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Welcome to the Caboolture Hospital Women’s and Newborn Services

Hello and welcome to your term in the Department of Obstetrics and Gynaecology 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.

Any information including policies and procedures in this handbook are not binding and may be changed or reviewed at any time. It is the aim of the staff in this unit to assist you in developing your clinical skills, both in obstetrics and gynaecology by formalised educational sessions and practical hands on experience.

It is hoped that you enjoy your time with us in the Obstetrics & Gynaecology 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 Obstetrics & Gynaecology Team

Clinical Director
Dr Mahilal Ratnapala

Fulltime Consultants
Dr Lindsay Cochrane
Dr Shahida Rehman
Dr Chris Weekes
Dr Lider Kukurt

Part-time Consultants
Dr Liana Tanda (Tuesday and Thursday)
Dr Caroline Wewengkang (Wednesday and Friday)
Frequently Asked Questions (FAQ’s)

1. I have not received any information regarding my employment.

This information gets posted 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) 5316 1101.

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.

For any information regarding payroll – please go to PARIS website:

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 – 5443 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. 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?**


<table>
<thead>
<tr>
<th><strong>Terms Often Used in the Hospital Setting</strong></th>
</tr>
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<tbody>
<tr>
<td><strong>Accessible</strong></td>
</tr>
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</table>
| **Activity based funding (ABF)** | A management tool that has the potential to enhance public accountability and drive technical efficiency in the delivery of health services by:  
- capturing consistent and detailed information on hospital sector activity and accurately measuring the costs of delivery  
- creating an explicit relationship between funds allocated and services provided  
- strengthening management’s focus on outputs, outcomes and quality  
- encouraging clinicians and managers to identify variations in costs and practices so these can be managed at a local level in the context of improving efficiency and effectiveness  
- providing mechanisms to reward good practice and support quality initiatives. |
| **Acute** | Having a short and relatively severe course. |
| **Acute care** | Care in which the clinical intent or treatment goal is to:  
- manage labour (obstetric)  
- cure illness or provide definitive treatment of injury  
- perform surgery  
- relieve symptoms of illness or injury (excluding palliative care)  
- reduce severity of an illness or injury  
- protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function  
- perform diagnostic or therapeutic procedures. |
<p>| <strong>Acute Hospital</strong> | Is generally a recognised hospital that provides acute care. Excludes dental and psychiatric hospitals. |
| <strong>Admission</strong> | The process whereby the hospital accepts responsibility for a patient's care and/or treatment. It follows a clinical decision, based on specified criteria, that a patient requires same-day or overnight care or treatment, which can occur in hospital and/or in the patient's home (for hospital-in-the-home patients). |
| <strong>Admitted patient</strong> | A patient who undergoes a hospital’s formal admission process as either an overnight stay patient or a same-day patient. |
| <strong>Allied Health staff</strong> | Professional staff with qualifications and ongoing competence in one or any combination of the following specialties: audiologist, clinical measurements scientist, dietitian, medical imaging technologist, occupational therapist, orthotists, pharmacist, physiotherapist, podiatrist, prosthetist, psychologist, social worker and speech pathologist. It may also include access to an Aboriginal and Torres Straight Islander health worker. |
| <strong>Ambulatory setting</strong> | A non-inpatient setting. |
| <strong>Available bed</strong> | A bed which is immediately available to be used by an admitted patient if required. A bed is immediately available for use if located in a suitable place for care with nursing and auxiliary staff available within a reasonable period, to service patients who might occupy them. |
| <strong>Benchmarking</strong> | Involves the collection of performance information to undertake comparisons of performance with similar organisations. |</p>
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Best practice</strong></td>
<td>Cooperative way in which organisations and their employees undertake business activities in all key processes—and use of benchmarking—that can be expected to lead to sustainable work class positive outcomes.</td>
</tr>
<tr>
<td><strong>Capital expenditure</strong></td>
<td>Expenditure on large-scale non-current assets (for example, new buildings and equipment) with a useful life extending over several years.</td>
</tr>
<tr>
<td><strong>Care type</strong></td>
<td>Defines the overall nature of a clinical service given to an admitted patient during an episode of care (admitted care), or the type of service provided by the hospital for boarders or posthumous organ procurement (other care).</td>
</tr>
<tr>
<td><strong>Casemix</strong></td>
<td>Range and types of patients (the mix of cases) treated by a hospital or other health service. Casemix classifications are a way of describing and comparing hospitals and other services.</td>
</tr>
<tr>
<td><strong>Clinical governance</strong></td>
<td>A framework through which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.</td>
</tr>
<tr>
<td><strong>Clinical practice</strong></td>
<td>Professional activity undertaken by health professionals to investigate patient symptoms and prevent and/or manage illness, together with associated professional activities for patient care.</td>
</tr>
<tr>
<td><strong>Continuing care</strong></td>
<td>Uninterrupted, seamless and integrated care provided across the continuum.</td>
</tr>
<tr>
<td><strong>Critical care</strong></td>
<td>Critical care services include intensive care units (ICU), high-dependency units (HDU) and coronary care units (CCU). Critical care services provide care for the critically ill or those vulnerable to critical illness, focusing on the level of care individual patients need, that may or may not be provided in the unit.</td>
</tr>
<tr>
<td><strong>EDD</strong></td>
<td>Estimated Date of Discharge.</td>
</tr>
<tr>
<td><strong>Elective care</strong></td>
<td>Care which, in the opinion of the treating clinician, is necessary and admission for which may be delayed for at least 24 hours.</td>
</tr>
<tr>
<td><strong>Emergencies</strong></td>
<td>Are immediately, imminently or potentially life-threatening conditions.</td>
</tr>
<tr>
<td><strong>Emergency department waiting time to service delivery</strong></td>
<td>Time elapsed for each patient from presentation to the emergency department to start of services by the treating clinician. It is calculated by deducting the date and time the patient presents from the date and time of the service event.</td>
</tr>
<tr>
<td><strong>Emergency surgery</strong></td>
<td>Surgery, which in the opinion of the treating clinician, is necessary and for which admission cannot be delayed more than 24 hours.</td>
</tr>
<tr>
<td><strong>Episode of care</strong></td>
<td>Period of admitted patient care between a formal or statistical admission and a formal or statistical separation, characterised by only one care type.</td>
</tr>
<tr>
<td><strong>Full-time equivalent staff (FTE)</strong></td>
<td>Refers to occupied full-time equivalent staff, which are full-time equivalent staff currently working in a position.</td>
</tr>
<tr>
<td><strong>Health behaviours</strong></td>
<td>An accumulation of attitudes, beliefs, knowledge and practices that result in a person’s health behaviours—for example, patterns of eating, physical activity, excess alcohol consumption and smoking.</td>
</tr>
<tr>
<td><strong>Health outcome</strong></td>
<td>Change in the health of an individual, or group of people or population, attributable to an intervention or series of interventions.</td>
</tr>
<tr>
<td><strong>Hospital</strong></td>
<td>A health care facility established under Commonwealth, State or Territory legislation as a hospital or a free-standing day procedure unit and authorised to provide treatment and/or care to patients.</td>
</tr>
<tr>
<td><strong>Hospital-in-the-home care (HITH)</strong></td>
<td>The provision of care to hospital admitted patients in their place of residence as a substitute for hospital accommodation.</td>
</tr>
<tr>
<td><strong>Immunisation</strong></td>
<td>Process of inducing immunity to an infectious agency by administering a vaccine.</td>
</tr>
<tr>
<td><strong>Incidence</strong></td>
<td>Number of new cases of a condition occurring within a given population, over a certain period of time.</td>
</tr>
<tr>
<td><strong>Indigenous health worker</strong></td>
<td>Indigenous health workers provide primary health care to Aboriginal and Torres Strait Islander individuals, families and communities.</td>
</tr>
<tr>
<td><strong>Length of stay</strong></td>
<td>Length of stay of an overnight patient is calculated by subtracting the date the patient is admitted from the date of separation and deducting days the patient was on leave. A same-day patient is allocated a length of stay of one day.</td>
