2018 Intern and RMO Orientation Manual

General Medicine
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Welcome to the Medical Unit, Caboolture Hospital

District Overview

Metro North Hospital and Health Service provides the full range of health services including rural, regional and tertiary teaching hospitals. The District covers an area of 4157 square kilometres and extends from the Brisbane River to north of Kilcoy. Hospitals within the Metro North Hospital and Health Service include Caboolture Hospital, Kilcoy Hospital, The Prince Charles Hospital, Redcliffe Hospital, Royal Brisbane & Women's Hospital Services within Metro North Health Service District include Aged Care / Residential / Acquired Brain Injury Services, Primary and Community Health Service, Mental Health Services and Oral Health Services.

Caboolture Hospital

The Caboolture hospital is a 233 bed hospital, with hospital services including Obstetrics/Gynaecology, General Surgery, General Medicine, Day Surgery, Pathology, Emergency Medicine, Gastroenterology, Paediatrics, Medical Imaging, Pharmacy and Mental Health. Allied Health services include Physiotherapy, Dietetics, Speech Pathology, Social Work and Occupational Therapy.

Philosophy of the Unit

- To **diagnose and treat illness** to ensure rapid return to a fulfilling life where possible and to **treat pain** to ensure a dignified life where a return to health is not possible.
- To **treat patients with dignity and respect** no matter what psychological, social or health problems they may have.
- To **help the relatives and friends of patients coping with illness** affecting a member of their family.
- Strict policy of **no discrimination in any aspect of life**.

Contacts

- **Dr Salih Bazdar, Clinical Director of Internal Medicine**
  - Colette Hackett – ESO to Director, T: 07 5433 8888

Term Supervisor

- **Dr Salih Bazdar**
## Consultants and teams

<table>
<thead>
<tr>
<th>CONSULTANTS</th>
<th>Specialty/ Subspecialty</th>
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<tbody>
<tr>
<td>Green Team</td>
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<tr>
<td>Dr Salih Bazdar</td>
<td>General Medicine</td>
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<tr>
<td>Dr Nyasha Magoche</td>
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<tr>
<td>2 x Registrar (BT)</td>
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<td>1x Junior Doctor</td>
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<td>Yellow Team</td>
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<td>Dr Iain Borthwick</td>
<td>General Medicine</td>
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<tr>
<td>Dr Mark Galbo</td>
<td>Stroke</td>
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<td>2 x Registrar</td>
<td>GEM</td>
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<td>2x Junior Doctors</td>
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<td>Red Team</td>
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<td>Dr Mukhlesur Rahman</td>
<td>General Medicine</td>
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<td>Dr Swapna Devadula</td>
<td>Rheumatology</td>
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<td>Blue Team</td>
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<td>Dr Uzo Dibia</td>
<td>General Medicine</td>
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<td>Dr Paul Joseph</td>
<td>Hospital in the Home (HITH)</td>
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<td>Dr Jamil Ahmed</td>
<td>Cardiology</td>
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<td>Orange Team</td>
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<tr>
<td>Dr Zaheer Bhikoo</td>
<td>Respiratory</td>
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<tr>
<td>Dr Paul Chapman</td>
<td>Infectious Diseases</td>
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<tr>
<td>1x Junior Doctor (non-intern)</td>
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## Visiting Medical Officers

- Dr Jai Ram (Cardiologist, covering General Medicine after hours)
- Dr Vernon Heazlewood (General Physician)

## Wards

- The **Medical Unit** – in **Wards 3A, 3B** and **Ward 4A** (the Unit often has outliers in other wards: e.g. Obstetrics & Gynaecology, Surgical (2A) and Paediatrics (Ground floor)).
- The **Coronary Care Unit (CCU)** (3rd floor, attached to ward 3A) for patients requiring close monitoring, including high-risk acute coronary syndromes and low-level, intensive-care patients.
The **GLAD Unit** (Gentlemen and Ladies Aging with Dignity) for inpatients with delirium and/or Behavioural and Psychological Symptoms of Dementia (BPSD) who require rigorous assessment and clinical and behavioural management implementation within a culture of dignity and compassion

**Nurse Unit Managers**

- Annette Tones (A/NUM 3A & CCU)
- Simon Thomas (3B & GLAD Unit)
- Rebecca Hitchcock (4A)

**Clinical experience in medicine (AMC Intern training – guide to terms)**

The Medical Board of Australia requires interns to undertake a term of at least 10 weeks providing experience in medicine. This term must provide supervised experience in caring for patients who have a broad range of medical conditions, and opportunities for the intern to participate in:

- assessing and admitting patients with acute medical problems
- managing inpatients with a range of medical conditions, including chronic conditions
- discharge planning, including preparing a discharge summary and other components of handover to a general practitioner, subacute facility, residential care facility, or ambulatory care.

Approved terms will provide generalist medical experience and may be in medical units and some medical subspecialties. The term in medicine must provide:

**Science and scholarship – The intern as scientist and scholar**

- Opportunities to consolidate, expand and apply knowledge of the aetiology, pathology, clinical features, natural history and prognosis of common and important medical presentations at all stages of life.
- Opportunities to access and use relevant treatment guidelines and protocols, and to seek and apply evidence to medical patient care.

