Northern Health

Term Description – Handbook – ROVER

1. Term details:			
Health Service:	Northern Health	**Term duration:**	Maximum: 13 weeks
Location/Site:	Northern Hospital Epping	**Clinical experience - Primary**:	C: Acute and critical illness patient care
Parent Health Service:	Northern Health	**Clinical experience - Secondary**:	B: Chronic illness patient care
Speciality/Dept.:	General Medicine Unit 4	**Non-clinical experience:**	*(PGY2 only)*
PGY Level:	PGY1	**Prerequisite learning:**	*(if relevant)*
Term Descriptor:	*General medical term, with a focus on aged care, ward-based management of patients with a range of acute and chronic medical conditions. Attendance at medical grand rounds and unit meetings. Work as part of a multi-disciplinary team and attend multi-disciplinary team meetings. Attendance at family meetings. Discharge planning and transfer of acute to community care.*		

2. Learning objectives:		
EPA1: Clinical Assessment	Domain 1	Be able to take relevant history and be competent in targeted examination for common general medical conditions including: COPD/ pneumonia/ Acute Coronary Syndrome/ delirium/ GI bleeding/ Sepsis/ heart failure
	Domain 2	Build knowledge and confidence in directing initial investigations and management for simple medical problems. Balance taking on responsibility for patient care with recognition of when to escalate to involve other professionals
	Domain 3	Identifies and considers culturally safe and appropriate means of obtaining patient histories and/or performing physical examination. Understands the importance of use of interpreters for communication
	Domain 4	Makes use of local service protocols and guidelines to inform clinical decision-making.
EPA2: Recognition and care of the acutely unwell patient	Domain 1	Identifies deteriorating or acutely unwell patients
	Domain 2	Recognises their own limitations and seeks help when required in an appropriate way.
	Domain 3	Accesses interpretive or culturally-focused services and considers relevant cultural or religious beliefs and practices.
	Domain 4	Observes local service protocols and guidelines on acutely unwell patients
EPA3: Prescribing	Domain 1	Initiates, modifies or ceases therapies (drugs, fluids, blood products, oxygen) safely, adheres to all relevant protocols and monitors patient reactions, reporting when relevant.
	Domain 2	Recognises their own limitations and seeks help when required in an appropriate way.
	Domain 3	Understands that social cultural background health literacy and patient preference may all impact on a patient's acceptance and adherence in taking medications and this should be considered when making prescription choices
	Domain 4	Makes use of local service protocols and guidelines to ensure decision-making is evidence-based and applies guidelines to individual patients appropriately
EPA4: Team communication	Domain 1	Creates verbal or written summaries of information that are timely, accurate, appropriate, relevant and understandable for patients, carers and/or other health professionals.

– *documentation, handover and referrals*	Domain 2	Maintains respect for patients, families, carers, and other health professionals, including respecting privacy and confidentiality.
	Domain 3	Includes relevant information regarding patients' cultural or ethnic background in the handover and whether an interpreter is required.
	Domain 4	Practices presenting patients on ward rounds and at internal team handovers to develop skills in safe and effective handover. Participates in unit meetings to practice presenting patients from the unit with discussion of best practice management and treatment.

