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**:	Choose an item.
Speciality/Dept.:	Obstetrics & Gyneacology	**Non-clinical experience:**	*(PGY2 only)*
PGY Level:	PGY2	**Prerequisite learning:**	*(if relevant)*
Term Descriptor:	*Obstetric and gyneacology terms with a mixture of ward-based inpatient management, outpatient clinics and attendance in theatre. Perform basic obstetric procedures. Opportunity to be involved in clinical audits and presentation at unit meetings.*		

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	Identifies and considers culturally safe and appropriate means of obtaining patient histories and/or performing physical examination.
	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	Recognises the need for timely escalation of care and escalates to appropriate staff or service, following escalation in care policies and procedures.
	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	Writes clearly legible prescriptions or charts using generic names.
	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	Makes use of local service protocols and guidelines to ensure decision-making is evidence-based and applies guidelines to individual patients appropriately
EPA4: Team communication – 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	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 Arzoo Khalid***	Head of Unit Obstetrics	Arzoo.Khalid@nh.org.au
Clinical Supervisor (primary)	***Allocated Consultant at start of term***	O&G Consultants	Click or tap here to enter text.
Cinical Supervisor (day to day)	***Allocated Consultant or Registrar on ward service***	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 Arzoo Khalid	Head of Unit Obstetrics	Arzoo.Khalid@nh.org.au
Dr Jo Vivian-Taylor	Head of Unit Gyneacology	Josephine.Vivan-Taylor@nh.org.au
Dr Leah Brown	Consultant	Leah.Brown@nh.org.au
Allocated per term	Senior Registrar	Click or tap here to enter text
Dr Priya Rajagopal	Consultant- Education Program	Click or tap here to enter text
CS booking midwife	Shan Law	Shan.S.Law@nh.org.au
Medical Workforce	Olga Stoitis	Olga.stoitis@nh.org.au
On call consultant	Allocated consultant	Via Switch

Labour Ward Reg	58408	Theatre Bookings (CS)	58855
Labour Ward HMO	58409	Theatre Booking (Gynae)	52220
Gynae Reg	52521	Pathology	58356
Gynae HMO	52613	Blood Bank	58363

Delivery Suite NIC	58318	Ultrasound	58670
Maternity Ward NIC	58210	Interpreters Office (TALS)	58188
Outpatients Clinic C Clinic C Fax	58771 8405 8766	Phone Interpreter (after hours)	8807 2300
Emergency / MET Call:	Dial 2222	Maternity Assessment Centre Delivery Suite Maternity Ward Fax	52277/58330 58213 8405 8201
Switchboard	Dial 9	Paediatrics Reg	52076
IT Help Desk	52222	Anaesthetics IC	58993
AO/Flow Coordinator	58110	Theatre NIC	58990

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 Click or tap here to enter text.	Enter Time Click or tap here to enter text.	Enter Time Click or tap here to enter text.	Enter Time 07:30 – 08:30 Registrar & HMO Education	Enter Time Click or tap here to enter text.	Enter Time Click or tap here to enter text.	Enter Time Click or tap here to enter text.
Afternoon	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time

	12:30 C-section meeting	12:30 Gynea pre-op meeting & Journal club	12:30 Neonatal M&M	12:30 – 13:30 HMO Education 12:30 Birth trauma care review- fortnightly Perinatal M&M fortnightly	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Evening	Enter Time Click or tap here to enter text.	Enter Time Click or tap here to enter text.	Enter Time Click or tap here to enter text.	Enter Time Click or tap here to enter text.	Enter Time Click or tap here to enter text.	Enter Time Click or tap here to enter text.	Enter Time Click or tap here to enter text.
Hours	Total	Total	Total	Total	Total	Total	Total

Obstetrics & Gynaecology HMO	Mon	Tues	Wed	Thur	Fri	Sat	Sun	Mon	Tues	Wed	Thur	Fri	Sat	Sun
Hmo 1	0800-1300 5h	0800-1700 9h	1300-1700 4h	1300-1700 4h	0800_2200 14h	OnC SLOC 1700-0759	0800-1300 5h	1300-1700 4h	0800-1700 9h	0800-1300 5h	0800-1700 9h			0800_2200 14h
					OnC SLOC 1700-0759									
HMO 2	OnC SLOC 0800-0759	0800-1300 5h	0800-1700 9h	0800-1700 9h	0800-1700 9h			OnC SLOC 0800-0759	0800-1300 5h	0800-1700 9h	0800_2200 14h	0800-1700 9h		
												OnC SLOC 1700-0759		
HMO 3		0800-1700 9h	0800_2200 14h	OnC SLOC 1700-0759		0800_2200 14h			0800_2200 14h	1300-1700 4h	0800-1700 9h		0800_2200 14h	