**Clinical practice – The intern as practitioner**

- Opportunities to assess and contribute to the care of patients with a broad range of medical conditions. This should include taking histories, performing physical and mental state examinations, developing management plans, ordering investigations, accessing clinical management resources, making referrals and monitoring progress, all under appropriate supervision.
- Clinical experience in a range of common medical conditions, including exacerbations of chronic conditions.
- Clinical experience in managing critically ill patients, both at presentation and as a result of deterioration during admission, including experience in assessing these patients and actively participating in their initial investigation and treatment.
- Opportunities to interpret investigations.
- Opportunities to observe and perform a range of procedural skills.
- Opportunities to develop knowledge and skills in safe and effective prescribing of medications, including fluids, blood and blood products.
- Opportunities to develop communication skills needed for safely delivering care through interaction with peers (particularly through handover), supervisors, patients and their families, and other health care workers involved in inpatient and ambulatory care. Interns should have opportunities to develop advanced skills in spoken, written and electronic communication.
- Opportunities to develop skills in obtaining informed consent, discussing poor outcomes and end of life of care in conjunction with experienced clinicians.
Opportunities to develop written communication skills including: entries in paper or electronic medical records, admission notes, progress notes, discharge notes, and letters to other health care practitioners.

**Health and society – The intern as a health advocate**

- Opportunities to discuss allocating resources in providing medical care.
- Opportunities to participate in quality assurance, quality improvement, risk management processes, and/or incident reporting.
- Opportunities to screen patients for common diseases, provide care for common chronic diseases and discuss healthcare behaviours with patients.
- Opportunities to develop knowledge about how inpatient medical care interacts with subacute, community and ambulatory care facilities, including appropriate discharge destinations and follow-up.

**Professionalism and leadership – The intern as a professional and leader**

- Opportunities to develop skills in prioritising workload to maximise patient and health service outcomes.
- Opportunities to understand the roles, responsibilities and interactions of various health professionals in managing each patient, and to play an active role in the multidisciplinary health care team.
- Opportunities to further develop and reflect on skills and behaviours for safe professional and ethical practice consistent with the Medical Board of Australia's Good Medical Practice: A Code of Conduct for Doctors in Australia.

**Unit orientation**

1. The Term Supervisor or delegate should ensure that you receive an orientation to the General Medicine Unit and your specific consultant team.
2. Within the 1st week you need to schedule a time with your Team Consultant to discuss your individual learning objectives and the learning opportunities available during the term. Use the Unit Orientation Checklist, page 2 as a guide (Appendix 1).

When developing your learning objectives please consider the capabilities identified in the [Australian Curriculum Framework for Junior Doctors](http://example.com) (ACFJD) and the [AMC Intern Outcome Statements](http://example.com). These templates clearly identify the core capabilities that you are required to develop over your prevocational training years to provide safe patient care and both are built around a number of key learning areas.

**Handover**

**Term to Term**

Term handover is an excellent learning experience, which can enhance the junior doctors’ communication, professionalism and clinical management skills.

- Contact the MEU to confirm the name of the next Intern/RMO allocated to General Medicine and to your team.
- It is the responsibility of the incoming RMO to meet with the outgoing RMO, to discuss clinical handover of complex patients, as well as unit and ward specific information. This process assists RMOs in their orientation to their new units.
- This process does not replace the responsibility of the Term Supervisor to provide unit orientation on the first day of the new term. It is equally the RMO’s responsibility to ensure that this unit orientation meeting occurs. At this meeting you and your supervisor will discuss your goals and learning objectives for your new term, and the new unit’s expectations of you.
The week before the end of a term, RMOs are reminded via email of the requirement to complete an End of Term Handover with the RMOs who are replacing them.

An email will be sent to you that will include the name of the person being replaced and his/her contact details.

(If the pager number is not included, please use the phone directory on the intranet homepage to find this, or contact switch. If the details provided are incorrect e.g. because a recent roster amendment has occurred, it remains your responsibility to follow up the correct person and undergo term handover.)

Protected time is allocated for this process after the RMO Education session at lunchtime on the Friday before the new term begins. RMOs are able to exchange information as above, as well as useful tips.

If either the previous or next RMO is not available on the relevant Friday, then it is the responsibility of the both RMOs to arrange a meeting between themselves.

Handover notes for the term can be documented and provided to the incoming resident for reference. Please use the space provided overleaf to record term handover details.

You may wish to consider providing details on the following:

- Ward Routine/Rounds, Clinics, Meetings, Training, Consultant/Registrar Expectations, Complex patients, Casemix, Discharge Summaries

**Shift to Shift**

- Weekday AM – Medical Handover is 08:00-08:15 Lecture Theatre, Education and Skills Centre, all to attend.
- The use of ISBAR Clinical Handover template will assist in optimising patient care.
- At the end of each shift patients must be handed over if they are unstable or are likely to require attention from covering residents and registrars or any after-hour job to be done.
- There is a new form to be filled out by the RMO after each day of work and to be left at the switchboard for the night ward call and similar for the weekend ward call.
- ‘TREND’ Handover System is in place. Training sessions will be organised.
- Sick patients should always be handed over verbally as well as through TREND system for weekends.
- The PHO/Registrars on duty on weekends will review new admissions from the night/day before and critically ill and CCU patients with the Consultant on duty for that weekend. Other patients can be discussed with the consultant if necessary.
- The RMO can request the MED REG/PHO to review those more complicated cases or those patients that become unstable.
- There is an additional Handover meeting on Fridays (1500 hours) with all staff to be present. This is usually held in Ward 3A. This is a verbal handover which provides additional security and reinforcement for the weekend.

**Intern/RMO Scope of Practice**

The Interns/ RMOs are responsible for the provision of safe, effective and equitable medical care to patients under the supervision of registrar and specialist medical staff.

**General**

- When your team is on-call you (Resident) collect the consultant patient lists from Ward 3A and bring them to handover. During handover you “drive” the PC for the Night Registrar presenting new patients to the team. At the end of handover, collect any patient lists, not required, and dispose of appropriately.
• Assess frequently and be aware of the management plan for all unit patients and record these accurately and clearly in the medical notes.
• Be familiar with the protocols and policies of the unit/department.
• Be responsible for accurate completion of medication charts and intravenous orders.
• Attend and present case summaries and management.
• Co-ordinate and arrange investigations.
• Communicate in caring manner patient’s condition to relatives ensuring confidentiality.
• Communicate management plan with nursing staff and allied health staff.
• Conduct self in an expected professional manner observing patients and staff rights and ensure patient confidentiality.
• Assess and complete admission records as required.
• Complete discharge summary on all patients before leaving unit and communication with attending medical team.
• Handover patients to duty intern/RMO at the end of shift giving a brief summary of patient’s case and assessment including management plan.
• Be involved in Quality Assurance and educational activities of the unit.
• Ensure adequately detailed handover of all patients at commencement and completion of each relief period.