</tr>
<tr>
<td><strong>Medical practitioner</strong></td>
<td>Person who is registered by the Medical Board of Queensland to practise medicine in Queensland, including both general and specialist practitioners.</td>
</tr>
<tr>
<td><strong>Medicare Local</strong></td>
<td>The Australian Government has committed to establishing from 1st July 2011, Medicare Locals; a national network of primary health care organisations. The establishment of Medicare Locals will build upon the strength of the current Divisions of General Practices Network to provide a broader range of health care activities and streamline services.</td>
</tr>
</tbody>
</table>
| **National Safety Quality Health Service (NSQHS) Standards** | Australian health ministers Endorsed the Australian Commission for Safety and Quality in Healthcare (NSQHS) Standards in September 2011 and the standards will be operational as mandatory standards from 1 January 2013. The ten NSQHS Standards focus on areas essential to improving the safety and quality of care for patients:  
1. **Governance for Safety and Quality in Health Service Organisations**  
2. **Partnering with Consumers**  
3. **Prevention and Controlling Healthcare Associated Infections**  
4. **Medical Safety**  
5. **Patient identification and Procedure matching**  
6. **Clinical Handover**  
7. **Blood and Blood Products**  
8. Preventing and managing Pressure Injuries  
9. Recognising and responding to clinical Deterioration in Acute Health care  
10. Preventing Falls and Harm from Falls.  
** Standard 1 and Standard 2 are overarching Standards which provide the context for the implementation of the other eight clinical standards. The standards provide a clear statement about the level of care consumers can expect from health services.** |
<p>| <strong>Non-admitted patient</strong> | A patient who does not undergo a hospital’s formal admission process. |
| <strong>Non-admitted patient occasion of services</strong> | An occasion of examination, consultation, treatment or other service provided to a nonadmitted patient in a functional unit of a health service facility. |
| <strong>Nurse practitioner</strong> | A registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessment and management of clients using nursing knowledge and skills and may include, but is not limited to, direct referral of clients to other healthcare professionals, prescribing medications, and ordering diagnostic investigations. |</p>
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Outpatient</td>
<td>Non-admitted health service provided or accessed by an individual at a hospital or health service facility.</td>
</tr>
<tr>
<td>Outpatient clinic service</td>
<td>Examination, consultation, treatment or other service provided to non-admitted non-emergency patients in a speciality unit or under an organisational arrangement administered by a hospital.</td>
</tr>
<tr>
<td>Overnight-stay patient</td>
<td>Patient who is admitted to and separated from the hospital on different dates (i.e., not same day patients).</td>
</tr>
<tr>
<td>Performance indicator</td>
<td>A measure that provides an ‘indication’ of progress towards achieving the organisation’s objectives. It usually has targets attached that define the level of performance expected against the performance indicator.</td>
</tr>
<tr>
<td>Population health</td>
<td>The prevention of illness and injury, and the protection and promotion through organised efforts and informed choices of society, organisations (public and private), communities and individuals.</td>
</tr>
<tr>
<td>Private hospital</td>
<td>Is either a private hospital or a free standing day hospital and is either a hospital owned by a for-profit company or a non-profit organisation and privately funded through payment for medical services by patients themselves or by insurers. Patients admitted to private hospital are treated by a doctor of their own choice.</td>
</tr>
</tbody>
</table>
| Public (Hospital) patient     | Is a patient who:                                                                                                                          • elects to be treated as a public patient, and so cannot choose the doctor who treats them, or  
• is receiving treatment in a private hospital or health authority. |
| Public hospital               | Hospital controlled by a state or territory health authority. Public hospitals offer free diagnostic services, treatment, care and accommodation to all eligible patients.                                    |
| Purchasing Framework          | The 2012-13 service agreements include a Healthcare Purchasing Framework which contains seven purchasing intentions. The Purchasing Framework aims to ensure that resources are committed in a way that improves health, reduces inequalities, and enhances patient experience. |
| Registered nurse              | An individual registered under national law to practise in the nursing and midwifery professions as a nurse other than as a student.                                                                  |
| Service Agreements            | A service agreement is in place between Queensland Health and each Hospital and Health Service. The service agreement defines the hospital services, health services, teaching, research and other services that are to be delivered by the Hospital and Health Service and the funding to be provided to the Hospital and Health Service for the delivery of these services. The service agreement also sets out how Queensland Health will manage the performance of Hospital and Health Services. |
| Sustainable                   | A health system that provides infrastructure, such as workforce, facilities and equipment, and is innovative and responsive to emerging needs—for example, research, monitoring within available resources. |
| Telehealth                    | The delivery of health-related services and information via telecommunication technologies. It includes:                                                                                                    |
|                              | • live, audio or/video interactive link for clinical consultations and educational purposes                                                                                                                |
|                              | • store and forward Telehealth, which can involve digital images, video, audio and clinical data being captured on the client computer then transmitted securely to a clinic at another location where they are studied by relevant specialists. |
|                              | • Teleradiology, for remote reporting and clinical advice for diagnostic images                                                                                                                        |
|                              | • Telehealth services and equipment to monitor people’s health in their home. The urgency of the patient’s need for medical and nursing care.                                                               |
| Triage category               |                                                                                                                                                                                                           |
| Weighted Activity Unit (WAU)  | Under Queensland Health’s case-mix funding model, activity is now measured in Weighted Activity Units (WAUs). A WAU is a numerical value that is intended to reflect the amount of resources utilised to treat one group of patients relative to other groups of patients. |
# Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ABF</td>
<td>Activity Based Funding</td>
</tr>
<tr>
<td>ABM</td>
<td>Aggression Behaviour Management</td>
</tr>
<tr>
<td>ACAS</td>
<td>Aged Care Assessment Service</td>
</tr>
<tr>
<td>ACHS</td>
<td>Australian Council on Healthcare Standards (ACHS) Accreditation</td>
</tr>
<tr>
<td>ACAT</td>
<td>Aged Care Assessment Team that makes decisions about appropriate placement options</td>
</tr>
<tr>
<td>AHPRA</td>
<td>Australian Health Practitioner Regulation Agency</td>
</tr>
<tr>
<td>ATSI</td>
<td>Aboriginal or Torres Strait Islander</td>
</tr>
<tr>
<td>CHIP</td>
<td>Community Health Interface Program (Nursing)</td>
</tr>
<tr>
<td>CKN</td>
<td>Clinician’s Knowledge Network</td>
</tr>
<tr>
<td>DCT</td>
<td>Director of Clinical Training</td>
</tr>
<tr>
<td>DRG</td>
<td>Diagnostic Related Group</td>
</tr>
<tr>
<td>EAS</td>
<td>Employee Assistance Scheme</td>
</tr>
<tr>
<td>EDS</td>
<td>Enterprise Discharge Summary</td>
</tr>
<tr>
<td>ELMO</td>
<td>E-Learning Online Training Environment</td>
</tr>
<tr>
<td>GPD</td>
<td>General Practice Directory</td>
</tr>
<tr>
<td>HBCIS</td>
<td>Hospital Based Corporate Information System (the patient information database)</td>
</tr>
<tr>
<td>HIMS</td>
<td>Health Information Management Systems (also known as Medical Records)</td>
</tr>
<tr>
<td>MEO</td>
<td>Medical Education Officer</td>
</tr>
<tr>
<td>MET</td>
<td>Medical Emergency Team</td>
</tr>
<tr>
<td>MNHHS</td>
<td>Metro North Hospital and Health Service</td>
</tr>
<tr>
<td>NEAT</td>
<td>National Emergency Access Targets</td>
</tr>
<tr>
<td>NEST</td>
<td>National Elective Surgery Targets</td>
</tr>
<tr>
<td>NSQHS</td>
<td>National Safety and quality in Health Care Standards</td>
</tr>
<tr>
<td>NUM</td>
<td>Nurse Unit Manager</td>
</tr>
</tbody>
</table>
### Resources Available:

**Terminology, definitions and abbreviations: The health of Queenslanders 2012**

Terminology, definitions and abbreviations (PDF 67KB)

Definitions and abbreviations: The Health of Queenslanders 2010

**Abbreviations & Acronyms**

**Glossary of key terms and abbreviations Qld basic Physician Training pathway**
Conduct at Work – Code of Conduct

From 1 January 2011 a new single Code of Conduct for the Queensland Public Service applied to all Queensland Health employees. The new Code of Conduct for the Queensland Public Service replaces the Queensland Health Code of Conduct. The new Code of Conduct for the Queensland Public Service reflects the principles of integrity and impartiality, promoting the public good, commitment to the system of government, accountability and transparency.

The Code of Conduct for the Queensland Public Service was developed in line with the government’s commitment and in consultation with agencies, employees and industrial representatives. The Code was designed to be relevant for all public sector agencies and their employees and reflects the amended ethics principles and values contained in the Public Sector Ethics Act 1994. It embodies Queensland Health values of caring for people, leadership, respect and integrity. These values should form the basis of the way we behave at work.

As Queensland Health employees, we occupy positions of trust, and have commitment and obligation to the public, but we also have the right to be treated with respect and to work in an environment that is free from bullying, harassment and discrimination.

The Code of Conduct applies to all Queensland Health Employees, including those who are working in temporary, part time or casual positions, volunteers, contractors, consultants or anyone who exercises power or controls resources for – or on behalf of – Queensland Health. It is not intended to be, and must not be used to intimidate or threaten employees.

We are all responsible for implementing the Code in our workplace. Managers have the added responsibility of ensuring that the Code is understood by all employees.

Along with describing the principles that should guide workplace behaviour, the Code explains how employees can raise concerns about breaches of the Code and how they should be addressed. This includes approaching union representatives.

For more information:

A new single Code of Conduct for the Queensland Public Service will apply to all Queensland Health employees from 1 January 2011.

The new Code of Conduct for the Queensland Public Service replaces the Queensland Health Code of Conduct.

This new Code of Conduct for the Queensland Public Service (Code of Conduct):
- applies to all public service agencies and employees at all times including when performing official duties
- recognises we can all demonstrate ethical leadership
- is a statement of commitment to the people of Queensland, their elected representatives and colleagues.

The Code of Conduct contains four principles of ethical behaviour which are supported by values and standards of conduct. The standards of conduct provide examples of how to put the principles and values into practice.

The following information is a brief summary of the principles and values contained in the Code of Conduct however Queensland Health employees need to uphold the new Code of Conduct from 1 January 2011.

**Principle 1 - Integrity and impartiality**
Seek to promote public confidence in the integrity of the public sector.

**Principle 1 Values include:**
- working to the highest ethical standards
- providing objective, independent, apolitical and impartial advice
- being honest, fair and respectful to all persons
- resolving or managing any conflict of interest in favour of the public interest.

**Principle 2 - Promoting the public good**
Recognise the public sector delivers programs and services for the benefit of the people of Queensland.

**Principle 2 Values include:**
- being responsive to the requirements of government and the public interest
- engaging the community in official public sector priorities, policies and decisions
- managing public resources effectively, efficiently and economically
- achieving excellence in service delivery and enhanced integration of services.

**Principle 3 - Commitment to the system of government**
Uphold the system of government and the laws of the State, Commonwealth and local government.

**Principle 3 Values include:**
- upholding the system of government and the laws of the State, the Commonwealth and local government
- being professional and impartial when carrying out official public sector priorities, policies and decisions

**Principle 4 - Accountability and transparency**
Recognise that public trust in public office requires high standards of public administration.

**Principle 4 Values include:**
- exercising proper diligence, care and attention
- using public resources in an effective and accountable way
- managing information as openly as practicable within the legal framework
- achieving high standards of public administration
- being innovative and continuously improve performance

**Agency-specific Standards of Practice**
Queensland Health will develop a Standard of Practice to supplement the Code of Conduct for the Queensland Public Service which will apply to all Queensland Health employees in the same way as the Code of Conduct.

**Copy of the new Code of Conduct**
To familiarise yourself with the new Code of Conduct for the Queensland Public Service by 1 January 2011 go to: http://www.health.qld.gov.au/codeofconduct

If you don’t have access to the internet please talk to your manager or your local People and Culture Unit.

**Training**
Training on the new Code of Conduct for the Queensland Public Service will be provided to all Queensland Health staff in 2011.
**Caboolture Hospital** provides general gynaecology and obstetric services

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Full Time Consultants</td>
<td>5</td>
</tr>
<tr>
<td>Part time Consultant 0.5FTE</td>
<td>2</td>
</tr>
<tr>
<td>Registrars/PHOs</td>
<td>8</td>
</tr>
<tr>
<td>Interns JHOs &amp;/or SHOs</td>
<td>2</td>
</tr>
</tbody>
</table>

**Statistical Data for Caboolture Hospital:**
Approximately -
- 1900+ births
- 6 antenatal clinics per week
- 2 elective caesarean lists per week
- 8 gynaecology operating sessions per week
- 500 major gynaecological procedures per year
- 1500 minor gynaecological procedures per year
- 6 gynaecology outpatient sessions per week
- 3 Colposcopy clinics per week
- Weekly Urology Clinic
- Weekly Pelvic Health Clinic
- Special Needs Clinic – on an as needs basis weekly with the respective team consultant
- EPAU – twice weekly
- Weekly teaching ultrasound
- Antenatal Day Assessment Unit (ANDAS) – daily during the week
- Obstetric Medical Clinic Weekly (let by obstetric physician from RBWH)
- Mirena (IUD) Clinic - weekly

**Responsibilities of the Consultants**

To provide support to trainees and ensure appropriate hands-on supervision and training at all times. This supervision should include:
- Regular constructive feedback
- Ensuring trainees are taken through each new procedure and are given adequate opportunities to practise their skills under supervision (e.g. caesarean sections, forceps, ventouse, episiotomy repairs and third degree tears). This should also include close observation of practice, e.g. observing the trainee perform a Caesarean section and tracking their preoperative assessment of a case, their intra-operative performance, and their post-operative care
- Taking trainees through the process of case follow-up and dealing with documentation
- Being present at birthing suite handovers and gynaecology ward rounds (as appropriate) in recognition that these are vital training opportunities
- Being readily available and supportive to trainees when on-call after hours and always coming in for designated procedures, where required (see below)
- Assisting trainees to improve their communication and decision-making skills
- Listening to trainees’ concerns about training and respecting their right to be assertive and questioning
- Acting as a mentor to trainees, including providing emotional support and career advice when appropriate
- Treating trainees with respect and courtesy.