3. Outcome statements:			
Domain 1: *The prevocational doctor as practitioner*	**Domain 2:** *The prevocational doctor as professional and leader*	**Domain 3:** *The prevocational doctor as a health advocate*	**Domain 4:** *The prevocational doctor as a scientist and scholar*
☒ 1.1 Place the needs and safety at the centre of the care process, working within statutory and regulatory requirements and guidelines. Demonstrate skills including effective handover, graded assertiveness, delegation and escalation, infection control, and adverse event reporting. *☐ 1.2 Communicate sensitively and effectively with patients, their family and carers, and health professionals, applying the principles of shared decision-making and informed consent.* *☐ 1.3 Demonstrate effective, culturally safe interpersonal skills, empathetic communication, and respect within an ethical framework inclusive of indigenous knowledges of wellbeing and health models to support Aboriginal and Torres Strait Islander patient care* *☒ 1.4 Perform and document patient assessments, incorporating a problem-focused medical history with a relevant physical examination, and generate a valid differential diagnosis and/or summary of the patient's health and other relevant issues* *☐ 1.5 Request and accurately interpret common and relevant investigations using evidence-informed knowledge and principles of sustainability and cost-effectiveness* *☒ 1.6 Safely perform a range of common procedural skills required for work as a PGY1 and PGY2 doctor.* *☐ 1.7 Make evidence-informed management decisions and referrals using principles of shared decision-making with patients, carers and health care team* *☒ 1.8 Prescribe therapies and other products including drugs, fluids, electrolytes, and blood products safely, effectively and economically* *☒ 1.9 Recognise, assess, communicate and escalate as required, and provide immediate*	*☒ 2.1 Demonstrate ethical behaviours and professional values including integrity, compassion, self-awareness, empathy, patient confidentiality and respect for all.* *☐ 2.2 Identify factors and optimise personal wellbeing and professional practice, including responding to fatigue, and recognising and respecting one's own limitations to mitigate risks associated with professional practice.* *☒ 2.3 Demonstrate lifelong learning behaviours and participate in, and contribute to, teaching, supervision and feedback.* *☐ 2.4 Take increasing responsibility for patient care, while recognising the limits of their expertise and involving other professionals as needed to contribute to patient care.* *☒ 2.5 Respect the roles and expertise of healthcare professionals, and learn and work collaboratively as a member of an inter-personal team.* *☒ 2.6 Contribute to safe and supportive work environments, including being aware of professional standards and institutional policies and processes regarding bullying, harassment and discrimination for themselves and others.* *☐ 2.7 Critically evaluate cultural safety and clinical competencies to improve culturally safe practice and create culturally safe environments for Aboriginal and Torres Strait Islander communities. Incorporate into the learning plan strategies to address any identified gaps in knowledge, skills, or behaviours that impact Aboriginal and Torres Strait Islander patient care.* *☒ 2.8 Effectively manage time and workload demands, be punctual, and show ability to prioritise workload to*	*☐ 3.1 Incorporate disease prevention, relevant health promotion and health surveillance into interactions with individual patients, including screening for common diseases, chronic conditions, and discussions of healthcare behaviours with patients* *☒ 3.2 Apply whole-of-person care principles to clinical practice, including consideration of a patients physical, emotional, social, economic, cultural and spiritual needs and their geographical location, acknowledging that these factors can influence a patient's description of symptoms, presentation of illness, healthcare behaviours and access to health services or resources.* *☐ 3.3 Demonstrate culturally safe practice with ongoing critical reflection of the impact of health practitioner's knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism and discrimination.* *☐ 3.4 Demonstrate knowledge of the systemic and clinician biases in the health system that impact on the service delivery for Aboriginal and Torres Strait Islander peoples. This includes understanding current evidence around systemic racism as a determinant of health and how racism maintains health inequity.* *☐ 3.5 Demonstrate knowledge of the ongoing impact of colonisation, intergenerational trauma and racism on the health and wellbeing of Aboriginal and Torres Strait Islander peoples.* *☒ 3.6 Partner with the patient in their healthcare journey, recognising the importance of interaction with and connection to the broader healthcare*	*☒ 4.1 Consolidate, expand and apply knowledge of the aetiology, pathology, clinical features, natural history and prognosis of common and important presentations in a variety of stages of life and settings.* *☐ 4.2 Access, critically appraise and apply evidence form the medical and scientific literature to clinical and professional practice.* *☐ 4.3 Participate in quality assurance and quality improvement activities such as peer review of performance, clinical audit, risk management, incident reporting and reflective practice.* *☐ 4.4 Demonstrate a knowledge of evidence-informed medicine and models of care that support and advance Aboriginal and Torres Strait Islander health.*

management to deteriorating and critically unwell patients. *☐ 1.10 Appropriately use and adapt to dynamic systems and technology to facilitate practice, including for documentation, communication, information management and supporting decision-making*	*manage patient outcomes and health service functions.*	*system. Where relevant, this should include culturally appropriate communication with caregivers and extended family members while also including and working collaboratively with other health professionals (including Aboriginal Health Workers, practitioners and Liaison Officers).*	

4. Supervision details:			
Supervision Role	***Name***	***Position***	***Contact***
DCT/SIT	***Dr Carol Chong***	Supervisor of Intern Training	Carol.Chong@nh.org.au
Term Supervisor	***Dr Yohanes Ariathianto***	Head of Unit	Yohanes.Ariathianto@nh.org.au
Clinical Supervisor (primary)	***Dr Yohanes Ariathianto***	Head of Unit	Yohanes.Ariathianto@nh.org.au
Cinical Supervisor (day to day)	***Unit Registrar***	General Medicine Unit Registrar	Via Medtasker or Switchboard
EPA Assessors *Health Professional that may assess EPAs*	• All Consultants • All Registrars • Click or tap here to enter name and role		

Team Structure **- Key Staff**		
Name	**Role**	**Contact**
Dr Yana Sunderland	Divisional Director	Yana.Sunderland@nh.org.au
Dr Yohanes Ariathianto	Head of Unit	Yohanes.Ariathianto@nh.org.au
Unit Consultant	General Medicine Physician	Via Switchboard
SMR	Senior Medical Registrar	Via Medtasker or Switchboard
Unit NUM	Unit NUM	Via Switchboard

5. Attachments:	
R-over document	See below
Unit orientation guide	See below
Timetable (sample in appendix)	See below

6. Accreditation details *(PMCV use only)*	
Accreditation body:	Click or tap here to enter text.

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Accreditation status:	Click or tap here to enter text.	
Accreditation ID:	Click or tap here to enter text.	
Number of accredited posts:	PGY1: number	PGY2: number
Accredited dates:	Approved date: date.	Review date: date.

