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.:	Medical Obstetrics	**Non-clinical experience:**	*(PGY2 only)*
PGY Level:	PGY1	**Prerequisite learning:**	*(if relevant)*
Term Descriptor:	*Medical Obstetric term involving the ward-based management of obstetric patients admitted with obstetric related or non-obstetric concurrent medical conditions from the pre to post-partum period. Attendance at clinics and review of investigations pending at discharge. Work within a multi-disciplinary team and liaise with the obstetric & gynaecology team.*		

2. Learning objectives:		
EPA1: Clinical Assessment	Domain 1	Performs an accurate, appropriate and person centred physical and/or mental state examination.
	Domain 2	Demonstrates professional conduct, honesty and integrity.
	Domain 3	Recognises and takes precautions where the patient may be vulnerable.
	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	Performs hand hygiene and takes infection control precautions at appropriate moments.
EPA3: Prescribing	Domain 1	Appropriately, safely & accurately prescribes therapies (drugs, fluids, blood products, oxygen), & demonstrates an understanding of the rationale, risks & benefits, contraindications, adverse effects, drug interactions, dosage & routes of administration
	Domain 2	Reports adverse events related to medications.
	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	Demonstrates knowledge of clinical pharmacology, including adverse effects and drug interactions, of the drugs they are prescribing.
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	Informs patients that handover of care will take place and to which team, service, or clinician as appropriate.

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. Carol Chong***	Supervisor of Intern Training	Carol.Chong@nh.org.au
Term Supervisor	***Dr Siaw Wong***	Head of Unit	Siaw.H.Wong@nh.org.au
Clinical Supervisor (primary)	***Allocated Consultant on ward service***	Medical Obstetrics Consultant	Click or tap here to enter text.
Cinical Supervisor (day to day)	***Allocated Registrar on ward***	Medical Obstetrics Registrar	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 Siaw Wong	Head of Unit	Siaw.H.Wong@nh.org.au
Unit NUM	NUM Maternity	Switchboard
Seda Kiroglu	Medical Obstetrics At Home	Medtasker
Dr Lucy McBride	Outpatient Clinic Lead	Lucy.McBride2@nh.org.au
O&G Registrar	O&G Registrar	#52521 or #58408

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: 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	08:00	08:00	08:00	08:00	08:00	Enter Time	Enter Time
	08:00 – 09:00 Obstetric Handover WR 9:15 Med Obs at home	08:00 – 09:00 Obstetric Handover WR	08:00 – 09:00 Grand Round 09:00 – 09:30 Journal Club fortnightly WR	08:00 – 09:00 Obstetric Handover WR 9:15 Med Obs at Home meeting	08:00 – 09:00 Obstetric Handover WR	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
	12:30 Med Obs/Renal Education 14:30 Med Obs at Home meeting	12:30 – 13:30 Intern Education 13:30 Radiology meeting	Click or tap here to enter text.	14:30 Med Obs at Home	Half day finish	Click or tap here to enter text.	Click or tap here to enter text.
Evening	20:00	20:00	20:00	20:00	20:00	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	12	12	12	12	12	Total	Total

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	Renal Office
Facilitator	Med Obs Registrar
Date	
Start	

11. Unit Overview	
Department	Medical Obstetrics
Location	Shares office with Renal Department (Renal Office)
Inpatient Beds	Mostly based in Maternity Wards (ward 10/11) Can have outlier patients in general medicine wards
Outpatients Clinics	Clinic B
Day Procedures	Iron infusions (organised by med obs/O&G) occur in Day Oncology Centre (ground floor of Tower)
Virtual Unit	N/A

12. Safety
N/A

13. Communication	
Medtasker	08:00 – 17:00 Roles: Medical Obstetrics → Medical Obstetrics Registrar/Intern Via switch after-hours
WhatsApp	Request access to WhatsApp group
Pager	#174 (Med Obs intern carries)
MS Teams	Medical Obstetrics Unit Meeting (Tues, 08:00) MOAH Meeting (Mon/Thurs, 14:00)