We provide training to diplomate, core and advanced trainees of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and to medical students as well as resident medical officers.
It is hoped that your attachment to the Department of Obstetrics and Gynaecology will be both profitable and enjoyable and we look forward to your time with us.

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

**Remember: Please don’t hesitate to ask** if you are uncertain about anything, as none of your concerns or questions will be considered trivial.

**Senior Medical Staff – Obstetrics and Gynaecology**

![Dr Mahilal Ratnapala](image)

**Dr Mahilal Ratnapala**

**DIRECTOR**

Dr Lindsay Cochrane  
Staff Specialist  

Dr Shahida Rehman  
Staff Specialist  

Dr Christopher Weekes  
Staff Specialist  

Dr Liana Tanda  
Staff Specialist  

Dr Caroline Wewengkang  
Staff Specialist  

Dr Lider Kukurt  
A/ Staff Specialist
Orientation

All staff must complete the relevant orientation, local work unit induction and ongoing training and assessment to achieve the legislative, mandatory and requisite requirements identified. Staff can locate information about mandatory training under ‘staff resources’ on the QHEPS intranet.

Mandatory Training on commencement of employment

- Orientation (provides new starters with information on MN and employment)
- Code of Conduct
- Aboriginal and Torres Strait Islander Cultural Practice Program
- Ethics Integrity and Accountability
- Infection Control
- Occupational Violence Prevention
- Fire Safety Training – First response
- Fire Safety Training – General evacuation
- Prevention and Management of Musculoskeletal Disorders
- Waste Management
- Australia Charter of Health Care Rights Awareness
- Child Abuse and Neglect Capability
- Blood Safe – all modules
- Fatigue Risk Management
- Patient Handling
- National Inpatient Medical Chart
- Basic Life Support
- Aseptic Non-Touch Technique
- Basic Obstetric skills workshop
- Laparoscopic skill workshop
- FSEP (Foetal surveillance education program) from RANZCOG
- Neonatal resuscitation workshop
- PROMPT workshop (Practical obstetric multi professional training) every 2 months

General Information

Personal Details

It is your responsibility to notify Payroll if any of your personal details change. The Personal Details Change form can be found on QHEPS on the Payroll and Rostering (PARIS) page. The completed form can be given to the Obstetrics & Gynaecology (O&G) ESO.

Network Access

The Queensland Health intranet is known as QHEPS (Queensland Health Electronic Publishing Service). The Women’s and Newborn Services has its own homepage which can be found by searching Women’s and Newborn using the QHEPS search function.
The page hosts a number of resources such as:
Further details of the RANZCOG Training Program including assessment dates and forms, audit information and training supervisors
– RANZCOG standards
– HR forms (AVAC, ID & proximity card applications)

Pagers & Switchboard

• It is each individual’s responsibility to maintain their Dect phone. New batteries can be obtained from the Switch Board located on the ground floor of the hospital.
• Broken or replacement pagers are also to be returned to the Switch Board area.
• Dect phones are issued at Switchboard Services
• Upon leaving the service line please return your Dect phone to Switchboard Services.

Media

Liaising with the media – A guide for MNHHS staff

Metro North Hospital and Health Service (MN) provides a professional media liaison and public relations service for staff and patients of all MN facilities. The Communications Department is the contact point for all external media to obtain information about services within the Caboolture Hospital. There are a number of policies, as well as state legislation, that govern the way Queensland Health staff interact with the media. These include:

• Protocol for media relations, Health Service Directive
• The Queensland Health Code of Conduct
• The Health Legislation Amendment Act 2005

These are available on QHEPS or by contacting MN Communications. To ensure hospital staff meet the requirements of these policies, all media liaison should be handled in the first instance by MN Communications.

NOTE: Under Queensland Health policy staff are not permitted to contact the media directly.
What to do when you start

**Introduce** yourself to the:
- Charge Nurses / Midwives
- Registrars and other junior medical staff
- Consultants

Find out the **times** of:
- ward rounds
- outpatient clinics
- theatre sessions
- educational activities
- handovers

**Familiarise** yourself with:
- ward layout
- bed numbers
- equipment
- exits
- role of fire officer
- resuscitation equipment
- stationery

Familiarise yourself with the patients by reading their **charts**.

Always **Write** in Progress notes – Write legibly and ensure your signature is legible (a stamp can be attained by contacting Sally-Ann Rattray on 8748). Date and Time all entries and place a patient sticker on the top of the sheet.

**Dictate letters** to GP's

**KNOW YOUR LIMITS – IF IN DOUBT ASK**
**Timetable**

**Hours/Overtime**

Normal rostered hours 08.00 to 16.30 except Thursday

- Labour Ward Handover 08.00
- Monday–Wednesday - Birth Suite Tea Room – Level 2
- Thursday (07.30) - Education Centre
- Friday - Birth Suite Tea Room – Level 2
- Obstetric Medical Meeting - Check on room consigned

All RMO's are expected to do all routine duties during rostered ordinary hours. Overtime can be claimed only with the prior approval from a Consultant. This will only be approved for an essential urgent clinical need and not to complete routine work. When claiming overtime, it is essential to name the Consultant who approved the overtime & the UR number of the patient seen.

**Protocol for unplanned leave (Sick)**

It is vital that Switchboard be notified when calling in Sick, the switchboard operator will then notify Medical Workforce Unit and the O&G Clinical Director's Support Officer who will then action shift / on call swaps.

**Handover**

The handover meeting involves midwifery staff, registrars, residents, students and consultants. All birth suite women, all antenatal and all gynaecology admissions are handed over. Any cases of interest in the wards will also be discussed and management will be planned for all cases. This handover meeting is followed by consultant led ward rounds.

**Ward Rounds**

Antenatal and gynaecology ward rounds are done daily at the end of the morning handover and at other times deemed necessary by either Registrars or Consultants. Postnatal ward rounds are done daily by the ward resident.

See the Day 1 caesareans, Day 1 instrumentals, 3rd / 4th degree tears, PPHs and any woman with medical issues i.e. PET / PIH

See all antenatal and gynaecological admissions

There are 5 teams with a Consultant and Registrar in each team.

Lindsay Cochrane (LC), Shahida Rehman (SR), Mahilal Ratnapala (MR), Chris Weekes (CW), Liana Tanda (LT) / Caroline Wewengkang (CaW)

Each team is responsible for the care of all patients admitted under the Consultant of the team. As Consultants work a 4 day roster, the Consultant on call for the day is also responsible for the care of all patients under the care of the Consultant who is on an RDO or any other Consultant on leave. Team Registrars will assist the Consultants with the ward round.

There are also midwifery teams with a consultant overseeing the team. The consultant for the team performs a weekly case conference.

Midwives and Me = SR
Damara = Core Midwifery Team
Ngarrama = CaW (Lider Kukurt currently overseeing)

Organise bloods, scans, medications and discharge arrangements
Try to do these the day before
Try to do them yourself
If you run out of time before OT / outpatients get the ward RMO to complete the jobs

It is best to arrive 10 to 15 minutes early each morning to familiarise yourself with the patients that may be in the ward so that you can better plan your day.

