2019 Orientation Manual - General Surgery
Surgical Department
Published by the State of Queensland (Metro North Hospital and Health Service), [Click to enter date]

[IBNN or ISBN if needed]

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For more information, contact:

[Name of branch/division/unit], Metro North Hospital and Health Service, [Address 1], [Address 2], [Suburb] [STATE] [Postcode], email [generic email address if available], phone [main phone number] for [branch/division/unit].

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Welcome to the Caboolture Hospital Surgical Services
Hello and welcome to your term in the Department of Surgical Services at Caboolture Hospital. We understand that in a new environment, you may feel overwhelmed or unsure of what to do.

To ensure that your transition into the department is as easy as possible, this booklet has been developed as a reference to the important information required for your term.

Information is regularly updated and reviewed including policies and procedures in this handbook. It is the aim of the staff in this unit to assist you in developing your clinical skills, by formalised educational sessions and practical hands on experience.

It is hoped that you enjoy your time with us in the Surgical Department at the Caboolture Hospital and should you have any questions or if you are unsure of anything please do not hesitate to ask your Consultant or Registrar.

Regards

**The Surgical Team**

**Clinical Director**
Dr Brian Kirkby

**Fulltime Consultants**
Dr Boris Strekozov
Dr Rasika Hendahewa
Dr Sujith Ratnayake

**Part-time Consultants**
Dr Daniel Mehanna (Monday all day and Thursday all day)
Dr Vinay Gounder (Monday 7-12pm, Tuesday 12-5pm and Wednesday all day)
Dr Mara Clarson (Friday all day)
Part-time Gastroenterology Consultants
Dr Enoka Gonsalkorala (Wednesday to Friday)
Dr Mahesh Jayanna (Monday all day, Tuesday all day and Friday 11:30-4pm)

Part-time General Practitioner with Special Interest
Dr Akanksha Bhargava (Tuesday all day)

Part-time ENT Consultant
Dr Sarah Pena (Tuesday all day once a month)

| Registrars/PHOs = 7 | Interns JHOs &/or SHOs = 5 |
Frequently Asked Questions (FAQ’s)

1. I have not received any information regarding my employment.
   This information gets emailed out to you from recruitment once the finalization of the position has been completed. If you have not received any information, please contact your Line Manager. For any information regarding Recruitment – please contact Recruitment Services on telephone: (07) 5433 8883.

2. Where do I get my payroll number?
   Once all your documents have been completed by yourself and sent to Payroll, your line manager receives an email with your payroll number details.

3. How do I get my ID badge?
   All staff are issued with and are required to wear identification badges. These badges are to be worn during working hours and should be worn at chest level. Badges remain the property of the Hospital and should be returned on resignation. Lost identification badges are to be reported to your direct supervisor immediately. The ID Badge cannot be generated without your payroll number.
   **ID photos can be taken at Caboolture during the following times:**
   07:30am – 08:00am on Day 1 Orientation
   13:30pm – 14:30pm Wednesdays at the Engineering Department on level 1 at the rear of the hospital (Please see Map on Page 38).
   **Photos taken at Orientation on a Monday morning will be processed and available on Thursday of the same week after lunch from the Engineering Department.**
   **ID cards can be picked up from Engineering from Tuesday to Thursday between 10.30 am- 2.30 pm. Please Contact the Engineering Department, Caboolture Hospital – 5433 5617 for any further information.**

4. What happens if I change my name, address or telephone number?
   It is the employee’s responsibility to notify payroll services of any change of name, address or telephone number (Via a personal details change form). Please remember that should you cease employment, group certificates will be issued at a later date to the last known address, and notification of any subsequent change of address is therefore imperative to ensure the forwarding of such certificates to the correct address.
   Notification forms are available on the PARIS Website.

5. What mandatory training do I have to attend and complete?
   For a list of mandatory training requirements and information please go to the QHEPS page: http://qheps.health.qld.gov.au/metronorth/red-cab-kilcoy/education/mandatory.htm
   Other training including driver safety, hazardous materials, waste management and complaints awareness is available at: http://elearn.com.au/qh/START.htm

6. Where can I park?
Car parking is available to all staff within the hospital grounds free of charge. Please leave the first 2 bays closest to the entrance to the main hospital for Patients to attend Emergency, Theatre and Specialist Outpatients Appointments. On Street Parking is also available and is not metered.

Gated Car parking is available for staff member’s swipe access with ID Badge

**INTRODUCTION**

Caboolture Hospital forms part of the Northside Health Service District. This new enlarged District came into effect in 2007 following an extensive reorganisation undertaken by Qld Health. The district has 4 hospitals, Redcliffe Hospital, Caboolture Hospital, Kilcoy Hospital and Prince Charles Hospital. The latter is the largest of the group and provides tertiary care services, primarily in the field of cardiac and cardio-thoracic surgery and medicine. All 3 hospitals are teaching hospitals of the University of Queensland Herston Medical School.

Caboolture Hospital is approximately 40 minutes from the city centre of Brisbane. Each of the hospitals in the district are approximately ½ an hour away from each other.

**CLINICAL SERVICES**

The major clinical specialties at Caboolture Hospital include general medicine, general surgery, paediatrics, obstetrics and gynaecology and adult mental health. The obstetric services are provided by a very large department. The general surgical services are triplicated at the 3 major sites in the District. Caboolture Hospital has a large emergency department with a high attendance as well as a busy outpatients department. A critical care unit was opened in November 2002 and is progressively expanding. Caboolture Hospital also has a comprehensive 24 hour radiology department in addition to other ancillary allied health services. The radiology department has facilities for multi-slice CT scanning, MRI, ultrasound, duplex as well as nuclear medicine.

The department of surgery is headed by Dr Brian Kirkby who is the Director of Surgery at Caboolture Hospital. The other consultants in the Department are:

Dr Boris Strekozov FRACS - Senior Staff Specialist
Dr Daniel Mehanna FRACS – Staff Specialist
Dr Sujith Hendahewa – Consultant Surgeon
Dr Rasika Hendahewa – Staff Specialist

Redcliffe Hospital provides the orthopaedics, vascular and urology services for the regions that are serviced by the Caboolture and Redcliffe Hospital catchment areas.

**WINSCRIBE – Medical Typing Dictation System.**

Please note in the first instance 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 into your desktop folders/correct them and then send them back to the author (person who emailed them to you) in a timely fashion. To make it easier I suggest you move them into your completed folder once each letter has been processed. You can email them singularly 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 or alternatively correct all of your letters then
email them back to the relevant author then move them into the completed folder. This
safeguards your letters and leaves a copy in your desktop Medical Typing/ Completed Folder.
Your co-operation in this process will assist in reducing your workload by re-correcting letters
and the interruptions to the typists and the management of the backlog of letters to be typed
and re-emailed.

**Medical Typing Returns via OWA Email - Will not be processed and sit in Cyberspace.**

**Log on with Own Personal ID and Password onto PCs Not Generic**

Do not edit any letters on a shared computer and return via OWA (Outlook Web Access) as
they will sit in cyberspace. Note the computers in clinic cannot be logged into with a personal
user ID and password. They are shared computers and can only be logged into via a generic
log in.

**Steps to follow:**

1. Log on to a computer with your own personal user ID and password.
2. Use Microsoft Office Outlook and not Outlook Web Access.
3. Edit letters and return by replying with changes regardless of whether there are any
corrections or not.

**ORIENTATION DATA**

**HOURS OF WORK**

Following the recent modification of the awards for junior medical officers, the normal hours of
duty in the Department of Surgery have changed to 7.00 am - 3.06 pm, giving a 38 hours per
week roster.

The registrar ward rounds should be done daily and should commence by 7.00 am. This should
enable the registrar to complete the rounds of his or her patients before proceeding onto clinical
handover meetings Tuesday to Friday at 7.30 am.

Consultant Ward Rounds are:

- B Kirkby - Monday to Friday
- B Strekozov - Monday, Wednesday to Friday
- D Mehanna - Monday, Thursday
- S Ratnayake - Monday to Thursday
- R Hendahewa - Monday to Wednesday, Friday

The normal work for the day should be completed during the designated hours.

It is an important aspect of time management that one prioritises his or her clinical
duties and also aims to keep to schedule. It is also understood that delays are
inevitable and that it is part and parcel of clinical surgery. However, it is important that
personnel should get away, as much as possible, on time and, hence should actively
seek to avoid unnecessary overtime.

**OPERATING SESSIONS**

The operating sessions would commence at 8:30 am for the morning lists and 1:00pm for the
afternoon lists. The registrar should be present in the operating theatre 15 minutes prior to the
knife to skin scheduled time indicated above.
Dr R Hendahewa  All Day Monday
Dr S Ratnayake  All Day Monday
Dr B Kirkby  All Day Tuesday
Dr B Strekozov  All Day Wednesday
Dr V Gounder  Half Day Wednesday
Dr D Mehanna  All Day Thursday
Dr M Clarson  Alternating half and full day on Friday’s

It is important for the registrar to be present in the theatre at the above times in order to avoid delays to the commencement of the theatre. It should be noted that operation room information management system (ORMIS) records all commencement data and also records delays and the reasons therein. These facts are reviewed at a weekly meeting held between the medical superintendent, the elective surgery coordinator and the theatre nurse manager. The knife to skin commencement time for operating theatres on Fridays is 9:15 am. Hence, the registrars should make an appearance at 9:00 am.

If the residents need to discuss any ward or urgent patient issues while the team registrar is scrubbed in they should not hesitate to change into scrubs and enter the theatre to discuss. This will ensure no delay in patient care occurs in the ward.

* Please see attached schedule for elective surgery sessions schedule.

OUTPATIENT CLINICS

The outpatient clinics would commence sharp at 8.30 am. It is very important not to keep the patients waiting unnecessarily as this would create an unfavourable impression amongst the public. There should be at least 2 registrars commencing the clinics at 8:30am without exception. These would be the registrar of the firm that is conducting the clinic and another registrar from another firm. Other remaining registrars who are not otherwise engaged should join the clinic as soon as possible.

All residents should attend clinics at the starting time as states in the weekly timetable. If you are unable to attend a clinic session, arrangements should be made to replace yourself with other residents in the team. This is the responsibility of the resident allocated as per the allocations.

When there are no rooms available, the residents can work on chart reviews using the computers at the back of the outpatient clinic area. The findings need to be discussed with a registrar or consultant for further plans.

Consultation services should be provided forthwith to the emergency department. As the emergency department has a high turnover, they are dependent on speedy transfer of patients to the clinical units in order to avoid the situation of ED surge. Hence, all calls should be answered within 15 minutes maximum. If the registrar, who is providing this service, is delayed for any reason, continuous consultations with the emergency department should be undertaken to ease this situation. The on call registrar for the day should always nominate a substitute registrar to act on his behalf if it happens to be one of his/her theatre days.
No Overbooked Clinics Policy and Process.

1. The No Overbooking Clinics Policy must be adhered to and there will be no overbooked clinics as defined in the templates discussed with Dr Kirkby. This is not negotiable.

2. If a patient needs to be added to a full clinic then the registrar is to discuss the case with the consultant in question to review the case/chart at the time.