14. Handover Process	
Morning	Renal on-call Registrar looks after Med Obs patients and takes Med Obs referrals after-hours. Renal on-call Registrar hands over to Med Obs day team about overnight inpatient updates and new patients accepted under the Medical Obstetrics bedcard. 08:00 O&G Handover (located in meeting room in front of ward 10/11 ward clerk desk) O&G team discuss their patients for the day including any patients under Medical Obstetrics bedcard and any patients they would like Med Obs to consult.
Afternoon	On intern half-day (Wednesday), divert intern medtasker role to Registrar On Registrar half-day (Thursday), divert registrar medtasker role to Intern
Night	Medical Obstetrics JMO Afterhours Cover For weekdays • AMT registrar to admit Medical Obstetrics patients after 5pm • From 5-8pm, Renal HMO to be contacted for Medical Obstetrics inpatients ward calls • From 8pm-8am (overnight), Downstairs Medical HMO to be contacted for Medical Obstetrics inpatients ward calls • From 5pm to 8am, Medical Obstetrics/Renal Registrar 1st on call through switch For weekends • Medical Obstetrics/Renal Registrar 1st on call through switch and will review Medical Obstetrics patients in the morning • AMT registrar to admit Medical Obstetrics patients • From 8am-8pm, AMT 2 HMO (ID, Endo, Medical Obstetrics) to be contacted for Medical Obstetrics inpatient ward calls • From 8pm-8am (overnight), Downstairs Medical HMO to be contacted for Medical Obstetrics inpatients ward calls

15. Shift Structure (see timetable above for more detail)			
	Intern	HMO	Registrar
Day	08:00 O&G Handover 08:30 Med Obs Ward Round	N/A	08:00 O&G Handover 08:30 Med Obs Ward Round
Afternoon	Ward jobs Teaching (intern/renal) MOAH Meeting Thalassaemia screening	N/A	Ward jobs Teaching (renal) Med Obs Clinics
Night	N/A	N/A	Renal/Med Obs Registrar on-call (based on roster, not every night)
Weekend	N/A	N/A	Renal/Med Obs Registrar (based on roster, not every weekend)

16. Shift Roles & Responsibilities			
	Intern	HMO	Registrar
Day	Update the inpatient/consults list on EMR Assist Registrar with ward round (note taking, ordering/chasing ix, charting medication, seeing patients) Facilitate inpatient discharges (discharge summary/scripts, organise outpatient ix/follow-up)	N/A	Facilitate ward round Facilitate ward jobs following the round
Afternoon	Assist MOAH team on Mon/Thurs (attend afternoon meeting, facilitate plans/discharges, organise scripts) Thalassaemia screening	N/A	Take new referrals from ED/consults from other teams + provide plans Attend Med Obs clinics
Night	N/A	N/A	Renal/Med Obs Registrar on-call (based on roster) will cover renal/med obs inpatients + take new referrals from ED after-hours
Weekend	N/A	N/A	Weekend Renal/Med Obs Registrar (based on roster) will cover renal/med obs inpatients + take new referrals over the weekend

17. Common Conditions

- Hyperemesis gravidarum
- Pre-eclampsia (PET)/HELLP syndrome
- Shortness of breath/fatigue/symptomatic anaemia/Iron deficiency
- Gestational thrombocytopenia
- PUO (both pre- and post-delivery)
- Headache (differential just as varied as in non-pregnant patients; venous sinus thrombosis; PET; post- dural puncture headache generally the ones not to miss)
- BPPV/Dizziness

- Puerperal sepsis
- UTI/pyelonephritis
- Seizures in pregnancy
- Abdominal pain (appendicitis/constipation)
- Cholecystitis/Cholestasis of pregnancy/acute fatty liver of pregnancy
- Transaminitis/hepatitis FI

18. Common Procedures

- IV cannulas
- Venepunctures
- Female IDC insertion

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/

RWH Pregnancy and Breastfeeding guidelines (BEST RESOURCE – SAVE A SHORTCUT)

- Search for "clinician's health channel" in desktop > Scroll to bottom of page, link is in list of information databases

SOMANZ guidelines in pregnancy https://www.somanz.org/approval-of-written-guidelines-by-somanz/