			OnC SLOC 1700-0759							OnC SLOC 1700-0759				
HMO 4	0800-1700 9h	0800-1700 9h		1300-1700 4h	0800_2200 14h	0800-1300 5h		0800_2200 14h			0800_2200 14h	0800-1700 9h		
	OnC SLOC 1700-0759													
HMO 5	0800-1700 9h	OnC SLOC 0800-0759	0800-1300 5h	0800_2200 14h	0800-1700 9h			0800_2200 14h	OnC SLOC 1700-0759		0800-1700 9h	0800_2200 14h		OnC SLOC 0800-0759
HMO 6	OnC ReCS LOC 0800-0759	0800_2200 14h		0800_2200 14h	OnC SLOC 0800-0759		0800_2200 14h	0800-1300 5h	0800-1700 9h	0800_2200 14h	0800-1300 5h	0800-1700 9h		OnC SLOC 1700-0759
									OnC SLOC 1700-0759					
HMO 7	0800-1700 9h	0800_2200 14h	OnC SLOC 0800-0759			0800_2200 14h		0800-1700 9h	0800-1300 5h	0800-1700 9h	0800-1700 9h		OnC SLOC 0800-0759	0800-1300 5h
											OnC SLOC 1700-0759			
HMO 8	hd0800-1700 9h	hd0800_2200 14h	hdReg Training	hd0800-1700 9h				hd1300-1700 4h	OnC SLOC 0800-0759	hd0800-1800 10h	hd0800-1300 5h	hd0800-1700 9h		hd0800_2200 14h
HMO 9	0800_2200 14h	0800-1700 9h	0800_2200 14h	OnC SLOC 0800-0759			OnC SLOC 1700-0759	1300-1700 4h	0800_2200 14h		OnC SLOC 0800-0759	0800_2200 14h	0800-1300 5h	
		OnC SLOC 1700-0759												
HMO 10	2130-0830	2130-0830	2130-0830								2130-0830	2130-0830	2130-0830	2130-0830
HMO 11				2130-0830	2130-0830	2130-0830	2130-0830	2130-0830	2130-0830	2130-0830				
HMO 12	0800_2200 14h	0800-1700 9h	0800-1700 9h	0800-1700 9h		OnC SLOC 0800-0759	OnC SLOC 0800-0759	0800-1300 5h	0800-1700 9h	OnC SLOC 0800-0759	0800-1700 9h		0800_2200 14h	

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	Northern Hospital – Epping Campus, 185 Cooper Street, Epping 3076
Facilitator	O&G Head of Obstetrics
Date	First day each term
Start	13:00

11. Unit Overview	
Department	Obstetrics and Gynaecology
Location	Ward 10, 11 & 12, Northern Hospital – Epping
Inpatient Beds	Ward 10 – 9 beds. Ward 11 – 29 beds, Ward 12 – MAC
Outpatients Clinics	Daily – TNH, CHS & BHS
Day Procedures	Broadmeadows Health Service
Virtual Unit	N/A

12. Safety

Obstetrics and Gynaecology is an incredibly diverse specialty, which involves collaboration with many other specialities including midwifery, paediatrics, anaesthetics and medicine just to name a few. O&G is very rewarding but can also be very confronting. Don't be afraid to ask for help when unsure. Unit debrief available.

Unit Specific Risks

- Safe medication prescribing (Pregnancy and Breastfeeding)
- Family violence
- Perinatal loss

13. Communication	
Medtasker	Inpatient (Registrar & HMO)
WhatsApp	JMO communication
Pager	Inpatient (Registrar & HMO) – For MET call alerts only
MS Teams	Unit Handover (AM & PM) and Unit Meetings

14. Handover Process	
Morning	Family Room – Ward 11. 08:00 daily with Birth Suite NUM and on call consultant
Afternoon	N/A
Night	Birth suite Nurses station 21:30. Consultant to attend via MS Teams

15. Shift Structure			
	Intern	HMO	Registrar
Day	N/A	08:00-22:00 (long day Gynae or birth suite) 08:00-17:00 (Ward HMO or clinic)	08:00-22:00 (long day Gynae or birth suite) 08:00-17:00 (Theatre or outpatient clinic)
Afternoon	N/A	13:00-17:00	13:00-17:00
Night	N/A	21:30 – 08:30 (11 hours)	21:30 – 08:30 (11 hours)
Weekend	N/A	08:00-22:00 (long day Gynae or birth suite) 08:00-13:00 (Ward HMO)	08:00-22:00 (long day Gynae or birth suite)

16. Shift Roles & Responsibilities			
	Intern	HMO	Registrar
Day	N/A	Login to medtasker Duties are specific to rostered role **Labour Ward HMO: 0800 – 2200** • Attends handover and is guided by labour ward registrar as to tasks needing to be done • Responsible for ongoing care of all admissions to birthing suite • Communicate directly with anaesthetics and paediatrics staff when these services are required • Support the labour ward registrar during obstetric emergencies which may involve: Consenting patients for emergency caesarean sections/trial of instrumental delivery/ manual removal of placenta/ repair of 3rd or 4th degree tears, inserting IVC/IDC, ordering oxytocics, liaising with paediatricians, anaesthetics and theatre nurses in charge, and setting up/assisting registrars with instrumental deliveries	Login to medtasker Duties are specific to rostered role