3. If a patient does need to be added to a full clinic making this clinic then become overbooked than another patient booked into this clinic will have to be transferred out of this clinic and booked into the Chart Review Clinic for that consultant to review and the registrar to action in the Tuesday Chart Review Clinic.

EARLY FOLLOW-UP CLINIC

An early follow-up clinic (ESFU) is held on Wednesday AM and Friday PM. This clinic performs an important quality function. The patient's are reviewed within a week or 2 of their discharge and their wounds inspected and also the relevant histology is checked and documented. Further information is also collated and appropriate audit forms are filled so that the Director of Surgery would receive the data from this clinic without delay in order to fulfil the requirements of the surgical audit and clinical indicators.
## DEPARTMENT OF SURGICAL UNIT WEEKLY TIMETABLE

<table>
<thead>
<tr>
<th>Week</th>
<th>Monday</th>
<th>Tuesday</th>
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<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
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<tr>
<td><strong>General Surgery Consultants</strong></td>
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<tr>
<td>Brian Kirkby</td>
<td>AM</td>
<td>Unit 1</td>
<td>ADMIN</td>
<td>OT</td>
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<td>ENDO</td>
<td>ADMIN</td>
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<td>PM</td>
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<td>Cst/Teach</td>
<td>ADMIN</td>
<td>ADMIN</td>
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<tr>
<td>Boris Strekozov</td>
<td>AM</td>
<td>Unit 1</td>
<td>ENDO</td>
<td>OFF</td>
<td>OT</td>
<td>CLINIC</td>
<td>CST</td>
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<td>CST</td>
<td>ENDO</td>
<td>CST</td>
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<tr>
<td>Daniel Mehanna</td>
<td>AM</td>
<td>Unit 2</td>
<td>ENDO</td>
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<tr>
<td>Rasika Hendahewa</td>
<td>AM</td>
<td>Unit 2</td>
<td>OT</td>
<td>ENDO</td>
<td>TEACH/CST</td>
<td>OFF</td>
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<td>PM</td>
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<td>CST</td>
<td>CLINIC</td>
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<tr>
<td>Suji Ratnayake</td>
<td>AM</td>
<td>Unit 2</td>
<td>OT</td>
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<td>ADMIN</td>
<td>ENDO</td>
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<td>PM</td>
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<td>ENDO</td>
<td>ADMIN</td>
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<tr>
<td>Mara Clarkson</td>
<td>AM</td>
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<tr>
<td>Vinay Gounder</td>
<td>AM</td>
<td>Unit 2</td>
<td>OFF</td>
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<tr>
<td>Emergency Theatres</td>
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<tr>
<td><strong>Gastroenterology Consultants</strong></td>
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<tr>
<td>Enoka Gonsallorala</td>
<td>AM</td>
<td>RBWH</td>
<td>RBWH</td>
<td>CLINIC</td>
<td>CLINIC</td>
<td>Ward Consults</td>
<td>5825/SWITCH</td>
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<tr>
<td>PM</td>
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<td>END</td>
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<tr>
<td>Jayanna Mahesh</td>
<td>AM</td>
<td>CLINIC</td>
<td>CLINIC NLAKES</td>
<td>ENDO</td>
<td>OFF</td>
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<td>8320/SWITCH</td>
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<td>(M730-1800, W730-1400, F1130-1800)</td>
<td>PM</td>
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<td>CLINIC NLAKES</td>
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<tr>
<td>Soong-Yuan Ooi</td>
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<td>PM</td>
<td>ENDO (WK)</td>
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<tr>
<td>Sarah Pena</td>
<td>AM</td>
<td></td>
<td>OT</td>
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<td>SWITCH</td>
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<tr>
<td>(Tuesdays)</td>
<td>PM</td>
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<td>CLINIC</td>
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<tr>
<td>Akanksha Bhargava</td>
<td>AM</td>
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<td>CLINIC (SURG)</td>
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<td>SWITCH</td>
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<td>(Tuesdays)</td>
<td>PM</td>
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<td>CLINIC (GASTRO)</td>
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MONDAY MORNING PROGRAM

The Surgical Unit Meeting commences sharply at 7.00am in the Executive Centre 2, Meeting room 2, with the weekly workload perusal a fortnight in advance with the Elective Surgery Coordinator. This is followed by the registrars presenting the peer review segment with Xrays and Scans where the weekly patient loads would be viewed on power point and further discussions about their management take place. Any administrative matters also would be discussed during this time.

FRIDAY MORNING PROGRAM

The Friday Surgical Unit Meeting commences at 7.30 am in the Lecture Room 1 on the Administration floor. This is followed by the registrars presenting the peer review segment with Xrays and Scans where the weekly patient loads would be viewed on power point and further discussions about their management take place. Following the clinical handover a registrar Journal Club presentation is usually scheduled as well.

DISCHARGE PLAN

All patients admitted to the unit should have an EDD (Expected Day of Discharge), their care can then be attended to depending on clinical progress. At the time of the discharge of the patient, the front sheet as well as the discharge summary should be completed and a copy of the completed discharge summary should be handed over to the patient. Therefore no patient who is discharged should leave the ward without a copy of the discharge summary with him/her. This would ensure appropriate continuity of care by the health providers in the community.

The accurate completion of the front sheet is also important as the medical records coders utilize this sheet for the coding of data. All surgical procedures performed, investigations done, as well as any complications that are noted should be entered on the front sheet. It would be good practice therefore to record any complications that are noted on the daily ward rounds and any special investigations like CT scans that are ordered to be entered on a daily basis on the front sheet so that the front sheet would be automatically completed by the time the patient is discharged. This would prevent the necessity to go through a voluminous chart at the time of the patient’s discharge and therefore would be both time efficient and accurate.

It is also the responsibility of the team Registrar or resident to ensure all the discharge summaries for patients who have come for day procedures have been completed in good time so that there is no back log in recovery and smooth patient flow is maintained.

WEEKLY CHART COMPLETION

A chart completion session would be conducted at 2.00 pm on Thursday afternoons during which all the charts of the patients who have been discharged up to that time in the week would be reviewed. This would be conducted with the involvement of all the designated surgical junior staff. All pathology and histology reports also would be reviewed and further management plans would be instituted.

The chart review that is conducted would also include clinical discussions and management plans as appropriate during this session. The purpose of this session is to ensure that appropriate documentation is carried out on the front sheets and adequate discharge
summaries have been done in order to allow the continuity of care to proceed in the community without any problems and pathology results to be checked.

**CLINICAL INDICATORS**

A number of ACHS Clinical Indicators (see appendix) are being collected for submission to ACHS twice a year. Please familiarise yourself with this.

**UNIT TEACHING PROGRAM**

<table>
<thead>
<tr>
<th>Day</th>
<th>Time</th>
<th>Activity</th>
<th>Tutor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>AM</td>
<td>Teaching Ward Round</td>
<td>Dr B Strekozov</td>
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<tr>
<td></td>
<td>12.00-1.00 PM</td>
<td>Registrar Topic Presentations Weekly</td>
<td>Nominated Registrars</td>
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<tr>
<td></td>
<td></td>
<td>Nutritionist Presentations Quarterly</td>
<td>Nominated Nutritionist</td>
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<td></td>
<td></td>
<td>Endoscopy Presentations Bimonthly</td>
<td>Nominated Presenter</td>
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<td></td>
<td>PM</td>
<td>Teaching Ward Round</td>
<td>Dr N Khan</td>
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<td>3.00 PM</td>
<td>Tutorial</td>
<td>Dr WG Premaratne’s Office</td>
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<td>• Medical Students</td>
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<td>• Residents</td>
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<tr>
<td>Tuesday</td>
<td>2.00 pm</td>
<td>RMO Teaching</td>
<td>Director Clinical Training, Medical Education Session</td>
</tr>
<tr>
<td>Wednesday</td>
<td>12.00-1.00 PM</td>
<td>Xray Tutorial (LR4) or Oncology MDTM (Skills Ctr)</td>
<td>Alternate weeks</td>
</tr>
<tr>
<td></td>
<td>3.00-3.30 PM</td>
<td>Tutorial</td>
<td>Dr WG Premaratne’s Office</td>
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<td></td>
<td></td>
<td>• Medical Students</td>
<td></td>
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<td></td>
<td></td>
<td>• Residents</td>
<td></td>
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<tr>
<td>Thursday</td>
<td>12.00-1.00 PM</td>
<td>Grand Rounds</td>
<td></td>
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<tr>
<td></td>
<td>1.00-3.00 PM</td>
<td>Chart Completion in HIU</td>
<td></td>
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<tr>
<td>Friday</td>
<td>7.30-9.30 AM</td>
<td>Journal Club</td>
<td>Nominated Registrars</td>
</tr>
<tr>
<td></td>
<td>11.00-12.00 PM</td>
<td>Teaching Ward Round</td>
<td>Dr B Strekozov</td>
</tr>
<tr>
<td></td>
<td>12.00-1.00 PM</td>
<td>Junior Doctor Tutorial</td>
<td>Whole Hospital</td>
</tr>
</tbody>
</table>

Note Sponsored lunches in the Skills Centre: Tables are to be cleaned off and food removed to Ward 2A so it is neat and tidy as you found it. To have your education sessions catered for you is a privilege not a right and if you do not appreciate or respect this privilege then it will be removed.

The Unit teaching program (above) will consist of the following: Informal teaching would be conducted during ward rounds as well as during attendance in the operating theatres and clinics. The appropriate investigations and work up of patients coming for major surgery as well as the possible postoperative complications and their management would be discussed. The Residents and the Registrars are encouraged to discuss these management plans for individual patients in order to propagate this teaching activity.

The Interns/ Residents are also expected to attend the formal Hospital wide medical education sessions that are being held on Thursdays and Fridays as well as the radiology meeting.

A Consultant Teaching Ward Round would be held twice a week on Monday PM (NK) and Friday AM R Hendahewa (BS) for the residents by Dr Strekozov and Dr Khan.
THURSDAY LUNCHTIME MEETINGS

Thursday lunch time is the Grand Rounds Presentations. The Departments that are presenting and the topic for discussion for the day could be obtained in advance from the Medical Education Officer. The Surgery Department would be involved in rotation with the other Departments in the participation of these presentations. The time schedule for the Thursday lunchtime meetings is as follows:

- 11:45 – 12:00 noon: lunch would be available
- 12:00 noon – 12:10 pm: presentation by the pharmaceuticals rep
- 12:10 pm – 12:40 pm: clinical presentation
- 12:40 pm – 1:00 pm: question time

As it is a very tight time schedule, please ensure that you are able to complete all your mornings’ activities in order to be present at this meeting by 12:00 noon without fail.

COMPLICATIONS & MORBIDITY / MORTALITY AUDIT - QUALITY ASSURANCE ACTIVITIES

As part of the quality assurance activities, the 2 Monthly Complications Audits include:

* Surgical Morbidity / mortality
* Surgical Complications
* Unexpected Readmission’s
* DRG Overstays

These audits would be undertaken on a 2 monthly basis in the morning handover sessions. There are also TCPH audits every 2 months which have pre allocated registrars who are required to travel to TCPH on the selected dates to present the Caboolture data. These Dates for audit meetings will be given to you at the commencement of your term.