On ward rounds
- **Document** date, time, and names of people in the round and check the patient sticker on progress note
- **Document** history, observations, examination findings, assessment and plan *legibly and meticulously*

**Example ward round note**

2/7/14

WR – weekes / green / smith + 4th year medical student

G1P0  K: 34+6
# known major grade placenta previa
# APH 100mls 1/7/14
Hb = 113, Steroids given @ 1700 1/7/14

Well this am, nil contractions, nil ongoing bleeding, FMF

O/E:  P 90, BP 110/70, Afebrile, CTG normal

![Fundus AGA](image)
![Cephalic 5/5](image)

Ax: Stable APH

Plan:
BD CTG
Steroids 5pm
USS – growth and wellbeing today
If nil further bleeding tomorrow am – discharge home with ANC follow-up in 1-2/52

Signed Bob Gleeson # 8322

Handovers are based on SBAR format.

**Duties: Wards**

**Delivery Suite, Maternity Ward and Special Care Nursery**  Level 2

**Surgical ward 2A**  Level 2
Gynaecology Patients will most commonly be on ward 2A but can be admitted to the Maternity Ward, Paediatric or Medical Wards. There may also be patients still waiting in emergency for a bed.

**Operating Theatres, High Dependency Unit, Preadmission Clinic**  Level 2

**Paediatric Ward**  Level 1

**Antenatal Clinics**  Specialist Clinics Building
Gynaecology Clinics

Specialist Clinics Building

Work Unit Guidelines are accessible on the Desktop on all computers used within the Unit.

Post-natal Check

1. Check antenatal course and history
   - Were there any medical concerns?
     - GDM / HTN / PET / Thyroid
   - Do they need MMR / dTP?
   - Will they need post-partum pap smear / OGTT / bloods?
   - Will they need medication ceased / adjusted?
   - Will they need follow-up? By whom and when?

2. Check the partogram and delivery
   - SVD / ventouse / forceps / caesarean?
   - Shoulder dystocia / PPH / MROP?
   - Perineal trauma?
   - Do they need debriefing?
   - Will there be specific changes to management of a future pregnancy and delivery?

3. See the woman
   - General check
   - Breasts - engorgement / mastitis / breastfeeding issues
   - Abdomen - fundus / pain / wound
   - Vaginal loss
   - Perineum
   - Bladder
   - Bowels

4. Contraception
   - Breastfeeding
   - Condoms / Mini-pill / OCP / Implanon / Mirena / Depot / Nuvaring / Tubal ligation / Vasectomy

5. Follow-up
   - Arrange follow-up through LMO or appropriate specialist
   - Advise pap smear 6/52 if out of date
   - Advise OGTT 6/52 if GDM
   - Arrange GOPD follow-up only if 3rd/4th degree tear or special needs / debriefing required after discussing with a registrar

The PHYSIOTHERAPIST should also see all 3rd/4th degree tears to arrange follow-up and give advice on bowel / bladder care

Please aim to DISCHARGE patients by lunchtime if possible.

EDS must be completed for every patient prior to discharge.

Anti-D

- Given to Rh negative mothers with Rh positive babies or Rh negative mothers with miscarriage, ectopic pregnancy, antepartum bleeding or any possible sensitising event.
- Order as Anti-D – IM – 625IU
- Prophylactic Anti-D is routinely given to all pregnant women who are rhesus negative (and without antibodies) at 28 & 34 weeks of gestation.

Rubella
• Given if non-immune or borderline before leaving hospital
• Order as: MMR – S/C – 1amp

Anaemia

• Prescribe Fe and Vit C for Hb <105
• Consider ordering Fe studies / B12 if <85 and microcytic or macrocytic
• Fe infusions can be ordered antenatally or postnatally, is safe and effective
**I-MED**

I-MED allows you to view Medical Images for all public patients electronically from any pc within the hospital. Each user requires an individual password to access iMed.

**User Name** = Initial and surname, eg. JBLOGGS  
**Password** = password1 (Staff need to change their password on first login)

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.

**EDS (Enterprise Discharge Summary)** to be done for all discharges prior to leaving hospital where possible.

Fill out discharge sheets – a blue discharge form and a white doctor’s discharge summary give copy to patient to take to GP. Plus just sign EMD form.  
It is helpful to fill out discharge sheets on Friday for patients going home on the weekend.  
**Note:** discharge summary must be succinct but give an accurate reflection of the events of the patient’s hospital stay

**Duties: Antenatal Clinic**

At each antenatal visit:
- Recheck dates and advise patient of EDC based on the earliest ultrasound demonstrating a viable fetus  
- Ask patient if any problems / concerns  
- Antenatal examination - as per record  
- Organise appropriate investigations

**Booking in Doctor’s visit**

Check all tests are complete:
- FBC  
- Blood Group  
- Antibody screen  
- Rubella  
- Syphilis (RPR/TPHA)  
- Hepatitis B & C  
- HIV  
- MSU  
- Counselling for 1st Trimester screening  
  Free B-hCG + PAPP-A  
  Nuchal translucency USS 11+6 - 13+6

Check when last Pap Smear performed and the result

Review past obstetric / medical / surgical history and medications. Perform a thorough systematic examination.

Discuss all women with a registrar / consultant and decide plan of management and follow-up share care with GP / midwife clinic / collaborative care / high risk model
High-risk women are seen at the doctor’s ANC, under the care of a Consultant. These patients are usually seen every 4 weeks to 28 weeks, every 2 weeks to 36 weeks and weekly to delivery. High risk women may also be managed by a MGP with consultant case-conferencing.

Low risk women are seen at 20 weeks following morphology, 28, 31, 34, 36, 38, 40 & 41 weeks at the midwife’s clinic. The midwifery teams will liaise with their individual consultants regarding management of specific women under their care.

Please ensure women are sent back to the midwifery clinic where possible and arrange case-conferencing if high risk.

18-20/40
Morphology USS

28/40
FBC + Antibody screen if Rh negative
Anti-D if Rh negative (repeat at 34/40)
Glucose tolerance test (needs to be booked in advance)
Discuss Whooping Cough (dTP) vaccination to be done via LMO

36/40
FBC + Antibody screen if Rh negative.
Discuss plan for delivery and book LSCS / induction of labour as appropriate

Booking a Caesarean Section
Discuss the case with the registrar / consultant
Check the EDC is correct
Liase with Sandy (NUM) to organise an appropriate date between 39-40/40 on a Monday or Thursday.
Fill out a booking form, consent form and give women copies of information sheets in the caesarean pack found in each consultation room.
Give the woman a completed blood form to be performed 3-7 days prior to the LSCS date.
If booking <39/40 consider steroids prior to delivery

Booking an Induction
Discuss the case with the registrar / consultant
Perform a vaginal examination if competent. Document the bishop’s score within the hand-held record
Phone the birth suite to book an appropriate date and method of induction.
Only 3 inductions can be performed each day and only 1 core-midwifery (non-MGP) woman.

ANDAS
ANDAS can be booked for women for:
- Iron infusions
- CTGs
- Steroids
- ECV
- Follow-up of ultrasounds

Appointments must be made with the Midwife working in ANDAS or through the ANC admin staff.

For an iron infusion the order needs to be written up on the fluid order form and a script sent to pharmacy prior to the appointment to enable time to retrieve iron from the pharmacy.
Duties: Delivery Suite

The Resident assigned to the Ward should liaise with the birth suite registrar / PHO frequently during the day.

