or treating a staff member injured at work or for whom rehabilitation may facilitate return to work, please contact the Workplace Rehabilitation Program Coordinator.

**Episodes of Care**

All Queensland Health hospitals must collect and report inpatient activity by “episode of care.” These are phases of treatment determined by patients’ classification rather than individual bed days. A single admission may have several associated episodes of care. Commonly patients move from acute to maintenance. It is important that if the patient then receives acute care that their episode type is changed back.

**Admission types:**

- Acute
- Rehabilitation – delivered in a designated unit
- Palliative – delivered in a designated unit
- Newborn
- Maintenance (for patient’s placement)
- Other care
- Organ Procurement
- Boarder

When one of your patient’s change episode type, let the Ward Receptionist know and they will assist you with the appropriate form.
Acute Care Guidelines

When a patient has been in hospital for 35 days, the medical team must decide if the patient needs continuing acute care, in which case an acute care certificate is issued. If not, as a long stay patient, they are charged for their continuing stay.

The following are guidelines for this decision although not hard rules.

1. Acute care includes treatment for the early significant improvement of the patient’s condition, management of exacerbations of symptoms in chronic conditions, or for life support.

2. Acute care is given to patients with medical fluctuating conditions or is active and requires regular professional monitoring and adjustment. Acute care is not routine or supportive treatment for stabilised conditions.

3. In evaluating the need for acute care, consider:
   a. Is current treatment likely to further improve the patient in the short-term allowing return to their previous environment?
   b. Is the degree of improvement consistent with the duration of treatment?
   c. Is it the treatment that is improving the patient’s condition?
   d. Does this care have to be provided in an acute hospital bed?
   e. Are these treatments and investigations unavailable in a nursing home?

4. Terminally ill in-patients requiring more than basic nursing care often need acute care.

5. Patients suffering from Psychiatric conditions may require long term acute care. A review of acute psychiatric public inpatients suggests the length of stay should rarely exceed 35 days. Ongoing treatment deliverable to outpatients or in day hospitals is not acute care.

6. Acute care includes post operative treatment and treatment of complications.

7. Patients remaining in hospital while awaiting nursing home placement are not considered to require acute care.

Maintenance Care Guidelines

Maintenance care is care in which the intent is prevention of functional deterioration and health of a patient with a disability or severe functional impairment. Following assessment or treatment the patient does not require further complex assessment or stabilisation, and requires care over an indefinite period. This care includes that provided to a patient who would normally receive care in another setting, such as at home, or in a nursing home, by a relative or carer, that is unavailable in the short term.
Tests

- Medical Administration monitors use and cost of private procedures and tests on public patients. The Director of Medical Services must approve all such requests in advance. Where a test or procedure is available through the public sector, then that test or procedure must be done publicly except in special circumstances. Do not order private tests without prior approval. **No approval, no payment!**

- Because of agreements between the Commonwealth and Queensland governments, tests and procedure for public hospital inpatients or outpatients cannot be billed to Medicare.

- Before referring patients to private practitioners, you need a personal provider number for each location you work in. The Commonwealth Government Health Insurance Commission (HIC) issues these numbers and you will receive the appropriate forms when you start. Interns need to consult with a senior staff member in this situation.

Medico-Legal Matters

- Refer legal concerns or inquiries to Medical Administration.

- If you receive a subpoena or notification of a claim against you relating to your employment within the district report it to Medical Administration immediately.

Queensland Confidentiality Laws

- Under the *Queensland Health Services Act 1991* (s63), it is an offence for you to disclose, directly or indirectly, any identifiable information without proper authority.

  You may only disclose information:

  - with the prior consent of the person it relates to or, if that person has died, with the consent of the senior available next of kin of that person; or

  - in general terms in accordance with recognised standards of the profession; or

  - (if you are a doctor) to the next of kin or a near relative of the patient in accordance with the recognised medical standards; or

  - if required for further treatment of a patient in accordance with the recognised standards of your profession; or

  - if legally required, for example:

    - Suspected child abuse or neglect (*Children’s Services Act*, 1965 s76K)
    - Suspected crimes (attempted or completed) (*Medical Act* 1939)
    - Notifiable disease, cancer, births and deaths (*Medical Act* 1939)
    - Non-accidental injuries (*Medical Act* 1939)
    - Notifying the Chief Executive of Queensland Transport of medically unfit drivers (*Traffic Act* 1949 s67A)
    - Tracing infected blood products (*Health Services Act 1991* s63(2)(d)) or
Informing legally authorised substitute decision makers, such as Statutory Health Attorneys (*Guardianship and Administration Act 2000*)

Always minimise dissemination of information within the hospitals and between services to that necessary for patient care. Be especially careful when sensitive information is involved. If in doubt, obtain consent or discuss with Medical Administration.