7. Approval		
Reviewed by:	Click or tap here to enter text.	Date:Click or tap to enter a date.
Delegated authority:	Click or tap here to enter text.	Date:Click or tap to enter a date.
Approved by:	Click or tap here to enter text.	Date:Click or tap to enter a date.

Appendix

Timetable example

	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
Morning	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time
	08:00 Handover 08:30 ward round 1130 MDT	08:00 Handover 08:30 ward round 1130 MDT	0:800 Handover 08:30 Med intern teaching 09:00 ward round 1130 MDT	08:00 Medical Grand round 09:00 Ward round 1130 MDT	08:00 Handover 08:30 ward round 1130 MDT	08:00 Handover 08:30 ward round	08:00 Handover 08:30 ward round
Afternoon	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time
	13:00 Ward work	12:30 – 13:30 Intern Education 13:00 Ward work 14:00 Unit meeting or Quality CUSP meeting (two weeks pe month)	13:00 Ward work	13:00 Ward work	13:00 Ward work	Click or tap here to enter text.	Click or tap here to enter text.
Evening	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time
	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Hours	Total	Total	Total	Total	Total	Total	Total

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REG Medical Unit 4	Mon	Tues	Wed	Thur	Fri	Sat	Sun	Mon	Tues	Wed	Thur	Fri	Sat	Sun
Reg 1			Registrar Training Time	07:30 - 20:30	08:00 - 20:30	08:00 - 20:30	08:00 - 20:30	08:00 - 20:30	Registrar Training Time	0800-1330				
									08:00 - 20:30	Training Time				
Reg 2	Registrar Training Time	Registrar Training Time	08:00 - 17:00	07:30 - 12:30	07:30 - 12:30			Registrar Training Time	Registrar Training Time	08:00 - 20:30	07:30 - 12:30	08:00 - 17:00		
	08:00 - 17:00	08:00 - 20:30		Registrar Training Time				08:00 - 17:00	08:00 - 17:00					
Reg 3	08:00 - 20:30	Registrar Training Time	0800-1330							Registrar Training Time	07:30 - 20:30	08:00 - 20:30	08:00 - 20:30	08:00 - 20:30
		08:00 - 17:30	Registrar Training Time											
INTERN Medical Unit 4	**Mon**	**Tues**	**Wed**	**Thur**	**Fri**	**Sat**	**Sun**	**Mon**	**Tues**	**Wed**	**Thur**	**Fri**	**Sat**	**Sun**
Intern 1	08:00 - 20:30	08:00 - 17:00	08:00 - 20:30								07:30 - 20:30	08:00 - 20:30	08:00 - 20:30	08:00 - 17:00
Intern 2				07:30 - 20:30	08:00 - 20:30	08:00 - 20:30	08:00 - 17:00	08:00 - 20:30	08:00 - 17:00	08:00 - 20:30				
Intern 3	08:00 - 17:00	08:00 - 20:30	08:00 - 17:00	07:30 - 17:00	07:30 - 12:30			08:00 - 17:00	08:00 - 20:30	08:00 - 17:00	07:30 - 17:00	08:00 - 13:00		

9. Hospital Orientation		
Hospital orientation occurs at the beginning of each term. Attendance is mandatory and paid non-clinical time. This is separate to the unit orientation. Follow the link for details, password: NorthernDoctors		
Location	NCHER, Northern Hospital – Epping	185 Cooper Street, Epping 3076
Facilitator	Medical Education Unit	Email: MedicalEducationUnit@nh.org.au
Date	First day of each term	
Start	08:00	

10. Unit Orientation	
Unit Orientation occurs at the beginning of each term. Attendance is mandatory and paid time. Orientation that occurs outside of your rostered hours should be submitted as overtime on the overtime reporting portal	
Location	Ward 4 (Home ward)
Facilitator	Ward consultant Registrar and NUM and HOU
Date	1st or 2nd day of rotation (Mon- B interns Tues- A interns) HOU will meet interns in first week of term
Start	8:30 am after medical handover

11. Unit Overview	
Department	Medicine
Location	Ward 4 – Office in corridor near ward 3/4 ward clerk desk
Inpatient Beds	10 – 15
Outpatients Clinics	No OPC for med 4 – for general medical follow up refer to general medical OPC (Med 1 – 3) there is capacity to follow up all gen med outpatients in these clinics in 2024 Med 4 A reg will attend BH wound clinic as part of Geriatric AT training
Day Procedures	Nil
Virtual Unit	Nil