**Professional**

• Take reasonable care for the health and safety of persons who are at your place of work and who may be affected by your acts or omissions at work, and co-operate with the hospital’s efforts to comply with Occupational Health and Safety requirements.
• Observe the hospital’s Infection Control policies and procedures.
• Be aware of the hospital’s Fire, Disaster and other emergency procedures and your role as set out in the Disaster Plan

**Intern - outside scope of practice**

Interns are not able to:

• Perform any skill or procedure outside their knowledge, skills and capability
• Initiate patient treatment/ management or changes to patient management without discussion and approval from the supervising senior medical officer. Interns can initiate treatment prior to liaising with senior medical officer for antibiotics and IV fluids.
• Discharge patients without consulting and reviewing case details with Registrar/ Consultant
• Break bad news to the patient or relatives/carers. The Intern will observe and learn communication techniques from senior medical staff to develop their own capability.

**Casemix and common conditions**

The following is a list of conditions and situations which Interns/RMOs may expect to see and manage during their General Medicine Term.
During the General Medical term the Intern/RMO, in consultation with senior medical staff, will develop knowledge and skills in the differential diagnosis, initial management planning and ongoing medical care for patients with the following common presentations:

**Cardiac**
- chest pain/ischaemic heart disease
- congestive cardiac failure
- cardiac arrhythmias
- hypertension

**Respiratory**
- pneumonia
- chronic obstructive airways disease
- asthma, breathlessness
- pneumonia/respiratory infection

**Renal/Genitourinary**
- dysuria and/or frequent micturition
- pyelonephritis and UTIs
- reduced urinary output
- urinary incontinence
- acute and chronic renal failure
- urinary tract infections

**Gastroenterology/Hepatology**
- gastroenteritis
- gastrointestinal bleeding
- constipation
- diarrhoea
- weight gain/loss
- alcoholic liver disease

**Neurology**
- dementia
- loss of consciousness
- headache
- seizure disorders
- stroke/TIA
- delirium

**Endocrine**
- diabetes

There will be other conditions that you may encounter during your term.

It is vital that you take the initiative to learn in an interactive way by observing, discussing, asking questions, reading and researching and in particular, by developing your practical clinical skills through your participation as a committed team member in the Department.

**Procedures and skills**

During this rotation, the listed skills and conditions below are likely to be seen or be available to perform. You will however need to actively seek out opportunities to complete some of them.

Visits to outpatient clinics must be pre-arranged and must not impact on service provision in your current term. The Staff Specialist in charge must be informed at the start of the shift of your wish to attend an outpatient clinic and you will only be able to go if the patient load of the department allows it.

**Skills in resuscitation**

the following acute presentations under direct Registrar supervision:

- Septic shock
- Cardiac arrest
- Status asthmaticus
- Status epilepticus
- Acute pulmonary oedema
Independently perform
the following skills:

- Comprehensive history, clinical examination
- Differential diagnosis and initial treatment plan
- IV cannulation (including for difficult patients)
- IDC insertions – male & female
- Venesection and ABGs

Perform the following procedural skills
after observing the technique, performing under the direct supervision by the Registrar:

- Lumber Puncture
- Pleurocentesis
- Abdominal Paracentesis

Developing confidence
in interpreting the following tests:

- liver function
- arterial blood gases
- electrolytes
- full blood count and diagnosis of aetiology of anaemia
- chest X-rays
- CTs
- pleural fluid analysis
- peritoneal fluid analysis
- cardiac enzymes
- ECG, including diagnosis of arrhythmia and AMI

Please discuss any additional areas or difficulties with obtaining these skills with your supervisor (Consultant and/or Registrar).

Common ward call scenarios
Be familiar with the routine and procedures for:

- Worsening oxygenation, SOB
- Hypotension and hypertension
- Arrhythmias and Chest pain
- Fluid chart, electrolytes abnormalities review and dehydration
- Transfusion guidelines
- New fevers
- Low urinary output or urine retention
- Warfarin doses, INR, medication doses / chart review
- Hypo / hyperglycaemia, insulin sliding scale
- IV cannulation / exams to collect.
RMO Roles and Responsibilities

Admissions

From the Emergency Department to the Medical Unit:

Formal admission by the registrar on call.

The admission process:

- Obtain full medical history, complete physical examination, develop a differential diagnosis and initial management plan.
- Discuss your admission with your Registrar.

Ordering Investigations:

Requested by the PHO/Registrar and the Consultant

The duty of the Resident is to order these tests each afternoon for the next morning and follow-up the results promptly.

(Later in the year the basic investigations may be initiated by the Resident. Only radiology and usual investigations can be ordered without senior doctor authorisation). Nuclear stress tests and echocardiograms must be authorised by a Consultant. A MRI can only be authorised by the Consultant).

Discharges

- This is the responsibility of the Intern/RMO and Registrar looking after the patient.
- Prepare the Discharge Medications and Discharge Summary as soon as possible. Complete all necessary parts. (Let the NUM know of any D/Cs ASAP to enable arrangements to be made i.e. transport etc.).
- Have the weekend discharge papers/forms and prescription ready, if the patient may possibly be discharged during the weekend. Print your name and DECT number clearly on your paperwork to Pharmacy. (Don’t leave it for the weekend ward call!)