		• Book patients on ETBS (Emergency Theatre Booking System) using login: whcn\username and password
		  ○ Anaesthetics – inform them of time frame, see table below in Appendix 1 (if unsure ask reg), situation, any medical complications, analgesia in labour and any anticipated complications
		  ○ Theatre in Charge – indicating time frame and ask if any other teams need to be contacted
		  ○ Paediatricians (need to be present for all caesarean/instrumental deliveries) – inform of indication of procedure, situation, time frame of procedure, gestation, GBS status, CTG, presence of mec liquor and time of membrane rupture
		• Gain practical skills in the following:
		  ○ Conducting normal vaginal delivery under supervision
		  ○ Vaginal examinations in labour with consent
		  ○ Induction of labour, artificial rupture of membrane and application of fetal scalp electrodes
		  ○ Repair straight forward episiotomies, 1st and 2nd degree tears
		• Assist in caesarean sections
		• Assess women with acute presentations in MAC (Maternity Assessment Centre) when required, developing differential diagnoses, conducting investigations and carrying out management plans under the supervision of your registrar
		• Update handover/ handover board
		• There is a great deal that can be learnt from the midwives on birth suite so please use this valuable resource and always remain respectful
		
		Gynaecology HMO: 0800 – 2200
		
		• Attends handover and is guided by Gynaecology Registrar	

		• Responsible for ordering and checking results of any investigations and management plans decided at handover or during ward round
		• Responsible for discharges of gynaecology and antenatal patients, to facilitate safe discharge, ensure each patient gets the following
		  ○ Completed discharge summary in a timely fashion
		  ○ Scripts for discharge medication
		  ○ Follow up appointment – referral to be made on CPF
		  ○ Medical certificate (if required)
		• Assist in assessment of referrals in ED along with Gynaecology registrar
		• Skills to get good at
		  ○ Taking a good O&G history
		  ○ Speculum examination
		  ○ Management of first trimester miscarriage
		  ○ Management of heavy menstrual bleeding
		• Update handover (a very important document)
		  ○ Start by creating a new copy (date - PM) – DO NOT edit on the existing handover that was prepared by the previous team
		  ○ Ensure the **gestations** of antenates are updated
		  ○ Update location of the patients
		  ○ Update pathology/imaging
		
		Discharges HMO: 0800 – 1700 (Weekdays) 0800 – 1300 (Weekends)
		This is an independent role but HMO can seek assistance/advice from gynae reg. There is no need to attend handover. Your main responsibilities include
		
		1. Conduct baby and mum checks on those who are flagged for discharge.
		2. Review mums who are day 1 post Caesarean Section (elective & emergency)
		
		At the start of the shift, approach the maternity ward NIC for a list of 1 + 2 and pick up the ophthalmoscope from her (required for baby check)
		
		Theatre HMO: 0730-1300 or 1300-1700	

		There will be opportunities to attend elective theatre lists either with a registrar or a consultant. Depending on your level of experience you may have opportunities to perform minor operations and well as assisting your registrar/consultant in more major procedures. It is the HMOs responsibility to see patient with the registrar pre operatively.	
Afternoon	N/A	Login to medtasker Duties are specific to rostered role	Login to medtasker Duties are specific to rostered role

Night	N/A	**Nights HMO: 2130 – 0830 (Alternating 7 nights on/off)**
		• Duties as per labour ward resident above
		• Check abnormal pathology results
		• Commence inductions at 0600am.
		  ○ Review history, indication, and CTG before starting.
		  ○ Remove cervical catheter/ cervidil
		  ○ Ensure fetus is still cephalic with a bedside scan
		  ○ Insert cannula
		  ○ Order G+H + FBE +/- CRP (if prolonged rupture of membranes) +/- PET bloods
		  ○ Order medications
		  1. Syntocinon (3rd stage + infusion for induction)
		  2. Antiemetics
		  3. Novorapid sliding scale (if GDM)
		  4. IV antibiotics (if Prolonged ROM or GBS positive)
		  ○ Practice Amniotomy + commence syntocinon
		• Update and print handover sheet *as above
		• Present patients at handover along with the Registrar
			Login to medtasker
			Attend unit handover
			Management of birth suite, ED presentations and inpatient admissions.

Weekend	N/A	Login to medtasker Duties are specific to rostered role	Login to medtasker Duties are specific to rostered role

17. Common Conditions
Familiarise yourself with management of early pregnancy loss – Guidelines on PROMPT and summary of management listed in the unit ROVER Familiarise yourself with the following Obstetric conditions – Gestational diabetes, Pre-eclampsia, reduced fetal movements, antepartum haemorrhage, post-partum haemorrhage.