12. Safety

Unit Specific Safety & Risks

Safe Prescribing

- Ensure all new patients' usual medications are charted and refer to 'Pharmacy Admission Note' to check all medications are correctly charted
- seek help from registrar or pharmacist if uncertain.
- Look up all medications you are not familiar with
- Special consideration for the APINCH Medications; Antimicrobials, Potassium, Insulin, Narcotics (opioids) and sedative medications, heparin and other anticoagulants (chemotherapy *not routinely prescribed in medicine)*
- Ensure you use antibiotic guidance system for all restricted antibiotics

Falls – review prevention plans and medication charts for high risk medications

Pressure injuries – review pressure areas regularly

Infection prevention – ensure you follow all guidelines regarding isolation and wear appropriate PPE

Agitated and aggressive patients – Med 4 cares for older patients including those with delirium and BPSD. The ward 4 nursing staff have expertise in this area and the geriatricians are experienced in managing these patients. You will learn re some key principles of managing these patients during your term on med 4. Focus is on keeping patients and staff safe using behavioural and other strategies.

13. Communication	
Medtasker	Intern role, medical registrar role Med tasks will come up through the day, please acknowledge the task as soon as you can and send message back to nurses with ETA's if you are busy and cant get the task done quickly
WhatsApp	No clinical group - medical registrars have group for contact with Senior medical registrar regarding operations and education activity
Pager	Carried by medical registrar – for MET call alerts this must be carried at all times
MS Teams	NH General Medicine Team – daily handover list weekend roster etc on this team

14. Handover Process	
Morning	TNH – General Medicine Handover – via MS TEAMS and in lecture theatre 8:00 all days except 7:30 Thursdays (Ward Medical Teams can tune in from their office)
Afternoon	To co intern and registrar in home ward office if finishing at 1700
Night	Ward 5/6 meeting room 20:00

15. Shift Structure		
	Intern	Registrar
Day	8:00 start (Thurs 7:30)	8:00 start (Tues and Thurs 7:30)
Afternoon	No PM shift	Training time cover shift cover as per roster – Wed /Fri
Night	No night shift	No night shift
Weekend	8:00 start as per roster	8:00 start as per roster 'B 'registrars

16. Shift Roles & Responsibilities		
	Intern	Registrar
Day	***8:00 Login to Medtasker*** 8:00 Handover form co intern re evening shift issue and night ward cover calls if issues overnight. Update patient list and bed- cards. Tick of discharges and prep scripts for new patients 8:30 - See sick and early discharges with registrar 9:00 see new patients with consultant of the day Then round with consultant / registrar A consultant round - Tues Thurs and Mon or Fri B consultant round - Mon Wed Fri 11:30 Daily Ward MDT – discharge planning meeting	***8:00 Login to Medtasker*** Med handover – MS Teams or Lec. Theatre Handover of all new patients and sick patients from overnight 8:30 - See sick and early discharges 9:00 see new patients with consultant of the day Then round with intern +/- consultant A consultant round - Tues Thurs and Mon or Fri B consultant round - Mon Wed Fri

	After ward round - Paper round with reg to prioritise and split jobs	11:30 Ward MDT – discharge planning meeting After ward round - Paper round with reg to prioritise and split jobs
Afternoon	Ward work Referrals, radiology, discharge paperwork, chase results Teaching as per roster	Ward work Complex referrals, update families, detailed review of complex patients, chase results OCP Med 4A reg (AT) attends BH wound clinic Tues afternoon – 4B reg covers Thurs TT 4A – med 4b covers Wed 4B TT – TT cover reg as per roster
Night	Nil	Nil
Weekend	***8:00 Login to Medtasker*** 8:00 Handover form co intern re evening shift issue and night ward cover calls if issues overnight. Update patient list and bed- cards. Tick of discharges and prep scripts for new patients 8:30 - See sick and early discharges with registrar See new patients with weekend consultant Ward round with registrar Ward work	***8:00 Login to Medtasker*** Med handover – MS Teams or Lec. Theatre Handover of all new patients and sick patients from overnight 8:30 - See sick and early discharges See new patients with weekend consultant Ward round with interns Ward work

17. Common Conditions

You will see a great range of medical conditions in the general medical patients. Many patients have multiple medical conditions. You will see lots of common conditions as well as some rarer ones in your term. Some common conditions you might see are:

● Exacerbation of CCF & its causes ● Exacerbation of COPD ● Other cardiac conditions AF NSTEMI

● Diabetes and its complications ● Acute and chronic renal impairment ● Delirium

● Respiratory infections including influenza and COVID 19 ● Fever in returned traveller

● Sepsis – Urinary, Cellulitis, Pneumonia, Prostatitis, Endocarditis, Epidural abscess, other

● Falls and functional decline

● Altered conscious state: Neurological: infection, stroke, post-ictal , Drugs, Metabolic, Accident/injury, Psychiatric, delirium

● Acute gout and other rheumatological conditions

● Delirium dementia and BPSD management

● Frailty and other geriatric syndromes

In General Medicine you will also see patients who have complex social and family situations, mental health or substance abuse issues as well as patients who are frail and have functional decline. Identifying understanding and considering these things when planning medical care in the short and long term is essential and is as important as learning about common medical conditions. General medicine is a specialty that embraces complexity.