EMERGENCY DEPARTMENT

If you happen to be the surgical registrar who is on duty and you are involved in an operation list or any other activity from which you cannot disengage yourself, it is important for you to inform the Emergency Department to call the Emergency Department substitute registrar so that there is no delay in the surgical assessment of the patient concerned.

The registrar attending these patients should ensure that the date and the time that he attended to the patient in the Emergency Department is recorded without fail.

The consultant on call for the day should be informed as soon as possible about the further management of these patients at all times. Please familiarise yourself with the rules of engagement between Surgery and Emergency Department.

INTERNAL REFERRALS

From time to time there will be referrals on patients who are already in the hospital under the care of other Departments. The duty surgical registrar should see these patients and convey that information to the oncall consultant. The consultant is expected to see all acute referrals within 24 hours.
PRIVATE PATIENTS

The junior staff would be involved in the management of all private patients as well without exception in the same manner as they handle public patients. The Health Department indemnity covers them for these private patients as well.

BOOKING OF THEATRE PATIENTS

A booking form should be completed for all surgical operations – elective as well as emergency. All boxes of the form should be completed appropriately. For acute cases the form should be handed over to the OT Co-ordinator and timing of the procedure should be organised promptly after discussion with on call Anaesthetist and OT Co-ordinator.

Please do not forget to indicate the category. This should happen at the morning handover meeting.

ACUTE CASE HANOVER

With each emergency admission, please do not forget to peruse the previous admissions in order to ensure that the patient has not been under the care of another Consultant Surgeon working in this department. If such is the case, that patient should be handed over to that Consultant as soon as practicable after rendering the care that is needed.

PATIENTS WITH PREVIOUS ADMISSIONS

Patients who have been treated previously by a surgeon will remain under his care during subsequent admissions irrespective of the surgical condition requiring admission. However the “on call” firm would render all necessary treatment until the “handover” which normally occurs at 7.30 am the following day.

THEATRE CALL BACKS AFTER HOURS

Theatres call backs after hours should be done through the After Hours Clinical Nurse Co-ordinator. Theatre call backs should be done only when it is deemed appropriate. All emergencies should normally be done during working hours without compromising patient care. However, please note that “without compromising clinical care” is the operative word here. If the patient’s condition needs surgery after hours then that should be carried out forthwith.

The A/H Surgical procedures should be concluded by 9.00 pm as much as possible.

MDT MEETINGS

A combined video-conferenced MDT meeting is held fortnightly on a Wednesday at 12:00 noon in the Skills Centre Seminar Room 4 with Redcliffe Hospital Staff. All available members attend this meeting. All patients referred to this clinic should have a referral letter summarising the condition and the specific questions directed to the panel of Oncologist/Radiologist/Surgeon. The registrar as allocated on the timetable will coordinate this activity.
Oncology MDTM Process to minimise the risk to patients, improve efficiencies with the MDTM processes and to make sure Dr Grogan (option B Dr) can have a named referral the following process must be followed:

- all MDTM referrals are to be sent directly to the MDTM Care Coordinator at Redcliffe to Coordinate the meeting (x8113 or email: Tiffanie Fox at CabooltureGenSurgMDT@health.qld.gov.au)
- Tuesday before the meeting the MDTM Care Coordinator from Redcliffe will prepare the charts and leave them in Caboolture HIU
- The Caboolture Surgical Care Coordinator (x8035) will take the charts from HIU to the MDTM meeting and remain for the meeting, (LR4 Videoconference with Redcliffe Hospital).
- The Caboolture Surgical Care Coordinator will take receipt of all referrals (named by the Registrars at the meeting) and any review appointments requested at Caboolture SOPD.
- The Caboolture Surgical Care Coordinator will advise the dedicated Specialist Outpatient Department AO of the appointments required including the time frame requested
- The dedicated Specialist Outpatient Department AO will make appointments, summarise all of this in an email and send back to the MDTM Care Coordinator for final confirmation

Pauline Rolph, Nurse Unit Manager
Adult and Paediatric Specialist Outpatients Department
Caboolture Hospital Ph 54338974 Fax- 54338726

PATHOLOGY SLIPS

Please make sure that the consultants name is entered clearly on all pathology slips. This helps in accurate record keeping, treatment and follow-up of patients. Breast Pathology requests – please use the separate detailed form provided for this purpose.

LEAVE NOTIFICATION AND OVERTIME

FATIGUE LEAVE/PAY

If you have not had your ten (10) hour break during the preceding 24 hours then you would be entitled to fatigue leave or pay. It is the practice of the Department of Surgery to encourage fatigue leave rather than fatigue pay. Therefore, if you have not had a ten (10) hour break the oncall Registrar should inform the switchboard operator of this fact. The switchboard operator would then take steps to inform all the relevant members of the surgical firm. The Director of Surgery would make a determination as to whether the Registrar in question needs to be called back on fatigue pay or should be granted fatigue leave.
ANNUAL & PLANNED LEAVE/SWAP SHIFT/ ROSTER ADJUSTMENTS/ OTHER ADMINISTRATION MATTERS

Please discuss all such matters with Ms Stevie Langton, (CabH_SupportOfficerSurg@health.qld.gov.au) the Administration Support Officer of the Department of Surgery in the first instance to check availability.

SICK & EMERGENT LEAVE NOTIFICATIONS,

You must call and notify the Switch Board Operator (07 5433 8888) when you are calling in for Sick or Emergent Leave as early as possible, preferably prior to the 7 am start time. The Switch Board Officer then notifies the Unit Director, Oncall Staff and the team and emails the Unit Support Officer, the Ward Clerk and the Medical Workforce Unit. Please be proactive and consider your team, giving an approximate time you will be off sick or on emergent leave, in order to manage and document service coverage in your absence. Your cooperation is most appreciated.

OVERTIME REPORTING

This should be done on an AVAC (till further notice) and submitted to the Director of Surgery within 48 hours of occurrence.

CLINICAL PATHWAYS

Clinical pathways are in use at Caboolture. Please obtain the relevant clinical pathways manual (if unsure check with the Senior Registrar) and peruse it carefully. There are a number of advantages to both the patient as well as the health care providers as well as to Queensland Health that can be achieved through the use of clinical pathways.

Currently clinical pathways are in use for:

- Laparoscopic cholecystectomy
- Adult appendectomy and paediatric appendectomy
- Mastectomy / CLE +/- ANC

It is the duty of the registrars and the residents to ensure that the necessary documentation takes place on the appropriate clinical pathway forms for each patient. Please note that where a clinical pathways format is being followed there is no necessity for duplicate entries in the chart. These would be needed only if there are complications or any other appropriate reason. It is hoped that this would certainly reduce the duplication of work and would improve time management.
QUALITY ACTIVITIES

A number of quality activities take place in the Unit. The following is a list of these:

1. The chart audit on a Thursday afternoon.
2. The early follow-up clinic on a Wednesday morning and Friday afternoons.
3. The peer review segment on Friday mornings.
4. The Surgical audit that takes place 2 monthly.
5. The clinical indicators that are collected monthly and submitted to the Quality Facilitator every 6 months to be submitted to ACHS.
6. The Bimonthly Complications Audit (morbidity/mortality) occurs on Mondays at noon.
7. The Combined Hospital Audit that occurs every 2/12.

EXPECTATIONS FROM THE RMO’S WORKING IN THE UNIT

1. Punctuality
2. Diligence
3. Accurate record keeping
4. Adhering to instructions
5. Strive to conform to the above at all times.

PREADMISSION CLINIC

Residents for Noting:

➢ Residents will have a 5 week rotations within teams, 1 on the wards and 1 attending clinics and theatre sessions.

ENTRIES IN THE CHARTS

Please note that all entries in the charts should be dated and timed. After the completion of the entry, all entries should be signed and your initials clearly written below your signature so that the person making the entry could be identified without delay. Strict adherence to this instruction is an absolute must.

HAEMATEMESIS AND MELAENA PATIENTS FROM ED

These referrals should be made to the medical Registrar and not to the surgical Registrar. Bleeding per rectum would be the responsibility of the surgical Registrar.
METRO NORTH HEALTH SERVICE DISTRICT
WORK UNIT GUIDELINE -

C-WUG-CIS-ORM01

TITLE
Entering Information into Operation Detail Screens

DESCRIPTION
How to correctly fill in Operation Details & Other Details Screens

TARGET AUDIENCE
Theatre Staff / Surgeons

FACILITY/SERVICE
Caboolture Hospital

To adjust/correct the “Operation Detail” in the Patient Details Screen, click in the Operation Detail window. These are free text cells. Adjust/add to the Operation Detail, Other Details, Diagnosis or Post Op Comments Sections as required. This is a legal document/record of the patient’s surgical visit, NO abbreviations are allowed.

The Operation Detail section should ONLY CONTAIN the operation name/detail. All other information should be in the OTHER DETAILS section. Entering information into the correct screens will enable efficient reporting.

This example is correct:

This example is not correct:

### Version
C-WUG-CIS-00

### Review Responsibility
NM-CIS & ORMIS
SCOPE OF PRACTICE FOR INTERNS IN THE SURGICAL UNIT

It is expected that Interns commencing a rotation to the surgical units will have a basic understanding of the principles of surgery, consistent with the level attained at the completion of undergraduate teaching of the subject. All interns will receive instruction on commencement of work in their unit, and are expected to consolidate this teaching with their own reading.

Interns are responsible for the provision of safe, effective and equitable medical care of patients in the Surgical Units.

- Interns are responsible to the Director of Surgery, through surgical registrars and consultant staff;
- Interns should be familiar with the policies and procedures of the Surgical Unit, as set out in the Handbook and Guidelines for Interns, RMOs and Registrars;
- It is expected that Interns will participate in the care of both inpatients and outpatients, including performing ward rounds for inpatients, attending theatre and outpatient clinics and liaising with General Practitioners;
- It is expected that interns will be familiar with surgical history taking and examination;
- Interns should attend outpatient clinics to become proficient in the assessment of non-emergency problems of patients and their work up;
- Interns should review in-patients, admit routine patients and same day OT patients.
- Interns should perform preoperative work up of patients presenting to the pre-admission clinic;
- Interns should attend the emergency department to learn about the assessment of emergency patients presenting with surgical conditions;
- Interns should gain hands on experience and achieve proficiency in suturing and excision of minor lesions from the skin;
- Interns should attend operating theatres to become proficient in assisting at major surgical cases as well as the operation of video cameras for laparoscopic procedures;
- Interns should achieve efficiency in the insertion and management of various invasive tubes eg: naso-gastric tubes, IV cannulae & blood gases, indwelling urinary catheters, T-tubes, as well as intercostal drainage tubes;
- Interns should achieve proficiency and knowledge of postoperative surgical complications and their management;
- Interns should be aware of and use the clinical pathways that are relevant to the unit’s procedures;
- Interns should take part in the consent processes for procedures & appropriate detailed counselling of patients under the supervision of Registrars;
- Interns are responsible for the legible completion of all paperwork, including patient notes, charting medications, discharge planning and summaries, front sheet signing and coding;
• It is expected that handover at the end of each shift will always take place, highlighting issues such as patients needing particular attention, results to be followed up, and other outstanding issues;

• It is expected that Interns will communicate with patients in a caring and sensitive manner, and respect patients’ confidentiality at all times;

• Interns will participate in the Units’ Intern/JHO/SHO roster, including normal working hours (0700 – 1506), overtime, and ward call as rostered;

• A surgical teaching program is in place, and it is expected that Interns will endeavour to attend these sessions wherever rostering allows as well as Facility Education Programs;

• It is expected that Interns will be proactive in ensuring that both mid term assessment and the formal end of term assessments are completed by their Supervisor(s).