ASIC guidelines for infections https://asid.au/resources/clinical-guidelines-2

20. Routine Orders

Pathology	• Most Med Obs patients are generally comparatively well and may not require daily bloods. Confirm with Reg who needs bloods on what days. • PET (pre-eclampsia) screen: FBE, UEC, LFTs, urate, Urine Protein/Creatinine ratio • Hyperemesis patients: VBG, CMP, UEC (to monitor electrolytes) • Cholestasis of pregnancy: LFTs, non-fasting bile acids +/- abdo USS • Deranged LFTs in pregnancy: viral serology (CMV, EBV, HIV, HSV, Hep B/C, VZV), autoimmune screen (ANA, AMA, AKLMS, ASMA, ANCA) +/- abdo USS • Antenatal screen (typically ordered by O&G)

<table>
<tr><td></td><td>

- D-dimer is NOT helpful in pregnancy

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<tr><td>Radiology</td><td>

- ie. Xray, CT and MRI, NOT USS – There is a specific consent form (in radiology or in the folder above the desk) to be signed by you & the patient
- Generally, we tend to do VQ scans if ?PE in pregnancy. Some consultants prefer CTPA as studies show radiation risk is similar.
- Radiographers will also usually ask you to get approval from a radiologist for CT and MRI
- Contrast usually contraindicated in pregnancy

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<tr><td>Pharmacology</td><td>

- Please consult SOMANZ/Royal Women's Hospital guidelines prior to prescribing medications to ensure safety in pregnancy

<u>COMMON MEDICATIONS SPECIFIC TO UNIT</u>
As with most meds – start low, go slow, up-titrate according to response

<table>
<tr><th>MEDICATION</th><th>INDICATION</th><th>ROUTE</th><th>DOSE</th></tr>
<tr><td>Nifedipine</td><td>Hypertension/PET (Pre/Peri/Post-partum)</td><td>PO</td><td>IR – 10mg STAT for MET calls.
SR – starting dose generally 30mg BD</td></tr>
<tr><td>Labetalol</td><td>Hypertension/PET (Antenatal/Peripartum)</td><td>PO/IV</td><td>Anywhere from 100mg BD to 800mg QID.
Can give 200mg PO STAT in MET call.</td></tr>
<tr><td>Methyldopa</td><td>Hypertension/PET (Antenatal)</td><td>PO</td><td>250mg BD starting dose</td></tr>
<tr><td>Enalapril</td><td>Hypertension/PET (Post-partum) – generally drug of choice in postpartum patients</td><td>PO</td><td>5mg BD starting dose, up to 20mg BD.
Cannot be used in pregnant patients</td></tr>
<tr><td>Pyroxidine (B6)</td><td>Mild nausea/vomiting</td><td>PO</td><td>Not used often, more for mild hyperemesis.
12.5/12.5/25mg mane/midi/nocte</td></tr>
<tr><td>Metoclopramide</td><td>Nausea/vomiting</td><td>PO/IV</td><td>10mg PO TDS – safe to continue throughout pregnancy</td></tr>
<tr><td>Ondansetron</td><td>Nausea/vomiting</td><td>PO/IV</td><td>4-8mg PO TDS – safe to continue throughout pregnancy</td></tr>
<tr><td>Doxylamine</td><td>Nausea/vomiting/sleep</td><td>PO</td><td>12.5-25mg nocte</td></tr>
<tr><td>Cyclizine</td><td>Nausea/vomiting/sleep</td><td>PO</td><td>50mg BD or TDS PRN</td></tr>
<tr><td>Omeprazole</td><td>Reflux/hyperemesis</td><td>PO</td><td>20mg PO, can be BD too</td></tr>
<tr><td>Prochlorperazine (Stemitil)</td><td>Nausea/Vomiting/Dizziness</td><td>PO/IV</td><td>5-10mg</td></tr>
<tr><td>Paracetamol</td><td>Pain</td><td>PO</td><td>1g PO QID</td></tr>
<tr><td>Endone</td><td>Pain</td><td>PO</td><td>May want to avoid if patient in labour (neonatal respiratory depression) or had/has intrathecal opioids (will be clear on med chart)</td></tr>
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	Aspirin	PET prophylaxis	PO	150mg note, operator dependent for time frame, generally 8-12/40 to 36/40 nocte dosing
	Movicol	Constipation	PO	1-2 sachet BD
	Lactulose	Constipation	PO	20mL Daily or BD
	Coloxyl ONLY	Constipation	PO	50-100mg PO Nocte or BD Do NOT use Senna in pregnancy
	(NOTE: Pregnant woman can typically have all analgesics except NSAIDs – Also never give NSAIDS with PET or proteinuria even post-partum)			