Your jobs will include:
- Cannulation / Bloods
- Ordering investigations as needed
- Assessing antenatal presentations and report to registrar
- PPROM / PROM / APH / reduced FMs / abdo pain etc.
- Assist with instrumental deliveries / caesareans / emergency gynae cases
- Assist with obstetric emergencies

Do perineal repairs

1. Familiarise yourself with the management principles of normal labour.

2. Learn to use a partogram to manage labour

3. Familiarise yourself with the procedures involved with common obstetric problems.

Protocols for the management of common obstetric problems are found in the Unit Manuals in birth suite and Website.

4. Communication - The midwifery staff will be much more experienced than you. We are very fortunate to have very experienced midwives who are also accustomed to teaching medical students and medical officers who are inexperienced. Please use their vast experience and knowledge to your benefit. If you approach them in a friendly inquisitive manner they will reciprocate.

5. The birth suite registrar / PHO or the Consultant should be notified before any procedures are performed.

Duties: Gynaecology

Your duties for gynaecology patients will involve:
- care of inpatients
- assistance at outpatients/gynaecology clinics
- assistance in the operating theatre

Booking an Operation
- Discuss the case with the Consultant or Registrar in the clinic
- Generally, the consultant or registrar will also review the woman and help with booking and consent
- Make sure Consent Form is complete and signed – do not consent for a procedure you have not seen or not performed.
- Venous Thromboembolism Risk Assessment Form must be completed. Prescribe appointment prophlaxis on chart. Graduated Compression Stockings must be prescribed TDS on the medication chart for all women. Risk status is determined by completion of this form.
- Fit, healthy patients having uncomplicated day surgery do not require any routine laboratory tests, or other investigations unless clinically indicated.
- Write up all current medications for patients to be admitted
- Look at the Booking Form for instructions for investigations required.
- Get the woman to complete booking questionnaire in waiting room.
- Place the chart in the “toast-rack” to be seen by PAC nursing staff.
Only the following patients require a FBC and group and hold
- All Caesarean sections
- All hysterectomies
- Myomectomies
- Some laparotomies eg. Removal of complex masses, endometriomas etc.

Bowel preparation may be requested for:
- Endometriosis surgery or when bowel adhesions are suspected.

The following medications should be ceased before any major surgery in the absence of possible adverse outcomes to a medical condition as a result of such cessation. Please discuss with the Consultant if in doubt.

Medication period of cessation prior to surgery
- Oral anticoagulants
- Warfarin 5 Days
- Oral Contraceptive Pill 4 Weeks
- Hormone Replacement Therapy 4 Weeks.

MAKE SURE NO PATIENT IS PREGNANT BEFORE ANY GYNAECOLOGICALPROCEDURE.

All patients under the age of 55 years, except those who have had a hysterectomy or sterilisation, undergoing any gynaecological surgical procedure (other than D&Cs for miscarriages / terminations) must have a urinary pregnancy test to exclude pregnancy on the day of surgery.

POST-OPERATIVE ANTICOAGULATION
As per Venous Thromboembolism Prophylaxis Guidelines

Medical Education
We aim to provide both formal and informal teaching in general obstetrics and gynaecological skills. Any feedback we can receive from resident medical staff is very much appreciated as education is a high priority in our unit and we want to improve this whenever possible.

Educational components to your term can be best thought of as informal and formal. Informal teaching in antenatal clinic, outpatients and theatre will involve presentation of cases to consultants and registrars and also presentation on ward rounds.

Formal education sessions are as follows and these are compulsory for all Medical Officers.
- **Choices in Childbirth** – This is a self directed learning program on CD ROM which is available on some computers in both hospitals. Early in your term you should go through this both concentrating on normal labour and also vacuum extraction.
- **Birth Suite Handover/Ward Round** 08.00-08.30 each morning, except Thursday (07.30)
- **Videoconference** every Thursday 07.30-08.30 between Redcliffe and Caboolture Hospital Units. Presentation by selected staff - case presentations or on a specific subject.
- **Journal Club** Monday lunchtime 12.15 – 1.00pm.
• **Perinatal Mortality and Morbidity meetings** held 3 monthly. These are held as a videoconference between Redcliffe and Caboolture Hospitals and District wide cases are discussed. You may be asked to participate in this presentation.

• **Medical Students** – During PBL, residents may join if interested.

• **Hospital Wide Meetings** Junior doctor education Friday – (11.45am – 1pm), Grand Rounds Thursday (11.45am – 1.00pm)

• **Audit meeting** – Monday 12-4pm Monthly

Staff within Redcliffe, Caboolture and Kilcoy Hospitals are supported by a multidisciplinary education team including Nursing, Medical, Allied Health, Mental Health and Corporate Staff Development.

Our aim is to provide an environment that is able to cater for the educational needs of all of our staff, students and local community by offering learning & development opportunities which incorporates a multi-disciplinary approach. The scope of these teams extends beyond training, and links into workforce planning and development to meet not only the current staffing needs but also the future workforce requirements.

To achieve this, the education staff works together across streams but also works to establish partnerships with external organisations to provide the required service.

**The Education Calendar for Caboolture-Kilcoy and Redcliffe Hospitals** are now located on QHEPS [http://qheps.health.qld.gov.au/metronorth/hr/mn-training-cal.htm](http://qheps.health.qld.gov.au/metronorth/hr/mn-training-cal.htm)

A **Course Booking Form** is required to be completed and authorized by the line manager and forwarded to the facility to commence the booking process.
Cultural Diversity in Health Care

Reasons Why You Need to Know About Cultural Diversity in Health Care:

- Multicultural communities are a significant part of your clientele.
- Culture influences how health care is sought and accessed.
- Growing evidence of quality and safety risk if language and cultural barriers are not well managed.

Metro North HHS Demographics:

- 13.59% of the HHS workforce is from a non English speaking background (NESB)
- 22.10% of the local community was born overseas (189,062 people). Many more would have a parent born overseas
- 10.1% (84,569 people) were born in NESB countries
- 35.2% (64,308 people) said they speak a language other than English at home

![Languages other than English spoken in the Northside](chart.png)
5 Cross Cultural Capabilities

- Knowledge
- Skills
- Behaviour

**Context**
We need to know that there are competing socio-economic and other factors that interplay with each culture, and that circumstances vary according to the context of the situation.

**Collaboration**
We need to have the skills and ability to build trust and rapport with those from CALD backgrounds and know when to use networking opportunities or engage communities for consultative or referral purposes.

**Cultural understanding**
We need to have an awareness of cultural differences so that we can respond appropriately. We need to understand that different behaviours may be influenced by culture.

**Communication**
We need to be sensitive to language barriers and how we communicate. We need to know when to use an interpreter and how to access/book interpreters.

**Self reflection**
We need to understand our own cultural and our own beliefs, values, biases and preferences before we can understand others and its impact on others.
EMERGENCY, AFTER HOURS or UNPLANNED INTERPRETER SERVICE REQUESTS

If you require and interpreter:

- weekends and after 4:30pm and before 8am weekdays
- any other situation where an interpreter is required immediately or on short notice. This can include:
  - emergency situations e.g. where an interpreter is required immediately (Accident and Emergency)
  - unplanned situations e.g. where an interpreter is required on very short notice (less than 24 hours) and / or a situation where it may not be possible to rearrange or access an interpreter through your hospital and Health Services Interpreter Service Coordinator
- do not enter your request into ISIS

Phone On Call (the Queensland Health External Service Provider) DIRECT for onsite, video conference or telephone interpreting services including Auslan (Australian sign language) from anywhere in Queensland.

