2019 Orientation Manual - DEPARTMENT OF INTERNAL MEDICINE
CABOOLTURE HOSPITAL
Welcome to the Medical Unit, Caboolture Hospital

INTRODUCTION

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. 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, Rheumatology, Respiratory medicine, Infectious Diseases, Geriatrics, 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**.
STAFFING

The **Senior Medical Staff** comprises of:

- Dr Salih Bazdar, Director of Internal Medicine
- **Consultants are:**
  - Dr Mukhlesur Rahman (General Physician, specialising in Rheumatology)
  - Dr Jamil Ahmed (Cardiologist)
  - Dr Iain Borthwick (General Physician, specialising in Geriatrics)
  - Dr Uzo Dibia (General Physician, specialising in HITH)
  - Dr Vishnumurthy Sannarangappa (Endocrinology)
  - Dr Marc Galbo (General Physcian, specialising in Geriatrics)
  - Dr Nyasha Magoche (General Physician, specialising in Geriatrics)
  - Dr Swapna Devadula (Rheumatology)
  - Dr Rakesh Malhotra (Endocrinology)
  - Dr Paul Chapman (Infectious Diseases)
  - Dr Zaheerodin Bhikoo (Respiratory)

RMOs are attached to 8 inpatient teams:

- Dr Mukhlesur Rahman (Rheumatology)
- Dr Jamil Ahmed (Cardiology)
- Dr Iain Borthwick (General Medicine)
- Dr Uzo Dibia (General Medicine/HITH)
- Dr Mark Galbo (General Medicine)
- Dr Nyasha Magoche (General Medicine)
- Dr Swapna Devadula (General Medicine)
- Dr Paul Chapman (Infectious Diseases) and Dr Zaheerodin Bhikoo (Respiratory)

At times RMOs attached to one team may be asked to assist another team if the ward loads are uneven.

Other **Senior Medical Officers** are:

- **Cardiologists:** Dr David Platts
- **Palliative Care:** Dr Grant Cameron
- **Gastroenterology:** Dr Mahesh Jayanna & Enoka Gonsalkorala
- **Respiratory:** Dr Raylene Bowman
- **Oncology:** Dr Darshit Thaker and Dr Michelle Grogan

The **Visiting Medical Officers** are:
Dr Jai Ram  Cardiologist

The **Resident Junior Staff** comprises of:
19 PHOs/Registrars (variable)
8 Junior Residents – SHO, JHO or interns (variable)

The **NUM’s** for the medical wards are:
Sheridan Hoffman (3A)
Simon Thomas (3B)
Katrina Johnson (4A)
Elizabeth (Rose) Cooper (CCU)
THE UNIT COMPRISES OF:

The Medical Unit – which is based in Ward 3A & 3B and Ward 4A (but the Unit often has outliers in other wards) e.g. Obstetrics & Gynaecology, Surgical (2A) and Paediatrics.

The Coronary Care Unit (CCU) - for patients requiring close monitoring, including high-risk acute coronary syndrome patients.

WHAT TO DO WHEN YOU START

Introduce yourself to the:
- Director’s administration support officer
- Medical Education Officers
- Medical Workforce Unit
- Nurse Unit Managers
- Other Residents, Registrars and PHOs
- Ward Clerks
- Directors of Clinical Training

Find out the times of:
- Daily Medical Handover
- Ward rounds
- Outpatient clinics
- Medical team unit meeting
- X-ray meeting
- Multi-disciplinary meeting
- MOPS education sessions
- Morning Peer Case presentations
- Morning MCQ Sessions

Familiarise yourself with:
- Ward layout and bed numbers
- Equipment, exits, Fire Officer
- Resuscitation equipment, Lampson system and IV trolley
- Stationery, useful computer programs (pathology/image system/ MIMS, CKN and others)
- Patients’ problems by reading their charts. Switchboard system and your portable phone/pager.
- 2 small rooms at the end of the corridor of Ward 3A, 3B & 4A with computers for RMOs to complete discharges.
- Location in Ward 3B for all doctor’s correspondence for patient results.
- Doctors’ Room - located on the ground level which has lockers, a massage chair, lounge chairs, shared kitchen facilities, pigeon holes (please check weekly), and a computer with printer.
Welcome to Unit, introduce new doctor to the multidisciplinary team

- Consultants and Registrars: how to contact all team members
- Nurse Unit Manager and Team, Allied Health members and Ward Receptionist

Education/Assessment: Provide and discuss

- Unit Orientation Manual
- Assessment and Feedback: Who will do this and when
- Unit Education sessions
- RMO Education and Grand Rounds Sessions
- College Education Programme/ Expected Self Directed Education
- Learning objectives in the Term
- Term Evaluation of the Unit at the end of term by the junior doctor
- New skills acquisition process i.e. doing new procedures
- Amount of supervision required

Team issues:

- Expectations, Roles and Responsibilities
- Reporting to Consultant. Staff who will provide supervision and who to contact if that person is unavailable
- Patient list, location of outlying patients
- Medical Record standards, Discharge summaries and prescriptions, problem lists and management plans
- Results handling: Pathology, Histology, X-ray
- Abnormal results handling
- Estimated Day of Discharge process
- Admission and Discharge processes
- Changes in practice for weekends and public holidays
- Outpatient and Theatre processes relevant to team
- Troubleshooting in the Unit – turf wars, local issues, recent errors
- Timing of lunch breaks, fatigue management
- Unit timetable and main tasks
- Where to find commonly used phone numbers and resources
- Operating theatre list
- Legal issues relating to this unit – Consent, Coroner, Death Certification
- Where things are on the Ward/Clinic
- Use of protocols and guidelines
- Rostering and overtime
- Leave arrangements
- Supervision of medical students and juniors
- Quality and Safety in this unit
- Handover processes in this unit
- Coding and episode of care/case mix practice

Local Unit Tour:

- Defibrillator and resuscitation equipment
- General Fire and Evacuation instructions to the Unit
- How to use your phone or pager
- Clinical notes, pathology results and x-rays
- Important clinical equipment relevant to role
- Storage for personal belongings

Do you know how to:

- Order radiology?
- Arrange referrals/consults?
- Call/respond to a MET/Code Blue?
- Contact Pharmacy?