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	• Please use EMR template for Admissions. Add document → Document type: Doctor Admission Note / Document template: Admission Note
Ward Rounds	• Please document Ward rounds on EMR under documentation. Add document → Document type: Doctor progress Note / Document template: Progress Note
Discharge Summary	• Please use EMR template for discharge summaries. Add document → Document type: Discharge Summary / Document template: Medical Discharge Summary
Outpatient Clinics	• Please use EMR template for clinic noctes

	Add document → Document type: Doctor Clinic Note / Document template: Progress Note • Please ensure you copy and paste the clinic notes from EMR onto an outpatient clinic note on CPF.
CDI Queries	N/A
Death Certificates	Please discuss with Medical Obstetrics Registrar https://www.bdm.vic.gov.au/medical-practitioners
Coroners	Please discuss with Medical Obstetrics Registrar https://coronerscourt.vic.gov.au/report-death-or-fire/how-report-death

23. Referrals	
Internal	• Medical Obstetrics referring to other specialities: Referral via Medtasker/switch based on specialty • Medical Obstetrics outpatient/Clinic referrals: Via CPF (Summary tab → submit internal referral) • MOAH referrals: 1. Put patient details (name/DOB/URNO) or bradma sticker into MOAH referral book which is located in ward 10/11 ward clerk desk. 2. Write MOAH referral note on EMR (as a progress note on discharge) • ED/other specialties referring to Medical Obstetrics: Via Medtasker in hours/via switch after hours.
External	N/A

24. Clinical Deterioration	
Escalation Process	• Nursing/Medical concerns verbally raised/raised via Medtasker to alert medical team of clinic status/deterioration
PreMet	• Premet called when patient's vital signs/observations are within pre-met criteria → Nursing/medical staff send Pre-met medtasker to alert home team + start Pre-met form on EMR (found under Former Browser) • Home team must attend/respond to Pre-met within 15mins of receiving Medtasker. • Home team must complete Pre-met form (found under Former Browser on EMR). This includes assessment and management plan for the Pre-met.
Code	• Code called by nursing/medical staff based on patient's disposition • Common codes you may see in Medical Obstetrics: Code Blue – unconscious patient Code Pink – obstetric emergency Code Green – obstetric emergency needing emC/S for delivery within 30 mins Code Grey – aggressive/abusive patient. Security called.

25. Night Shift Support	
Unit	Renal/Med Obs Registrar on-call (based on roster) will cover renal/med obs inpatients + take new referrals from ED after-hours

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	
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

Renal Teaching:
Monday 12:30 in person in the renal office. Presentations usually from Renal Registrars and Med Obs Registrar.

Medical Obstetrics Unit Meeting:
Tuesday morning at 08:00 via MS Teams. Unit consultants, Registrar and Intern attend with special guest speakers from time to time.

Intern Teaching:
Tuesday 12:30 in person in the TNH Lecture Theatre. This is part of intern protected teaching time.

O&G Teaching:
Thursday 07:30 via MS teams. (Optional for Medical Obstetrics team)

Renal Unit Meeting:
Friday afternoon at 12:30 in the TNH Lecture Theatre. Renal unit consultants/Registrars/Residents/CKD nurses/Allied Health staff and Medical Obstetrics Registrar/intern all attend in person. Lunch Provided.

29. Unit Meetings

Medical Obstetrics Unit Meeting:
Tuesday morning at 08:00 via MS Teams. Unit consultants, Registrar and Intern attend with special guest speakers from time to time.

Radiology Meeting:

MedObs and Renal share a radiology meeting with Med 3 on Tuesday afternoon 13:30 in the radiology library room.