APPENDICES

Please find a number of appendices to this document which elaborates what has already been said. Please also refer to the original document (kept in the office of the Director of Surgery) for further attachments.

IN SUMMARY

Please also take time to refer to the schedule of the different surgeons and the different activities that are taking place during the week. I wish you a happy time in the Department of Surgery and hope that you will be able to gain both theoretical as well as practical experience during your time here.

If you have in problems please do not hesitate to talk to the Director of Surgery as soon as possible.

Note: In order to complete the term successfully, each resident must attend one clinic and one theatre session/week every week. A register would be maintained for this purpose.

DR BRIAN KIRKBY
DIRECTOR OF SURGERY
Orientation of New Registrars & Residents

1. No consultant name on the Audit Form
2. No Stamp on the entry
3. Patients for Royal Brisbane & Women's Hospital list should be no different – Ralph Dean coming on Friday. Book for ESRC & Advice
4. Adequate length of medical certificate, 2/52 for “routine ileostomy”
5. Work being left behind for after hours ward call to do & incorrect discharge summaries
6. Scope booking forms. I will audit these. Will be referred to the consultant if the information is inadequate.
   a. Plan
      i. IBS?
      ii. Haemorrhoids?
      iii. Anaemia?
7. Criteria lead discharge
8. Suture removal & ESRC Clinic Appointment to be scheduled after 2/52.
9. Surgical Unit Complications Audit
   a. Complete EDSs
   b. Check the Front Red Sheet and make sure all relevant information including complications are written down
   c. Ensure the correct surgeon is listed – if under a surgeon previously
   d. CLO Test
   e. Sign off Pathology
   f. Change / take action on any actual follow up plan.
   g. Letter to GPs if deemed path necessary.

INTERN LEARNING OBJECTIVES

By the completion of this term Interns may expect to acquire the following knowledge:

- Understanding of peri-operative fluid and electrolyte management
- A critical approach to investigations and their results
- Understanding of wound management
- Insight into acute surgical conditions and their management, and exposure to complex Hepatobiliary, pancreatic and upper GI surgical cases.
- Attention to continuity of care after discharge from hospital including discharge summaries, front-sheet information, discharge medications and instruction
- Knowledge of Allied Health services including Physiotherapy, Social Work, Community Nursing, Rehabilitation, Nursing Homes etc.
• Management of their time and prioritisation of their work
• A personal sense of responsibility to both colleagues and patient care.
• Teamwork skills, including interpersonal skills, with patients, relatives, nurses, supervisors, and colleagues.

During this rotation, the listed skills and conditions below are likely to be seen or be available to perform. Interns will however need to actively seek out opportunities to complete some of them, eg: provide appropriate sedation and/or premedication.

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.

**Common Conditions Interns/RMOs can expect to be exposed to:**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Seen</th>
<th>Managed under Registrar Supervision</th>
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<tbody>
<tr>
<td><strong>Abdominal Pain</strong> (appendicitis, bowel obstruction, diverticulitis, cholecystitis, pancreatitis)</td>
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<td><strong>Multiple Trauma</strong></td>
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<td><strong>Gastrointestinal bleeding</strong></td>
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<tr>
<td><strong>Neoplasia</strong> (liver, pancreas, stomach, oesophagus, colon)</td>
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<td><strong>Post-operative care</strong></td>
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<tr>
<td>• Post-operative pyrexia</td>
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<tr>
<td>• Post-operative confusion</td>
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<tr>
<td>• Post-operative oliguria</td>
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</tbody>
</table>


Clinical Skills and Procedures

The following skills and procedures are to be observed and/or performed under Registrar Supervision

<table>
<thead>
<tr>
<th>SKILL/PROCEDURE</th>
<th>OBSERVED</th>
<th>PERFORMED</th>
<th>SIGNED</th>
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<tbody>
<tr>
<td><strong>SURGICAL</strong></td>
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<tr>
<td>Scrub gown and glove</td>
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<tr>
<td>Sterile dressing of wounds</td>
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<tr>
<td>Assisting in the operating theatre</td>
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<tr>
<td>Surgical knots and simple wound suturing</td>
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<tr>
<td>Local anaesthesia</td>
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<tr>
<td>Simple skin lesion excision</td>
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<tr>
<td>Suture removal</td>
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<tr>
<td>Complex wound suturing(ADV)</td>
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<tr>
<td>Arterial Blood Gases</td>
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<td>12 lead ECG</td>
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<tr>
<td><strong>Urogenital</strong></td>
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<tr>
<td>Bladder Catheterisation</td>
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<td>Urine dipstick testing</td>
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<td><strong>Trauma</strong></td>
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<td>Primary Trauma Survey</td>
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<td>Secondary Trauma Survey</td>
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<td>Tertiary Trauma Survey</td>
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<tr>
<td>Principles of EMST</td>
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<td><strong>General</strong></td>
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<tr>
<td>Blood pressure measurement</td>
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<td>Pulse oximetry reading</td>
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<td>Core temperature measurement</td>
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<td>Blood sugar estimation</td>
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<td>Venepuncture</td>
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<td>Intravenous cannulation</td>
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<td>Intravenous infusion set-up</td>
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<tr>
<td>Intravenous fluid &amp; electrolyte therapy</td>
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<tr>
<td>Anticoagulant prescription/monitoring</td>
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<tr>
<td>Antibiotic prescription/monitoring</td>
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<tr>
<td>Insulin prescription/monitoring</td>
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<tr>
<td>Intramuscular injections</td>
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<tr>
<td>Subcutaneous injections</td>
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**Scope of Practice: What the Intern is not able to do**

1. Perform any skill or procedure outside of the above scope of practice
2. Initiate patient treatment/management or changes to patient treatment /management 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)
3. Obtain consent from the patient or relatives for surgical operations/procedures (but Interns can only obtain consent in the presence of the Registrar /Consultant and patient after the procedure has been clearly explained to the patient.) Interns must not obtain consent independently
4. Discharge patients without consulting and reviewing the case details with Registrar/Consultant.
5. Break bad news to the patient or relatives (but the Intern will observe and learn about performing this task from the Registrar/Consultant)
6. Death Certificates
INTERN EDUCATION TUTORIALS

ONE TOPIC EVERY WEEK THURSDAY 1:00-1:30

INTERN AND REGISTRAR TO ORGANISE TIME

TOPICS TO BE COVERED BY REGISTRARS WITH THE INTERNS

1. Communications
2. Fluid balance
3. Antibiotic policy – surgical patients
4. Post-op complication
   - Urinary retention
   - Pyrexia
   - Abdominal distension
   - Low urinary output
5. Management of drains and tubes
6. Post-Thyroidectomy complications
7. Assessment and management of trauma patient
8. Pre-op work-up for major surgical operations
   - Procedure for frozen sections
   - Hookwires
   - Scintiscans for sentinel nodes
9. Haematemesis and melaena – initial management
10. Head injury management
11. Intestinal obstruction
12. Wound Products / Wounds and their management
13. Deep venous thrombosis and thromboprophylaxis
14. Analysis of abdominal pain
15. Acute pancreatitis – management and complications
16. Peptic ulcer disease
17. Gastroesophageal reflux disease
18. Carcinoma of the large bowel
19. External herniae and complications
FACILITY POLICY ON SUPERVISION OF CLINICAL EXPERIENCE FOR JUNIOR DOCTORS

1. INTRODUCTION
Supervision of clinical experience allows junior doctors to learn in safety as they progress towards independent practice.

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

3. LEVELS OF SUPERVISION
There are three such levels, viz.:

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 (ie 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
5.1.1.1 Orientation
5.1.1.2 Mid term assessment
5.1.1.3 End of term
5.1.1.4 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 (ie 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 received 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.

Handover of Patients – ISOBAR

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

**Note:** Standing Item in Surgical Unit Meeting on Monday mornings at 7.00 am the registrars' Peer Review Data must include the Handover Information and Consultations:
❖ Total Number of Consults (to include all consults)
❖ Number seen by the Consultant within 24 hours
❖ This number is then sent to the Director of Medical Services.
RMO END OF TERM HANDOVER 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.
  o (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.
  o 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:
  o Ward Routine/Rounds, Clinics, Meetings, Training, Consultant/Registrar Expectations, Complex patients, Casemix, Discharge Summaries

Reminders:

CURRENT UNIT

☐ 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

**LIST OF CLINICAL INDICATORS THAT ARE BEING CURRENTLY CREDITED BY THE SURGICAL UNIT**

1. **ALL SKIN MALIGNANCIES**
   
   The denominator for this indicator is the number of skin malignancies excised. The numerator is the number of skin lesions excised where the margin of excision is incomplete.

2. **LAPAROSCOPIC CHOLECYSTECTOMY**
   
   The denominator is the number of laparoscopic cholecystectomies performed. The numerator is the number of common bile duct injuries.

3. **THE NUMBER OF COLON CANCERS REMOVED**
   
   The denominator being the total number of colon cancers removed. The numerator is the number of anastomotic leakage.

4. **NUMBER OF RECTAL MALIGNANCIES REMOVED**
   
   The denominator is the total number of rectal malignancies removed. The numerator is the number sustaining an anastomotic leak.

5. **HISTOLOGICAL PROOF OF ACUTE APPENDICITIS IN CHILDREN 17 YEARS AND UNDER UNDERGOING APPENDECTOMY.**
   
   The denominator is the total number of appendectomies done in children 17 years and under. Two numerators should be collected. The first numerator is the number of histologically positive cases. The second numerator, where histology is negative, is the presence of any other significant intra-abdominal pathology.

**LIST OF COMPLICATIONS FOR COLONOSCOPY**

<table>
<thead>
<tr>
<th>➢ Perforation</th>
<th>➢ Missed Lesions</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Haemorrhage</td>
<td></td>
</tr>
</tbody>
</table>

This is the standard list of complications that patient's should be counselled about.

**LIST OF COMPLICATIONS FOR INGUINAL HERNIA**

<table>
<thead>
<tr>
<th>➢ Infection</th>
<th>➢ Recurrence</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Haemorrhage</td>
<td></td>
</tr>
<tr>
<td>➢ Mesh Rejection</td>
<td>➢ Testicular Atrophy</td>
</tr>
<tr>
<td>➢ Postoperative Neuralgia</td>
<td>➢ Damage to Internal Organs</td>
</tr>
</tbody>
</table>
This is the standard list of complications that patient’s should be counselled about.

**LIST OF COMPLICATIONS FOR LAPAROSCOPIC, CHOLECYSTECTOMY & IOC**

<table>
<thead>
<tr>
<th>➢ Infection</th>
<th>➢ Incisional Hernia</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Haemorrhage</td>
<td>➢ Failure to Relieve Symptoms</td>
</tr>
<tr>
<td>➢ Anaesthetic Difficulties</td>
<td>➢ Staple Migration</td>
</tr>
<tr>
<td>➢ Unsightly Scarring</td>
<td>➢ Spillage of Stones</td>
</tr>
<tr>
<td>➢ Inadvertent Damage to Other Organs including bowel</td>
<td>➢ PE &amp; DVT</td>
</tr>
<tr>
<td>➢ Damage to Common Bile Duct</td>
<td>➢ Bilioma</td>
</tr>
<tr>
<td>➢ Conversion to an Open Procedure</td>
<td>➢ Necessity for ERCP</td>
</tr>
</tbody>
</table>

This is the standard list of complications that patient’s should be counselled about.