Where is the (Hospital Physical Tour):

- Operating Theatre
- Medical Records (Health Information Unit)
- Education Centre & Lecture rooms
- Director of Medical Services, Medical Education Unit (DCT/MEO) offices
- Medical Imaging
- Outpatients Department
- Switchboard
- Pre Admission Clinic
- General hospital tour

Unit Timetable

- Consultant rounds
- Outreach services
- Clinic and theatre
- Other responsibilities
MEDICAL OFFICER EDUCATION PLAN

UNIT NAME: _____________________________

GOALS FOR THIS TERM
What specific learning objectives and skills do you want to learn?
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________

UNIT EXPECTATIONS OF THE JUNIOR DOCTOR
SCOPE OF PRACTICE

Discussed ☐

Discussed ☐

Junior Doctor/Registrar Signature
Clinical Supervisor’s Signature
________________________
Print Name
Print Name
________________________
Date
Date

Review of Learning Objectives
*to be completed with Mid Term and End of Term assessments

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<thead>
<tr>
<th>Mid-Term</th>
<th>End of Term</th>
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<td>Date:</td>
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<tr>
<td>Progress:</td>
<td>Achievements:</td>
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<td>Amendments (optional):</td>
<td>Recommendations:</td>
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<td>Recommendations:</td>
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Please return this form after your Unit Orientation to the Caboolture Hospital Medical Education Unit
REMEMBER:

“A good relationship with all staff members is the key to open your doors to this medical unit and make your learning process easier!”

“Professional courtesy towards all staff members must be the rule!”
“Despite being very busy, they are always ready to answer your questions and show you the hospital’s routine.”

“Nowadays many current Residents, PHOs and Registrars are from overseas and may not be familiar with some rules, routines and systems.”
Please be patient and helpful!
“Work as a team!”

RESIDENT MEDICAL OFFICER (RMO) DUTIES
Including Interns

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, differential diagnosis and treatment 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 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, 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

Emergency endoscopy / colonoscopy: Needs Dr Jayanna’s approval – use Emergency Booking Form.

Under Revision: 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.

**DRUG CHARTS:**

**GOLDEN RULE!**

*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”.

**ROSTERS AND TIMETABLE:**

**The RMO SHIFTS / ROSTERS involve a cycle of 7 days shifts**

**Week Day shift:** 08:00 – 16:06 hours - normal everyday ward duties.

**Ward call shifts:** 16:30 – 22:30 hours - after the normal work day, for emergencies, cannulations, and “wardy jobs” (one RMO for each week day).

**Remote call shifts:** from 16:30 - 8:00 hours - can be called back to the hospital in an event of extra need, like surgery assistance, extra help, etc.

**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: **08:00-16:30 hours and 14:30 to 22:30 hours**, with one RMO per shift. (2 RMOs on special days); generally rostered for Saturday and Sunday of the same weekend.

*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 Calls and RC rosters, he/she must organize it, complete an AVAC (Attendance Variation and Allowance Claim) and forward it to admin, as soon as possible.

**PATIENT HAND-OVERS:**

• 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 3B. This is a verbal handover which provides additional security and reinforcement for the weekend.
Use of the ISOBAR Clinical Handover Template will assist in optimizing patient care.

**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

Remember: ... “It’s team work!” .... is the theme that operates best!

**Note 1: Golden Rule!**

The ward calls and weekends shifts can be quite “demanding”, mainly at the beginning of your term, but do not hesitate in ringing or calling the registrar of the day and ask for help; no matter how “foolish” it may appear!

“Normally” they are quite happy in helping you as soon as they are available!

**Remember...** The life of the patient is in your hands and many mistakes are made due to pride or ignorance. Sometimes we cannot avoid mistakes, but... if you are not sure about something.... ask! ... Ask the registrar, colleagues or nurses! Do not feel guilty or embarrassed. It is part of your learning process!

(Check the “Common Ward Call Scenarios and Management tips” in your “Red book”) and guidelines on CKN programs on the computers (antibiotics guideline, books online, MIMS, etc.). All Very Useful!

Remember: ... You are here to learn ...not only to work!

*Never be afraid to call a MET - if you are unsure – make the call!*
**Note 2: Friendship Rule!**

*To make your life and your colleagues’ lives easier, LEAVE THE PRESCRIPTIONS AND DISCHARGE PAPERS READY FOR THE POSSIBLE WEEKEND DISCHARGES AND RE- WRITE THE MEDICATION CHART ON FRIDAYS, IF IT IS ALMOST FULL!*  

( … It is not fair to leave it for the weekend ward call!)

**General Medicine**

**INTERN/RMO SCOPE OF PRACTICE and daily tasks:**

**Under Registrar Supervision.**

**Responsible for:** Provision of safe, effective and equitable medical care to patients under the supervision of the Registrar and Specialist 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.

**Personal**

- 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

**General Medicine Unit Objectives:** *By the completion of this term the Intern/RMO may expect to acquire the following knowledge:*

- Simple care of patients with common medical problems.
• Appreciation of teamwork and involvement with Allied Health.

• Development of flexibility in assessment and management 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.**

The following is a list of conditions and situations which Interns/RMOs may expect to see and manage during their General Medicine Term:

**RMO/INTERN LEARNING OBJECTIVES:**

At the end of your time in the Unit, we expect that you should be able to **diagnose and manage** the following common problems and conditions:

- chest pain/ischaemic heart disease
- asthma
- pneumonia
- chronic obstructive airways disease
- congestive cardiac failure
- pulmonary embolism and DVT
- stroke
- breathlessness
- cardiac arrhythmias
- constipation
- delirium
- dysuria and/or frequent micturition
- falls, especially in the elderly
- non-specific febrile illness
- pneumonia/respiratory infection
- pyelonephritis and UTIs
- reduced urinary output
- urinary incontinence
- weight gain
- weight loss
- dementia
- acute and chronic renal failure
- anaemia
- urinary tract infections
- gastroenteritis
- alcoholic liver disease
- diabetes
- loss of consciousness
- leg ulcers
- joint disorders
- hypertension
- headache
- gastrointestinal bleeding
- septicaemia
- seizure disorders
- stroke/TIA
- tiredness/anaemia
- sexually transmitted infections
- diarrhoea

*Please note: there will be many other disorders that you will encounter during your medical term. You will need to undertake self-directed learning.*

You should have some **skill in resuscitation** of the following acute presentations under direct Registrar supervision:

- septic shock
- cardiac arrest
- status asthmaticus
- status epilepticus
- acute pulmonary oedema

You should be able to **independently perform** the following procedural skills

- IV cannulation (including for difficult patients)
- IDC insertions – male & female
- ABGs

You should be able to **perform** the following procedural skills after observing and still being directly supervised by the Registrar:

- Lumber Puncture
- Pleurocentesis
- Paracentesis

You should be developing confidence in **interpreting the following tests:**
Please discuss any additional areas or difficulties with obtaining these skills with your supervisor (Consultant and/or Registrar).