Familiarise yourself with the following Gynaecological conditions – Heavy menstrual bleeding, postmenopausal bleeding, pelvic pain

https://intranet.nh.org.au/departments-and-services/prompt-policy-procedures-guidelines/prompt-policies-procedures-and-forms/

18. Common Procedures

Caesarean section
Episiotomy and perinatal tear repair
IV cannulation + venesection
IDC insertion
Hysteroscopy D&C
Suction D&C
Incision and drainage of labial abscess
Laparoscopy
Hysterectomy – Vaginal, abdominal and laparoscopic

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/

Safer Care Victoria Maternity ehandbook - https://www.safercare.vic.gov.au/clinical-guidance/maternity

UK Medical Eligibility Criteria for Contraceptive Use (UKMEC) - https://www.ukmec.co.uk/

The Royal Women's Pregnancy and Breastfeeding Medicines Guide - https://thewomenspbmg.org.au/

Prescribing guidance is also available in the Therapeutic Guidelines

20. Routine Orders

Pathology	Discuss with reg/consultant prior to ordering
Radiology	Discuss with reg/consultant prior to ordering

Pharmacology

MEDICATION	INDICATION	ROUTE	DOSE	FREQUENCY
Benzylpenicillin	GBS +ve	IV	3g loading 1.8g Q4H in labour	

	Clindamycin	GBS +ve (penicillin allergy)	IV	900mg, Q8H in labour
	Cephazolin	Infection	IV	1g, TDS
	Metronidazole	Infection	IV	500mg, BD
	Morphine	Labour analgesia	IM	10mg
	Temazepam		PO	10mg, nocte, PRN (give 1 in take home pack)
	Syntocinon	Active 3rd stage Mx	IM/IV	10 units
	Syntocinon	IOL	Fluid chart	10 units, APP (run with concurrent CSL bag)
	Syntocinon	PPH Mx	Fluid chart	40 units, over 4 hours
	Misoprostol	PPH Mx	PR	1mg, STAT
	Ergometrine	PPH Mx	IM and IV	250mcg
	Oxycodone IR	Postnatal analgesia	PO	5-40mg q3H, PRN
	Tramadol	Postnatal Analgesia	PO	50-100mg, TDS

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	Obstetric admissions come from the Emergency department, antenatal clinic, MAC, other acute hospital (Kilmore) or direct admission from birth suite. Gynaecological admissions come from the Emergency department, other TNH inpatient specialities or theatre.

	Use the admission workflow on EMR
Ward Rounds	Use the ward round workflow on EMR
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	Use the maternity workflow on EMR Gynaecology Outpatient clinics, prescriptions and investigations remain on CPF
CDI Queries	Medtasker
Death Certificates	Perinatal loss – 1. Complete two copies Medical Certificate Cause of Perinatal Death (MCCPD) via BDM RIO Online portal a. One copy to be transported with the baby to the mortuary b. One copy to be placed in the health record 2. Victorian Perinatal Autopsy Service Perinatal Death ≥ 20 weeks - VPAS Post Mortem Consent. Please complete if patient also declines a post mortem. 3. Consultative Council on Obstetric and Paediatric Mortality and Morbidity (Perinatal - CCOPMM) Stillbirth or Neonatal Death template complete and place in perspex document holder in Birthing Suite.
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	Clinic: Referrals to this clinic are made electronically via e-referrals on CPF. Inpatient referrals are made directly to the Gynaecology register on X52521
External	Obstetric Inpatient retrievals and referrals are coordinated via PIPER – For all Paediatric, Neonatal and Perinatal Emergency Calls **Telephone PIPER dedicated 24-hour emergency line on 1300 137 650.** • The referral is conferenced with the PIPER Consultant Obstetrician and the call coordinator. • Advice is provided. • PIPER will assist with organising the transfer and the appropriate healthcare facility required for the referred woman

24. Clinical Deterioration	
Escalation Process	MatRAP and Code Pink for Obstetric emergencies – refer to PROMPT
PreMet	Resident and registrar review
Code	Resident and registrar to follow standard procedures and discuss with consultant

25. Night Shift Support	
Unit	N/A
Periop	N/A
Take 2 @ 2	Meeting to escalate concerns

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

Thursday mornings 07:30-08:30 via Teams. A roster will be sent out in advance. Junior medical staff will be expected to present on a subject in accordance with the roster.

29. Unit Meetings

Meetings	Day	Venue
CS Meeting	Monday, 1230	Teams
Gynae Pre Op Meeting	Tuesday, 1230	Teams
Neonatal M&M	Every 2 months	Teams
Perinatal M&M	Every month	Teams
Gynae M&M	Every 6 months	Teams

30. Research and Quality Improvement
Monthly perinatal M&M and six-monthly Gynaecology M&M Caesarean and Gynaecology pre-op meetings Perinatal loss committee Northern Health and the Department of O&G strongly encourages JMO's to be involved in research. Research audits can be undertaken under the guidance of Dr Arzoo Khalid and Prof Lisa Hui.

31. Career Support
Discuss with RANZCOG ITP Coordinator – Dr Leah Brown or Head's of unit – Dr Arzoo Khalid (Obstetrics) and Dr Josephine Vivian-Taylor (Gynaecology).