SPECIAL ATTENTION: Medication to be written in Medical Chart properly i.e. Generic Name, the dose, frequency (write time of administration in the slots), indication, sign and write your name in capital letters.

- Notify the patient, the nursing staff and the ward clerk of the planned discharge. Organise Community Services and other allied health services ASAP.
- Outpatient appointments can be requested and must be organised prior to discharge, as well as follow up exams. (Holter monitor, echo, MPS, etc.)
- Register the patient with the QML WARFARIN PROGRAM (contact QML LAB via phone), if the patient started on warfarin during admission, organise and explain the follow-up to the patient and also include information at the discharge summary for GP knowledge. QML must also be informed on D/C if the patient is under their care and was admitted to hospital.
- Note: There is a multidisciplinary meeting during the week, on Tuesdays, where all patients are discussed with the NPC and Allied Health to plan discharges and to refer patients to Allied Health. There is a ‘mini’ multidisciplinary meeting on Fridays at 1:15pm in the Conference Room.

Private Patients

Private patients under visiting consultants are solely looked after by that consultant except for emergencies. Private patients under Drs Bazdar, Ahmed and Rahman are still looked after by the team.
Endoscopy/ Colonoscopy

Outpatient or non-emergency inpatient endoscopies / colonoscopies: Under Revision – Please ask your PHO/Registrar

Please ask your PHO/Registrar.

Social Security, Certificates and other forms
Filled out by the Resident looking after the patient (Ask your registrar or clerk available to show you). Specific referrals to other services (mental health, surgery, etc.) are faxed as soon as possible or handed to the clerk to be booked.

Medication Charts
- Write in Drug Allergies and keep checking allergy slot whenever writing up drugs
- Keep it up to date (Check it before the weekends don’t leave it for the weekend ward call)!
- Re-write in full if any alteration is done
- Fill in all the correct fields (time, dosage, allergies etc.)
- Include all the pre-admission medications (with changes if necessary)
- Write legibly. Sign it and print full name in capital letters.
- Notify the allocated nurse when making new orders.

Patient Clinical Review and Ward Rounds
- The Resident needs to review each patient under their care clinically each day.
- There will be a daily ward-round during the week with either the Consultant or the Registrar. (That is the time for reviewing investigation results, patient’s progress and the management plans.)
- All patients admitted to the Critical Care Unit will be seen each day by the Duty Consultant.
- The general units have consultant-rounds two or three times a week.
- Make sure results are available for ward rounds. (Order Pathology the afternoon before).
- Organise the various investigations after the rounds.
- Pathology slips must be filled out early if you want the blood collector to take the blood or leave it ready on the day before. (Also for weekends and Monday mornings). Sometimes the RMO can be asked to collect blood or cannulate a patient during the day shift, if necessary.
- Image requests (US, ECHO, XRAY, MPS, CT) are requested in specific “Southern yellow/white request “ and left in specific boxes to be taken by the ward man as soon as possible. Radiology requests to be discussed over the phone.
- In-patient echoes & EST to be done on blue referral forms with explanation “WHY”.

Registrar and Principal House Officer (PHO) Duties

The Day on-call Reg/PHO commences at 8.00am and goes through until 2:00pm. (For daytime admissions and also MET CALL.).

The Afternoon on-call Reg/PHO usually commences at 2:00pm until 8:00 p.m. (For afternoon admissions and also MET CALL.)
The Night call Reg/PHO duty starts at 8:00 p.m. until 8:30 a.m. (For after-hours admissions and also MET CALL.)

Swaps between Registrars on the roster are reasonable as long as it does not lead to increased costs to the Hospital in overtime, all parties and their Consultants have consented, and main Switch is notified. Swaps are possible only after AVAC (Attendance Variation & Allowance Claim) Form is filled in (see the Medical Support Officer).

**Registrars**

**Normal hours**

- Responsible for management of inpatients in their Unit; admission of new patients to their Unit and supervision of the Resident assigned to the Unit.
- Each patient should be seen daily by both the Registrar and Resident.
- The Registrar is also responsible for outpatient duties with relevant consultant.
- Exercise Stress Tests done as per roster.
- EDS is the duty of RMOs but Registrars are welcome to do it to help out.
- Teaching / orientation and assistance are also duties of the Registrar/PHO with the Residents. Use each opportunity to give some constructive input.
- If management decisions are required and the Registrar/PHO is uncertain or there are critically-ill patient issues: discuss with the Consultant responsible for the patient or the full-time Physician.
- Patients who are critically unwell should always be notified to the full-time Physician.

**Cardiac Sciences Unit**

**Phone: 8236**

The Cardiac Sciences Unit (CSU) is located on Ward 3A, behind the nurse’s station.

Cardiac Sciences is staffed Monday to Friday 8am to 4:30pm and provides the following investigations:

Inpatient and outpatient exercise stress testing
- Holter monitoring
- Inpatient transthoracic echo
- Inpatient and outpatient Exercise stress echo and Dobutamine stress echo.

All outpatient exercise test and holter monitor referrals are to be written on a blue request form and referred to the CSU staff for booking. Inpatient exercise tests can be arranged through consultation with the Chest Pain Assessment Service (CPAS 8427). The CPAS nurse will liaise with CSU staff and suitable arrangements will be made.

The Cardiac Sciences Unit aims to provide a transthoracic echo service for acutely ill inpatients four days a week. All outpatient echo referrals are to be made to Southern X-ray.

Inpatient echo referrals are to be written on a blue request form. It is the requesting medical team’s responsibility to ensure that this form is taken to Cardiac Sciences and booked appropriately. There is a booking list located in the Cardiac Sciences room that the blue form must be attached to and the patient details entered on the booking list. It is extremely helpful to the CSU staff if the medical staff can prioritise their patients as either urgent (A), semi-urgent (B) or not clinically urgent (C). If patients are not prioritised by the medical staff they will be assumed to be non-urgent.