**Scope of Practice: What the Intern is not able to do**

- Perform any skill or procedure outside of the above scope of practice
- initiate patient treatment/management or changes to patient/treatment without discussion and approval from the supervising senior medical officer. (Registrar/Consultant) (Can initiate treatment prior to liaising with Senior Medical Officer for antibiotics or IV fluids)
- Discharge patients without consulting and reviewing the case details with Registrar/Consultant.
- Break bad news to the patient or relatives (but the Intern will observe and learn about performing this task from the Registrar/Consultant)

**COMMON WARD CALL SCENARIOS**

… Be familiar with the routine; ask some tips from your registrar.

| a) Worsening oxygenation, SOB | g) New fevers |
| b) Hypotension and hypertension | h) Low urinary output or urine retention |
| c) Arrhythmias and Chest pain | i) Warfarin doses, INR, medication doses / chart review |
| e) Fluid chart, electrolytes abnormalities review and dehydration | j) Hypo / hyperglycaemia, insulin sliding scale |
| f) Transfusion guidelines | k) IV cannulation / exams to collect |

Remember please…

- The Resident is the primary Doctor caring for the patients admitted to the Unit. Refer any concerns or worries immediately to the PHO or Registrar.
- 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.
- The Medical Education Unit (MEU), situated adjacent to the Medical Workforce Unit, has been established to help you identify your ongoing medical education and training needs, and to develop programs suited to your individual needs.
- Some reviews of common ward call emergencies / guidelines / scenarios are available on the desktop of Ward 3A’s main-room computer. (Adaptation from the guideline of QLD Health -Gold Coast guideline) .Feel free to check this and print it.
EDUCATION:

- This ranges from informal bedside tutorials and Hospital Clinical Meeting presentations each week. The Residents are expected to attend educational sessions unless called to the ward for emergency and present topics at clinical meetings.
- Tuesday PM: X-ray meeting
- Intern Only Education
- Wednesday AM: MOPS alternate week with Peer Cases
- Wednesday PM: Medical Department Case Presentation – Case Presentation/Journal Club/MM Meeting
- Thursday: Grand Rounds
- Friday: RMO Education
- Each Ward Round is an Education Session.

REGISTRAR AND PRINCIPAL HOUSE OFFICER (PHO) DUTIES

ROSTERS:

*The Day on-call Reg/PHO* commences at 8.00am and goes through until 20:30pm. (For daytime admissions)
*The Afternoon on-call Reg/PHO* commences at 12:00pm until 8:30 p.m. (For afternoon admissions and MET CALL after 1630.)
*The Night call Reg/PHO* duty starts at 8:00 p.m. until 8:30 a.m. (For after-hours admissions and MET CALL.)

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

**Weekend duties**

- 3 registrars rostered on both days
- Reg 1: team of the Reg on call
- Reg 2: ED admissions Reg
- Reg 3: ward reviews and discharge review Reg
- **It is good practice to help the other registrars if not busy**
- Hours and duty break down in the table below:

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<tr>
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<th>Saturday</th>
<th>Sunday</th>
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<tbody>
<tr>
<td>Reg 1</td>
<td>0800-2030 Post take Ward Round then ED admissions &amp; MET calls 1530-2030</td>
<td>0800-1400 Post take Ward Round</td>
</tr>
<tr>
<td>Reg 2</td>
<td>0800-2030 ED admissions Calls from external facilities</td>
<td>0800-2030 ED admissions Calls from external facilities &amp; MET calls 1530-2030</td>
</tr>
<tr>
<td>Reg 3</td>
<td>0800-1630 Ward reviews and discharges MET calls 0800-1530</td>
<td>0800-2030 Ward reviews and discharges MET calls 0800-1530</td>
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**Half day**

- Half day can be taken on a day other than the rostered day, provided it is in the same fortnight and agreed to by both Consultant and Registrar.
REGISTRAR DUTIES:

- 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 is allocated to a staff member each day, as is the duty of holding the MET pager.
- EDS is the duty of the team, and ideally should be before discharge, if not within 48 hours.
- 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.
- Death Certificate needs to be completed within 24 hours and discussed with your consultant.

SPECIFIC ISSUES:

1. **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 board round. Where there are urgent ward or Emergency Department requirements precluding this, the RMO should be seconded to this meeting.

2. **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 transferral 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.

3. **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.

   THERE IS A NEW ELECTRONIC SYSTEM OF REFERRAL.

4. **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.

5. **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.

6. **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:**
  1. TIRE Assessment in ED
  2. Major GIT Bleeds with haemodynamic instability (↓BP, tachycardia, tachypnea, O\textsubscript{2} desaturation, ongoing bleeding), should be urgently discussed: During Officer Hours – with Dr Jayanna/ Dr Gonsalkorala and After Hours – with RBH for transfer
  3. ALL GIT Bleeds should be discussed with Dr Jayanna/ Dr Gonsalkorala or if not on duty, by on-call Medical Consultant
  4. Unstable GIT Bleeds should under **NO** circumstances, be admitted to the General Medicine Ward of Caboolture Hospital.
- **Referrals for Endoscopy:** Contact Dr Jayanna/ Dr Gonsalkorala.

- **Medical Consult 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.

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<thead>
<tr>
<th>NOV CONSULT TEAMS</th>
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<tr>
<td>SURGICAL - MAGOCHIE</td>
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<td>O &amp; G- DIBIA</td>
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<td>INFEC. DISEASES- CHAPMAN</td>
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<tr>
<td>TUES, THURS, FRI</td>
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<td>Shares Registrar with RESPIRATORY</td>
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<tr>
<td>INFECTIOUS DISEASES</td>
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<tr>
<td>AFTER HRS ONLY (1700-0800)</td>
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<tr>
<td>TPCH switch *2005</td>
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</table>

This is updated on the weekly timetable

- **High Dependency 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 considered to be at a low risk, but with non-life-threatening arrhythmias may be admitted to a telemetry bed.

  Patients who have multiple organ failure should be normally managed in the Intensive Care Unit at Redcliffe.

  Any patients requiring inotropic support or requiring non-invasive ventilatory support should be discussed with the HDU Consultant, Caboolture Hospital. If not available, ED or Medical doctor on duty should contact ICU at RBH or Redcliffe Hospital.

7. **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
   - Monday to Friday Education and Skills Centre
   - Saturday and Sunday in 3A
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 patient’s 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 located in this booklet. 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.

### Addis Score Chart

<table>
<thead>
<tr>
<th>ADDS 0</th>
<th>ADDS 1-3</th>
<th>ADDS 4-5</th>
<th>ADDS 6-7</th>
<th>ADDS ≥ 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue observations as per minimum standard or prescription.</td>
<td>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)</td>
<td>1. Ward doctor (JHO, Ward Call) to review patient within 30 minutes. 2. Team Leader notified 3. Observations at least every 30 minutes 4. Nurse escort</td>
<td>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</td>
<td>1. Consider MET Call 2. Registrar to review within 10 minutes and ensure Consultant is notified 3. Nurse ± Medical escort</td>
</tr>
</tbody>
</table>
| If > 60 minutes with no review and score not decreased. | Registrar (SHO) to review patient within 30 minutes. | If > 60 minutes with no review and score not decreased. | If > 60 minutes with no review and score not decreased. | If review delayed or score not decreased. |}

### The Medical Emergency Team (MET)

Registrar and Consultant notified to review.
Consider MET Call / ICU Consult
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 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 a 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).