**LIST OF COMPLICATIONS FOR OGD**

| ➢ Haemorrhage                  | ➢ Perforation                    |
| ➢ Missed Lesions               |                                  |

This is the standard list of complications that patient’s should be counselled about.
SURGICAL UNIT DOCUMENTATION

COMPLICATIONS WHICH MAY AFFECT DRG ASSIGNMENT AND IMPACT ON THE UNIT’S FUNDING

(These must be recorded on the front Red Sheet)

- ACCIDENTAL PUNCTURE/LACERATION DURING PROCEDURE
- ADHESIONS (also document if adhesions were divided during procedure)
- ALCOHOLISM (but not non-dependent alcohol abuse/intox)
- ANAEMIA (inc. acute post haemorrhagic, chronic blood loss or aplastic anaemia) NB unspecified anaemia will not affect DRG assignment)
- ANGINA ATTACK
- ASPIRATION PNEUMONIA
- ATELECTASIS/PULMONARY COLLAPSE
- ATRIAL FIBRILLATION
- BOWEL OBSTRUCTION
- CARDIAC FAILURE
- COAD
- COMMON BILE DUCT EXPLORATION
- DEHYDRATION
- DIABETES (IDDM & uncontrolled NIDDM)
- DRUG DEPENDENCE (but not non-dependent drug abuse)
- EPILEPSY (grand mal – other forms of epilepsy will not affect DRG assignment)
- GASTROINTESTINAL HAEMORRHAGE

- HAEMATEMESIS / MELENA
- HEART VALVE DISORDERS (stenosis, insufficiency, regurgitation etc)
- HAEMATURIA
- ILEUS
- PERITONITIS
- PLEURAL EFFUSION
- PNEUMONIA & ASPIRATION PNEUMONIA
- POST OP HAEMORRHAGE OR HAEMATOMA
- POST OP WOUND INFECTION OR DISRUPTION
- RENAL FAILURE (acute or chronic)
- SEPTICAEMIA
- SHOCK
- SKIN ULCERS
- URINARY RETENTION
- URETHRITIS / CYSTITIS / PYELONEPHRITIS
- VOLVULUS
**Excellent**
- No solid stool
- Minimal amounts of clear fluid that requires suctioning
- Visualisation is clear

**Good**
- Minimal solid stool
- Large amounts of clear fluid that requires suctioning
- Visualisation is clear

**Fair**
- Collections of semisolid debris that are cleared with difficulty
- Visualisation is difficult

**Poor**
- Solid or semisolid debris that cannot be cleared effectively
- Visualisation is not adequate
MEMORANDUM

DATE: 29 November 2001 / Updated May 2008

TO: Dr P Scarlett
Dr C Lusink
Dr B Strekovich
Dr D Mehanna
Surgical Registrars and Residents

FROM: Dr WG Premaratne, Director of Surgery

RE: BOOKING OF ELECTIVE SURGERY PATIENTS

Patients who need investigations as part of the pre-operative work-up would need to have the required request form filled in at the time of their clinic attendance. These forms should be attached to the bookings forms in category 2 patients and given to the patient in category 1 patients so that at the time the bookings person sends for the patient he/she could take steps to have the bloods done as well. Having it done prior to their presentation at the pre-admissions clinic would lead to a more efficient, more patient focused and clinically appropriate way of completing the pre-operative work-up.

Your co-operation in this context would be greatly appreciated.

DR W G PREMARATNE MS, FRCS (Eng) FRACS

MEMORANDUM

DATE: 10 July 2003 / Updated May 2008

TO: Surgical Registrars

FROM: Dr WG Premaratne, Director of Surgery

RE: PATIENT TRANSFERS INTO AND OUT OF THE DISTRICT

Please note that all transfers of patients into and out of the Caboolture Hospital should be authorised by the Medical Superintendent.

DR GAMINI PREMARATNE MS, FRCS (Eng) FRACS
DIRECTOR OF SURGERY
Ensuring Intended Surgery

Description: Specific steps that must be taken to ensure that the indicated surgical procedure is performed on the correct patient, at the correct site, and if applicable with the intended implant.

Target Audience: All surgical staff including VMO’s

Queensland Health Policy - Ensuring Intended Surgery Policy No 26961

POLICY SUPPORTED:

The sentinel events of wrong site surgery, wrong surgery, and surgery on a wrong patient, are preventable. It is the aim of Queensland Health to ensure a uniform protocol in all Queensland Hospitals so as to minimise the occurrence of such events.

EVIDENCE TO SUPPORT THE SYSTEM SOLUTION

Analysis of multiple Root Cause Analyses from the Veterans Health Administration (2004) led to the identification of 5 specific vulnerabilities which led to wrong surgery. A process was developed and piloted that addressed these common system failures. These were:

Step 1. Including the site of the procedure, name of the procedure and the reason for the procedure in Step 1: Informed Consent Check (this would have prevented 45% of the number of wrong-site surgery incidents)

Step 2. Having the surgeon and patient collaboratively carry out Step 2: Mark the Site, (this would have prevented 65% of wrong site incidents)

Step 3. Asking the patient to state his/her details instead of confirming at Step 3: Identify Patient on admission to Operating Suite (this would have prevented 75% of wrong site incidents)

Step 4. Taking time out in the Operating Room to do Step 4: Final Check, when members of the team check the patient’s details and type of surgery (this would have prevented 85% of wrong site incidents) and having two members of the team check images for surgery (this would have prevented 20% of wrong site incidents).

ENSURING INTENDED SURGERY REQUIRES A 4 STEP PROCESS (see poster). The steps are:
Step 1. Informed Consent Check
Step 2. Mark the Site
Step 3. Identify Patient on admission to Operating Suite
Step 4. Final Check

Step 1. “INFORMED CONSENT”
Treating Medical Officers (TMO) are responsible for this step and their responsibilities are clearly stated in the Informed Consent for Invasive Procedures Policy No. 14025 (http://www.health.qld.gov.au/informedconsent).
The “Informed Consent” process commences when the patient attends clinics for consultation.

**Responsibilities include**

- Providing the patient or the patient’s substitute decision maker about the necessary information so that the patient is adequately informed about his/her surgery.
- Clearly stating on the Informed Consent the patient’s full name, surgery to be performed, site and side of surgery. The side of the operation must be written in full, for example LEFT must not be abbreviated to “L.”
- Letting the patient know that the checking process for the Operating Rooms involves marking on his/her operative body part with the surgeon’s initials.
- Obtaining consent from the patient or the patient’s substitute decision maker in accordance with the principles set out in the Informed Consent for Invasive Procedures Policy.

**Rationale:** This is to ensure that the patient understands where the surgeon intends to operate, as well as what procedure is to be performed and why. To improve safety, it gives the patient or their representative the opportunity to identify a mistake at a time that is removed from when the surgery is imminent when there may be many distractions that prevent attention to what is on the consent form.

NB: If the patient refuses to have the site marked it will be documented by the TMO in the client record and on the consent for invasive procedure.

**Step 2. “MARK THE SITE”**

The TMO who is performing the surgery or another medical officer who is a member of the surgical team assigned to be present in the Operating Room during the procedure is responsible for this step. It is highly preferable to carry out marking prior to the patient entering the Operating Room and before induction of anaesthesia. Therefore marking should be attended to before Step 3 “Identify Patient on admission to Operating Suite,” but must be attended to before Step 4 “Final Check.”

NB: Step 2 will be carried out in the Perioperative Centre, Holding Bay or Anaesthetic Room prior to entering Theatre at both Caboolture and Redcliffe Hospital with Step 1 and 3 being reinforced.

**RESPONSIBILITIES INCLUDE:-**

- Consulting with the patient or the patient’s substitute decision maker as well as verifying with the signed Consent Form, the correct site and side of surgery.
- **Signing unambiguously with his or her initials within the operative field.** For example, it is not appropriate to mark the right hand when in fact the index finger of the right hand is being operated on. In cases involving multiple skin lesions, then the surgeon’s initials will be written with a numeric superscript in chronological order of importance for surgery.
- Using the recommended tool for marking the operative site(s) that is an indelible Artline 750 pen.
- Not marking non-operative sites.
- Halting the proposed surgery if there is a discrepancy in this part of the checking process until the discrepancy can be resolved to the satisfaction of the TMO and the patient.

If the anaesthetist is performing the first invasive procedure such as a local anaesthetic block, it is their responsibility to ensure that Step 2 has been done.

**EXCEPTIONS**

- In the case of upper and lower gastro-intestinal endoscopy procedures no marking is required.
- In the case of teeth extractions and other dental surgery no marking is required (a diagram is the ideal way of demonstrating the site and side of surgery in these cases).
- In the case of severe burns with multiple skin grafting, and some Ear Nose and Throat surgery, such as a tonsillectomy, no marking is required.
- In the case of a spinal surgery, the operative field will be marked as stated above, but the exact level of surgery will be established intraoperatively using imaging.
• In the case of premature infants with delicate skin, marking will not be used to mark the operative site(s) as it may cause permanent tattooing (NSW Department of Health, 2004).
• If a patient refuses to have his/her operative site(s) marked, then exact circumstances relating to the refusal must be documented on the Operation Report and signed by the TMO.

WHERE THE URGENCY OF SURGERY PRECLUDES MARKING:

**Rationale:** Marking the site makes clear where the surgery is to be performed. Having the surgeon or another designated medical officer of the surgical team mark the site will help ensure that the mark is put at the correct site. Although patients need to corroborate the site as the surgeon marks it, patients are not to mark the site. Marking of non-operative sites may cause confusion and have the opposite of the intended effect. For example, “X” may signify “operate here” to one person and “don’t operate here” to another. In the VHA series, over 50% of wrong surgeries were due to a ‘wrong patient’ error. The inclusion of making mid-line procedures and the use of initials rather than arrows may reduce the risk of wrong patient error.

**Step 3. “Identify Patient on admission to Operating Suite”**
The nurse admitting the patient to the Operating Suite is responsible for this step.

**NB: Step3 and Step 1 will be reinforced at Preadmission Clinic, at Day of Surgery Ward, in the Anaesthetic Room and Holding Bay.**

**Responsibilities include**
• Asking the patient to state (not confirm) their full name, date of birth, the procedure s/he is having, and the site/side of the procedure.
• Signing and dating that the Ensuring Intended Surgery protocol, which is illustrated in Attachment 2, has been completed on Surgical Check Sheet.

**Exceptions**
• If the patient is unable to state his/her name, date of birth and procedure then an appropriate substitute decision maker must be present to state the details and this must be documented in the notes.

**Rationale:** Asking the patient to state rather than confirm his/her name helps prevent miscommunication and wrong-patient procedures. Patients who are hard-of-hearing or distracted by illness or other temporary or permanent disability may say “yes” to a name that is not theirs, but it is very unlikely that they will misstate their name and birth date when asked.