18. Common Procedures

● Venepuncture/ IVC ● IDC ● ABG ● Lumbar puncture - done by Regs but can assist

● PICC lines - done by Radiology (always dual lumen!) ● Ascitic tap – done by registrar but can assist

19. Clinical Guidelines

The My Favourite Links page on the intranet contains the links to a number of useful clinical guidelines
https://intranet.nh.org.au/applications/
ETG- Electronic Therapeutic Guidelines
AMH- Australian Medicines Handbook MIMS
Up to Date
"For Clinicians" Header on the intranet Home page – has a range of commonly used resources used by doctors
PROMPT- This site contains the hospital policy and procedure manuals. It can only be accessed from the intranet - https://intranet.nh.org.au/departments-and-services/prompt-policy-procedures-guidelines/prompt-policies-procedures-and-forms/

20. Routine Orders

Pathology	There are no routine order sets in general medicine. Order sets will depend on the condition and the current patient assessment. Most patients do not need daily blood tests so consider why you need a test before you order them Check that bloods like TSH iron HBA1c has not been ordered recently prior to ordering them again
Radiology	CT should be discussed with your registrar / consultant MRI should all be discussed and approved by your consultant Once you have submitted a CT/ US or MRI request please check the EMR Radiology Order Management System to check that the scan has been approved. If it states 'for discussion' then radiology needs more information and you will need to go down and discuss that test with the radiographer/ radiologist

	For any Interventional Radiology process – you need a recent coags, consent form as well as radiology request, speak with Radiologist on duty to approve - THEN go to procedural booking nurses to book time in
Pharmacology	See - Safe prescribing section in Safety section of this handbook The ward pharmacist is there to help you please check with them if you are uncertain Look up all drugs that you are not familiar with and check doses if uncertain Ask you registrar or consultant if not sure if you should continue or withhold medications Warfarin dosing should be done in consultation with your registrar Please refer to the anticoagulation stewardship pharmacist or haematology team for patients with complex anticoagulant regimens

21. IT Programs	
EMR	The EMR is in use for documentation, medication ordering and radiology/pathology requests. It is being used for all inpatients, as well as maternity clinics and pre-anaesthetic clinics. Located in the intranet > My Favourite Links > EMR Live Environment EMR Training courses are located on the LMS- https://mylearning.nh.org.au/login/start.php Training is compulsory; you will need to complete the elearning within the first week of commencing. Please contact medical workforce, or check the EMR website for more information on how to complete EMR training https://emr.nh.org.au/ When starting a new rotation, please reach out to Term Supervisor to ensure you are oriented to the EMR specific workflows for that unit as well. EMR is NOT a primary communication system. Please use Medtasker and phones for referrals and communication.
CPF	The source of information for all outpatients' clinics, investigations, GP referrals and scanned admission notes prior to September 2023. Located in the intranet > My Favourite Links > CPF https://cpf.nh.org.au/udr/
PACS	XERO Viewer Pacs- https://nivimages.ssg.org.au/ or located in My Favourite Links, look for the CXR icon This is where you can find radiology images
My Health Record	Centralised health record https://shrdhipsviewer.prod.services/nhcn
Safe Script	Monitoring system for restricted prescription medications https://www.safescript.vic.gov.au/
Antibiotic Guidance	iGuidance in My Favourite links (Pharmacy will only supply one day unless this is done) Some antibiotics you can get guidance by selecting the condition. Otherwise you will have to refer to ID, explain rationale behind ABx choice/ ask for their opinion and they do the guidance.
	Interpreter via phone: 84058188

	Endoscopy results: on the CPF patient screen – endobase. Username: endobhs. Password: endobhs Echo and angio results: Phillips Xcelera. Username and login same as CPF

22. Documentation	
Admission	Mostly done by AMT team – use EMR admission form
Ward Rounds	EMR ward round note or progress note. Can use ward round template with progress note to save time – can be saved as Auto text
Discharge Summary	EMR discharge summary workflow – please use this format as this will generate upload to Myhealth record and fax to GP when completed
Outpatient Clinics	General Medical Outpatients referrals ***via referral on CPF*** (no EMR option for referrals) Outpatient notes are all documented on CPF under the outpatient tabs
CDI Queries	Will be sent via Medtasker
Death Certificates	Discus with your registrar / consultant re if coroners' case and if not then cause of death before completing, Link is direct via Births Deaths and Marriages. Link – Death Certificates on the Favourite links page https://www.bdm.vic.gov.au/medical-practitioners
Coroners	Discuss every death with your reg/ consultant to check if it should be coroners. If uncertain then call to speak to a delegate from the coroner's office and document your conversation in EMR notes. Coroner deposition is done via - E Medical Deposition Form https://coronerscourt.vic.gov.au/report-death-or-fire/how-report-death