32. Medical Students on the Unit
MD3: Follow Gynaecology resident and registrar, clinic consultant or attend birth suite.

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 the chief registrar/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 Chief registrar for approval.
Unplanned Leave- Notification and documentation process	**Personal Leave documentation required:** ***Please inform the Chief registrar as soon as possible of any unplanned leave*** For 3 single absences per year, the doctor will not be required to provide any supporting evidence to substantiate their personal leave. For other days absent due to personal illness or injury the doctor is required to provide evidence of illness. To be eligible for payment, the doctor is required to notify the Health Service **two hours** before the start of their shift, or as soon as practicable.

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

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

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

34. JMO Rover

1a. Mum check

- Follow the pro-forma in the patient's chart *(EMR quick text: .MATdischarge_postnatal_review)*
- If patient had an uncomplicated normal vaginal delivery, her check can be completed by midwifes

Scenarios		
PPH	Check day 1 FBE Check antenatal ferritin levels	Offer IV or PO iron on discharge Transfuse PRBC as per protocol
Mum Rhesus negative	Check baby's group and DAT	If baby is rh neg – do nothing If baby is rh pos – order 625IU anti-D and Kleihauer (blood test)
GDM	6/52 OGTT with GP follow up	
Gestational hypothyroidism	Mum: 6/52 TFT with GP Baby: Day 10 TSH T4 T3	Inform paeds so that they can follow up baby's results
Rubella non immune	MMR vaccine post-partum	Check rubella IgG titre with GP 6 weeks
3rd/4th degree tears	Check bowels PT referral while inpatient IV antis 24/48 hours (as per op report)	Script for PO augmentin duo forte + laxatives Outpatient gynae clinic in 6 weeks (submit internal referral on CPF)

For all mums:

- Advised signs of endometritis + mastitis

- Advised nothing per vaginal (intercourse/tampons) for 6 weeks
- Examine for DRAM (diastasis recti of the abdominal muscle), refer to physio if significant.
- Advised safe interpregnancy interval (min. 12 months for vaginal delivery; min. 18 months for LUSCS)
- Follow on with contraception discussion* see below
- Remind mums to do CST (if overdue) with GP in 6 weeks

1b. Baby check

- Dani (neonatal nurse practitioner) will provide a demonstration before the start of each term.
- When in doubt, always speak to an experience midwife and/or refer to paeds reg

2. Day 1 CS check *(EMR quick text: .MATDay1PostCS)*

- Review as per proforma: PV loss, pain, TOV progress, bowels, mobilisation
- * Refer to HITH if patient has a VAC (prevenar dressing) on the day of review to avoid delays with discharge. This dressing often comes off on day 10 post op (clarify with op report)
  - HITH registrar will appreciate the following information: estimated date of discharge + date of CS + when does the dressing come off + can the patient give herself clexane
- Do discharge script: paracetamol + ibuprofen + oxycodone IR + movicol +/- clexane +/- contraception

Contraception (as per UK Medical Eligibility Criteria for Contraceptive Use (UKMEC)

Table 3: Summary of UK Medical Eligibility Criteria for Contraceptive Use (UKMEC) categories applicable to women after childbirth[18]

Condition	Cu-IUD	LNG-IUS	IMP	DMPA	POP	CHC
Postpartum (in breastfeeding women)						
a) 0 to <6 weeks	See below		1	2	1	4
b) ≥6 weeks to <6 months (primarily breastfeeding)			1	1	1	2
c) ≥6 months			1	1	1	1
Postpartum (in non-breastfeeding women)						
a) 0 to <3 weeks	See below					
(i) With other risk factors for VTE*			1	2	1	4
(ii) Without other risk factors			1	2	1	3
b) 3 to <6 weeks						
(i) With other risk factors for VTE*			1	2	1	3
(ii) Without other risk factors			1	1	1	2
c) ≥6 weeks			1	1	1	1
Postpartum (in breastfeeding or non-breastfeeding women, including post-caesarean section)						
a) 0 to <48 hours	1	1	See above			
b) 48 hours to <4 weeks	3	3				
c) ≥4 weeks	1	1				
d) Postpartum sepsis	4	4				

* In the presence of other risk factors for VTE, such as thrombophilia, immobility, transfusion at delivery, body mass index ≥30 kg/m^2, postpartum haemorrhage, post-caesarean delivery, pre-eclampsia or smoking, use of CHC may pose an additional increased risk for VTE.

CHC, combined hormonal contraception; Cu-IUD, copper intrauterine device; DMPA, progestogen-only injectable: depot medroxyprogesterone acetate; IMP, progestogen-only implant; LNG-IUS, levonorgestrel-releasing intrauterine system; POP, progestogen-only pill; VTE, venous thromboembolism.