Please provide adequate clinical information on request forms. For example: Nature of presentation (chest pain with negative troponin, SOB with signs of failure on chest x-ray), previous cardiac surgery, blood cultures resulting in suspected endocarditis.

An echo booking list is also located on the door of CSU for after-hours bookings only. Please do not use this list unless you are booking a patient outside of CSU operating hours.
Transthoracic echo reports are completed at the end of each study and a preliminary sonographer report is issued. Finalisation of these reports is done by cardiologists on a weekly basis.

Transthoracic echo reports are filed in the clinical investigations section of the patient chart. Please feel free to ask CSU staff for assistance if a report cannot be located.

Outpatient Exercise stress echo (ESE) and Dobutamine Stress echo (DSE) referrals are to be made on the blue form and referred to CSU for booking. All ESE and DSE referrals will be assessed by a cardiologist before the patient is offered an appointment.

**Recognition and Management of the Deteriorating Patient**

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 through 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 (Q-ADDS: Appendix 4a)

**Escalation of Clinical Management Issues**


(see Appendix 4b)

**The Medical Emergency Team (MET)**

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 REVIEW MUST BE WRITTEN IN THE CHART.
- 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 standardised calling criteria that is found and used throughout the hospital. The criterion is applicable to patients and non-patients (i.e. visitors or staff of Caboolture Hospital).

Emergency Response Process
(see Appendix 5)

Supervision and reporting lines
All Interns’ must work under either direct (Level 1) or indirect (Level 2) supervision at all times. In general, patient history taking, examination and initial management (including initial treatment and simple investigation) are undertaken by the Intern under supervision unless an Intern is informed otherwise. Discussion with supervisors surrounding all care should take place as per usual clinical handover requirements. Your first point of contact for patient concerns or queries is the registrar of the team and then the responsible consultant.

For any unresolved clinical issues your next line of contact is the Clinical Director of Medicine/ Term Supervisor – Dr Salih Bazdar.

Caboolture Hospital Proc 003318 Supervision of Junior Doctors:
- The responsibilities of providing overall supervision of junior doctors’ work performance and training lies with the Term Supervisors. In this respect, they are responsible for implementing the Unit’s educational programs and have mentoring, teaching, appraisal and assessment roles.
- Clinical Supervisors provide direct supervision of the junior doctor’s work. It is their responsibility to:
  - Provide mentoring, teaching and appraisal to the junior doctor throughout his or her rotation.
  - Liaise regularly with the Term Supervisors if any noticeable performance and/or personal issues arise.
  - Liaise with the Term Supervisors to provide appraisal information regarding the junior doctor, which is then used to complete assessment documentation.

If you have any concerns regarding your level of supervision, in the first instance, discuss this with your Term Supervisor – Dr Salih Bazdar. If this is unresolved the next line of contact is the Medical Education Unit: Medical Education Officer/s and/or Director of Clinical Training (DCT)/ Deputy DCT.

If the concern or issue remains unresolved the executive line of communication is Dr Annaud Choudhry, Deputy Director of Medical Services (DDMS).

For educational issues contact the Medical Education Unit: Medical Education Officer/s and/or Director of Clinical Training (DCT).

The opportunity to discuss issues or concerns for Junior Doctors is offered at the regular Junior Doctor meetings with Medical Executive is organised twice per term.

Unit Roster and Timetable
- The RMO SHIFTS / ROSTERS involve a cycle of 7 days and shifts across 24 hours
- Week Day shift: 08:00 – 16:06 hours - normal everyday ward duties.
### Timetable

<table>
<thead>
<tr>
<th>Time</th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM</td>
<td>08:00-08:15</td>
<td>Medical Handover</td>
<td></td>
<td></td>
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</tr>
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<td>AM</td>
<td>Daily Ward Rounds</td>
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<tr>
<td>12:15-13:00</td>
<td>Medical X-ray Mtg</td>
<td>12:00-13:00 Med video-TPCH Grand Rounds</td>
<td>Grand Rounds</td>
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<tr>
<td>13:00-14:00</td>
<td>Intern Only Education protected</td>
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<tr>
<td>PM</td>
<td>Dept. Case Teaching sessions</td>
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<tr>
<td>15:00-15:30</td>
<td></td>
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<tr>
<td>14:30-16:00</td>
<td>EDS Protected time for Discharge Summary Completion</td>
<td>Caboolture Hospital is prioritising the completion of Discharge Summaries to enhance the ongoing care for patients in their community.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day shift</td>
<td>RMO</td>
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</table>

- **Visiting Specialist Rounds**: Interns are not required to attend PM ward rounds, Discharge Summaries take priority.
- **Specialist Outpatient Department**: Interns do not attend SOPD.
- **Echo/Stress testing**: occurs daily. Interns may arrange to attend and observe where clinical duties permit and they have an interest.

### After hours/Weekends/ On Call

**Ward-call shifts (including evening and night shifts):** 14:30 (15:00 on Thursdays) – 23:30 hours / 2230 (or 2200)-0830 - after the normal work day, for emergencies, cannulations, and “ward jobs” (2 RMOs assigned each day & 2 RMOs each week night). During the medical term Interns undertake ward call duties, for a maximum of 1 fortnight per term. On occasion, other RMOs (not interns) may be required to do 2 fortnights per term. Interns are always paired with a more senior RMO.

**Weekend Morning Ward-call shifts: 0730-1630 hours Saturday and Sunday.** Duties as per ‘ward-call shifts’.

**Remote call shifts (DMS RMO On-call):** from 16:06 Friday - 07:00hours Mondays - can be called back to the hospital in an event of extra need, like surgery assistance, extra help, etc. Interns take part in this roster.