23. Referrals	
Internal	Inpatient consults Via Medtasker, some teams will use phone – AGSU some surgical specialties. Please make referrals as early as possible in the day and know what question your unit is asking of them (if uncertain speak to your unit registrar) Outpatient referrals – CPF – Summary tab – bottom right of the page is 'Submit internal referral' link
External	Ad hoc no frequently used pathways

24. Clinical Deterioration	
Escalation Process	Interns will be paired with a registrar at all times (may be A or B) so can always call for help. Intern or Reg should call then consultant if further escalation is required. Your ward consultant will take calls in hours and after hours. However, if afterhours they are not available call the on-call AMT consultant for time critical or urgent queries (daily roster and number via switch board) Call MET call or code if patient meets these criteria and needs urgent review
PreMet	Intern will answer these but seek advice from unit registrar
Code	Attended by home team registrar and wider hospital code teams

25. Night Shift Support

Unit	Downstairs Night HMO - Night Ward cover is allocated to cover your team – please handover any complex patients. Night ward cover will flag issues from overnight with team Sick unstable patients from overnight will be flagged at the morning general medical handover
Periop	Attends MET Calls and codes however will leave home team registrar to manage general medical MET calls in hours. Contact 0418 428 781 or via Medtasker
Take 2 @ 2	Downstairs Night HMO - Night ward cover attends this meeting

26. Assessments: PGY1 & PGY2	
All forms are located on the Northern Doctors website under the Assessments tab	
Beginning of Term	Meet with Term Supervisor to set learning goals for the term using the Term Description Learning Objectives as a basis for the discussion
Mid-Term & End of Term	To be completed at the mid and end of term meetings
EPAs	Minimum of x2 EPA assessments to be completed per term

27. Mandatory Training

- Mandatory Training is located on the LMS- https://mylearning.nh.org.au/login/start.php
- Mandatory training is compulsory and part of your contract with Northern Health and needs to be completed by the first month of your start date. If not completed you will come of the floor to complete.
- Hand Hygiene needs to be completed by the end of your first week.
- If you have completed the mandatory training elsewhere you may be able to apply for recognition of prior learning

28. Unit Education

Protected intern teaching 1230- 1330 Tuesdays -Lecture Theatre and TEAMS
Unit meeting – *changed in 2024* to Mon 1400 1st week of the month – Lecture theatre and TEAMS
General Medical Intern teaching – Clinical Pearls Wed 8:30 – 900 TEAMS
Medical Grand Rounds 800- 900 – lecture theatre or TEAMS
BPT registrar Education – 1300- 1400 Friday Conf room 4 and TEAMS
BPT consortium clinical/ written exam education lecture series – 1600- 1700 Wed
BPT clinical exam prep programme – see consortium website for more details
Geriatric AT training (4A reg) – State wide Geriatric training – Thurs afternoon as per Sate Based Training Roster

29. Unit Meetings

Unit meeting – *changed in 2024* to Mon 1400 1st week of the month – Lecture theatre and TEAMS
CUSP (quality meeting) – changed in 2024 to Mon 1400 3rd week of the month – Lecture theatre and TEAMS

30. Research and Quality Improvement

If you are interested in research please speak to your unit head to see how you can get involved.

CUSP – Clinical Unit Safely Program – is a monthly quality meeting attended by medical nursing and allied health staff that looks at how your team and ward are doing in terms of quality and outcomes. There is also opportunity to suggest local quality improvement activities that you can get involved in in this meeting

31. Career Support
Head of Unit Yohanes Ariathianto or ward consultant Director of intern training – Dr Carol Chong Basic Physician training - Directors of Physician Training – Edwina Holbeach, Yana Sunderland, Mueed Main, Vinita Rane Basic Physician training - Consortium Manager – Laura Ivins

32. Medical Students on the Unit
Medical students rotate through the unit please make them welcome

33. Rostering	
Shift Swap	The doctor initiating the roster swap is responsible for arranging with an appropriate colleague. Once you have arranged a colleague to perform the swap, please email your MWU coordinator and cc in the colleague. All swaps should be kept to within the pay period fortnight where possible. In exceptional circumstances where this cannot be achieved, please discuss with the MWU coordinator prior. All shift swaps should be like hours for like hours. Proposed shift swaps must be emailed to your MWU coordinator for approval.
Unplanned Leave- Notification and documentation process	**Personal Leave documentation required:** For 3 single absences per year, the doctor will not be required to provide any supporting evidence to substantiate their personal leave. For other days absent due to personal illness or injury the doctor is required to provide evidence of illness. To be eligible for payment, the doctor is required to notify the Health Service **two hours** before the start of their shift, or as soon as practicable.