Table 1: Definition of UK Medical Eligibility Criteria for Contraceptive Use (UKMEC) categories[18]

UKMEC	Definition of category
Category 1	A condition for which there is no restriction for the use of the method.
Category 2	A condition where the advantages of using the method generally outweigh the theoretical or proven risks.
Category 3	A condition where the theoretical or proven risks usually outweigh the advantages of using the method. The provision of a method requires expert clinical judgement and/or referral to a specialist contraceptive provider, since use of the method is not usually recommended unless other more appropriate methods are not available or not acceptable.
Category 4	A condition which represents an unacceptable health risk if the method is used.

In summary, Implanon or levonorgestrel 30mcg daily (POP) are very safe for any women immediately postpartum regardless of breastfeeding status. IM depo-provera is also safe. COCP should be avoided.

Mirena or the copper IUD should either be inserted within 2 days postpartum (which is not practised very much in TNH) or after 4-6 weeks.

Theatre lists http://dsuselfrequest.nh.org.au/internal/sessionschedule/index.php
The indication for the procedure is clear

- All preoperative investigations have been chased up
- The patient is accurately consented
- Examine the patient as indicated
- Discuss the procedure with the patient and answer any questions

If you have any concerns to discuss this with your registrar/ consultants assigned to your list.

Antenatal Clinics: 0830 – 1300 or 1330 – 1700

Model of antenatal care

1. Low risk midwife clinic
2. Collaborative clinic
- Usually has one risk factor
- When presenting to consultant useful to state " ms xx is in collab for xxxx (the risk factor)"
3. High risk obstetrician clinic
- When first starting out, it is a good idea to run pass every patient with the consultant

Collaborative Clinic

Familiarize yourself with i-COPE – perinatal mental health form

- Patient completes the form online which then gets scanned on CPF
- I-COPE is screening tool for perinatal mental health assessment, check CPF for completion of screening form

Family Violence screening in antenatal clinic

- Usually completed by midwives on first F2F visit
- Check family screening notes if not done – assess (refer to antenatal clinic folders)

20 weeks visit

- Take a full history
  - Past pregnancy issues, modes of delivery (vaginal vs caesarean)
  - Size of previous babies
  - Past medical history + any regular medication
  - Past surgical history (gastric sleeve)
  - Gynae history
  - Smoking/drugs/etoh
  - Check booking bloods: Blood group + antibodies, serology, rubella, genetic screening
  - Weigh the patient
- Check morphology scan
  - Normal morphology
  - Placenta clear of cervical os? – beware <2cm
  - Cervix long + closed? Beware <2.5cm in length on TVUS
- Provide 26-28 week bloods

28 weeks : 'pregnancy planning' check the following bloods

- OGTT
- FBE
- Vit D, Ferritin
- Blood group + antibodies
- Growth scans (if any)
- Delivery planning – vaginal vs CS

OGTT

- Diagnose GDM if fasting ³ 5.1, 1 hr ³ 10.0, 2 hr ³ 8.5
- Refer to GDM group session (this is done on Q-flow, specify if patient speaks English or NESB)
- Refer to Obstetrics endocrine (this is done on CPF internal referral)
- Growth scans

FBE

- Anaemia: differentiate between iron deficiency vs thalassemia
- Platelets: thrombocytopenia

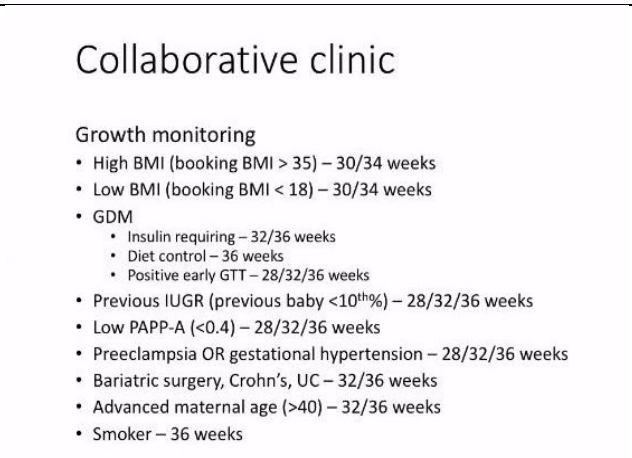
Vit D + Ferritin

- Almost everyone needs replacing
- Oral iron: Maltofer is anecdotally less constipating than Ferrograde C

Blood group + antibodies

- If Rh negative: require Anti D at 28 and 34 weeks
- If presence of antibodies, note the titre and discuss with consultant

Who needs growth scans and when? Some consultant's plan may defer from another, so it is always good to just ask. The following is a general guideline.