**Step 4. “Final Check”**
The TMO is responsible for this step. Ideally it is best to carry out this step when the patient is awake. However, if this is not possible then the step can be performed post induction of anaesthesia but before prepping and draping. If the anaesthetist is performing the first invasive procedure such as a local anaesthetic block, it is their responsibility to ensure that Step 2 has been done.

**Responsibilities in the Final Check include**
• Ceasing all non-critical activities in the Operating Room and summoning the attention of all staff in the Operating Room.
**NB: Step 4 will commence in the Operating Theatre**
• Simultaneously checking with the anaesthetist and circulating nurse or instrument nurse, to verify the patient’s:-
  - Correct name and date of birth or URN.
  - Surgical procedure(s).
  - Correct marking of surgical site(s).
  - Prosthesis is available, if required.
Imaging data, if required, are correct and properly labelled.

• Having the surgeon sign contemporaneously that the step has been completed on the Surgical Check Sheet as in Table 1, or through some other official Queensland Health documentation.
• In case of extreme emergency the Final Check may be omitted, which would be documented accordingly.

**Alert**

If there is a discrepancy with any details regarding patient identity, correct invasive procedure etc The Senior Consultant must make the final decision. If the Senior Consultant is not present then staff involved in the procedure must escalate the issue. The procedure must be stopped until discrepancy is resolved.

**Rationale:** Verifying the information just prior to commencing surgery, by an assemblage of persons from the surgical team, helps prevent wrong-site surgery. Having members of the surgical team overtly clarify the details demonstrates a clear understanding of the surgery to be performed. Undertaking the check as close to surgery as possible prevents situations occurring that could influence wrong-site surgery. Errors in determining the appropriate site due to lack of availability or improper labelling of images is a real vulnerability and methods to mitigate this vulnerability need to be in place.

**Issues Related to ensuring Intended Surgery**

Failure to comply with Ensuring Intended Surgery policy without good reason, increase the risk of wrong surgery and may lead to disciplinary actions.

• Wilfully neglecting to carry out the protocol may lead to an employee’s indemnity being jeopardised, according to the Industrial Relations Policies 3.8-4


• If wrong-site surgery does occur then procedures stated in the Incident Management Policy No. 23360

[http://qheps.health.qld.gov.au/hssb/risk/im/home.htm](http://qheps.health.qld.gov.au/hssb/risk/im/home.htm) must be followed. That is, necessary action should be undertaken to minimise the effect of the wrong surgery and ensure that the patient obtains the necessary surgery. The incident is then reported as a sentinel event and a Root Cause Analysis (RCA) is commissioned by the District Manager within 7 working days. A RCA should be conducted in all cases to determine causality.

• Even though this policy specifically relates to invasive surgery, the protocols herein are applicable to other procedures including chemotherapy and radiotherapy.
Ensuring Correct Surgery Process

Step 1 Consent
- Specialist Outpatients Department Medical Officer
  - Completion of Informed Consent for Surgery

Step 2 Mark Site
- Preadmission Clinic Reinforce Step 1 and 3 Nurse
  - Consent checked for completion, content & comprehension

Step 3 Patient ID
- Perioperative Centre or Admission Ward Reinforce Step 1 and 3 Nurse/TMO
  - Consent checked for completion, content & comprehension
- Treating Medical Officer (TMO) commences prior to anaesthesia in POC, Holding Bay or Anaesthetic Bay
  - TMO Marks the site with indelible pen
- Patient Identification is checked on admission & in Holding Bay or Anaesthetic Room
  - Completion of Perioperative Checklist
- Final Check in Operating Theatre
  - Entire Team stops and participates
NB The patients Identification is checked at a number of stages

Performance Indicators: Annual Chart audit of 100 charts to evaluate the implementation of the procedure, to be Driven by the Director of Surgery

Review Date: Annually verified for currency or as changes occur, and reviewed every 3 years via the Document Development Checklist and process.

Developed By: Clinical Service Coordinator
Nurse Unit Managers Operating Theatres across the District

Medical Imaging Department

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

Medical Imaging Office (Phone 8692)
0800 – 1700 Monday – Friday

General Radiography (Phone 8694)
0800 -1700 Monday - Friday for routine examinations.
1700 - 2245 Monday – Friday Urgent examinations.
0800 – 2245 Weekends and Public Holidays for urgent examinations.
On call 2245 – 0800 for urgent cases as per after hours protocols.

Please be mindful that after 1630 Monday- Friday and at any time on weekends and public holidays there are a maximum of 2 Radiographers covering the whole hospital at any one time. At times there will only be 1 Radiographer covering the entire campus. There are no shifts allocated for Procedures, Theatre, CT or Ultrasound out of routine hours. This work is co-ordinated by the duty Radiographer (8694).

Radiologist’s Hours
In general 2 Radiologists are rostered to the department between 0800 – 1800 Monday – Friday. There is an education session every Tuesday at 0800 – 0900 on the 3rd floor. (Except Tuesdays following a public holiday). The Radiologists encourage teaching of Medical staff and are freely available for consultation but good manners should prevail. See after hours protocol’s for on call arrangements for urgent CT examinations.

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

CT (Phone x-ray office 8692 for routine cases)
0900-1600 Monday - Friday for routine cases. An appointment system operates. For urgent cases during routine hours liaise directly with staff in CT (8694). For urgent cases out of hours contact the duty Radiographer (8694) to arrange these cases. Routine cases are reported by the Radiologist on duty on a daily basis. Out of hours CT cases are reported via an internet based system and reports are faxed back to either the Medical Imaging Department or to the ED Department.

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

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

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

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

Routine hours 0900 - 1630 Monday – Friday. An appointment system operates. **Please liaise directly with the Sonographers regarding urgent cases.** Patients seen after hours who require an ultrasound done the next working please ask the patient to phone the department on 54983055 & ask for an appointment. (Please put the request in the Medical Imaging tray in ED.)

On Call roster operates outside of these hours. Please see after hours protocols for applicable call in criteria.

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

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

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

No after hours or on call service available.

**On Call**

Call in staff are located by calling switch and asking for the appropriate staff.

Please familiarise yourself with the after hours protocols before calling Medical Imaging staff.

**Electronic Image and Reports look up.**

At present there is no availability to view images electronically anywhere in the Hospital apart from in Medical Imaging. Reports can be viewed by accessing the RIPS system which is available when logged on to Hospital PC's.

**Request forms**

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

Separate referrals are required for each individual modality.

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

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

**Questions/Concerns**

In the first instance please direct any concerns or questions to the duty Radiographer / Sonographer. Any concerns that the Imaging staff are not able to assist with please speak to the Site Manager, Mr David Holmes. The Radiologist in charge of the Department is Dr Richard Lamprecht. The X-ray Office Manager is Ms Rebecca Graham.

**Disaster Plan**

In the event of a Disaster additional Medical Imaging staff can be located by the phone list available at switch.
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 Names** = Initial and surname, eg. 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”
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.
<table>
<thead>
<tr>
<th>Function</th>
<th>Key</th>
<th>Tool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open a new window</td>
<td>Ctrl+N</td>
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<tr>
<td>Exit the application</td>
<td>Ctrl+Q</td>
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**3D and Measurement Tools**

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<td>Calibrate Measurements</td>
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Preserving evidence when a “reportable death” occurs in a health care setting

**Purpose of the guidelines**

These guidelines are intended to help health care staff and first response police officers decide what steps need to be taken to preserve evidence when a death has occurred in a hospital or other medical facility. Staff and police should consider the factors listed below. If in doubt about any aspect, health care staff or police should consult with a coroner or forensic pathologist.

**In principle**

When deciding what interference with a death scene in a medical setting should occur and what instruments, equipment and specimens should be seized, those managing the facility and the investigators must try to balance three competing priorities:

- the forensic needs of the investigation,
- the need for the hospital or medical facility to continue to treat other patients, and
- the sensitivities of the family and their need to have contact with the deceased in the least distressing condition.

The greater the likelihood that a crime has occurred or seriously deficient practice has contributed to the death, the greater the emphasis that must be given to the interests of the investigation. In these rare cases in which criminal or civil proceedings are likely, continuity of the chain of possession and strict proof of events leading to the death can justify an operating theatre or hospital ward being treated as a crime scene.

In most other cases, the needs of the facility to have free access to operating theatres etc should be given priority. In most cases, the cause of death and the factors that contributed to it can be established from witness statements, medical records and notes, instrument settings etc making the isolation of the scene unnecessary. In all cases, the needs of the family to have contact with the deceased should be considered and the desirability of cleaning the body to make such viewing less traumatic should only be over ridden if the need to preserve evidence justifies it.

**In practice**

**Preserving the scenes of death**

Scenes of homicides, etc resulting from an incident within a health care facility

a) Scenes of death that involve, or may involve, homicides, suspicious deaths, suicides or accidents resulting from an incident within the facility itself should be preserved for

¹These guidelines are only meant to apply to deaths covered by the Coroners Act 2003 s8(3)(d) “the death was not reasonably expected to be the outcome of a health care procedure.” Violent or suspicious deaths that just happen to occur in a hospital should be treated in the same way as any other violent or suspicious death. Guidelines concerning the preservation of evidence for deaths in a medical setting Version 1 examination by police, in exactly the same way as if the death had occurred in the general community.

Careful scene preservation is in the best interest of the health facility. For example, thorough and independent scene examination in a suicide may deflect unjustified criticism from a psychiatric unit. As in the community, if the patient has been removed elsewhere for treatment and dies, or is likely to die, the scene of the incident (not the scene of death) should be preserved for examination.

b) Scenes of “medical adverse events”
Deaths from “medical adverse events” are rarely of sufficient complexity to warrant preservation of the scene for examination by police or other experts. The key question is whether examination of an intact scene might help understand what happened.

In most reportable deaths that occur in health care settings, scene preservation is unnecessary and undesirable because of disruption to the health care facility. For example, operating theatres in which deaths have occurred generally do not require preservation for inspection by police.

However, medical equipment at (or from) the scene must be preserved for independent examination if this may help understand the cause or circumstances of a reportable death. Medical equipment still attached to the body raises special issues and is considered next.

Preserving medical equipment attached to the body

This includes items entering the body (e.g. cannulae, lines, ET and NG tubes, catheters drains) and devices attached to these (e.g. drip bags, syringes, drain bottles and bags, urine bags).

The general rule is that medical equipment attached to the body must remain in place for the pathologist to examine as part of the autopsy whenever a deceased has been undergoing medical treatment at the time of death, regardless of the health care setting.

The reason is that, even though such items are often irrelevant to the investigation, it is difficult to predict which will be needed and in which cases. Generally, it is just as easy for items to be described, removed, examined where necessary, and discarded in the mortuary as elsewhere.

