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**:	B: Chronic illness patient care
Parent Health Service:	Northern Health	**Clinical experience - Secondary**:	Choose an item.
Speciality/Dept.:	Hospital in the Home	**Non-clinical experience:**	*(PGY2 only)*
PGY Level:	PGY2	**Prerequisite learning:**	*(if relevant)*
Term Descriptor:	*Hospital in the Home unit covers a breath of general medical, surgical and specialist surgical conditions. Involves managing patients including Heart Failure, long term IV antibiotics, Peri-procedural anti-coagulation and chronic care. Assessing patients in hospital setting prior to discharge, clinic review for evaluations, telehealth and telephone consults and occasional home visits. Documentation of admission, discharge and appropriate ordering of investigations. Discussion of all patients with registrar and consultant.*		

2. Learning objectives:		
EPA1: Clinical Assessment	Domain 1	Obtains person-centred histories tailored to the clinical situation in a culturally safe and appropriate way.
	Domain 2	Recognises their own limitations and seeks help when required in an appropriate way.
	Domain 3	Recognises and takes precautions where the patient may be vulnerable.
	Domain 4	Demonstrates the ability to manage uncertainty in clinical decision-making.
EPA2: Recognition and care of the acutely unwell patient	Domain 1	Recognises the need for timely escalation of care and escalates to appropriate staff or service, following escalation in care policies and procedures.
	Domain 2	Seeks guidance and feedback from the health care team to reflect on the encounter and improve future patient care.
	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	Observes local service protocols and guidelines on acutely unwell patients
EPA3: Prescribing	Domain 1	As appropriate, monitors and adjusts medications.
	Domain 2	Maintains patient privacy and confidentiality.
	Domain 3	Considers population-level constraints on prescribing, including: antibiotics, PPI, statins. Considers medications that are suitable for administration in the community.
	Domain 4	Applies the principles of safe prescribing, particularly for drugs with a risk of significant adverse effects, using evidence-based prescribing resources, as appropriate.
EPA4: Team communication – documentation,	Domain 1	Produces medical record entries that are timely, accurate, concise and understandable.
	Domain 2	Demonstrates professional conduct, honesty and integrity.

handover and referrals	Domain 3	Includes relevant information regarding patients' cultural or ethnic background in the handover and whether an interpreter is required.
	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***	HMO Supervisor	Chiu.Kang@nh.org.au
Term Supervisor	***TBC***	Click or tap here to enter text.	Click or tap here to enter text.
Clinical Supervisor (primary)	Click or tap here to enter text.		Click or tap here to enter text.
Cinical Supervisor (day to day)	***Allocated consultant on unit***	Click or tap here to enter text.	Click or tap here to enter text.
EPA Assessors *Health Professional that may assess EPAs*	• All Consultants • Click or tap here to enter name and role • Click or tap here to enter name and role		

***Team Structure* - Key Staff**		
Name	**Role**	**Contact**
Rabin Sinnappu	Head of Unit	Rabin.Sinnappu@nh.org.au
Unit Consultants	Unit Consultants	Click or tap here to enter text
Lynne Santamaria	NUM	Click or tap here to enter text
Click or tap here to enter text.	Unit Registrars	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

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.

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
	08:30 – 09:30 Clinical handover 09:30 Clinical Meeting + coffee	08:30 – 09:30 Clinical handover	08:30 – 09:30 Clinical handover	08:00 – 09:00 Grand Round 09:00 – 09:30 Clinical handover	08:30 – 09:30 Clinical handover	08:30 – 09:30 Clinical handover	08:30 – 09:30 Clinical handover
Afternoon	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.	12:30 – 13:30 HMO Education		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

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
HITH 1-35 A (Reg 1)		HITH 1-35 A 08:00-17:00	HITH 1-35 A TT 12:00-17:00		HITH 1-35 A 08:00-17:00	HITH 1-35 A 08:00-18:00 Phone OC	HITH 1-35 A 08:00-18:00 Phone OC
HITH 1-35 B (Reg 2)	HITH 1-35 B 08:00-17:30	HITH 1-35 B TT 12:00-16:00	HITH 1-35 B 08:00-18:00	HITH 1-35 B 08:00-17:30*	HITH Admit 09:00-19:00		

