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**:	A: Undifferentiated illness patient care
Speciality/Dept.:	General and Colorectal Surgery	**Non-clinical experience:**	*(PGY2 only)*
PGY Level:	PGY2	**Prerequisite learning:**	*(if relevant)*
Term Descriptor:	*Colorectal and General surgical term with ward-based management of patients of colorectal and acute general surgical patients. Attendance at theatre and outpatient clinics is strongly encouraged where time permitted. Populate CANMAP data and participate in unit audits. Attend outpatient clinics and liaise with HITH. Attendance at M&M and weekly Surgical Forum.*		

2. Learning objectives:		
EPA1: Clinical Assessment	Domain 1	Performs an accurate, appropriate and person-centred history and examination. Appropriate ordering of investigations- pathology and radiology.
	Domain 2	Recognises their own limitations and seeks help when required in an appropriate way.
	Domain 3	Incorporates psychosocial considerations and stage in illness journey into assessment, acknowledging these factors can influence a patient's experience of illness and healthcare behaviours. Encourage lifestyle modifications- smoking cessation, safe alcohol use and dietary considerations.
	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 and escalates appropriately
	Domain 2	Works effectively as a member of a team and uses other team members, based on knowledge of their roles and skills, as required.
	Domain 3	Accesses interpretive or culturally-focused services and considers relevant cultural or religious beliefs and practices.
	Domain 4	Complies with escalation protocols and maintains up-to-date certification in advanced life support appropriate to the level of training.
EPA3: Prescribing	Domain 1	Appropriately, safely & accurately prescribes therapies (drugs, fluids, blood products, oxygen, DOACs, DVT prophylaxis), & demonstrates an understanding of the rationale, risks & benefits, contraindications, adverse effects, drug interactions, dosage & routes of administration, and antibiotic stewardship
	Domain 2	Works collaboratively with the multidisciplinary team, including pharmacists and nursing staff.
	Domain 3	Acknowledges and respects patients' cultural and religious background, attitude and beliefs, and how these might influence the acceptability of pharmacological and non-pharmacological management approaches.
	Domain 4	Prescribes in accordance with institutional policies, including policies on antibiotic stewardship.
EPA4: Team communication – documentation,	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.
	Domain 2	Demonstrates professional conduct, honesty and integrity.

handover and referrals	Domain 3	Recognises the importance of self-determined decision-making, partnership and collaboration in healthcare which is driven by the individual, family and community.
	Domain 4	Ensures all outstanding investigations, results or procedures will be followed up by receiving units and clinicians.

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 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*	*☒ 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 manage patient outcomes and health service functions.*	*☒ 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 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*	*☒ 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.*

		(including Aboriginal Health Workers, practitioners and Liaison Officers).	

4. Supervision details:			
Supervision Role	***Name***	***Position***	***Contact***
DCT/SIT	***Dr Chiu Kang***	Supervisor of HMO Training	Chiu.Kang@nh.org.au
Term Supervisor	***Dr Neil Strugnell***	Head of Unit	Neil.Strugnell@nh.org.au
Clinical Supervisor (primary)	***Allocated Fellow & Registrar***	Click or tap here to enter text.	Click or tap here to enter text.
Cinical Supervisor (day to day)	***Allocated Fellow & Registrar***	Click or tap here to enter text.	Click or tap here to enter text.
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 Neil Strugnell	Head of Unit	Neil.Strugnell@nh.org.au
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text
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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.
Accreditation status:	Click or tap here to enter text.
Accreditation ID:	Click or tap here to enter text.