Renal Unit Meeting:
Friday afternoon at 12:30 in the TNH Lecture Theatre. Renal unit consultants/Registrars/Residents/CKD nurses/Allied Health staff and Medical Obstetrics Registrar/intern all attend in person. Lunch Provided.

30. Research and Quality Improvement

Medical Obstetrics JMO/Registrar has opportunity to get involved with Quarterly Audit in 2024.

31. Career Support

Discussion with Medical Obstetrics Consultants/Head of Unit for Career progression opportunities

32. Medical Students on the Unit

Medical students may be allocated to Medical Obstetrics Unit.
Med Obs team should incorporate students into the team and give them opportunities to get involved with patient care including helping with ward rounds, opportunities to do procedures (cannula/venepunctures) and offering teaching about common medical conditions seen in Medical Obstetrics patients.

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>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>
Overtime	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.

34. JMO Rover

MOAH:

- What is MOAH?
    - Medical Obstetrics at Home is a service run by midwives on Mondays and Thursdays. These midwives visit patients at home or call them to check in about BP or hyperemesis (and can give IVT at home)
  - Who to refer
    - All patients with pre-eclampsia, essential HTN, pregnancy-induced hypertension
    - Severe hyperemesis (most patients who get admitted under Med Obs are severe hyperemesis)
  - How to refer patients to MOAH:
- There is a MOAH book at the ward 13 reception desk. Put the patient's sticker in here (or write it by hand)
  - The ward clerk will monitor when the patient will be discharged and add to MOAH bed portal when they are discharged.
- On the ward round:
  - Let the patient know they will be going home with MOAH and that they will be contacted on Mondays/Thursdays. Get patient to save the MOAH number in their phone (0456 588 023)
  - If the patient has BP issues and has a BP machine at home, provide the patient with the MOAH pamphlet for recording BP measurements
  - Give patient any relevant repeat path (e.g. PET screen in 6/52) – include the GP details so they get faxed the results
- EMR documentation

  - Add a note call "Transfer/Discharge documentation" and title it "MOAH referral"
  - Use the auto-text template to write a referral to the midwives (to make their life easier). You can find auto-text templates in Med Obs > Junior Staff
  - For BP issues:
    - GXPX status, mode of delivery, date of delivery, PET symptoms, PET pathology, discharge medications, whether or not patient has a BP machine, whether or not you gave the patient a path slip for repeat PET bloods/urine
  - For hyperemesis:
    - GXPX status, gestation, discharge medications
- MOAH discharges
  - Once discharged off MOAH, intern needs to write a quick discharge summary explaining what has been done and what plan is
  - Use auto-text feature on EMR for these
    - You can find auto-text templates in the Med Obs folder > Junior Staff.
  - Fax the DC summary to the GP. Place in envelope with patient's address on front and give to ward clerk for posting (can put path slip in here too if pt doesn't have one). Also put the HTN flyer in here (in MOAH folder)

THALASSAEMIA LIST

- The Medical Obstetrics intern chases thalassaemia screening at TNH. O&G will also look out for results and request partner testing if they see the result first in antenatal clinic.
- Read up about thalassaemia/sick cell to be able to provide simple explanations to patients:
  - Simple: https://www.stjude.org/treatment/disease/sickle-cell-disease/diagnosing-sickle-cell/alpha-thalassemia-trait.html
  - More detail: https://www.genetics.edu.au/PDF/Thalassaemia_fact_sheet-CGE.pdf
  - https://www.tasca.org.au/carrier-screening/ (can email this link to patients)
- Each week you will get an email sent to NH-MedicalObstetricsHaematology@nh.org.au (get access from Head of Unit) from the haematologist Vanessa with all the patients that underwent the testing.
- The list will state which patients require partner testing
  - Call the patient and explain that you are following up their blood tests
  - Explain that one of the things tested was thalassaemia
  - Explain that while patient's result is getting DNA analysis, we would like to test the partner too
  - Use advanced search on cpf to search up partner's details
  - If patient has never been to Northen Health, you will need to create a URNO
    - Go to ipm → patient search
    - Write partner's first & last name & DOB and click 'search'
    - ipm will say 'no patient found, would you like to proceed with quick registration' → click yes
    - Fill in whatever details you can – mainly name, DOB, address, phone number, medicare number (if they have it)
  - Print stickers
  - Email a pathology slip (FBE, iron studies, Hb electrophoresis +/- DNA analysis) to the patient/partner that has the partner sticker AND has the woman's details in the 'clinical notes' section
  - You will then need to chase the partner results and call patient to inform if negative/positive. Refer to genetic clinic if partner is also positive for carrying the thalassaemia trait.