HITH 36-70 (Reg 3)	HITH 36-70 08:30-17:00	HITH 36-70 08:30-17:00	HITH 36-70 08:00-12:00 TT 12:00-17:00	HITH 36-70 08:30-17:00	HITH 36-70 08:30-17:00		
HITH Admit (Reg 4)	HITH Admit 09:00-19:00	HITH Admit 09:00-19:00	HITH Admit 09:00-18:00	HITH Admit 08:00-18:00*	HITH Admit TT 12:00-16:00		
HITH HMO 1	HITH 1-35 A 08:30-17:30	HITH 1-35 A 08:30-17:30	HITH 1-35 A 08:30-17:00	HITH 1-35 A 08:00-17:00			
HITH HMO 2		HITH 36-70 08:30-17:00	HITH Admit 08:30-17:00		HITH 36-70 08:30-17:00	HITH 36-70 08:30-16:00	HITH 36-70 08:30-16:00
HITH HMO 3	HITH 36-70 08:30-17:30		HITH 36-70 08:30-17:30	HITH 36-70 08:30-17:00	HITH Admit 08:30-17:00		
HITH HMO 4	HITH Admit 08:30-17:00	HITH Admit 08:30-17:00			HITH 1-35 08:30-17:00	HITH 1-35 08:30-16:00	HITH 1-35 08:30-16:00

*1 hour of training time (grand rounds) from 08:00-09:00 for 1-35B Registrar and Admissions Registrar
*HMOs rotate through rosters 1-4 and divide between 1-35/36-80/Admissions between themselves

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	HITH Portables (Portables, 7)
Facilitator	Head of unit
Date	First week of rotation
Start	08:30

11. Unit Overview	
Department	Hospital in the Home
Location	Portables 6, 7
Inpatient Beds	70 General HITH + 16 Paediatrics HITH
Outpatients Clinics	Daily – Outpatient clinic D, Room 22
Day Procedures	N/A

Virtual Unit	Heart Failure Virtual Ward Round (HF HITH, for beds 1-35)

12. Safety

Unit Specific Safety & Risks

- Safe medication prescribing for high-risk medications – anticoagulants, antimicrobials, opioids
- COVID screening
- Patient assessments and appropriate triage - Symptom assessment and management
- Discharge planning
- Interdisciplinary team and patients - communication skills
- Home visit safety - When admitting patients to HITH, important to consider safety of staff visiting homes: Patients need to pass the safety check – no current substance misuse/hx of violence/risk issues. If the home environment is difficult, there is a potential option of patients coming into hospital via HITH clinic for care

13. Communication	
Medtasker	HMO and Registrar roles
WhatsApp	Nil
Pager	Nil
MS Teams	Daily handover sheets

14. Handover Process	
Morning	08:30 – Portable 6 (beds 1-35) and Portable 7 (beds 35-80) Doctors communication diary – to be reviewed daily
Afternoon	N/A
Night	N/A

15. Shift Structure			
	Intern	HMO	Registrar
Day	-	08:30 Handover (09:00 Thurs)	08:30 Handover (09:00 Thurs)
Afternoon	-	No evening shifts	No evening shifts
Night	-	No night shifts	No night shifts
Weekend	-		

16. Shift Roles & Responsibilities			
	Intern	HMO	Registrar
Day	-	Login to medtasker Morning handover Discharge summaries, warfarin plans Outpatient referrals and appointments Assist with HITH Admissions and Clinic Patient phone reviews	Login to medtasker Morning handover HF VWR Meeting (beds 1-35) HITH Admissions (Admissions Reg) HITH Outpatient clinic reviews Patient phone reviews

			Admissions Reg: • Find out bed capacity each day. If at capacity then patients will need to be waitlisted. • Talk to the flow liaison nurse (also a useful resource if you are unsure whether a referral if feasible) • Refer to the bed management portal – get the nurses to show you how to use
Afternoon	-	Update Pathology dates (Teams sheet) Update handover sheet (Teams) Chasing pathology results Write pathology requests	Update Pathology dates (Teams sheet) Update handover sheet (Teams) Chasing pathology results Write pathology requests
Night	-	-	-
Weekend	-	2 HMOs rostered on weekends: • Beds 1-35 • Beds 36-80	Weekend registrar is weekend on-call (Saturday 8am to Monday 8am). Weekend registrar is not expected to review patients at home or after hours UNLESS patient passes away expectedly in RACF – may need to certify death the next morning (very rare)