**Medicine-specific Weekend shifts**: similar to ward call shifts, but includes the visit (review) of those patients that need special attention during weekends. It is divided in 2 rosters: 08:00-16:06 hours with one RMO per standard day shift, 2 RMOs on public holiday day shifts generally rostered for Saturday and Sunday of the same weekend. During the medical term Interns work day, evening and night shifts under the supervision of the Consultant and/or registrars.

**Note**: You need to arrange your break and food times according to the job requirements on the day.
When the RMO needs to swap Ward Call and Remote Call rosters, he/she must organize it, complete an AVAC (Attendance Variation and Allowance Claim) and forward it to Medical Workforce Unit, as soon as possible.


### Education – Protected Teaching Time

<table>
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<tr>
<th>Intern Only Education</th>
<th>Tuesday (weekly) 13:00-14:00</th>
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<td>Education and Skills Centre</td>
<td>Intern attendance required</td>
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<table>
<thead>
<tr>
<th>RMO Education</th>
<th>Friday (weekly) 12:15-13:00</th>
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</thead>
<tbody>
<tr>
<td>Junior Doctor Professional Development Program</td>
<td>Intern attendance required</td>
</tr>
<tr>
<td>Education and Skills Centre</td>
<td>JHO/SHO attendance required</td>
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</table>

### Educational Opportunities

Education opportunities range from:

- Informal bedside tutorials
- Learning on a ward round
- Hospital Clinical Meeting presentations
- RMO are expected to attend education sessions unless called to the ward for an emergency
- RMO are expected to present topics at clinical meetings

### Assessment

- You are required to complete both mid-term and end of term assessments (10-12 week terms)
- If you are undertaking a 5-6 week term you are required to complete an end of term assessment only. It is highly recommended that you seek informal feedback at the midpoint in the term.
- At Caboolture Hospital – term assessments are completed using paper-based forms:
  - AMC Intern training - Term Assessment form (Appendix 2)
  - CH JHO/SHO Assessment Form (Appendix 3)
- It is your responsibility to make an appointment with your term supervisor, or delegate, for these to be completed in a timely manner. You will receive an email from the Medical Education Unit (MEU) before the assessment is
due. You must collect the pre-labelled assessment form from the MEU, and return the completed form to the MEU. All term assessments are signed by the Director of Clinical Training.

The term supervisor - Dr Salih Bazdar is responsible for ensuring mid and end of term assessments are completed and that the Intern and Resident Medical Officer receives a feedback meeting and signs the completed assessment form. The Term Supervisor will liaise with the supervising consultants, registrars and other relevant members of the multidisciplinary team regarding your progress during the rotation.

All consultants, registrars and relevant team members in the unit provide input into your assessment. In addition assessments completed during any ward call shifts are also considered. The designated supervisor, or suitably qualified delegate, will complete the assessment form and provide you constructive feedback on your progress.

During this meeting you are encouraged to reflect on the unit learning objectives and your individual learning objectives and evaluate your progress towards achieving these. Specific comments in relation to these can be documented on the relevant assessment form.

**Underperforming junior doctor/ Doctor in Distress**

If concerns regarding individual progress are identified an early intervention session with the RMO, supervisor and a member of the Medical Education Unit will be convened. If an assessment, at mid-term identifies concerns regarding progress an Improving Performance Action Plan (IPAP) (Appendix 4a – Intern; Appendix 4b JHO/SHO) will be formulated during a meeting between the junior doctor, the educational supervisor and a member of the Medical Education Unit. The goal is to have a collaborative plan to support the junior doctor’s progress towards satisfactory completion of the term. If an RMO has concerns regarding their mid or end of term assessment these should be directed to the Term Supervisor in the first instance, followed by the Director of Clinical Training.

If you have any questions or are experiencing any difficulties with your mid or end of term assessments please contact the Medical Education Unit E: MEU-Caboolture@health.qld.gov.au or Michelle Jenkinson MEU Administration T: 07 5433 8243.

**AMC- Intern training – Assessing and certifying completion**

**Remediation**

Additional remediation is required where there is continuing concern about an intern’s performance. Normally, the Director of Clinical Training would make this decision, initiate the remediation, and communicate the requirements directly to term supervisors and the Director of Medical Services. Additional remediation is indicated when intern performance:

- does not meet the requirements of one of the terms, and/or
- does not satisfy the requirements of a previous remediation plan, and/or
- raises sufficiently complex issues during the scheduled term supervisor assessment to require more detailed consideration and action.

Additional remediation may include undertaking a period of very close supervision and/or additional work in emergency medical care, medicine and surgery in lieu of other terms or experiences.

There may be circumstances where the intern training provider considers it not appropriate to offer the intern additional remediation within that employment period, or that remediation is unlikely to be successful. The intern training provider should report this to the Medical Board of Australia, using the same process of certifying completion of internship described below.
Assessment review and quality

Under national standard 5.2.7, intern training providers must establish review groups to assist with more complex decisions on remediation. A senior clinician with experience in educating and training interns should chair the group.

Given the close nexus between training and employment concerns in internship, the review group should include employer representatives and relevant educators. Assessment review groups should have clear and transparent procedures for deciding on any course of action and for resolving disputes and appeals.

Caboolture Hospital’s – Junior Doctor Assessment Panel undertakes the performance review group function, and is convened on an as-needed basis.

Unit Evaluation

At the completion of your term you are required to complete a unit evaluation. The Medical Education Unit will provide a Survey Monkey link for you complete the evaluation at the end of each term. This evaluation is confidential and all data is de-identified and provided to units in an annual report. Feedback from junior doctors has prompted significant improvements to many units in the past and we strongly encourage you to provide honest and frank feedback at the end of your term. We do however, recognize that feedback throughout the term is also important and that from time to time issues may arise that require an emergent response. We also welcome and encourage you to provide feedback throughout the term. This can be provided directly to the Medical Education Unit.