**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</td>
</tr>
<tr>
<td></td>
<td>that does not fit the above criteria</td>
</tr>
</tbody>
</table>
**Basic Life Support**

**Basic Life Support Flow Chart**

1. **D** Check for Danger
   - Hazards / Risks / Safety?

2. **R** Responsive? (Unconscious?)
   - If not, Call for help
   - Call 000 / Resuscitation Team

3. **A** Open Airway
   - Look for signs of life

4. **B** Give 2 Initial Breaths if not breathing normally

5. **C** Give 30 chest Compressions
   - (almost 2 compressions / second)
   - followed by 2 breaths

6. **D** Attach AED as soon as available and follow its prompts

Continue CPR until qualified personnel arrive or signs of life return

NO SIGNS OF LIFE = Unconscious, Unresponsive,
Not Breathing Normally, Not Moving
AED = Automated External Defibrillator
Adult Cardiorespiratory Arrest

BLS Algorithm
if appropriate

Attach Defib - monitor

Assess rhythm/pulse

Shockable
VF / Pulseless VT

Attempt Defibrillation
1 shock
Manual Biphasic 200J
Manual Monophasic 360J

Immediate CPR
2 Minutes

Non-Shockable
PEA / Asystole

During CPR
IF NOT ALREADY DONE
Check electrode/paddle position & contact
Attempt/verify/secure IV access
Give adrenaline 1mg & repeat every 3 minutes

CORRECT REVERSIBLE CAUSES
• Hypoxaemia
• Hypovolaemia
• Hypo/Hyperthermia
• Hypo/Hyperkalaemia & other metabolic disorders
• Tamponade
• Tension pneumothorax
• Toxins / Poisons / Drugs
• Thrombosis - pulmonary / coronary

CONSIDER
Advanced airway
Antiarrhythmic
Amiodarone 300 mg
Lignocaine 1-1.5 mg/kg
Magnesium 5 mmol
Electrolytes
Potassium 5 mmol
Buffer
NaHCO3 1 mmol/kg
Atropine (0.3 mg) + Pacing (for asystole & severe bradycardia)

Note:
1. For witnessed arrest, when using a manual defibrillator, give up to 3 stacked shocks at first defibrillation attempt. If further shocks are required these should be single shocks.
2. Default biphasic energy.
GENERAL ISSUES – can be better clarified with the admin staff...

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 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: [http://qheps.health.qld.gov.au/paris/forms/home.htm](http://qheps.health.qld.gov.au/paris/forms/home.htm)

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 AVAC 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 (933).
- **TPN** (total parenteral nutrition service): contact Tracey Bladen (ext. 8692 / pager 524)
- **Pain service**: call anaesthetic secretary (ext. 8378) or the palliative care service or doctor.
- **Speech therapy, dietician and other allied health**: can be contacted by pager.
- **Rehab**: fill in and fax the specific form and phone the Rehab/geriatrics registrar.
- **MRI scans**: fill up all camps of the request form; 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 PCH Registrar by phone and explain your reasons; fill in the new computerised form and send it as soon as possible.

CARDIAC SCIENCES UNIT
CABOOLTURE HOSPITAL
Phone: 8236

The Cardiac Sciences Unit (CSU) is located on Ward 3A, near the lifts. 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 patient's 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.

iMED

iMed is now available for your use. iMed will allow you to view your Medical Images electronically from any pc within the hospital. Each user requires an individual password to access iMed.

**iMed Password:**

- **User Name** = Initial and surname, e.g. PROLPH
- **Password** = password1 (Staff need to change their password on first login)

You will be able to access all patients input as Public Patients (inpatients and outpatients) for Caboolture Hospital and Redcliffe Hospital.

Please find attached a quick reference guide for iMed and instructions on how the clinician is to change their password.

Changing your iMed Password:

1. Log in using your temporary password.
2. In the bottom left hand corner, select the “yellow padlock”
   - ![Your password is current](image)
3. This will bring up the change password screen, complete details and then select change password.
4. Log out of iMed, using the log out button found in the right hand corner.

5. Log back into iMed using your new password.
### 3D and Measurement Tools

<table>
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<th>Function</th>
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When will iMed online be available to staff?

- iMed online is now available to all Clinicians.

What does that mean to Clinical Staff?

- All medical images and reports are available electronically as soon as examinations are completed.
- Images are available throughout the hospital simultaneously.
- Hardcopy films will still be available; however will be phased out over a period of time.

Implementation

- Training has commenced.
- Individual iMed passwords will be required. These will be emailed to you.
- Cheat sheets will be available and will be placed beside each pc.

How will Medical Images be viewed?

- All medical Images can be accessed using any computer in Caboolture hospital.
- Double click on the i-Med Online Icon located on your computer desk top.
- If the i-Med Online icon is not present on the desk top you will need to log a help desk call (1800 198 175) to have it installed.

If you have any questions about this project please do not hesitate in contacting Trisha Belford ext. 8528.
New Staff member is to start with QH

Staff member receives "Start up Package" from Medical Workforce Unit

Start up Package is returned to Medical Workforce Unit

Medical Workforce Unit fax iMed System Access form to Southern Xray

Southern Xray provide the new staff member with access to iMed online.

Southern Xray email the Doctor and cc Helen_Vale@health.qld.gov.au with the user id and password.

Helen Vale, Medical Workforce Unit files their user id and password on their HR file for future reference.

Is this person starting mid term?

YES

New staff member attends orientation – iMed inservice/overview is provided as per orientation schedule.

NO

New staff member makes a time with Southern Xray Caboolture Hospital to be provided with a iMed overview and how to complete a request form.
Recommendations for Terminology, Abbreviations and Symbols used in the Prescribing and Administration of Medicines

Introduction
One of the major causes of medication errors is the ongoing use of potentially dangerous abbreviations and dose expressions. This is a critical patient safety issue. A study to identify and quantify prescribing errors in a large US urban teaching hospital found that 29% of prescriptions contained a dangerous abbreviation. An abbreviation used by a prescriber may mean something quite different to the person interpreting the prescription. Abbreviations may not only be misunderstood but can also be combined with other words or numerals to appear as something altogether unintended.