    - You can keep track of thalassaemia jobs with the Excel spreadsheet (Med Obs → Haematology → Thalassaemia intern list)
- For patients who are iron deficient, if you have time, call them to see if they are taking supplementation. If they are >30/40 gestation, you can offer to organise an iron infusion.
    - This is less of a priority than thalassaemia
    - Iron is not recommended in first trimester
    - Oral iron can cause constipation so counsel patients about aperients

OUTPATIENT RESPONSIBILITIES

Chasing things for discharged patients

- Many inpatients will be discharged with pending investigations (e.g. patients with diarrhoea with pending faecal PCR). Add these to the outpatient jobs list in EMR – include a date in the 'actions' list to help you keep track of when to chase things. In the discharge summary, write that Med Obs is chasing these results and will be in touch with patient if management changes.

Clinic

- Intern will often go to haematology clinic on Friday afternoon (Vanessa Manitta) and might be asked to help out at other clinics
- Log into Q-flow (intranet → favourite links → Q-flow). Select your room number and type of clinic, then go to service console and select the consultant
- For face-to-face reviews, press 'call patient' so that the patient gets alerted to go to your room
- For phone reviews, 'silent call' a patient to allocate yourself to them (so that others know that you are calling the patient)
- Take a targeted history + exam, present to the consultant. For phone calls, tell the patient you will call them back once you've discussed with the boss. For face-to-face, ask the patient to wait in the room while you discuss with consultant.

Consultant jobs

- Consultants will often whatsapp/SMS/email you with requests (things to chase, iron infusions, Holter, etc.) Add these to the outpatient jobs to keep track.

MOAH outpatient jobs

- Scripts – can write these on EMR or paper. Email/fax to the patient's pharmacy. Also put the physical script in an envelope with the pharmacy address on the front and give to any ward clerk to mail out (pharmacies need physical scripts in order to dispense repeats). Call the patient to let them know you've faxed/emailed the script.
- Pathology – email to the patient (often under 'patient info' on EMR, otherwise call patient). Include the renal office fax number (84058402) in case the patient goes to an alternative pathology company.

Iron infusions

- Call patient to consent them on the phone and ask about allergies. Advise patient that Day Medical Unit will contact them with their appointment time.
- Print patient stickers from iPM
- Fill in iron infusion consent form (found on Prompt)

- Write script – EMR or paper (1000mg carboxymaltose in 250mL 0.9% sodium chloride over 15 minutes)
- Complete a Day Oncology referral form (found on Prompt)
- Drop off the consent, script, referral and stickers to Day Oncology (next to new entrance to Tower building).

You may get Medtasked to complete iron infusion paperwork from Day Onc for patients who have had an iron infusion organised by O&G, if you're not busy then help out when you can

IV fluids in Day Medical Unit

- Rare, but sometimes women with hyperemesis need extra IVT (on top of what MOAH can provide) to help keep them at home and prevent ED admissions. This can be organised with Day Medical/Onc
- Complete Day Onc/Medical Unit referral form (on Prompt)
- Complete paper fluid administration order (the form with blue semicircles border) – typically sodium chloride 0.9% 1000mL over 2 hours
- You will need a referral form & fluid form for every IVT session (i.e. if patient needs IVT every week for 4 weeks, then need 4x forms)
- Drop off at Day Onc/Medical unit and discuss with the admin person there
- For patients who live in Kilmore, the hospital there does outpatient IVT on Wednesdays

35. Document Status		
Updated by	Shefani Perera (med obs intern) / Dr Siaw Hui Wong (Head of Unit)	07/12/23
Reviewed by	Dr Natina Monteleone	23/01/2024
Next review date		