Examination

- BP
- Weight
- Urine dipstick
    a. Protein: presence may suggest pre-eclampsia especially when the women also has high BP, send it for formal **urine PCR** + **urine MCS** (sometime a contaminated specimen suggesting of UTI/epithelial ++ can cause urine PCR to be falsely elevated)
    b. Glucose: presence suggest poorly controlled GDM
- Symphysial fundal height: measure from pubic symphysis (bony landmark) to fundus
    - Number of weeks shoud correspond to fundal height in cm (+/- 2 cm)
    - If measuring large/small for date – check with a senior and offer growth scans
- Presentaion and abdominal station
- Doppler – listen to fetal heart (normal 110-160 bpm)

Common paperwork in antenatal clinic (what to fill in)

Iron infusion (outpatient)

1. Consent (hospital wide template)
2. Day oncology form – choose category 1 or 2 to determine urgency of infusion
3. Script

Caesarean section (+/- bilateral tubal ligation) consent

1. NOA
2. Risk stratification form

Induction of labour consent

1. NOA
2. Online booking portal (baby icon)
3. Perform a VE to determine Bishop score (if gestation age greater than 37)

Gynaecology Clinic – 0830 – 1300 or 1330-1700

Gynaecology clinic is an excellent opportunity to learn how to assess patients as well as managing common gynaecological conditions. It is also excellent in gaining valuable skills such as speculum examination, inserting intrauterine contraception, and endometrial sampling. This will be guided by your consultant in clinic. All new patients will need to be discussed with the consultant, as well as any issue arising in review patients.

Pre – admission clinic PAC 0830-1200

In this clinic, you review patient pre-operatively to ensure their fitness for surgery. Patients are often seen 1-2 weeks prior to their planned major operation. You will see patients together with a nurse who can provide you with valuable advice should you run into any trouble. If you are concerned about a patient undergoing anaesthesia, speak to the anaesthetists on call. You may also need to provide information about when to stop their regular medication (hypoglycemics, antiplatelets, anticoagulants, hypertensive).

Early Pregnancy Assessment Service (EPAS) HMO: 1330 – 1700 or 0830-1200

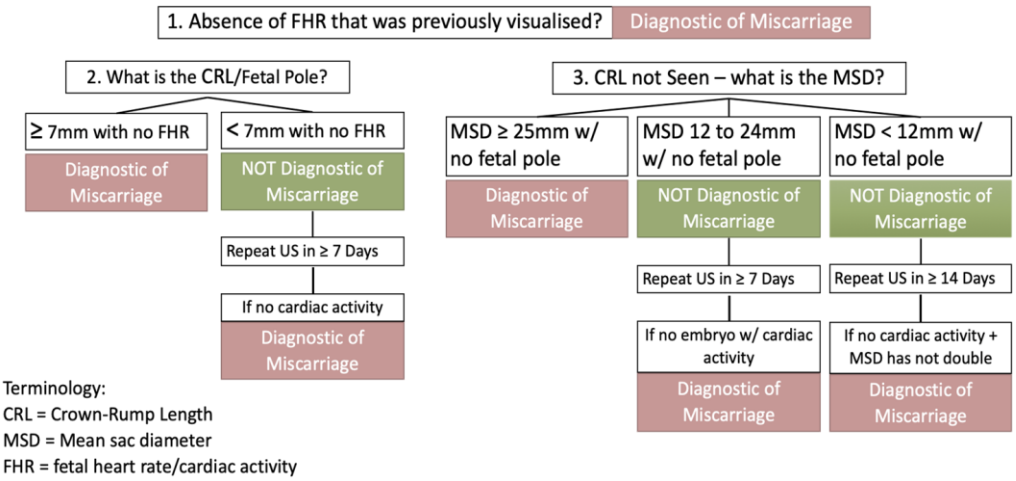
Generally HMO telehealth service led under the supervision of the consultant running the concurrent antenatal/gynaecology clinic. Please see roster for EPAS consultant for the day. If for some reason there is no available consultant these cases can be discussed with the gynaecology registrar.

Generally the patients seen in EPAS are:

- Patients referred from the emergency department with bleeding in the first trimester that were assessed and well enough to be discharged home. Generally, you will need to chase up any ultrasounds requested and bHCG.
- This may then involve counselling patients regarding management options of incomplete or missed miscarriages (see below) and booking patients for suction curettage or medical management.

First, we need to be sure about our diagnosis of miscarriage. Depending on situation, imaging is often the mainstay of diagnosis. DO NOT tell a patient they are having a miscarriage based on a bHCG.

How do we diagnose miscarriage on an ultrasound?



Once we have diagnosed miscarriage, we can offer expectant, medical or surgical management with empathy. Please ensure you have read the PROMPT guideline: O&G - Miscarriage (1st Trimester) at the start of your rotation.