In addition, there have been changes to training of health care professionals, to health care delivery and to societal expectations, which also necessitate a rethinking of the language used to communicate medication prescribing and administration. Latin was once the language of health care and its use made medical literature universally readable among educated persons. Today, English is the predominant language of medical literature. Despite this, Latin abbreviations continue to be used amongst health professionals. Although this may be a timesaving convenience, their routine use does not promote patient safety.

Changes to policy enabling staff with differing levels of training to administer medicines, also necessitates the use of English. This training does not include Latin nor does it include comprehensive training in terms used for the administration of medicines. In addition, patients and their carers have the right to understand what is being prescribed and administered to them. Prescribing using codes or an outmoded language is no longer acceptable.

Prescriptions should not contain ANY abbreviations other than those that are in universal and common use, such as the term 'prn' meaning 'when required'. All drug names, protocols and procedures should be in English and written in full.

It is recommended that hospitals develop policies for prescribing terminology together with strategies for implementation within their institutions. In developing strategies, hospitals may wish to refer to the Joint Commission on Accreditation of Healthcare Organisations (JCAHO) "implementation tips" for eliminating dangerous abbreviations (http://www.jointcommission.org/PatientSafety/DoNotUseList/).

Although this document provides recommendations it is not all-inclusive. There may also be specific circumstances where other terminology may be considered safe. However, before hospital Drug and Therapeutic Committees (DTCs) decide to include such terminology in local policies the principles outlined in Table 1 should be applied. DTCs should continue to monitor incidents associated with prescribing terminology.

Scope
The principles and recommendations apply to:
- ALL medication orders or prescriptions that are handwritten or pre-printed
- ALL communications and records concerning medicines, including telephone/verbal orders/prescriptions, medication administration records and labels for drug storage.

Please note this document is valid as at January 2010 and will be modified on the basis of reported adverse events associated with terminology, abbreviations and/or symbols used in the prescribing or administration of medicines. In addition, when moving to electronic prescribing a reassessment of what is safe terminology should be made.
**TABLE 1: Principles for consistent prescribing terminology**

1. Use plain English - avoid jargon
2. Write in full - avoid using abbreviations wherever possible, including Latin abbreviations
3. Print all text - especially drug names
4. Use generic drug names

**Exception may be made for combination products,** but only if the trade name adequately identifies the medication being prescribed. For example, if trade names are used, combination products containing a penicillin (eg Augmentin®, Timentin®) may not be identified as penicillins.

**Exception may also be made where significant bioavailability issues exist,** for example cyclosporin, amphotericin

5. **Write drug names in full. NEVER abbreviate any drug name**

Some examples of **unacceptable** drug name abbreviations are: G-CSF (use filgrastim or lenograstim or pegfilgrastim), AZT (use zidovudine), 5-FU (use fluorouracil), DTIC (use dacarbazine), EPO (use epoetin), TAC (use tacrolimus)

**Exception may be made for modified release products**

For slow release, controlled release, continuous release or other modified release products, the description used in the trade name to denote the release characteristics should be included with the generic drug name, for example tramadol SR, carbamazepine CR

**For multi-drug protocols, prescribe each drug in full and do not use acronyms,** for example do not prescribe chemotherapy as ‘CHOP’. Prescribe each drug separately

6. **Do not use chemical names/symbols,** for example HCl (hydrochloric acid or hydrochloride) may be mistaken for KCl (potassium chloride)

**Do not include the salt of the chemical unless it is clinically significant,** for example mycophenolate mofetil or mycophenolate sodium. Where a salt is part of the name it should follow the drug name and not precede it

7. **Dose**

- **Use words or Hindu-Arabic numbers,** i.e., 1, 2, 3 etc
  - **Do not use Roman numerals,** i.e., do not use I for two, III for three, V for five etc

- **Use metric units,** such as gram or mL
  - **Do not use apothecary units,** such as minim or drams

- **Use a leading zero in front of a decimal point for a dose less than 1,** for example use 0.5 not .5
  - **Do not use trailing zeros,** for example use 5 not 5.0

- **For oral liquid preparations, express dose in weight as well as volume,** for example in the case of morphine oral solution (5mg/mL) prescribe the dose in mg and confirm the volume in brackets: eg 10mg (2mL)

- **Express dosage frequency unambiguously,** for example use ‘three times a week’ not ‘three times weekly’ as the latter could be confused as ‘every three weeks’

8. **Avoid fractions,** for example
  - 1/7 could be interpreted as ‘for one day’, ‘once daily’, ‘for one week’ or ‘once weekly’
  - 1/2 could be interpreted as ‘half’ or as ‘one to two’

9. **Do not use symbols**

10. **Avoid acronyms or abbreviations for medical terms and procedure names on orders or prescriptions,** for example avoid EBM meaning ‘expressed breast milk’
TABLE 2: Acceptable terms and abbreviations

The following table lists the terms and abbreviations that are commonly used and understood and therefore considered acceptable for use. Where there is more than one acceptable term the preferred term is shown first in the right hand column.

<table>
<thead>
<tr>
<th>Intended meaning</th>
<th>Acceptable Terms or Abbreviations</th>
</tr>
</thead>
<tbody>
<tr>
<td>(in the) morning</td>
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<tr>
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<tr>
<td>(at) night</td>
<td>night, ncte</td>
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<tr>
<td>twice a day</td>
<td>bd</td>
</tr>
<tr>
<td>three times a day</td>
<td>tds</td>
</tr>
<tr>
<td>four times a day</td>
<td>qid</td>
</tr>
<tr>
<td>every 4 hours</td>
<td>every 4 hrs, 4 hourly, 4 hrly</td>
</tr>
<tr>
<td>every 6 hours</td>
<td>every 6 hrs, 6 hourly, 6 hrly</td>
</tr>
<tr>
<td>every 8 hours</td>
<td>every 8 hrs, 8 hourly, 8 hrly</td>
</tr>
<tr>
<td>once a week</td>
<td>once a week and specify the day in full, eg, once a week on Tuesdays</td>
</tr>
<tr>
<td>three times a week</td>
<td>three times a week and specify the exact days in full, eg three times a week on Mondays, Wednesdays and Saturdays</td>
</tr>
<tr>
<td>when required</td>
<td>prn</td>
</tr>
<tr>
<td>immediately</td>
<td>stat</td>
</tr>
<tr>
<td>before food</td>
<td>before food</td>
</tr>
<tr>
<td>after food</td>
<td>after food</td>
</tr>
<tr>
<td>with food</td>
<td>with food</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Route of administration</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>epidural</td>
<td>epidural</td>
</tr>
<tr>
<td>inhale, inhalation</td>
<td>inhale, inhalation</td>
</tr>
<tr>
<td>intraarticular</td>
<td>intraarticular</td>
</tr>
<tr>
<td>intramuscular</td>
<td>IM</td>
</tr>
<tr>
<td>intrathecal</td>
<td>intrathecal</td>
</tr>
<tr>
<td>intranasal</td>
<td>intranasal</td>
</tr>
<tr>
<td>intravenous</td>
<td>IV</td>
</tr>
<tr>
<td>irrigation</td>
<td>irrigation</td>
</tr>
<tr>
<td>left</td>
<td>left</td>
</tr>
<tr>
<td>nebulised</td>
<td>NEB</td>
</tr>
<tr>
<td>naso-gastric</td>
<td>NG</td>
</tr>
<tr>
<td>oral</td>
<td>PO</td>
</tr>
<tr>
<td>percutaneous enteral gastrostomy</td>
<td>PEG</td>
</tr>
<tr>
<td>per vagina</td>
<td>PV</td>
</tr>
<tr>
<td>per rectum</td>
<td>PR</td>
</tr>
<tr>
<td>peripherally inserted central catheter</td>
<td>PICC</td>
</tr>
<tr>
<td>right</td>
<td>right</td>
</tr>
<tr>
<td>subcutaneous</td>
<td>subcut</td>
</tr>
<tr>
<td>sublingual</td>
<td>subling</td>
</tr>
<tr>
<td>topical</td>
<td>topical</td>
</tr>
</tbody>
</table>
TABLE 3: Error-prone abbreviations, symbols and dose designations to be avoided