Specific Issues

Daily Ward Round: All new patients admitted in the previous 24 hours or over the week-end will be discussed at a daily board round, Allied Health referrals will be made verbally and written and initial discharge planning should take place. Hand over the patients/admissions at: 8:00 a.m. from the night Registrar.

*It is expected that both PHO/Registrars should attend the daily ward round. Where there are urgent ward or Emergency Department requirements precluding this, the RMO should be seconded to this meeting.

Transfers of Patients: All requests from other Hospitals for transferral of a patient to the Medical Unit require prior approval from the Consultant of the day. Once a patient is accepted for transfer to the Caboolture Hospital, then the requesting hospital should discuss the issue with the Bed Manager on ext. 8693. He/she will organise to take the patient when a bed becomes available.

Under no circumstances should a patient be accepted prior to the bed being organised.

All transfers from the Medical Unit should be notified to the Consultant of the day or, on weekends and after hours, to the duty Physician.

Acute High Risk Coronary Syndrome: High-risk unstable coronary syndrome and patients suitable for coronary angiography are currently arranged to be transferred to the Prince Charles Hospital (TPCH) and Royal Brisbane and Women’s Hospital (RBWH). These patients should be discussed during working hours with the Senior Cardiology Registrar on duty at Prince Charles following the decision by the Physician on duty that the patient is suitable for angiography. This will normally occur during the coronary care ward round, but can occur at the discretion of the medical registrar or consultant at any time of day or night.

For electronic ACS referrals: locate the ACS referral icon on desktop of computer OR via internet explorer (not Firefox) search ‘ACS Manager’ and follow links to ACS Manager Login.

The department of medicine generic details are-
User: Caboolture
Password: cab

All **YELLOW** highlighted fields are mandatory.

If the ACS referral pathway is not functioning, the alternative pathway is to contact the TPCH or RBWH cardiology advanced trainee by telephone, and document the referral in patient notes (including information that ACS website is 'down')

**Private Patient Responsibilities:** Private patients under Drs Bazdar, Rahman & Ahmed remain under the care of the team.

**Educational Activities:** There is a Medical tutorial weekly at Caboolture Hospital. This aims to provide education for the Medical Students, RMOs and Registrars/PHOs. All Residents and registrars assigned to the Medical Unit will be rostered to present topics of their choice at these tutorials. The training sessions are held on Wednesdays at 1300 hours.

**Discharges:** Patients with simple problems that are stable would normally be discharged to the care of their general practitioner.

Any other patients’ needs are to be discussed with the Consultant in care.

Please remember: ambulance transport must be booked before 1200 hours on the preceding day.

**Admissions:** Transfers from other hospitals must be discussed with the Consultant of the day.

**Other common situations:**

**Chronic back pain:** should not be admitted under the Medical Unit unless clinical assessment suspects acute problems.

**Acute back pain: secondary to osteoporotic fractures or injury** may be looked after by the Medical Unit where appropriate.

**GIT Bleeds:**

- **TIRE Assessment in ED**
- Major GIT Bleeds with haemodynamic instability (↓BP, tachycardia, tachypnea, O₂ desaturation, ongoing bleeding), should be urgently discussed: During Officer Hours – with Dr Jayanna and After Hours – with RBH for transfer
- **ALL** GIT Bleeds should be discussed with Consultant Gastroenterologist or if not on duty, by on-call Medical Consultant
- Unstable GIT Bleeds should under **NO** circumstances, be admitted to the General Medicine Ward of Caboolture Hospital.

**Referrals for Endoscopy:** Contact Dr Consultant Gastroenterologist or the team’s Registrar.

**Medical Consultant to Other Units:** Registrar of the team sees the patient and discusses with Consultant. Consultant to see patient ASAP no later than the following morning.

**There is a Consult Form which is to be used for all consults.** The first section is to be completed by the requesting Department and the second section completed by the medical department. These details are also required to be entered into the consults database on Data 3: K Drive (ask the Clinical Directors Support Officer for details) and then file the completed consult form in the patient’s chart.

**Coronary Care Unit admission: (CCU)**
Acute high-risk coronary syndrome or suspected high-risk coronary syndrome in a patient who would be a candidate for resuscitation in the event of a cardiac arrest. Also all patients who require intravenous nitrate or inotropic infusion, invasive blood pressure monitoring or invasive central venous or requiring non-invasive ventilation.

Patients who are considered to be at a low risk, but with non-life-threatening arrhythmias may be admitted to a telemetry bed.

**Intensive Care Unit (CRICU) admission**

All ICU referrals are consultant-to-consultant

Patients who have multiple organ failure should be normally managed in the Intensive Care Unit (CRICU). Any patients requiring inotropic and/or ventilatory support should be discussed by the Medical consultant with the ICU Consultant, Caboolture Hospital. **Handovers:** At the end of each shift patients must be handed over if they are unstable or are likely to require attention from covering residents and registrars or any after hour job to be done.

- The PHO/ Registrars on duty on weekends will review new admissions from the night/day before, critically ill and CCU patients with the Consultant on duty for that weekend. Other patients can be discussed with the consultant if necessary.
- Remember to give support to your RMO on call.
- Handovers daily:
  - 7 days/week 0800 hours, Mon-Fri in Education & Skills centre,
  - Saturday & Sunday on Ward 3A
  - Friday afternoon handover 1500hrs, ward 3A or 3B

**General Issues**

**Computer guide; DECT phone…**

Staff and colleagues can show you the first steps if you have any doubts.

**Computer:** The main two programs used are: Pathology AUSLAB and imaging WINRIPS. Both are easy and can be accessed using your login and password and each patient’s results can be checked with their UR number. If the results are not yet available to be viewed on screen, contact the relevant Department via phone. Staff will be happy to fax you the results.