17. Common Conditions

- Heart failure management
- Anticoagulation management: Warfarin titration, bridging Clexane, or Clexane-only administration
- Rapid warfarin reversal
- IV antibiotics
- IV drug infusions (e.g. remdesivir, iron, steroids)
- IBD @ Home
- TOV @ Home
- Blood transfusions at nursing homes – require attendance/supervision by HMO
- Chemotherapy disconnects
- Drain tube management
- Surgical wound care + dressing management, including pressure dressings (VAC, SNAP, Prevena)

Specific challenges in HITH

- Patient assessments and appropriate triage: Patients can deteriorate at home and can be more vulnerable in their home environments. Do not hesitate to call patients, bring them to HITH clinic, transfer them to the emergency department. If you have clinical concern about a potential emergency & potentially life-threatening situation for a patient, an ambulance should be called to the patients' residence (000) and you should handover to ED and the primary team.
- Responding to requests for high-risk medications
- Communication with the treating team
- Documentation

Good documentation is critical to provide an accurate record of the patient's stay in hospital, decision making processes and rationale and handover between the multiple clinicians engaged in the patient's care. Remember - "if it is not documented, it didn't happen". Your documentation is also vital for 'clinical coding', which is necessary for Department of Health data reporting and hospital financial reimbursement

- Discharge planning – e.g. warfarin plans, medication changes, outpatient follow-up

18. Common Procedures

N/A

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/

PADUA score

VTE prophylaxis: HITH doctors should do VTE Padua Prediction Score (can be found below or on MDCalc) for HITH patients on admission to determine anticoagulation need. This should be performed on every patient on admission to HITH and be documented on the admission note. If a patient scores greater than 4, please liaise with the home team regarding the recommendation for VTE prophylaxis. If the home do not wish for HITH to commence the patient on DVT prophylaxis, document this clearly on the admission note. This is not applicable for patients already on anticoagulation. Clinical judgement should always be used for your patients with consideration of risk of bleeding (HAS-BLED score).

Items	Score
Active cancer (metastases and/or chemoradiotherapy in the previous 6 months)	3
Previous VTE (with the exclusion of superficial vein thrombosis)	3
Bedrest for ≥3 days	3
Thrombophilia	3
Recent (≤1 month) trauma and/or surgery	2
Elderly age (≥70 years)	1
Heart and/or respiratory failure	1
Acute myocardial infarction or ischemic stroke	1
Acute infection and/or rheumatologic disorder	1
Obesity (BMI ≥30 kg/m^2)	1
Ongoing hormonal treatment	1

High risk of VTE: ≥4 points. VTE: Venous thromboembolism; BMI: Body mass index.

Padua Prediction Score

20. Routine Orders	
Pathology	Not all patients need daily bloods. Assess need for bloods accordingly. HITH uses hybrid EMR-paper system – blood tests are requested on paper. Do not order path on EMR as nurses cannot access that then to take bloods. Make sure to write bed number of patient on pathology slip (in addition to BRAGMA). Update the 'Pathology Board' on Teams with the date for each patient's next blood test. . Pathology board is used by HITH liaisons to make allocations for the following day.
Radiology	Can order radiology on EMR as otherwise would for inpatient. Can tick outpatient box but then in special instructions, specify that pt is a HITH patient. If booking urgent Ix, important to ring radiography after booking scan on EMR and try finalise an appointment date and time.
Pharmacology	• HITH medications that the nurses are physically given (i.e. Clexane, Abx) need to be physically charted (on drug chart nurses can sign) but also on EMR (and subsequently suspended) to ensure accuracy of discharge summary • EMR medications need to be SUSPENDED as the nursing staff administer HITH medications from paper charts. If a medication is not suspended, then EMR will keep giving notifications that the medication is due and needs to be signed off. All new meds charted (esp HF meds from VWR) need to be charted on EMR and then subsequently suspended afterwards (also make sure if it's a dose change that the old previous dose medication is discontinued). • Document any medication changes or new plans on EMR. • Always check if patient has a Webster pack and let pharmacist know. A Webster pack may be a barrier to discharge over the weekend if medication changes are required, so always pre-empt the nursing home +/- Webster pack discharges over weekends **IV Antibiotics** • Require weekly bloods • Note indication, end dates, and ID outpatient advice & ID guidance