<table>
<tr><td></td><td>
<table>
<tr><td>In hours Monday to Friday
0730 - 1630</td><td>Step 1:
Medical Workforce Reception
8405 8276</td><td>Step 2:
Notify unit</td><td>Please ensure you notify both MWU & your unit</td></tr>
<tr><td>After hours Monday to Friday
Between 1630 – 2200

After hours Monday to Friday
Between 2200-0730</td><td>Step 1:
Between 1630 – 2200
Medical Workforce On-call Phone
0438 201 362

Between 2200-0730
Hospital / After Hours Coordinator
(8405 8110 or via switch)</td><td>Step 2:
Notify unit (at a suitable time)</td><td>Please ensure you notify both MWU or After Hours (depending on the time) & your unit at a suitable time.</td></tr>
<tr><td>In hours Weekends & Public Holidays
0700 - 2200</td><td>Step 1:
Medical Workforce On-call Phone
0438 201 362</td><td>Step 2:
Notify</td><td>Please ensure you notify both MWU & your unit</td></tr>
<tr><td>After hours Weekends & Public Holidays
2200-0700</td><td>Step 1:
Hospital / After Hours Coordinator
(8405 8110 or via switch)</td><td>Step 2:
Notify unit</td><td>Please ensure you notify both MWU & your unit</td></tr>
</table>
</td></tr>
<tr><td>Overtime</td><td>All overtime should be submitted into the Overtime Portal
This can be accessed via the intranet whilst onsite at Northern Health
Please include the reason for your overtime- i.e. ward workload, delayed handover, include UR where relevant.</td></tr>
</table>

34. JMO Rover

Medical Unit 4 is our aged care general medical team. While you will look after a range of patients the unit specializes in caring for patients who are older and frailer or have geriatric syndromes such as falls and delirium. In addition, they will take patients with moderate to severe BPSD. For frailer aged care patient's consideration of the benefit / burden of various tests and treatments is important. It is not infrequent that during an admission the trajectory of the goals of care will change to a palliative approach to care or end of life care.

STRUCTURE OF THE UNIT

Each General Medical team is divided into a A and B subunit. Each subunit has a consultant registrar and intern. However, to assist with afterhours and weekend workflow in 2024 the B reg and A and B interns are week on week off with only the A registrar being Mon – Fri. This means on Mon Wed Fri, both interns stay back till 2030. On Tues and Thurs one intern covers from 1700-2030 and on Sat and Sun both interns are on with one covering from 1600- 2030. One Tuesday per fortnight the B intern and reg will cover 1700-2030. We have been unable to align the rosters completely to have one person from each team at this time so good handover of patients from the A team will be required.

- General Medical patients are allocated to your unit based on their admission location – i.e. each medical unit is assigned a specific home ward and some outliers areas. Patients allocated to that ward is the responsibility of the medical unit of that ward.
- AMT are unable to notify of every afternoon transfer to the ward however will Medtask or call if the patient is unstable or has urgent things that need to be followed up

- Allocations are updated and reviewed each morning at the general medical handover – unit workload is assessed and balanced as much as possible however in general teams should manage all Gen Med patients on their home wards.
- We try to reduce numbers of outliers however they can fluctuate, if you have a complex patient who is an outlier ask your ward NUM to move them to your home ward.
- One of your ward consultants will see any new patient (if not seen by AMT consultant) with your team 5 days per week on weekdays. On weekends the weekend consultant will review new patients with your team.
- 'A' consultants round Tues Thurs mornings and one other day Mon or Fri. 'B' consultants round Mon Wed Fri

HOME WARDS AND DISCHAGE PLANNING

Each medical team has a home ward with aim for the majority of patients to be on this ward. Please introduce yourself tot the NUM and nurses in charge. They are here to work closely with you and assist you keep them updated re what's happening with your patients and check in with them when you arrive on or leave the ward.