Exceptions can be made to the general rule – if removal is documented in the medical records (a sketch is useful), or in a report to the coroner and pathologist; AND if justified by the following:

- To attempt resuscitation or other medical treatment –this is always an over-riding priority
- To make the body safe to handle (e.g. removal of a needle)

Guidelines concerning the preservation of evidence for deaths in a medical setting Version 1 3

- To meet the request of a family member wishing to view the deceased before autopsy without unsightly equipment such as an NG tube or airway, unless a problem such as incorrect positioning may have contributed to death in which case the tube should be left in place

The following questions should be considered before removing equipment, ideally in consultation with an independent professional (e.g. senior nurse, anaesthetist or forensic pathologist):

- Could the item itself have caused or contributed to death (e.g. ET tube in the oesophagus, infusion pump delivering medication incorrectly)?
- What are the alternatives to complete removal (e.g. defer viewing until after autopsy when the deceased may be more presentable anyway; or cut an NG or ET tube just inside the body leaving the tip in situ)?
- Could independent examination of the equipment, either in situ or after removal, assist the investigation (e.g. to document the settings, or check for faults)?
Preservation of other evidence in a health care setting

a) Preserving clothing and jewellery
Examination of clothing (and sometimes jewellery) can assist the pathologist and police reconstruct events (e.g. by inspecting knife or bullet holes). Clothing removed to allow resuscitation should be placed in a bag accompanying the body to the mortuary. Jewellery (and other valuables) removed in the health care facility should be documented and returned to the family in accordance with the facility’s own procedures. However, in homicides, suspicious deaths and deaths in custody, items still on the body at the time of death should be left in situ for examination in the mortuary.

b) Preserving other non-medical items attached to the body
Items such as a noose used for self-inflicted hanging and a knife still protruding from the body should be preserved in situ wherever possible. If removed to allow medical treatment or for safety reasons, the items should be documented in the medical records and preserved separately for the police and pathologist to examine (e.g. in a bag accompanying the body).

c) Preserving trace evidence, blood stains, etc on the body
Generally, vital resuscitation attempts irretrievably contaminate any trace evidence on the body, especially on the face. Cleaning the face to allow viewing by the family is therefore usually permissible. In alleged sexual assaults, however, the genital area should not be disturbed prior to forensic examination. Consult a forensic pathologist if in doubt.

d) Preserving injuries
Although medical treatment is always a priority, injuries possibly due to an assault should ideally be preserved intact for the pathologist to examine. For example, examination of

Guidelines concerning the preservation of evidence for deaths in a medical setting Version 1

penetrating injuries (e.g. knife and firearm wounds) is critical to the reconstruction of events, and surgical incisions should avoid such wounds where possible.

e) Preserving pathology samples to assist the coroner’s investigation
Some pathology samples may need to be preserved for transfer to the forensic pathologist, toxicologist or other expert for separate examination. Examples include blood (or other samples) taken at the time of hospital admission as these may offer the best evidence of intoxication with alcohol, drugs or poisons at the time of an incident; and anatomical pathology specimens relevant to the autopsy, such as an excised bullet wound, traumatically ruptured spleen, or placenta in a perinatal death. Admission samples should never be disposed of in cases where there is any real likelihood that the patient may die.

f) Take blood samples when adverse reaction to anaesthetics or drugs may be involved
Deaths that may be due to an anaphylactic reaction or other form of hypersensitivity to a drug, anaesthetics or any other agent are reportable. In such cases, blood should be taken from the body for testing within 4 hrs of death for tryptase and any other testing that may shed light on the cause of death. Police should therefore immediately contact the local coroner (and if that can’t be done the state coroner) to obtain consent for this to happen. The blood should then be stored in clean glass vials and refrigerated immediately. The form 1 should note the location of these samples.

Michael Barnes, State Coroner, January 2007

Guidelines concerning the preservation of evidence for deaths in a medical setting Version 1
Background

One of the major causes of medication errors is the ongoing use of potentially dangerous abbreviations and dose expressions.¹

In November 2008, The Australian Commission on Safety and Quality in Healthcare (ACSQHC) released the document “National terminology, abbreviations and symbols to be used in the prescribing and administration of medicines in Australian hospitals.” The objectives of the ACSQHC document are to establish:
- Principles for consistent prescribing terminology;
- A set of recommended terms and acceptable abbreviations; and
- A list of error-prone abbreviations, symbols and dose designations that have a history of causing error and must be avoided.

Issues

- The “National terminology, abbreviations and symbols to be used in the prescribing and administration of medicines in Australian hospitals” document supersedes any other guidelines developed either locally or state-wide eg. Safe Medication Management Unit (SMMU) guidelines.
- Several additional error prone abbreviations, not mentioned in the Queensland Health Guidelines for use of abbreviations in the prescribing and administration of medicines*, but specified in the national document include:
  - mcg is an unacceptable abbreviation, micrograms or mcg must be written
  - CVL for Central Venous Line is not listed as an acceptable term
  - ¹ for hour (e.g. q2¹) is listed as an error prone abbreviation to be avoided as it is often seen as q20. The word hour should be written i.e. q 2 hourly
  - @ (the symbol for ‘at’) is listed as an error prone abbreviation as mistaken for 2 e.g. “@ night” should be “at night”

/ (forward slash) is listed as an error prone abbreviation as mistaken for the number 1 when used to separate doses. eg ‘25 units/10units’ misread as ‘25 units and 110 units’

Recommendations

The Safe Medication Management Unit recommends sites endorse the national terminology document through either 1. Local Medicines Committees (DMC) or 2. Area Clinical Governance Units.

A copy of the ACSQHC document can be obtained from:

Medication Services Queensland Contact Details

If you require any further information please contact:
Carol Reid: Senior Clinician Manager, Medication Systems: Risk Management
Julie Stokes: Director, Safe Medication Management Unit
Ph: 07 3131 6525
Fax: 07 3131 6522

References

3. Queensland Health Safe Medication Practice Unit. Guidelines for the Use of Abbreviations 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.\textsuperscript{1} 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.\textsuperscript{2} 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.\textsuperscript{3} Today, English is the predominant language of medical literature.\textsuperscript{4} 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.\textsuperscript{5}

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.

Objectives

In order to promote patient safety and clear and unambiguous prescribing of medicines, this document establishes the following:

- Principles for consistent prescribing terminology (Table 1)
- A set of recommended terms and acceptable abbreviations (Table 2)
- A list of error-prone abbreviations, symbols and dose designations that have a history of causing error and must be avoided (Table 3)

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.\textsuperscript{6}

Prescriptions should not contain ANY abbreviations other than those that are in universal and common use, such as the term ‘pm’ 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.

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 (e.g., 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 trimcinolone)
   - 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 GR, 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, e.g. 1, 2, 3 etc
   - Do not use Roman numerals, e.g., do not use ii for two, iii for three, v for five etc
   - Use metric units, such as gram or mL
   - Do not use apothecary units, such as minims 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: e.g., 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>
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<th>Acceptable Terms or Abbreviations</th>
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<td>(at) midday</td>
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<tr>
<td>(at) night</td>
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<td>twice a day</td>
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<td>three times a day</td>
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</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>
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### TABLE 2: Acceptable terms and abbreviations (continued)

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.

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<tr>
<td>powder</td>
<td>powder</td>
</tr>
<tr>
<td>suppository</td>
<td>supp</td>
</tr>
<tr>
<td>tablet</td>
<td>tablet, tab</td>
</tr>
<tr>
<td>patient controlled analgesia</td>
<td>PCA</td>
</tr>
</tbody>
</table>
**TABLE 3: Error-prone abbreviations, symbols and dose designations to be avoided**

(Adapted from the Institute of Safe Medication Practises [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>µg, mcg or ug</td>
<td>microgram</td>
<td>Mistaken as ‘mg’</td>
<td>microg, microgram</td>
</tr>
<tr>
<td>BD 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>DC</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</td>
<td>half-strength at bedtime, hours of sleep</td>
<td>Mistaken as bedtime</td>
<td>‘half-strength’ or ‘bedtime’ whichever is intended</td>
</tr>
<tr>
<td>HS or hs</td>
<td></td>
<td>Mistaken as half-strength</td>
<td></td>
</tr>
<tr>
<td>IU</td>
<td>injection</td>
<td>Mistaken as ‘IV’ or ‘intravascular’</td>
<td>inj., injection</td>
</tr>
<tr>
<td>IN</td>
<td>intranasal</td>
<td>Mistaken as ‘IN’ 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’ (right)</td>
<td>morning</td>
</tr>
<tr>
<td>N</td>
<td>night</td>
<td>Mistaken for ‘m’ (morning)</td>
<td>night</td>
</tr>
<tr>
<td>Oc or Occ</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 BD (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>GW</td>
<td>once a week</td>
<td>Not universally understood</td>
<td>once a week</td>
</tr>
<tr>
<td>pf</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 ‘qhr’ or every hour</td>
<td>‘night’, ‘daily at bedtime’</td>
</tr>
<tr>
<td>Qh</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>Ss</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>SSRI or SSI</td>
<td>sliding scale regular insulin or sliding scale insulin</td>
<td>Mistaken as selective serotonin reuptake inhibitor; Mistaken as 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</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>i/D</td>
<td>one daily</td>
<td>Mistaken as ‘tid’</td>
<td>one daily</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 (e.g. 4U seen as ‘40’ or 4u seen as ‘44’). Mistaken as ‘cc’ so dose given as a volume instead of units (e.g. 4u seen as 4 cc)</td>
<td>unit</td>
</tr>
<tr>
<td>unng</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 hry’</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></td>
<td>Hindu-Arabic numbers, 1, 2, 3, 4 etc or words</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 (e.g. 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 (e.g. .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 (e.g. 100000 units, 1000000 units)</td>
<td>100000 units, 1000000</td>
<td>100000 has been mistaken as 10,000, or 1,000,000; 1000000 has been mistaken as 100,000</td>
<td>For figures above 100 use words to express intent e.g., one thousand, one million, six million etc. Otherwise use commas for dosing units at or above 1,000</td>
</tr>
<tr>
<td>10^6 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 ‘3 doses’</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/10units’ 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>and</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>
### Fluids available at Caboolture Hospital