	• Some antibiotics need to be made up in a special bag by an external company & delivered to TNH; this sometimes takes 48-hours which may affect admissions –liaise with HITH pharmacist ASAP once details confirmed upon receiving a referral • Vanc Levels in HITH are for continuous infusions, thus desired level is: 20-25 • Always add UEC to Vanc level Path Slip **Remdesivir infusions** • Loading dose (given by Inpatient team or in COMET clinic): 200mg • Doses for Days 2 & 3: 100mg • HITH Reg to chase baseline bloods (UEC & LFT) **Blood Transfusion in Nursing Homes** Must be attended at nursing home by HITH HMO for first 30 minutes to ensure nil transfusion reactions

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 the admission workflow on EMR Info/Documents required for HITH admission: • GOPC completed by home team – Try to get home team to do as isn't HITH responsibility & HITH not the most appropriate to have these discussions. Will then fill out form as per home teams decision.

	• Clear plans for follow-up especially whether ID needs to r/v prior to cessation of any IV Abx • Home team Discharge summary • HITH Reg and nurse r/v PRIOR to discharge -> if simple i.e. prevena or wound admitting doctors may not have to review – check with HITH Liaison Flow nurse. • Drug chart (we complete this) and it only needs medications we are managing eg. Abx/ Frusemide etc. Clexane needs to be charted on medication charts regardless of if it is being self-administered or by HITH nursing staff • Script – this does NOT need to include supply of clexane (if self-administered by patiens upon discharge from the ward) or IV Abx as pharmacy will supply off our drug chart. It does however need adequate analgesia etc for patient to self-administer • Interim drug charts for NH patients • Must be in our catchment area (refer to map) • Medicare ineligible patients need to be approved by medicare ineligible team (this comes up relatively frequently) • HITH Admission note in EMR within the current episode --> Print and put in folder DIRECT ADMITS eg. Iron, blood transfusions, chemo disconnects, preop bridging clexane, remdesivir infusions • Complete the relevant charts (i.e. iron infusion form + consent, warfarin chart, medication chart) • GOPC forms – ideally home teams/ referrers should be completing, otherwise use the legal tab in CPF or ring the patient/ NOK to have discussion where possible (this is last resort as we have not met the patient before). • HITH Admission note
Ward Rounds	Use the Handover sheet on Teams ("Pathology Board" = medical handover sheet)
Discharge Summary	Use the discharge workflow on EMR Signing and submitting will send an electronic copy to the GP and upload to My health record
Outpatient Clinics	Correspondence from Outpatient clinics, prescriptions and investigations remain on CPF HITH Outpatient clinic progress is documented on EMR
CDI Queries	To ensure accurate and comprehensive documentation in real-time, the Clinical Documentation Specialist (CDS) will identify any deficiencies in documentation in the healthcare record and will query these via Medtasker. These will show up as "CDI Query". Please action these queries by documenting in the healthcare record. This can be done by documenting: • on the next progress note (paper format), or • on an electronic progress note in CPF by noting "CDI query response", and/or • on the discharge summary in CPF
Death Certificates	Death certificates are completed online. https://www.bdm.vic.gov.au/medical-practitioners Hard copies are to be printed out for the patient file/funeral director, in addition to the electronic submission. Print 2 copies, sign them, and save a PDF to the Teams folders (HITH Medical folder).
Coroners	Reportable deaths: Death certificates should not be completed if it is a Coroner's case. This will require a phone call to the Coroner's office followed by an e-medical deposition. It is important that the medical team identifies patients who will be reported to the Coroner ahead of time. Patients' whose death is reportable will need to have a statement of identification completed by the next of kin, and attachments such as butterfly cannulas etc are left in situ. Any uncertainty about whether a death is reportable should be escalated to the consultant

	https://www.coronerscourt.vic.gov.au/report-death-or-fire/reportable-deaths

23. Referrals	
Internal	Referrals to specialist outpatient clinics are made electronically via e-referrals on CPF. This includes HF HARP and HF Rehab – important to send these for relevant HF VWR patients (will be included in HF VWR plans). Referrals to HF HITH need to be accepted by a HF team member – Registrar, NP, etc. Referrals to General HITH (eg for vac mx, warfarin, etc) are sent to HITH Admissions Reg via Medtasker.
External	