In order to move patients up from Ed to the wards we do have a focus on getting some of our discharges out earlier in the day. This is better for patient who hate waiting on trolleys in Ed as well as our AMT team who need to move on to see new patients. The ward staff will ask you to prep some of your discharge as early morning or 8:30 discharges completing paperwork the day before. Alternately you might make these early discharges Criteria Led Discharges by completing a simple form with the criteria that they can be discharged on (ie sats > 92% / afebrile etc) and the senior nurse can review and sign off. They will call you if there are any issues with not fulfilling criteria, abnormal observations or blood tests. There may be other things we try during your term to assist with early discharges

Waiting for what escalation
If patients are waiting for scans or other investigations / specialty referrals/ or hospital transfers and you think they have been waiting too long or need one thing done prior to discharge, consider escalating to the operations director of medicine (in hours) or hospital coordinator afterhours. Operations director – 0419 550 210

CLINICAL FRAILTY SCORE
All general medical patients > 65 yo should have a clinical frailly score documented in their admission / first ward round and it can be helpful to document this in the free text section of the GOPC form. The score should reflect the person's function 2 weeks prior to admission to best capture their usual or baseline function. It should not be done for patients under 65yo or with a fixed disability. The CFS correlates assists to identify a person as being frail and therefore at higher risk of deterioration of function or need for increased community supports. Of note a higher CFS has also been shown to correlate with poorer outcomes from CPR resuscitation or ICU admission so can be considered when making decisions re GOPC.

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

DALHOUSIE UNIVERSITY *Inspiring Minds*

TIPS FROM PREVIOUS INTERNS

1. *Rostered hours, realistic hours, cover shifts, weekend shifts*
   (In 2024 there is increased intern cover after hours – two interns 3 evenings per week and two interns on weekends 800-1600 so this should help manage workload)

- Learn the art of handover aim to get out on time as much as you can
- Help each other out to ensure ALL INTERNS get out as close to time as possible – YOU ARE ALL ONE BIG TEAM, SUPPORT EACH OTHER.
- Try and do as many jobs as possible on the round - radiology and pathology requests
- You may not be able to do all tasks each day prioritise what needs to done an its ok to leave some things to the next day

2. *Tips for managing discharge summary workload*

- Prep as much as you can as you go – don't leave a discharge summary of a 1-month admission to the cover intern
- Write a problem list of things that have happened through the admission
- Ix: only include full report/result if it's a significant investigation
- Medications: it's important to document the changes, can check the Pharmacy Admission note and home medications and compare with D/C script
- GP and OP clinic plans: make them as clear as possible

3. *Ordering of investigations, chasing results*

- Make sure you put in bloods for relevant days on Saturday, Sunday and Monday before you leave on Friday

4. Ward daily MDT (allied health meeting) - Good to go to with your reg at the start of the rotation to understand your pts plan as a whole, the things each allied health team are looking for and what they can help you with, discharge planning so you can prioritise which summaries you do etc. The team like to know estimated discharge dates – these can be changed/revised/you are allowed to be wrong. Give short summary of progress and any AH referrals.
5. *Other useful tips*

- Try and attend as many MET calls as possible – good learning opportunity, good skills under pressure and being comfortable managing unwell patients (will also get to witness some good family GOPC/end of life discussions)
- Learn how to certify death, do death certificates. Call the coroners court if there's any doubt about whether a death is reportable or not. They're very helpful and easy to talk to. Have your death certificate registration at the start of the rotation.
- Patients post-taked by AMT may appear on your bedcard in the afternoon/you can get medtasked about them. Some jobs can wait until rounds the next day, others can't, hopefully AMT will enact their plan before transferring. If they are complex call the AMT team to get verbal handover
- Can have very irregular registrars especially towards the end of the year which can be difficult. Talk with someone about it on your team like your ward consultant, SMR or Carol Chong, the Intern Supervisor.
- If you find a common theme in your patients during your rotation go ahead and make some notes- you may have some interesting information for future presentation at unit meeting grand round or publication of a case study or series.
- Given MED4 is geriatric focused, the team is often managing at least one patient approaching or at comfort care. Make sure GOPC-forms have been filled out for every patient when they're admitted, and consider early discussions with family about direction of care if appropriate. Consultants are almost always approached for guidance in these decisions

FOR REGISTRARS

- **Registrar training time** – is noted in your roster and is a mix of educations meetings that occur during your clinical shifts or paid in addition to this time. For paid TT when rostered off you should attend any scheduled training sessions that relate to your BPT training pathway – ie clinical exam prep for BPT3 or Written exam prep for BPT2. This may be in person or virtually.
  A registrars TT per fortnight
  Journal club, Grand round, BPT Friday teaching weekly plus additional 5 hours paid TT – totals 10 hours
  B registrars TT per fortnight
  Journal club, Grand Round and BPT teaching on week on only plus paid TT 7.5 hours – totals 10
  Please ensure you attend all the education activities – if you identify something that is stopping you from attending please speak to SMR / unit head/ divisional director

- TT is covered on Wed by TT cover for med 4B registrar. Med 4B registrar covers med 4A registrar aged care training time on Thursdays.

35. Document Status		
Updated by	Dr Yana Sunderland	December 2023
Reviewed by	Dr Natina Monteleone	18/01/2024
Next review date		April 2024