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Number of accredited posts:	PGY1: 4	PGY2: 1 (may be PGY2 or 3)
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
	07:45- 09:30 HMO Colorectal Ca MDM- fortnightly OT	OT	OT	OP Clinic	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Afternoon	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time
	OT	OT	Click or tap here to enter text.	12:30 – 13:30 HMO Education	Click or tap here to enter text.	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.	17:30 Surgical Forum	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

General Surgery Unit 1	Mon	Tues	Wed	Thur	Fri	Sat	Sun	Mon	Tues	Wed	Thur	Fri	Sat	Sun
Fellow	0800-1636	0800-1636	0800-1636	0800-1636	0800-1636			0800-1636	0800-1636	0800-1636	0800-1636	0800-1636		
Fellow Unit 1 - Colorectal (Research)														
Fellow	0800-1636	0800-1636	0800-1636	0800-1636	0800-1636			0800-1636	0800-1636	0800-1636	0800-1636	0800-1636		
Registrar Unit 1 - Colorectal														
Reg	0700-1730	0700-1730	0700-1730	0700-1830	0800-1200			0700-1730	0700-1730	0800-1730	0700-1330	0730-1330	0800-1200	0800-1200
HMO Unit 1 - Colorectal														
HMO	0700-1700	0700-1700	0700-1330	0700-1700	0700-1700			0700-1700	0700-1700	0700-1330	0700-1700	0700-1230		
Intern Unit 1 - Colorectal														
Intern 1	0630-1630	0700-1630	0700-1630	0700-1630				1230-2200 Gen Surg	1230-2200 Gen Surg	1230-2200 Gen Surg	1230-2200 Gen Surg			
Intern 2	0700-1430	0630-1330	0630-1430	0630-1430	0630-1430			0630-1630	0630-1630	0700-1630	0700-1630			
Intern 3	1230-2200 Gen Surg	1230-2200 Gen Surg	1230-2200 Gen Surg	1230-2200 Gen Surg				0700-1430	0630-1330	0630-1430	0630-1430	0630-1430		

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 16
Facilitator	Accredited Registrar
Date	1st day of Rotation
Start	

11. Unit Overview	
Department	Colorectal/ Surgical 1
Location	Department of Surgery/ Ward 16
Inpatient Beds	Ward 16
Outpatients Clinics	Specialist clinic D – Thursday AM
Day Procedures	Theatre complex
Virtual Unit	MDM and Radiology via teams (email sent out prior to NH email)

12. Safety
Unit Specific Safety & Risks Please ask a reg before changing patients diet/ charting aperients/ inserting or removing tubes (NGT/IDC)

13. Communication	
Medtasker	Inpatients (intern) roles Cover role (intern)
WhatsApp	Per team at the time
Pager	180? AM S1 pager as well
MS Teams	For MDM and Radiology. No unit specific Teams channel

14. Handover Process	
Day	Wd 16 doctors office – 6 30 am from night cover
Afternoon	Intern to intern handover at location suitable (often ward 16 doctors office)
Night	To night cover Wd 16
Weekend	Wd 16 doctors office to and from night cover

15. Shift Structure		
	Intern	HMO
Day	07:00 – 16:30	07:00 – 17:00
Afternoon	16:30 – 22:00	N/A
Night	N/A	N/A
Weekend	N/A	N/A

16. Shift Roles & Responsibilities		
	Intern	HMO
Day (early)	• The early intern updates the list in the morning/night before. Operation and indication, days postop, diet, outputs, ABx, add new pts and consults	

	• Recommended to go in 30mins-1hr prior to WR start time to prep the list. Write down fluid balance including DT OP, NGT OP etc. Input amount from yesterday (amount from day before yesterday) • Ward round and ward jobs rest of day. One intern can help in theatre • Check electrolytes and replace as needed, do a blood round (either intern can do this task) and update the team • Can help whole day intern by putting in blood slips for next day, and the Friday shift put blood slips in for the weekend and Monday morning to help the weekend intern out	
Afternoon (and whole day intern)	• Help with list prep especially post take days • Often carries both pager 180, and handles Medtask diversion to the other interns • Do fluid review at around 3pm letting the group know of urine output (we aim >30mls/hr), if bowels opened, any nausea or vomiting, IVT they are on • On Afternoon shift – please make sure to eyeball patients at the start of your shift • If surg1 is on take that day, attend an AGSU handover with AGSU interns either F2F or tele. Update list post this handover/prep ward notes for next day with the new patients included • Fellow/Reg will often want to do an evening/post OT ward round – Questions from AM round need answers by then • Your first shift will be the cover shift, 16:30-22:00 you will cover Gen surg 1-4 (get a handover around 16:00-16:30 from your other surg interns- let them know where to meet you in the group)- same thing on the following Wednesday • While on cover shift, go to front main reception of hospital to get cover pager • Make sure the bloods for the next day are all in before you leave – including postops	
Night	N/A	
Weekend	You will cover surg 1&2 + paeds surg over the weekend! Get a good handover from surg 2, and make sure they do bloods for Saturday to Monday AM. • Registrars from each team alternate weekends – get their number • You can either print 2 separate lists or combined list for surg 1 and 2- remember to add the paeds surg patients somewhere on list. The unit code for paeds	