24. Clinical Deterioration	
Escalation Process	Check GOPC
PreMet	Resident and registrar review
Code	Resident and registrar to follow standard procedures and discuss with consultant about transfer to acute medical unit

25. Night Shift Support	
Unit	N/A
Periop	N/A
Take 2 @ 2	N/A

26. Assessments: PGY1 & PGY2	
All forms are located on the Northern Doctors website under the Assessments tab Both HMOs and REGs must ask Dr Rabin Sinnappu to complete mid-term and end of term assessments	
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

- Grand Rounds - Thursday 8AM-9AM
- HITH education sessions – Will be informed of times/availabilities when booked (e.g. HF, warfarin, ECGs)

29. Unit Meetings

Morning handover: 08:30AM daily (including weekends).

- Beds 1-35 in Portable 6.
- Beds 36-80 in Portable 7 on weekdays, Portable 6 on weekends.

HF HITH handover: 11:00AM on weekdays, for Beds 1-35

HITH education: Will be informed of times/availabilities when booked, depending on staff availability

30. Research and Quality Improvement

31. Career Support

Discuss with head of unit

32. Medical Students on the Unit

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	**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.

<table>
<tr><td>documentation process</td><td>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 <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 where relevant.</td></tr>
</table>

34. JMO Rover

Patient assessments

- Patients can be more vulnerable in their home environments. Patients can also deteriorate at home and HITH staff should be proactive with assessing patients. You will often change your management according to reviews by other staff members. Do not hesitate to call patients, bring them to HITH clinic, transfer them to the emergency department. Speak with HITH nursing staff about your patients. Communication is key on HITH. Be proactive with organising investigations for HITH patients - eg ordering CTPA for suspected PEs.
- If you have clinical concern about a potential emergency & potentially life-threatening situation for a patient I.e. Potential MI, PE, Haemorrhage, stroke, sepsis etc an ambulance should be called to the patients' residence. This can be called by the HITH doctor orr by the nurse on the road. Call emergency services on 000.Inform ED AO of incoming admissions. Complete HITH to ED handover note. Inform primary team of the need for admissions.
- Due to government funding, General Practitioners are not to be visited while patients are under HITH. HITH doctors will address most issues patients may have that are not related to their hospital admission. If you believe a patient needs to see their GP, discuss with liaison nurse +/- your consultant

Warfarin titration +/- Clexane bridging

General protocol for Doctors

- Step 1: Dose warfarin chart as per INR
- Step 2: Complete pathology slip for next INR

- Step 3: Give back to nurse who needs to notify patient of warfarin dosage OR Call patient yourself and document this

Details about warfarin/clexane:

- INR is usually done every 2 days
  - Consider next day INR, particularly if INR is near target range, for faster discharge or supratherapeutic INR
- INR isn't known until PMs
  - This affects how you chart AM/PM clexane (examples below)
  - Nurses only carry patient drug charts, NOT WARFARIN CHARTS. So if clexane is on the chart then it will be given unless chart altered/nurse contacted
  - If making a change to clexane plan, document and update HITH liaison nurse. Once the folder is back in the office, amend drug chart and inform the pharmacist as well. (This is to ensure that there is enough supply of the clexane until we need to dose)
- BD or Daily clexane?
  - BD for mechanical valves and active clots or as per Haem
  - Otherwise daily for everyone else (1.5mg/kg/day if renal function allows) unless high BMI and then for discuss with Haematology as may need bd
  - Check renal function and weight
- Dose of Clexane
  - 1mg/kg bd or 1.5mg/kg/day, dose reduced if CrCl<30
  - Use the patient's weight and round the dose to the nearest 10mg where practicable
  - Criteria for doing Antixa level on patients:
  1. Age >80 years
  2. Obese patients (>100kg) or less than 50kg
  3. Patient has borderline renal function 30-40 gfr
  4. If patient is on clexane for greater than a week, the patient will have weekly antiXa to ensure it remains in range.
- Target Xa level for BD dosing 0.5-1.0 (preferred method)
- Target Xa level for daily dosing 0.8-1.5 (less preferred method)

Be cognisant of any new medicines that may have been started during a hospital admission as warfarin has a narrow therapeutic index & interactions can be potentially lethal. If in doubt discuss with your friendly HITH pharmacists.