(Adapted from the Institute of Safe Medication Practices [ISMP] list of the same name4, with permission from ISMP)

<table>
<thead>
<tr>
<th>Error-prone Abbreviation</th>
<th>Intended Meaning</th>
<th>Why?</th>
<th>What should be used</th>
</tr>
</thead>
<tbody>
<tr>
<td>µg, mcg or μg</td>
<td>microgram</td>
<td>Mistaken as ‘mg’</td>
<td>microg, microgram</td>
</tr>
<tr>
<td>BID or bid</td>
<td>twice daily</td>
<td>Mistaken as ‘bid’ (three times daily)</td>
<td>bd</td>
</tr>
<tr>
<td>BT or bt</td>
<td>bedtime</td>
<td>Mistaken as ‘BID’ (twice daily)</td>
<td>bedtime</td>
</tr>
<tr>
<td>cc</td>
<td>cubic centimetres</td>
<td>Mistaken as ‘c’ (units)</td>
<td>mL</td>
</tr>
<tr>
<td>D/C or D/C</td>
<td>discharge or discontinue</td>
<td>Premature discontinuation of medications if discharge intended</td>
<td>‘discharge’ or ‘discontinue’ whichever is intended</td>
</tr>
<tr>
<td>e or E</td>
<td>ear or eye</td>
<td>Mistaken for ‘ear’ when ‘eye’ intended or for ‘eye’ when ‘ear’ intended</td>
<td>‘eye’ or ‘ear’ and specify whether ‘left’, ‘right’ or ‘both’</td>
</tr>
<tr>
<td>gtt or gutt</td>
<td>drops</td>
<td>Latin abbreviation meaning ‘drops’, not universally understood</td>
<td>‘drops’ or ‘eye drops’ whichever is intended</td>
</tr>
<tr>
<td>HS or hs</td>
<td>half-strength</td>
<td>Mistaken as bedtime</td>
<td>‘half-strength’ or ‘bedtime’ whichever is intended</td>
</tr>
<tr>
<td>at bedtime, hours of sleep</td>
<td></td>
<td>Mistaken as half-strength</td>
<td></td>
</tr>
<tr>
<td>IJ</td>
<td>injection</td>
<td>Mistaken as ‘IV’ or ‘intrajugular’</td>
<td>inj, injection</td>
</tr>
<tr>
<td>IN</td>
<td>intranasal</td>
<td>Mistaken as ‘IM’ or ‘IV’</td>
<td>intranasal</td>
</tr>
<tr>
<td>IT</td>
<td>intrathecal</td>
<td>Mistaken as ‘intravenous’</td>
<td>intrathecal</td>
</tr>
<tr>
<td>IU</td>
<td>International units</td>
<td>Mistaken as ‘IV’ (intravenous) or ‘10’ (ten)</td>
<td>International units</td>
</tr>
<tr>
<td>M</td>
<td>morning</td>
<td>Mistaken for ‘m’ (night)</td>
<td>morning</td>
</tr>
<tr>
<td>N</td>
<td>night</td>
<td>Mistaken for ‘n’ (morning)</td>
<td>night</td>
</tr>
<tr>
<td>Oc or Oco</td>
<td>eye ointment</td>
<td>Mistaken for eye drops</td>
<td>eye ointment</td>
</tr>
<tr>
<td>mist</td>
<td>mixture</td>
<td>Latin abbreviation, not universally understood</td>
<td>mixture</td>
</tr>
<tr>
<td>o.d. or OD</td>
<td>once daily</td>
<td>Mistaken as ‘right eye’ (OD-oculus dexter), leading to oral liquid medications administered in the eye. Can also be mistaken for BID (twice daily)</td>
<td>‘daily’, preferably specifying the time of the day, eg ‘morning’, ‘midday’, ‘at night’</td>
</tr>
<tr>
<td>OJ</td>
<td>orange juice</td>
<td>Mistaken as ‘OD’ or ‘OS’ (right or left eye); drugs meant to be diluted in orange juice may be given in the eye</td>
<td>orange juice</td>
</tr>
<tr>
<td>OW</td>
<td>once a week</td>
<td>Not universally understood</td>
<td>once a week</td>
</tr>
<tr>
<td>p/f</td>
<td>per fortnight</td>
<td>Not universally understood</td>
<td>every two weeks, per fortnight</td>
</tr>
<tr>
<td>qd or QD</td>
<td>every day</td>
<td>Mistaken as ‘Qid’, especially if the period after the ‘q’ or the tail of the ‘q’ is misunderstood as an ‘i’</td>
<td>daily</td>
</tr>
<tr>
<td>pulv</td>
<td>powder</td>
<td>Latin abbreviation, not universally understood</td>
<td>powder</td>
</tr>
<tr>
<td>Qhs</td>
<td>nightly at bedtime</td>
<td>Mistaken as ‘qhs’ or every hour</td>
<td>‘night’, ‘daily at bedtime’</td>
</tr>
<tr>
<td>Oh</td>
<td>every hour</td>
<td>Not universally understood</td>
<td>‘hourly’, ‘every hour’</td>
</tr>
<tr>
<td>qod or QOD</td>
<td>every other day</td>
<td>Mistaken as ‘qod’ (daily) or ‘qid’ (four times daily)</td>
<td>‘every second day’, ‘on alternate days’</td>
</tr>
<tr>
<td>Q6PM etc</td>
<td>every evening at 6 pm</td>
<td>Mistaken as every six hours</td>
<td>‘6pm daily’, ‘every night at 6pm’, ‘every day at 6 pm’</td>
</tr>
</tbody>
</table>
### TABLE 3: Error-prone abbreviations, symbols and dose designations to be avoided (continued)