Telephone: 3115 6999

Note: The majority of after hours, emergency and unplanned interpreting will be provided through telephone interpreting. You may also be placed on hold while a telephone interpreter is organised. Onsite and video conference interpreting can be requested (e.g. Auslan)

You will need to provide the information below:

Service information
- cost centre (you must provide a cost centre)
- date, time and duration of appointment
- facility, service, ward/clinic/unit
- location

Patient information
- patient ID number
- name, date of birth, gender

Interpreter requirements
- language
- cultural requirements (if required e.g. dialect, ethnicity, religion)
- gender preference (if required)

Requester Information
- your full name
- your full phone number

REMEMBER – after EVERY interpreter service assignment, complete the Assignment Completion Sheet and fax it to your NHS Interpreter Service Coordinator.

For more information go to: qhps.health.qld.gov.au/multicultural

Interpreter Service Information System (ISIS)
**RMO End of Term Handover Policy**

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.

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

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

**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.
E-Health – Enterprise Discharge Summary (EDS)

Contact:
Senior Health Information Manager – P: 5433 8110
E: CabH-eHealth@health.qld.gov.au

The Enterprise Discharge Summary (EDS) is a computerised discharge summary.

The EDS application uses information from a number of feeder systems already in use within QH to create a legible, consistent, electronic discharge summary. It allows the summary to be delivered electronically to General Practices in a secure, timely and standardised format.

The target timeframe for summaries to be completed by clinicians is 48 hours post discharge. It is also an expectation that all summaries are completed before the end of each term.

The discharge summary should be the basis of communication with referring or subsequent health care providers. In addition the discharge summary serves as a ready source of information to hospital staff if the patient has subsequent admissions. It is essential for the continuity and quality of patient care.

The discharge summary is also essential for accurate assignment of ICD-10-AM and ACHI codes and the subsequent casemix (DRG) classification that determines the funding to the hospital for the mix of patients treated.
It is the Administration Officers responsibility in Unit / Service areas to distribute the discharge summary.

The Viewer

Contact: Senior Health Information Manager – 5433 8110
Email: CabH-eHealth@health.qld.gov.au

The Viewer is a read-only web-based application that leverages the technologies used by several existing Queensland Health enterprise systems.

The Viewer includes summary information from:
- Validated results and tests ordered (AUSLAB)
- Problems and primary diagnosis from Queensland Health Emergency Departments (EDIS)
- Discharge summaries (EDS)
- Medication profiles and adverse reactions (eLMS)
- Patient demographics and admission/discharge history (HBCIS/ePADT/Client Directory)
- Operation notes (ORMIS)
- Radiology results (QRIS/RIS/HBCIS).

Auscare – Pathology

All pathology reports need signing off on line on Auscare.

It is your responsibility to sign off pathology of patients under your consultants team regularly without delay.

Chart Reviews

Usually charts for review need to be completed at the end of each clinic.

ANDAS

Daily during the week 5 days – 8am to 4:30pm

EPAU
Twice a week (Monday & Thursday 8am to 12pm)

**Credentialing**

Credentialing for procedures published on a database, need regular updating. These are usually done in consultation with SMO at time of formative/summative assessments.

**MAT-DASH**

Refer to for work unit guidelines and education.
National Safety And Quality Health Service (NSQHS) Standards

“It's everyone’s responsibility”

Australian Health Ministers endorsed the Australian Commission for Safety & Quality in Healthcare National Safety and Quality Health Service (NSQHS) Standards in September 2011 and the standards will be operational as mandatory standards from 1 January 2013.

The ten (10) NSQHS Standards focus on areas essential to improving the safety and quality of care for patients:

1. Governance for Safety and Quality in Health Service Organisations
2. Partnering with Consumers
3. Preventing and Controlling Healthcare Associated Infections
4. Medication Safety
5. Patient Identification and Procedure Matching
6. Clinical Handover
7. Blood and Blood Products
8. Preventing and Managing Pressure Injuries
9. Recognising and Responding to Clinical Deterioration in Acute Health Care
10. Preventing Falls and Harm from Falls
Caboolture Hospital 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**
   - 1.1 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. **Assessment Feedback**
   - 5.1.1 Orientation
   - 5.1.2 Mid term assessment
   - 5.1.3 End of term
Orientation and Learning Objectives

All junior doctors (Interns, JHOs and SHOs) should take time to become fully familiar with the orientation manual and relevant O&G workplace guidelines available from the consultant (and Clinical Support Officer O&G) at the commencement or rotation.

All junior doctors should ensure you are proactive in receiving a 1-1 orientation from your 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 your rotation to the unit and information on the unit’s casemix and clinical opportunities for you to learn specific procedural skills and manage relevant clinical conditions.

Assessment and Feedback

Assessment Opportunities

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

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

Mid term feedback is generally an informal discussion (appraisal) between the supervisor and junior doctor providing individual feedback to you on your progress.

The Mid Term Interview (appraisal) is formative (does not contribute to overall assessment sign-off) and gives an opportunity to discuss your performance and give feedback in an informal setting.

This is also an excellent opportunity to discuss progress made towards the achievement of your learning objectives discussed with you at orientation. Please note that all Interns will have a formal RMO assessment completed by your supervisor.

End of Term Assessment is summative (and contributes to AHPRA/MBA required assessments) and should be scheduled as a formal interview, at which time both you and your supervisor to discuss the assessment form and sign off on it.

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

Unsatisfactory Performance

If you receive an unsatisfactory assessment at mid term or end of term, you should have received appropriate constructive feedback and an Improving Performance Action Plan (IPAP). The Medical education Unit (DCTs and MEOs), in addition to your supervisor, will be able to assist you in formulation of this plan and also to provide advice and assistance (EAS if appropriate) to you in meeting the terms of the IPAP.
**Welcome to Unit, introduce new doctor to the multidisciplinary team**

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

**Education/Assessment: Provide and discuss**

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

**Team issues:**

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

**Local Unit Tour:**

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

**Do you know how to:**

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

**Where is the (Hospital Physical Tour):**

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

**Unit Timetable**

- Consultant rounds
- Outreach services
- Clinic and theatre
- Other responsibilities
Learning Objectives Guideline

1.0 Purpose
The purpose of this accreditation guideline is to ensure that all facilities and sites that are accredited to train interns in Queensland are aware of the accreditation requirements about learning objectives. This guideline is used by survey teams during an accreditation review to determine adherence (or otherwise) to the standards describing learning objectives.

2.0 Scope
This guideline applies to all facilities and sites in Queensland that provide intern medical training programs.

3.0 Context
Evidence demonstrates that teaching and learning which has a ‘voiced’ focus provides a stronger learning environment with improved educational outcomes than teaching and learning where objectives remain unstated. The act of noting what is hoped to be learned is an important component of the teaching and learning planning cycle.
The department or unit in which an intern is training is the primary source of learning objectives for that department or unit. Learning objectives set by the department or unit may be the core of learning objectives for all interns that train in the department or unit across the full year.
In addition, learning objectives become individualised when the training experience, level of competence, and timing of the placement of each particular intern is considered. Discussion with interns about core learning objectives may result in a refined set that is particular to that intern. This may include areas of learning desired by a particular intern that is outside the typical.