Beware of complications in clexane administration:

- Rectus sheath haematomas: In rectus sheath haematomas, a branch of the inferior epigastric artery is injured at its insertion into the rectus abdominis muscle. Patient usually gives a peculiar history of sudden, severe, unilateral abdominal pain which aggravates on movement. Ecchymosis may sometimes present as a late feature. On examination, tenderness may be present along with a palpable abdominal lump. There may also be unexplained tachycardia or hypotension, fall in haematocrit, peritoneal or bladder irritation, abdominal distension or abdominal cramping.
- Retroperitoneal bleeding: Retroperitoneal bleeding caused by lumbar artery lesion is rare and mostly related to iatrogenic or trauma. Aneurysm or anticoagulation therapy is the most common causes of non-traumatic bleeding. Retroperitoneal haematomas can present clinically with groin, flank, abdominal or back pain and it has also been reported as inguinal hernia with appearance of groin swelling

Discharge Protocols for "New Warfarin" vs "Continuing Warfarin"

All discharges with warfarin management require:

- A warfarin discharge plan (HMO to Fax to pathology service) with previous INRs and Warfarin doses (For TNH path referral - no need to call haem reg as specified in form. It will suffice to email the TNH path warfarin referrals address provided with the discharge plan as well as the pathology slip)
- Pathology slip for INR with Rule 3 exemption written on it (a stamp is also available) – this rule allows repeated INRs without path slips. Use the pathology brand path slips available (more so if new referral) eg. Clinical labs path slips for Clinical labs

For New Warfarin patients: Requires 2 consecutive therapeutic INRs prior to discharge
For continuing warfarin: Can be discharged on day of 1st therapeutic INR if stable

HF HITH
HITH works closely with the HF HITH team to manage HF patients. HF HITH patients need to be approved by the HF team before accepting for HITH admission. HF HITH Virtual Ward Round Meeting occurs daily at 11am in ward 15 meeting room. HITH 1-35 registrar is expected to attend.

Tips for HF HITH patients:

- Referrals via CPF for HF Rehab and HF HARP (if required – specified by HF team):
    - HF Rehab: referral type (community access) -> Speciality (SACS) -> Subspecialty (cardiac rehab)
    - HF HARP: referral type (community access) -> Specialty (HIP/HARP) -> Subspecialty (chronic heart failure)
- HMO (on 1-35) – important to check HF VWR note each day to see pending jobs
- Medication changes from meeting need to be updated on EMR -> any new meds require script printed for HF pharmacist (can leave in their tray)
- **Iron infusions** require phoning pt for consent and filling out paper iron transfusion order form and completing written iron prescription (leave in HF pharmacist tray, they will organise for pt to get on day of discharge from HITH)
- Any HF HITH pt issues over weekend (i.e. worsening renal function or nursing concerns) need to be escalated to weekend cardiology reg on call for advice re management

VAC / SNAP / PREVENA / Wound dressings

- VAC and SNAP are different types pressure dressings for surgical wounds (SNAP has a manual function and is a down-step from a VAC dressing). Prevena is another pressure dressing usually done for 7-10/7 post-LUSCS in high BMI females
- Due to thrombosis risk in high BMI individuals, LUSCS also receive 5/7 of clexane either 40mg or 60mg depending on BMI
- Prevena usually removed 1/52 post LUSCS and then discharged

Wound and Drain Tube Management

- Track surgical outpatient advice and drain tube outputs
- When admitting, make sure to have reportable drain output limits and when to remove and follow up plans

35. Document Status		
Updated by	Dr Rabin Sinnappu	December 2023
Reviewed by	Dr Natina Monteleone	23/01/2024
Next review date		April 2024