	surg is paed4 (cpf codes surg1, surg2, paed4 -paste the bolded into unit code section if that helps!) - You will round on and manage all three teams, so have the lists up to date and if you have combined the lists, make sure surg 2 has list for Monday morning in their file! - There will be an HMO covering surg 3&4, and another covering spec surg teams	

17. Common Conditions

Assessment of fluid balance and electrolyte abnormalities
Mechanical small bowel obstruction
Ileus
Large bowel obstruction
Ostomy care – Jenn and emma , our stoma nurses are a wealth of information
Large bowel resections
Post operative fever
Post operative bleeding
Colorectal cancer
Inflammatory bowel diseases
Bowel obstruction
Fistulas
Diverticular disease and complications

18. Common Procedures

INSERTION OF IV CANNULA

- Ward nurses will often be able to insert these but will contact you when they are unsuccessful
- After hours if you have 2 x missed attempts, escalate to AGSU reg, if they also fail, this will need to be escalated to the after hours anaesthetic registrar
- After hours cannulas may be urgent if the patient requires ongoing IV Antibiotics or they need an urgent CT scan and the current cannula they have insitu is too small or too peripheral

INSERTION OF INDWELLING URINARY CATHETER – Male and Female patients. On the ward or in theatre

- Must have an understanding of the sterile field
- Fix IDC on the thigh to prevent tugging
- Patients who have had ureteric stents inserted and/ or removed intraoperatively may have some post operative haematuria. The IDC can also leak from the point of insertion of the stents – clear tegaderm can be used to seal these holes
- For patients that have had any concurrent urological procedure – check with a senior prior to removal or exchange of IDC
- If a patient has an IDC, we must visit the need for ongoing catheter vs TOV on the WR

INSERTION & MAINTENANCE OF WIDEBORE NASOGASTRIC TUBES

- Post surgical patients can develop ileus and require a nasogastric tube for drainage

- Appropriate insertion and position check – aspiration of enteric content/ auscultation of bubbling/ CXR to check position
- On ward rounds, the daily NGT outputs (and inputs) need to be documented, also document if NGT is to be on free drainage, spigotted with regular aspirates or aspirates to symptoms
- Basic trouble shooting
  – what to do if NGT not draining – Ensure NGT is in the stomach (check Xray/ aspirate), move NGT to correct position based on Xray
  - ensure NGT is adequately fixated to the nose and atleast one additional fixation point
  - Nasal/ throat discomfort with NGT – Can use lignocaine viscous for throat, Xylocaine spray, TLC
- How to remove NGT – Counsel patient. Take off nasal tape, pull NGT out, ensure tip intact, discard whole NGT
- Patients with NGTs often will either be NPO, on CF or FF – It is unusual for a patient to be on solid diet and still require a nasogastric tube

BASIC ASSESMENT OF A POST OPERATIVE WOUND
- The team will often review post operative wounds on the ward. Make sure to take a peek so you get a good understanding of the various normal looking post operative wounds
- Know how to remove sutures/ staples
- Understand the priciples of managing a wound infection – sending wound swabs, changing a wound dressing (packing etc)
- You maybe called to review an oozing post operative wound. Review the operation note. Assess the patient vitally and then specifically asses the wound by taking. Apply firm localized pressure over the wound for 20minutes. This should stop most bleeding, redress with a padded dressing as this will help monitor any ongoing ooze. Always notify a senior of this and what measures you have taken to control it (especially if they are scrubbed in theatre) . Always Urgently escalate any postoperative bleeding in a haemodynamically unstable patient
- If you review a wound on the ward, and it is a burst abdomen (RARE), urgently escalate this to a senior member of the team. While awaiting review. Keep the patient fasted, strict supine bed rest, moist sterile towel over the wound and evisceration while awaiting review