(Adapted from the Institute of Safe Medication Practices [ISMP] list of the same name, with permission from ISMP)

<table>
<thead>
<tr>
<th>Error-prone Abbreviation</th>
<th>Intended Meaning</th>
<th>Why?</th>
<th>What should be used</th>
</tr>
</thead>
<tbody>
<tr>
<td>SC</td>
<td>subcutaneous</td>
<td>Mistaken as ‘SL’ (Sublingual)</td>
<td>‘subcut’, ‘subcutaneous’</td>
</tr>
<tr>
<td>SL or S/L</td>
<td>sublingual</td>
<td>Mistaken as ‘SC’ (Subcutaneous)</td>
<td>‘subling’, ‘under the tongue’</td>
</tr>
<tr>
<td>Se</td>
<td>sliding scale (insulin) or half (apothecary)</td>
<td>Mistaken as ‘55’</td>
<td>‘sliding scale’ or ‘half’ whichever is intended</td>
</tr>
<tr>
<td>SSI or SSI</td>
<td>sliding scale regular insulin or sliding scale insulin</td>
<td>Mistaken as selective serotonin reuptake inhibitor (SSRI) or Strong Solution of Iodine (Lugols)</td>
<td>sliding scale insulin</td>
</tr>
<tr>
<td>TID</td>
<td>three times a day</td>
<td>Mistaken as ‘bd’</td>
<td>tds ‘three times a day’</td>
</tr>
<tr>
<td>TIW</td>
<td>three times a week</td>
<td>Mistaken as ‘three times daily’</td>
<td>‘three times a week’ and specify exact days in full, for example ‘on Mondays, Wednesdays and Saturdays’</td>
</tr>
<tr>
<td>VID</td>
<td>one daily</td>
<td>Mistaken as ‘tid’</td>
<td>one daily unit</td>
</tr>
<tr>
<td>U or u</td>
<td>unit</td>
<td>Mistaken as the numbers ‘0’ or ‘4’, causing a 10-fold overdose or greater (eg 4U seen as ‘40’ or 4u seen as ‘44’). Mistaken as ‘cc’ so dose given as a volume instead of units (eg 4u seen as 4 cc)</td>
<td>unit</td>
</tr>
<tr>
<td>ung</td>
<td>ointment</td>
<td>Latin abbreviation, not universally understood</td>
<td>ointment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Error-prone frequency and dosage abbreviations</th>
<th>Intended Meaning</th>
<th>Why?</th>
<th>What should be used</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/24</td>
<td>every six hours</td>
<td>Mistaken as ‘six times a day’</td>
<td>‘every 6 hrs’, ‘6 hourly’, ‘6 hrly’</td>
</tr>
<tr>
<td>1/7</td>
<td>for one day</td>
<td>Mistaken as ‘for one week’</td>
<td>for one day only</td>
</tr>
<tr>
<td>1/2</td>
<td>half</td>
<td>Mistaken as ‘one or two’</td>
<td>half</td>
</tr>
<tr>
<td>i, ii, iii, iv (Roman numerals)</td>
<td>1, 2, 3, 4 etc</td>
<td>Hindu-Arabic numbers, 1, 2, 3, 4 etc or words</td>
<td></td>
</tr>
</tbody>
</table>
### TABLE 3: Error-prone abbreviations, symbols and dose designations to be avoided (continued)

(Adapted from the Institute of Safe Medication Practices [ISMP] list of the same name, with permission from ISMP)

<table>
<thead>
<tr>
<th>Error-prone dose designations and other information</th>
<th>Intended meaning</th>
<th>Why?</th>
<th>What should be used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trailing zero after decimal point (eg. 1.0mg)</td>
<td>1mg</td>
<td>Mistaken as 10mg if the decimal point is not seen</td>
<td>Do not use trailing zeros for doses expressed in whole numbers</td>
</tr>
<tr>
<td>No leading zero before a decimal point (eg. .5mg)</td>
<td>0.5mg</td>
<td>Mistaken as 5mg if the decimal point is not seen</td>
<td>Use zero before a decimal point when the dose is less than a whole unit</td>
</tr>
<tr>
<td>Large doses without properly placed commas (eg 1,000,000 units)</td>
<td>100,000 units, 1,000,000</td>
<td>100000 has been mistaken as 10,000, or 1,000,000; 100000 has been mistaken as 100,000</td>
<td>For figures above 100 use words to express intent eg. one thousand, one million, six million etc. Otherwise use commas for doses in units at or above 1,000 units</td>
</tr>
<tr>
<td>10⁶ etc</td>
<td>one million</td>
<td>Not universally understood</td>
<td>Use one million or 1,000,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Error-prone symbols</th>
<th>Intended Meaning</th>
<th>Why?</th>
<th>What should be used</th>
</tr>
</thead>
<tbody>
<tr>
<td>X3d</td>
<td>for three days</td>
<td>Mistaken as &quot;3 doses&quot;</td>
<td>for three days</td>
</tr>
<tr>
<td>&gt; or &lt;</td>
<td>greater than or less than</td>
<td>Mistaken or used as the opposite of intended; ‘&lt;10’ mistaken as ‘40’</td>
<td>‘greater than’ or ‘less than’</td>
</tr>
<tr>
<td>/ (slash mark)</td>
<td>separates two doses or indicates ‘per’</td>
<td>Mistaken as the number 1 eg ‘25 units/10 units’ misread as ‘25 units and 110 units’</td>
<td>‘per’ rather than a slash mark to separate doses</td>
</tr>
<tr>
<td>@</td>
<td>at</td>
<td>Mistaken as ‘2’</td>
<td>at</td>
</tr>
<tr>
<td>&amp;</td>
<td>end</td>
<td>Mistaken as ‘2’</td>
<td>and</td>
</tr>
<tr>
<td>+</td>
<td>plus or and</td>
<td>Mistaken as ‘4’</td>
<td>and</td>
</tr>
<tr>
<td>*</td>
<td>hour</td>
<td>Mistaken as a zero (eg q2 seen as q20)</td>
<td>hour</td>
</tr>
</tbody>
</table>
This document was endorsed by Australian Health Ministers in December 2008 for use in all Australian hospitals. It was prepared for, and is maintained by, the Australian Commission on Safety and Quality in Health Care.