**Notifiable Diseases**

- The *Health Act* requires notification of certain diseases unless the pathology laboratory tells you they have already done this.
- Be especially vigilant for measles, polio, and tuberculosis.
- The Public Health Unit at The Prince Charles Hospital can advise on management and the public health response.
- You should also consider notifying other rare, new or unusual disease, especially if it has public health implications.
- Notifiable conditions
- List of Clinical and Provisional Diagnosis Notifiable Conditions

**Reports for Solicitors and Insurance Companies**

- Direct all requests for reports (but not medical certificates) to Medical Administration who liaise with the solicitors or insurance companies.
- Be clear in the report that it is prepared from the medical record and provide only factual information supported by the record. This may include history, examination, investigations and treatment.
- You may make a brief statement of the patient’s status when last seen. However, it is not necessary to comment on prognosis or level of disability. These are questions of expert opinion and should be referred to private experts for assessment. The hospital only expects you to summarise the patient’s management at the hospital. Do not offer opinions.
- The hospital only provides these reports when given written patient consent and appropriate fees are paid.

**Talking to the Media or Lawyers**

Do not release information to the media or lawyers. Refer all requests to Medical Administration.

**Medical Certificates**

Patients usually tell you if they need a certificate, but it is a good habit to routinely ask when circumstances suggest the patient will probably need a certificate. This question actually saves everybody time in the long run.
- Only backdate a certificate when there is a record that the patient was seen for that condition at this hospital. The issue of a false certificate can incur serious consequences for you with the Medical Board of Queensland.
• Remember that it is not your job to decide if a patient is eligible for particular benefits or compensation. This is the role of relevant authority. Your responsibility is to give a certificate stating the facts as you observe them.

• Try to give the patient the right type of certificate or otherwise they will be seeking one on the right form:
  o **Workers’ Compensation**: for injuries and illnesses received at work or travelling to or from work. Provide a specific diagnosis and anatomical detail. Vague terms such as “medical condition” and “RSI” are unacceptable. Improper completion results in the patient returning for more details and delays their benefits.

  o **Social Security Sickness Benefit** medical certificate: if the patient is applying for sickness benefits.

  o **QH24**: this is the general certificate, usually for the employer. Unlike the workers’ compensation forms where specific clinical detail is legally required, specific details are not required and “medical condition” is usually adequate. You can provide specific details with the patient’s consent and the railways and police departments usually need more detail.

Record the type and the dates of certificates in the medical record – for example, “QH24 to 15th August 2014.”

**Police**

• Notify regarding bullet wounds, stabbings, injuries caused by other weapons, strangulation and asphyxiation unless you are sure that the cause was accidental.

• Under the *Traffic Act* (s33 and s35) the police can make detailed inquiries relating to vehicle accidents, though should avoid seeking information that is clearly irrelevant to the case.

**Police statements**

Please refer to the Ethical Standards Unit (Criminal Matters) via QHEPS

Initially refer all requests for police statements to Medical Administration. Include:

• the date and time that you attended the patient,
• a list of injuries noted,
• a summary of treatment, and
• prognosis if reasonable.

You may include information provided by the patient or others but state the source of the information. Also ensure that these statements are documented in the clinical record.

• **Do not release information** that may cause embarrassment to the patient where that information is not relevant to the case. If in doubt seek the permission of the patient or discuss the issues with Medical Administration.

**Health Professionals and Blood Alcohol Testing**

Under Section 80 of the *Transport Operations (Road Use Management) Act 1995*, a Police Officer can request that a health care professional take a blood sample from a patient for blood alcohol testing. A “health care professional” may be a doctor, a nurse, or a “qualified assistant (when directed by a doctor or a nurse)”, such as a phlebotomist.
If the patient is able to give consent, and a doctor, familiar with the patient’s injuries and state of health, approves, then the Police Officer will inform the patient that they are required to give a blood sample. If the patient consents to the test, the Police Officer will give you a sample kit and the paperwork to complete. The Police Officer will be responsible for delivering the sample kit for analysis. If the patient does not consent, the Police Officer will ask you to complete and sign a certificate to confirm that that patient failed to provide a specimen.

If the patient is unconscious, or otherwise unable to give consent, the Police Officer can require that a sample of blood be taken from the patient by a doctor, nurse or qualified assistant. The doctor or nurse does not need consent from the patient to take the specimen. The doctor or nurse does not have to comply with this request if they believe that (i) taking the sample would prejudicial to the person’s treatment, or (ii) they have another reasonable excuse (other critically ill patients require urgent attention), and will not commit an offence if they fail to comply with the Police Officer’s request.

If the patient cannot give consent, the person taking the sample will be given two sampling kits. One will go to the Police Officer, and one will be given to the patient. The patient’s own sample must be (1) sealed appropriately to avoid tampering, (2) placed in cold storage until given to the patient, and (3) given to the patient as soon as is practical. The patient should be informed that the sample was taken under police instruction, in accordance with the Transport Operations Act.

As always, the process of taking the samples, or reasons why the samples were not taken, should be clearly documented in the patient’s medical records.

If you are not sure whether you can or should comply with these requests, your Consultant or Medical Administration should be contacted, to provide clarification and support.

**Correctional Services Patients**

Correctional Service patients should be sent to Princess Alexandra Hospital Security Unit as soon as clinically possible phone 3240 5770 or 3240 5773. Those with primary psychiatric diagnosis go to John Oxley Hospital.
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