SIMPLE SKIN SUTURING
- In theatre , at the end of the case you are welcome to help close skin – common techniques are interrupted and continuous subcuticular sutures and skin staples

INSERTION OF RECTAL TUBE
- You may be required to insert a soft foley catheter into the rectum for rectal contrast CT scans. After hours you maybe required to inject intrarectal contrast in radiology prior to the CT scan

MANAGEMENT OF DRAIN TUBES
- Drains are inserted intraoperatively or radiologically for a variety of reasons
- The drain tube output and character should be documented as part of the daily ward round note
- Always check of DT is meant to be on suction or free drainage
- Long term drains maybe cut and bagged

FLUSHING OF DRAINS/CATHETER/ RECTAL TUBE

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
Up to Date

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	FBE/ UEC/ CMP/ LFT + D3 CRP in elective uncomplicated post ops, or daily CRP in others
Radiology	CXR, AXR, GG follow through, CTCAP with IV contrast, CT Abdo with IV/ PO/ Rectal contrast, PET scan – whole body, MRI rectu

Pharmacology

MEDICATION	INDICATION	ROUTE	DOSE	FREQUENCY
Moviprep	Bowel prep	PO	AM scopes: CF only. Moviprep 1L in 1hr at 4pm the day before, then again at 6pm, and again at 5am. Fast from 06:30. PM scopes: CF from 4pm previous day, then Moviprep at 4pm, 6pm, 8am and 11am.	If extended prep is required, then use 4L split dose Moviprep ie: add another dose at 4am for AM scopes and 6am for PM
Augmentin Duo forte	Only if renal function okay, otherwise give Augmentin (500/125mg BD)	PO	875/125mg	BD
Metronidazole		IV PO	500mg 400mg	BD TDS
Ceftriaxone		IV	1g	Daily
Cephazolin		IV	2g	QID
Cephalexin		PO	500mg	QID
Iron infusion	Iron deficiency	IV	1000mg if >50kg	
Fleet enema	Most EUA cases	PR/Rectal tube	1-2 stat, chart separately	

	Loperamide	High stoma output	PO	Start at 2mg but titrate up to 4	Tds
	Metoclopramide	Hiccups, nausea	PO/IV	10mg	TDS reg or PRN
	Ondansetron	Nausea/vomiting	Subling/IV	4-8mg regular or PRN	TDS

- DVT prophylaxis
  - NS prefers heparin 5000 units subcut BD for 3/7 then switch to clexane 40mg subcut daily
  - Post discharge clexane – consultants decide case by case, don't forget to ask!
    - Strugnell and Bui patients who had bowel cancer resections most likely require 30 days of clexane from the day of surgery
    - **NEED CLEXANE EDUCATION BY NURSES PRIOR TO DISCHARGE – START EARLY**
  - Other consultants are happy with prophylactic clexane, cease when mobile at home

- Replace electrolytes
  - Aim K>4, Mg>1, Phosphate>1 especially in stoma patients
  - K: NSaline 100ml with 10mmol KCl over 1/24 (premade minibags)
  - Mg: NSaline 100ml with 10mmol MgSo4 over 1/24
  - PO4: NSaline 250mls with 10mmol NaH2PO4 or KH2PO4 over 4 hours or PO Phosphate Sandoz 500mg – usually just give two stat
  - Calcium – oral only or else you need telemetry
  - Replace with PO + IV especially if fasting->free fluids, aim replacing PO only once patient tolerating diet (Light ward diet or full ward diet) but really base it on severity
  - On discharge, continue about 7 days of the oral version of whatever electrolytes the patient was needing to be replaced