<table>
<thead>
<tr>
<th>Fluid Type</th>
<th>Description</th>
<th>Quantity</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fat Emulsion</strong></td>
<td>Plastic Emulsion 20%, 500mL, Clinofusc</td>
<td>(10)</td>
<td></td>
</tr>
<tr>
<td><strong>Glucose 10%</strong></td>
<td>IV infusion 500mL, AHB0163 Baxter</td>
<td>(18)</td>
<td></td>
</tr>
<tr>
<td><strong>Glucose 3.3%</strong></td>
<td>Sodium Chloride 0.3% - Potassium Chloride 20mmol/L infusion 1L, AKH6015 Baxter</td>
<td>(12)</td>
<td></td>
</tr>
<tr>
<td><strong>Glucose 3.3%</strong></td>
<td>Sodium Chloride 0.3% - Potassium Chloride 20mmol/L infusion 1L, AHB1034 Baxter</td>
<td>(12)</td>
<td></td>
</tr>
<tr>
<td><strong>Glucose 4%</strong></td>
<td>Sodium Chloride 0.18% - Potassium Chloride 40mmol/L infusion 1L, AKH6033 Baxter</td>
<td>(12)</td>
<td></td>
</tr>
<tr>
<td><strong>Glucose 4%</strong></td>
<td>Sodium Chloride 0.18% - Potassium Chloride 20mmol/L infusion 1L, AHB1254 Baxter</td>
<td>(12)</td>
<td></td>
</tr>
<tr>
<td><strong>Glucose 5%</strong></td>
<td>Sodium Chloride 0.45% - Potassium Chloride 20mmol/L infusion 1L, AKH6024 Baxter</td>
<td>(12)</td>
<td></td>
</tr>
<tr>
<td><strong>Glucose 5%</strong></td>
<td>Sodium Chloride 0.9% - Potassium Chloride 20mmol/L infusion 1L, AHB6066 Baxter</td>
<td>(12)</td>
<td></td>
</tr>
<tr>
<td><strong>Glucose 5%</strong></td>
<td>Sodium Chloride 0.9% - Potassium Chloride 20mmol/L infusion 1L, AHB1064 Baxter</td>
<td>(12)</td>
<td></td>
</tr>
<tr>
<td><strong>Glucose 5%</strong></td>
<td>Sodium Chloride 0.9% - Potassium Chloride 20mmol/L infusion 1L, AHB6066 Baxter</td>
<td>(12)</td>
<td></td>
</tr>
<tr>
<td><strong>Glucose 5%</strong></td>
<td>Sodium Chloride 0.9% - Potassium Chloride 20mmol/L infusion 1L, AHB1064 Baxter</td>
<td>(12)</td>
<td></td>
</tr>
<tr>
<td><strong>Glucose 5% (Non-PVC)</strong></td>
<td>IV infusion 500mL, AHE0063 Baxter (Aviva)</td>
<td>(24)</td>
<td></td>
</tr>
<tr>
<td><strong>Glucose 5% (IV)</strong></td>
<td>Infusion 250mL, AHB0062 Baxter</td>
<td>(24)</td>
<td></td>
</tr>
<tr>
<td><strong>Glucose 5% (IV)</strong></td>
<td>Infusion 100mL, AHB0087 Baxter (Single Pack IV)</td>
<td>(48)</td>
<td></td>
</tr>
<tr>
<td><strong>Glucose 5% (IV)</strong></td>
<td>Infusion 1L, AHB0084 Baxter</td>
<td>(12)</td>
<td></td>
</tr>
<tr>
<td><strong>Glucose 50%</strong></td>
<td>IV infusion 500mL, AHB0253 Baxter</td>
<td>(18)</td>
<td></td>
</tr>
<tr>
<td><strong>Glycine Uromatil</strong></td>
<td>Uromatil 1.5%, 2,000mL, AHB7316 Baxter</td>
<td>(6)</td>
<td></td>
</tr>
<tr>
<td><strong>Hartmanns (Sodium Chloride - Lactate Compound)</strong></td>
<td>IV infusion 1L, AHB2324 Baxter</td>
<td>(12)</td>
<td></td>
</tr>
<tr>
<td><strong>Mannitol Infusion 20%</strong></td>
<td>500mL, AHB3025 Baxter</td>
<td>(18)</td>
<td></td>
</tr>
<tr>
<td><strong>Sodium Chloride 0.29%</strong></td>
<td>Potassium Chloride 10mmol/L infusion 100mL, AHB6082 Baxter</td>
<td>(48)</td>
<td></td>
</tr>
<tr>
<td><strong>Sodium Chloride 0.9%</strong></td>
<td>Potassium Chloride 20mmol/L infusion 1L, AHB1784 Baxter</td>
<td>(12)</td>
<td></td>
</tr>
<tr>
<td><strong>Sodium Chloride 0.9%</strong></td>
<td>Potassium Chloride 40mmol/L infusion 100mL, AHB6053 Baxter</td>
<td>(48)</td>
<td></td>
</tr>
<tr>
<td><strong>Sodium Chloride 0.9%</strong></td>
<td>Potassium Chloride 40mmol/L infusion 1L, AHB6034 Baxter</td>
<td>(12)</td>
<td></td>
</tr>
<tr>
<td><strong>Sodium Chloride</strong></td>
<td>0.9%, 3000mL, AHB7127 Baxter</td>
<td>(4)</td>
<td></td>
</tr>
<tr>
<td><strong>Sodium Chloride</strong></td>
<td>Infusion 0.9%, 1L, AHB7124</td>
<td>(10)</td>
<td></td>
</tr>
<tr>
<td><strong>Sodium Chloride</strong></td>
<td>Infusion 0.9%, 500mL, AHB7123</td>
<td>(15)</td>
<td></td>
</tr>
<tr>
<td><strong>Sodium Chloride</strong></td>
<td>Infusion 0.45%, 500mL, AHB1313 Baxter</td>
<td>(18)</td>
<td></td>
</tr>
<tr>
<td><strong>Sodium Chloride</strong></td>
<td>Infusion 0.9%, 150mL, AHB1307 Baxter</td>
<td>(48)</td>
<td></td>
</tr>
<tr>
<td><strong>Sodium Chloride</strong></td>
<td>Infusion 0.9%, 1L, AHB1324 Baxter</td>
<td>(12)</td>
<td></td>
</tr>
<tr>
<td><strong>Sodium Chloride</strong></td>
<td>Infusion 0.9%, 250mL, AHB1322 Baxter</td>
<td>(24)</td>
<td></td>
</tr>
<tr>
<td><strong>Sodium Chloride</strong></td>
<td>Infusion 0.9%, 500mL, AHB1323 Baxter</td>
<td>(18)</td>
<td></td>
</tr>
<tr>
<td><strong>Sodium Chloride</strong></td>
<td>Infusion 3%, 250mL, AHB6046 Baxter</td>
<td>(24)</td>
<td></td>
</tr>
<tr>
<td><strong>Water For Injection (IV)</strong></td>
<td>Infusion 1L, AHB0304 Baxter</td>
<td>(12)</td>
<td></td>
</tr>
<tr>
<td><strong>Water For Irrigation</strong></td>
<td>Infusion 1L, AHB7114 Baxter</td>
<td>(10)</td>
<td></td>
</tr>
<tr>
<td><strong>Water For Irrigation</strong></td>
<td>Infusion 500mL, AHB7113 Baxter</td>
<td>(15)</td>
<td></td>
</tr>
</tbody>
</table>
Discharge Medication Process

**Please ensure your patient undergoes discharge medication review prior to being discharged from Caboolture Hospital**

- Clinical pharmacists are available to assist the discharge process and provide inpatient and discharge medication reconciliation and review on Monday to Friday 8am to 4:30pm.
- Once decision is made that patient is appropriate for discharge, please communicate this information to the nursing team leader and clinical pharmacist.
- Please notify patients that pharmaceutical review is required prior to being discharged from the hospital and to allow realistic time-frames for the discharge process to occur.

Prior to discharge, clinical pharmacists will:
- Reconcile inpatient and patient-owned medications and assess appropriateness on discharge
  - Reducing risk of medication-related harm and risk of readmission.
  - Identify any potential drug interactions/contraindications
  - Ensure optimal medication regime for discharge (deprescribing)
- Facilitate the supply of medications required for discharge
  - New/temporary/changed medicines
- Liaise with aged-care facilities and external health-care providers
  - Nursing homes
  - Community Pharmacies (dose administration aids) and GPs
  - Hospital-in-the-Home (HITH)
- Review discharge prescription for PBS, legal and clinical compliance.
- Provide a discharge medication record to patients (DMR)
  - Populates EDS with medication list!
- Provide discharge medication education and counselling for patients

All discharge prescriptions are to be reviewed by a pharmacist prior to discharge (Mon-Fri),
- DO NOT give discharge prescriptions to patients without prior review by a pharmacist.

Aged Care/Residential Care Facility discharges
- Once notified by a patient flow nurse of a patient being discharged to an aged-care/residential-care facility, please ensure a discharge prescription is completed for ALL medications at least 48 hours prior to the discharge date.
- Community pharmacies require at least 24-48 hours to prepare dose-administration aids
- Inadequate time-frames may result in discharge being delayed or increase risk of medication errors and readmission.

**Thankyou for your cooperation with this process**

Any questions/comments regarding this process can be referred to:
David Hughes - Assistant Director of Pharmacy, Dept: 8747 - Email: david.hughes@health.qld.gov.au
On-Call Pharmacy Service

Caboolture Hospital Pharmacy Department operates an on-call clinical pharmacy service outside of normal business hours and on weekends. (Contactable 24 hours a day)

This service is to provide clinical medication advice, and also to facilitate the supply of medications when necessary.

The on-call pharmacist is not on site at Caboolture/Kilcoy Hospitals, and the facility incurs a cost for each phone call.

Please ensure your phone call is clinically appropriate prior to calling the on-call pharmacist.

For CLINICAL MEDICATION ADVICE:
- **Nursing staff** – please discuss medication issue with medical officer or after-hours nurse manager initially. If issue is unable to be resolved, the after-hours nurse manager may contact on-call pharmacist.
- **Junior Doctors** – initially please discuss medication issue with medical registrar. If issue not able to be resolved – contact on-call pharmacist via hospital switchboard.
- **Registrars/Consultants** – Please contact on-call pharmacist via hospital switch board.

For information on prescribing discharge/outpatient items as per Pharmaceutical Benefits Scheme (PBS), please refer to [www.pbs.gov.au](http://www.pbs.gov.au).

For medication SUPPLY:
- Contact After-Hours Nurse Manager
- If product is unavailable in hospital/after-hours drug store then After-Hours Nurse Manager will contact on-call pharmacist.
- The on-call pharmacist may be required to attend the hospital to supply the item, or source the item from another facility.

Any questions regarding this service can be referred to:
David Hughes - Assistant Director of Pharmacy
Dect: 8747  Email: david.hughes@health.qld.gov.au

Caboolture Hospital Pharmacy
Ph: 5433 8662
**EDS – Patients requiring SOPD appointment and follow-up**

In order to ensure that your patient has the appropriate SOPD appointment scheduled it is a requirement for all SOPD appointments to:

- Be documented in the Follow Up Arrangements section in the Management Plan tab (Please see below as an example).

<table>
<thead>
<tr>
<th>Person Name</th>
<th>Service Requested</th>
<th>Comments</th>
<th>Proposed Start</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESFU</td>
<td>Early Support/ Follow Up Clinic</td>
<td>032</td>
<td></td>
</tr>
<tr>
<td>Dr. Rahman</td>
<td>Rheumatology follow up appointment</td>
<td>032</td>
<td></td>
</tr>
</tbody>
</table>

- **Failure to document your SOPD appointments in this section may result in appointments being over looked and could potentially impact patient care.**

- Please also note: If it is a new referral then the Specialist Clinic New Patient Referral Form is required to be completed as well and sent to SOPD.

- If your patient requires an SOPD follow up appointment and you have successfully added it to the Follow Up Arrangements section in EDS then you also need to add "Referrals - Caboolture Hospital" to the Recipients List (please see below)

- Adding "Referrals - Caboolture Hospital" will inform the Ward Clerk to send the EDS to SOPD for them to make the appropriate appointment.

- The Ward Clerk is then responsible for ticking the Distribution List and signing to indicate that the EDS has been faxed or emailed to SOPD.

Should you require any assistance or training in the above processes could you please contact me on 5433 8757 and I am more than happy to go through these processes with you.

Many thanks

Grant

Grant Duffill
Program Coordinator - Health Information Management
Caboolture & Kilcoy Hospitals
Metro North Health Service District
Phone: 5433 8757
Fax: 5433 8706
E-mail: Grant_Duffill@health.qld.gov.au