**DECT phones:** these are obtained from the switchboard. Please advise the Clinical Director’s Medical Support Officer of the number once collected from Switch. On leaving the normal day of work, hand it back to Switch for recharge. On changing departments Switch will confirm your DECT number. Ask the switchboard staff to show you how the phone works.

**Winscribe:** Medical Typing Dictation System. All queries regarding medical typing/letters or requests for urgent letters to be typed, are to be directed to Senior Supervisor Administration Services, ext. 8557 who will manage your request in consultation with the relevant typist. When receiving your medical typing letters for proofing and correction save the letters onto your desktop/correct them and then send them back to the author (person who emailed them to you) in a timely fashion. This can be done when the letter is saved, opened, corrected, then go File/Save & Send which automatically attaches it to your email for emailing it back to this sender. This safeguards your letters and leaves a copy on your desktop.

Your co-operation in this process will assist in reducing your workload by re-correcting letters that are not received and the interruptions to the typists and the management of the backlog of letters to be typed and re-emailed.

**Sick Leave, Recreational Leave, Fatigue Leave:**

**Sick Leave:** please inform the switchboard 5433 8000 and the Clinical Director’s Medical Support Officer or the medical superintendent as soon as possible.
Fatigue Leave: must be authorised by the Director of Medicine or Consultant on call.

Recreational Leave: approved on a first-come basis and organised by the rostering staff member.

Leave forms, AVAC and other relevant payroll forms can be found on QHEPs:


**Shift Swaps**

**SWAP SHIFT PROCESS – ROSTER DISTRIBUTED**

- Medical Officer requesting the change to fill out Swap Shift Form then arrange for the Medical Officer who is accepting the change to sign the Form
- Medical Officer requesting the change to give the completed Form (with all signatures) to Clinical Directors’ Support Officer (CDSO) who checks that it is award compliant and satisfies the business rules for the unit
- If the Swap Shift Form is not award compliant it will be returned unauthorised. If it does not satisfy the business rules the CDSO will discuss with the requesting Doctor and in extenuating circumstances may forward the request to the Clinical Director
- If the Clinical Director requires endorsement by a Senior Registrar or SMO with roster responsibility the CDSO will forward to them
- CDSO will forward endorsed Swap Form to Clinical Director for approval
- No personal arrangements should be made around Swap requests until final approval by the Director is given
- SHIFT REQUEST - If the roster has not been distributed a shift request can be made.

**Discharge Against Medical Advice; Mental Health Act**

refer to Discharge Against Medical Advice form.


**Referrals to other dept. and services:**

- **Psychiatric referral:** Fill in and FAX specific forms for this and contact the psychiatric liaison nurse (ext5796).
- **Pain service referral:** call anaesthetic consultant on-call (registrar overnight) extension 8212 ESO (ext. 5956), for additional assistance during office hours, contact acute pain service (CN or CNC) 8209 or the palliative care service or doctor.
- **Speech therapy, dietician and other allied health:** each ward has an allocated dietician, speech therapist, OT, & Physio. Phone numbers available at ward clerk desks, internal enquiries in office hours can be directed to x8193
- **Rehab:** fill in and fax the specific form and phone the Rehab/geriatrics registrar.
- **MRI scans:** fill up all fields of the request form & MRI Safety Checklist; discuss with radiologist and contact the medical consultant for approval. (Be sure of the reasons and urgency.)
- **Special medications:** need approval from superintendent.
- **Laboratory:** all requests sent to lab after 9 p.m. weekdays, and 6 p.m. weekend and holidays, will be processed only on the next day, unless urgent process is requested
- **Autopsies:** requested for unexpected death or unknown cause or if an important complication occurred. Please read amendments to Coroner’s Act 2003
- **Orthopaedic referral:** contact them or call ortho by mobile (Redcliffe Hospital).
• **CVP and PIC lines**: normally done by ICU / ANAESTHETIC STAFF - contact them and explain your reasons.
• **Angiography**: Contact the TPCH Registrar by phone and explain your reasons; fill in the new computerised form and send it as soon as possible.

**Junior Doctor Clinical Training & Education Procedures**

• Supervision of Junior Doctors
• Orientation for Interns and Junior Doctors
• Performance Assessment of Junior Doctors
• Underperforming Junior Doctors
• Term Evaluation and Feedback
• Junior Doctor Assessment Panel

**Reminders**

**Current unit**

• Seek out your current Term Supervisor/ Consultant to facilitate the completion and discussion of your End of Term Assessment. (Collect the pre-labelled Intern or JHO/SHO Term Assessment form from MEU).
• Complete the Unit Evaluation Form for your current term - Survey Monkey link sent from Medical Education Unit
• Ensure that you meet with the next RMO for term handover

**Next unit**

• Identify and read through the Unit Orientation Manual for your new term
• Visit your new unit/ward for an informal orientation, and ensure that you meet up with the current RMO
• Ensure that you meet with your new supervisor to discuss your goals, learning objectives and Scope of Practice for your new term, and the new unit's expectations of you.

**Final comment**

Note: Many questions, doubts and details with regard to the topics above can be better clarified by a more experienced colleague or one of the Consultants or the Support Officer.

A more detailed document is available if you wish to know more about some topics.

We are a dynamic and constantly changing Unit. Therefore, if there is any issue of interest we have not mentioned please do not hesitate to ask. We hope you enjoy your time with us.

Dr Salih Bazdar
Clinical Director of Internal Medicine
Caboolture Hospital
## APPENDIX

<table>
<thead>
<tr>
<th>Appendix 1 – Unit Orientation Checklist</th>
<th>UNIT ORIENTATION CHECKLIST - GOAL SETTING and Review of Learn Objs V2016 04.pdf</th>
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<tr>
<td>Appendix 2a – Intern training - Term Assessment form</td>
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<td>Appendix 2b – JHO/SHO Term Assessment form</td>
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