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/

22. Documentation	
Admission	Use EMR workflow c/O, HOPC, PMHx, PSHx – especially all abdo surgeries, Social Hx. O/E Vitals, pertinent systemic findings, abdo exam, DRE
Ward Rounds	Use EMR workflow Members on round. Date/ Time One line patient summary eg D2 elective R Hemicolectomy Current issues in Hashtags Patient updates- history Examination findings Bowels/ stoma out put Fluid balance – including outputs from any lines New pertinent pathology (including histo) Plan - Always include nutritional intake - Plans for and lines and drains - Any investigations that are being ordered/ chased - Any intervention that has been planned and if this has been organized (Including starting stopping medication) - Any allied health input - Any discharge planning
Discharge Summary	Use EMR workflow Diagnosis Intervention – Medical/ Surgical Complications and any further intervention Follow up plan (perhaps the most important part of the discharge summary) - Note next clinic review - Any investigation/ MDM discussion prior to next review - Any wound reviews that GP is expected to do - When if any sutures/ staples need to come out A fair number of patients go home with HITH
Outpatient Clinics	Thursdays – AM Reg/ HMO clinic. PM Fellow clinic. These are often overbooked. If the ward is sorted, then these can be attended
CDI Queries	Medtasker
Death Certificates	https://www.bdm.vic.gov.au/medical-practitioners

Coroners	https://coronerscourt.vic.gov.au/report-death-or-fire/how-report-death

23. Referrals	
Internal	Via Medtasker or CPF Clinic: Referrals to this clinic are made electronically via e-referrals on CPF. If you think referral to other clinic is indicated, please discuss with registrar
External	As per other hospital policy

24. Clinical Deterioration	
Escalation Process	Any concerns call the registrar, if they are in theatre. Go to theatre and voice your concerns. Do not text in the group as this maynot be seen for many hours. Group messaging should only be used for routine updates and blood round
PreMet	Intern and HMO review, notify registrar of reason for premet and any action taken
Code	Intern/HMO + Reg review and escalate to consultant responsible for patient

25. Night Shift Support	
Unit	Call Unit HMO or Registrar in hours and AGSU Registrar after hours. Colorectal Fellow can be called if urgent and relevant consultant also if deteriorating patient.
Periop	
Take 2 @ 2	N/A

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
Teaching on run during ward rounds in morning and evenings. Interns should alternate attending theatre where education and anatomy questions discussion occurs intra-operatively.

29. Unit Meetings
MDM fortnightly Weeks 2 and 4 0745-0915. HMO submits to CANMAP Monthly radiology meetings Week 2 of Northern health Cycle on MS Teams 0800-0900. HMO submits list to Radiologist and circulates agenda to Consultants / Fellows / Registrars / Interns Fortnightly IBD MDM: Weeks 1 & 3. 0800-0830. Co-ordinated by Gastroenterology Fellows

30. Research and Quality Improvement
HMOs and Interns are encouraged to approach Registrar regarding novel cases for Case report publication. HMOs may be asked to assist Colorectal Research Fellow or Clinical Fellow for ongoing unit projects.

31. Career Support
HMOs are encouraged to speak with unit head, Dr Neil Strugnell, General Surgery Head of Research, DR Russel Hodgson, Colorectal Research Lead, Dr Basil D'Souza, HMO Surgical Co-ordinator, Dr Chiu Kang, and SET Supervisor, Dr Krinal Mori, particularly when wishing to pursue a Surgical career. The above mentors can recommend key contacts when HMOs wish to pursue alternative career streams.

32. Medical Students on the Unit
MD4s during academic University of Melbourne terms and occasionally MD2s or International elective students.

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.

<table>
<tr><td></td><td>To be eligible for payment, the doctor is required to notify the Health Service <u>two hours</u> before the start of their shift, or as soon as practicable.
<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</td></tr>
</table>

34. JMO Rover

35. Document Status		
Updated by	Dr Sarah Jinnaah / Dr Neil Strugnell	23/01/2024
Reviewed by	Dr Natina Monteleone	01/02/2024
Next review date		April 2024