The Australian Commission on Safety and Quality in Health Care was created by Australian Health Ministers to lead and coordinate improvements in the safety and quality of Australian health care. Its work includes a large range of activities in medication safety and quality including national standardisations. Further information on the Commission’s Medication Safety Program is available from www.safetyandquality.gov.au

The original version of this document was prepared by a Working Group of the NSW TAG Safer Medicines Group in consultation with health practitioners and with reference to the following documents:

- St Vincent’s Hospital, Sydney, Standard Abbreviations for Prescribing (adapted with permission from Central Coast Health)
- Sydney Children’s Hospital, Recommendations on ‘Safe Prescribing’ October 03
- National Prescribing Service - National Prescribing Curriculum.
- Australian Medicines Handbook 2006
- Prince of Wales Hospital and Sydney Children’s Hospital approved list of abbreviations
- National Inpatient Medication Chart – NSW Health Guidelines for use
- Australian Pharmaceutical Formulary and Handbook (APF), 19th Edition
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Medication errors related to potentially dangerous abbreviations 2001
- Institute for Safe Medication Practices (ISMP), List of Error-Prone Abbreviations, Symbols, and Dose Designations, 2005
- Queensland Health Department’s state-wide abbreviation guidelines used in prescribing and administering medications.

NSW TAG gratefully acknowledges all those who provided comment during the consultation phase. The working group also acknowledges the assistance of Karen Kaye, Executive Officer, NSW TAG

References:

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Ms Linda Graudins, Quality Use of Medicines Pharmacist, Sydney Children’s Hospital
Ms Maria Kelly, Executive Officer, NSW Therapeutic Advisory Group
Ms Josephine Montgomery, Quality and Safety Branch, NSW Health Department
Dr Gary Nicholls, Clinical Pharmacist, St Vincent's Hospital, Sydney
INTRODUCTION
Supervision of clinical experience allows junior doctors to learn in safety as they progress towards independent practice.

SUPERVISORS
Supervisors must be doctors registered with the Medical Board of Queensland.

3. LEVELS OF SUPERVISION
There are three such levels:

3.1. Level 1 The Supervisor is present in the clinical unit.
3.2. Level 2 The Supervisor is present in the hospital or facility.
3.3. Level 3 The Supervisor is on call from an on call residence, or from his or her usual residence.

4. MINIMUM SUPERVISION LEVELS

4.1 PGY 1/INTERNS
4.1.1 Supervision must be at Level 1 or 2 for all interns.
4.1.2 Supervision must be provided by a supervisor with appropriate experience of the particular discipline. The supervisor must have at least two years’ clinical experience (i.e. PGY 3 or more senior)

4.2 PGY 2/JHOs
4.2.1 Supervision may be at Level 1, 2, or 3
The same standards of supervision must apply both in-hours and out-of-hours. Junior doctors must be encouraged to seek advice and/or assistance as early as possible whenever they are concerned about a clinical issue. This applies both in and out of hours. At all stages of training, a supervisor must attend whenever a junior doctor requests assistance.

5. ORIENTATION, ASSESSMENT AND FEEDBACK

5.1.1 Orientation
5.1.2 Mid-term assessment
5.1.3 End of term
5.1.4 Unsatisfactory performance

ORIENTATION AND LEARNING OBJECTIVES

All junior doctors (Interns, JHOs and SHOs) should take time to become fully familiar with this orientation manual, as well as relevant UNIT workplace guidelines, which are available from the consultant (and the Clinical Support Officer) at the commencement of the rotation.

All junior doctors should ensure they are proactive in receiving a 1-1 orientation from their supervisor (consultant or registrar) on commencement.

At orientation please also take the time to discuss your individual learning objectives (based on the Australian Curriculum Framework for Junior Doctors (ACFJD) with your term supervisor.
This discussion should also identify the junior doctors’ learning objectives for the unit, as well as information about the unit’s casemix, and clinical opportunities for you to learn specific procedural skills, and to manage relevant clinical conditions.

**ASSESSMENT AND FEEDBACK**

**ASSESSMENT PROCESS**

An intern will be assessed in all five terms in the first postgraduate year (PGY 1). It is essential that the performance in all these terms is satisfactory, to enable the intern to progress to general registration as a PGY2.

All interns will have a formal end of term assessment completed by their supervisors.

All pre-vocational junior doctors at Caboolture Hospital are assessed in a similar manner during their terms in all units.

Please endeavour to ensure your supervisor arranges tasks in which you can be observed and assessed, particularly procedural skills and clinical management of patients.

**FEEDBACK**

During the term you will be provided with formal and informal feedback on your performance (clinical, professionalism, communication) from your supervisor.

**Mid Term**

The mid-term (appraisal) interview is formative (i.e. it does not contribute to your final assessment).

This mid-term interview provides an opportunity for a discussion between the supervisor and the junior doctor, and an appraisal of your current performance.

He or she provides you with individual and constructive feedback on your progress, and any necessary guidance in order to improve your performance.

This is also an excellent opportunity to discuss progress made towards the achievement of your learning objectives which will have been discussed with you at orientation.

**End of Term**

The End of Term Assessment is summative (i.e. it will indicate whether your performance has been satisfactory or unsatisfactory).

This interview should be scheduled as a formal interview, at which time both you and your supervisor will discuss the assessment form and sign off on it.

Please be proactive in ensuring you receive both mid-term and end-of-term feedback.

For interns and those junior doctors without general registration, the Australian Health Practitioner Registration Agency will be informed of the result of your assessment.

**UNSATISFACTORY PERFORMANCE**

If you receive an unsatisfactory assessment at mid-term or end of term, your supervisor will contact the Medical Education Unit.

An Improving Performance Action Plan (IPAP) will be developed by your supervisor with the assistance of the Medical Education Unit (DCTs and MEOs).

The personnel of the MEU will be able to assist you in complying with the requirements of the IPAP; they are also able to support you and provide you with advice and assistance in many ways.
They can also arrange access to the Employee Assistance Service (EAS) – professional psychological support - if appropriate.

**RMO END OF TERM HANOVER POLICY**

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

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._

**Process:**

- 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

**Clinical Unit:** ____________________________ 2011 Term 1 2 3 4 5 (Please Circle)

**Resident’s Name:** ____________________________

**Contact Details:** ____________________________

_______________________________________________

_______________________________________________

**Reminders:**

- Complete the Unit Evaluation Form for your current term, and return to Medical Education Unit
- Seek out your current Term Supervisor to facilitate the completion and discussion of your End of Term Assessment
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 and learning objectives for your new term

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.

Feel free to ask…
   We hope you enjoy your time with us…

DR SALIH BAZDAR
DIRECTOR OF INTERNAL MEDICINE
CABOOLTURE HOSPITAL