4.0 The standards

<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
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<tbody>
<tr>
<td>3.1.3</td>
<td>Interns participate in formal orientation programs, which are designed and evaluated to ensure relevant learning occurs</td>
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<td>5.2.1</td>
<td>The intern training program provides regular, formal and documented feedback to intern on their performance within each term</td>
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<td>8.1.3</td>
<td>Intern supervisors understand their roles and responsibilities in assisting interns to meet learning objectives, and demonstrate a commitment to intern training.</td>
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</table>

5.0 Development of learning objectives
Each department or unit that trains interns is to have an accessible record of the outcomes the department wishes interns to achieve while learning within the department or unit. Core departmental learning objectives may be developed from the Australian Medical Council (AMC) intern outcome statements and intern training guidelines for terms, or from the Australian Curriculum Framework for Junior Doctors (ACF), or from locally based teaching and learning plans.
Learning objectives need to reflect the AMC requirements for all terms (both compulsory and non-compulsory). Evidence of the involvement of departmental personnel in the development of these learning objectives is desired.

6.0 Accreditation Review guiding principles

6.1 Existence
Departments and units that train interns are required to have a process by which learning objectives are developed and examples of core learning objectives.

6.2 Access
The core learning objectives developed by the department are to be accessible to each intern that has the opportunity to train in that department or unit. Examples of accessible learning objectives may be through orientation booklets or through facility intranets.

6.3 Individualisation
Both the term supervisors and the interns are to have the opportunity to individualise the core set of learning objectives at the beginning of (or prior to) each placement. Consideration is to be given the competence level and scope of practice of the intern as well as the desire for particular learning by the intern to assist with their career progression or career decision making.

6.4 Use during assessment
Review and discussion of learning objectives forms an important part of feedback and review of progress at mid and end of term assessment meetings between the supervisor and the intern.

6.5 Term evaluation
Term evaluations are a key source of information that is able to assist Medical Education Units in their goal of improving intern training. Acknowledging that term evaluations need to remain concise, important questions to ask interns through this process include access to information about department learning objectives, ability to input into learning objectives, and use of learning objectives to guide assessment processes.

6.6 Monitoring
A key role of a Medical Education Unit is the monitoring of the processes that ensure effective intern training, teaching and learning occurs within in department or unit that is accredited to train interns. This includes review of the development of learning objectives, the use and usefulness of learning objectives and the evaluation of these processes.

During an accreditation review, as well as adherence to each standard noted above, the mechanisms of this monitoring within the practical reality of a working health facility are of interest to Queensland Prevocational Medical Accreditation (QPMA).
### Australia Curriculum Framework for Junior Doctors – Relevant to the O&G term

#### Skills & Procedures

- Venepuncture
- IV cannulation
- Blood culture (peripheral)
- IV infusion including the prescription of fluids
- IV infusion of blood & blood products
- Urethral catheterisation in adult females
- Gynaecological speculum & pelvic examination
- Surgical knots & simple suture insertion

#### COMMON SYMPTOMS & SIGNS

- Fever
- Nausea & Vomiting
- Abdominal pain
- Dysuria /or frequent micturition
- Pain & bleeding in early pregnancy
- Depression

#### COMMON CLINICAL PROBLEMS & CONDITIONS

- Non-specific febrile illness
- Sepsis
- Shock
- Diabetes mellitus & direct complications
- Thyroid disorders
- Electrolyte disturbances
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<td>Common skin rashes in pregnancy</td>
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<td>Acute abdomen</td>
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<td>Pyelonephritis &amp; UTIs</td>
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<td>Menstrual disorders</td>
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<td>Management of anticoagulation</td>
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<td>Deliberate self-harm &amp; suicidal behaviours</td>
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<td>Common malignancies</td>
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<td>Chemotherapy &amp; radiotherapy side effects</td>
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<td>Child abuse</td>
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<td>Domestic violence</td>
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### Alerts and Adverse Reactions Form

**Facility:** .................................................................

**Special Mental Health**
- Mental Health Act status (MHEAL)
- Other Mental Health (CMENT)

**Special Needs and / or Preferences**
- Cultural and / or Religious Need (CREU)  
- Other special needs and / or preferences (OSPRE) 

### Signature Log (All persons documenting on this form must supply a sample of their initials and signature below)

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<tr>
<th>Initials</th>
<th>Print Name</th>
<th>Designation</th>
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### ALERT AND ADVERSE REACTION TYPE DEFINITIONS

- **Adult guardian**
  - The client's rights and interests are protected under Adult Guardian legislation.

- **Advanced Health directive in existence**
  - The client has an Advanced Health Directive. An Advanced Health Directive allows a client to give directions about their future healthcare should they lose the capacity to make decisions. It may include instructions to withdraw medical treatment designed to prolong life.

- **Adverse Reaction – Pharmacologic**
  - Pharmacologic drug agent resulting in adverse reaction. The client currently has or has a history of a harmful or undesirable response to an agent/substance.

- **Adverse Reaction – Non-Pharmacologic**
  - Non-pharmacologic agent resulting in an adverse reaction e.g. animal or insect, food, plant or other i.e. rubber, soap, latex, perfume.

- **Aggressive behaviour**
  - The client currently has or has a history of aggressive behaviour.

- **Antisocial behaviour**
  - The client currently has or has a history of antisocial behaviour.

- **Chronic disorder**
  - The client currently has or has a history of a chronic disorder.

- **CRAB**
  - Carbapenem resistant Acinetobacter.

- **Cultural and/or Religious need**
  - The client currently has or has a history of a cultural or religious need.

- **Device in situ**
  - The client has an implanted or external device that may affect treatment (eg. an insulin pump, pacemaker, internal fixation).

- **ESBL**
  - Extended spectrum Beta-lactamase producing organisms.

- **Fails**
  - The client currently has or has a history of experiencing falls.

- **Legal**
  - The client has an active medical legal request.

- **Mental Health Act status**
  - Client currently has/has a history of information recorded pertaining to the Mental Health Act.

- **MRAB**
  - Multi resistant Acinetobacter.

- **MRSA**
  - Methicillin resistant Staphylococcus aureus .

- **MRST**
  - Multi drug resistant (Pulmonary) Tuberculosis.

- **MRMRSA**
  - Non-methicillin resistant Staphylococcus aureus.

- **Other administrative**
  - An administrative alert that is not defined elsewhere.

- **Other clinical**
  - A clinical alert that is not defined elsewhere.

- **Other infectious organism**
  - Other infectious organism that is not defined elsewhere.

- **Other safety and security**
  - Other safety and/or security alert not defined elsewhere.

- **Other Special Mental Health**
  - A Mental Health alert not elsewhere classified.

- **Other special needs / Preferences**
  - A special need and/or preferences alert not defined elsewhere.

- **Power of attorney in existence**
  - The client has a nominated power of attorney. This is a legal document authorising another person to act on behalf of the client's affairs.

- **Release of Information**
  - Directions exist for either authority to or restrictions on the release of information to the client.

- **Resuscitation Plan exists**
  - The client has an active Resuscitation plan.

- **Satellite record exists**
  - The client has multiple clinical records.

- **SCAN (Child at risk)**
  - The client or client's child may be at risk of abuse or neglect.

- **Self harm behaviour**
  - The client currently has or has a history of self harming behaviour.

- **Unborn child**
  - Risk to client's unborn child.

- **VRE**
  - Vancomycin resistant Enterococcus.
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**See if you can get the co-contribution.**
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**Talk to QSuper today.**
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