	Expectant management	**Medical management**	**Surgical management**

Suitable patients	Stable patient	Stable patients No severe asthma Not allergic to misoprostol Sac >35mm; CRL >25mm for inpatient medical mx	For stable and unstable patient Sac >35mm; CRL >25mm (but still a patient's choice)
Risks	- Failure rate 40-50% - Will take ~2 weeks to pass/Unpredictable time frame - Will need ongoing follow up in 2 weeks + ongoing - May require surgery/meds	- Bleeding, cramps - (Side effects of miso) Nausea, vomiting, diarrhoea 40% - Failure rate up to 25% - May require surgery	- Risk of surgery + anesthesia - Can be difficult to book a place
Benefits	Natural – avoid meds + surgery	Avoid surgery	- Planned procedure with predictable time frame - Immediate symptom relief - Less blood loss & duration of bleeding

MEDICAL MANAGEMENT

Medical management as an outpatient can be offered if patients meet the following criteria:

- Pregnancy size < 9+0 weeks on ultrasound (GS<35mm, CRL<25mm)
- Prepared to cope with anticipated pain and bleeding at the time of passage of products of conception
- Well supported at home
- Can readily access an emergency department with expertise in dealing with miscarriage complications if needed Process of medication management

For patients undergoing outpatient medical management:

- Give a prescription (to be collected from TNH pharmacy only) for:
  - Misoprostol 800mcg (4 x 200mcg) buccal followed by a repeat dose of 400mcg (2 x 200mcg tablets) 4 hours later if POC not passed
  - Analgesia: NSAID and paracetamol with codeine OR tramadol OR oxycodone
  - Anti-emetics: Metoclopramide or ondansetron and Give Northern Health - O&G - Early bleeding in Pregnancy - English
- Explain possible side effects from Misoprostol
- Explain the risks of pain and bleeding at home and advise them to present to Northern Hospital emergency department if they develop heavy bleeding, significant pain or symptoms or signs of infection
- Give Anti-D if rhesus negative
- Give a plan for follow-up.

For patients requiring admission for medical management

- Call AO (x58100) to find a date that patient can be admitted (day stay)

- Write **admission note, medication chart** (misoprostol, analgesia (paracetamol, NSAIDs), antiemetics), **script for discharge** (analgesia, antemetics)
    - Leave them in the birth suite tray
- Add patient to handover, stating the day that they are coming in
- Useful to print PROMPT guidelines for the nurses
- Gynae HMO will be paged when the patient has arrived on the schedule
    - Do discharge summary + refer EPAS follow up in 1 week

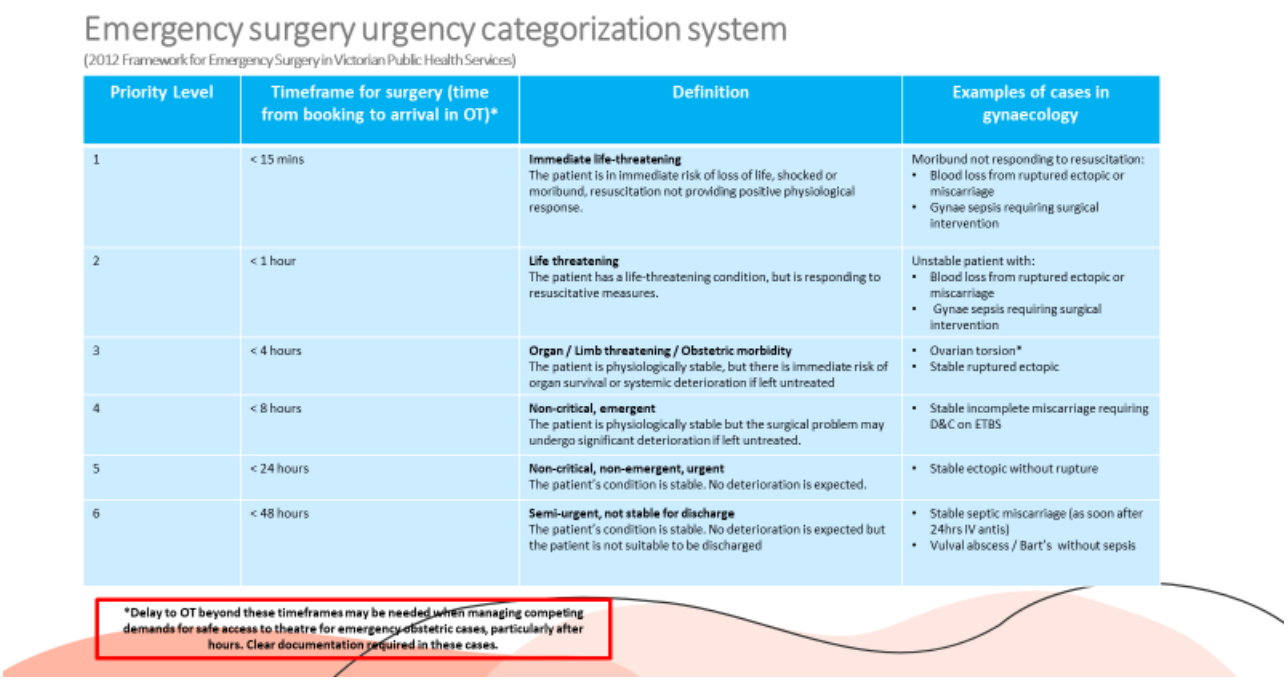
SURGICAL MANAGEMENT SUCTION D&C

- All patients to be booked for theatre must be discussed with registrar/consultant. This includes any special preconditions and booking category. Generally low risk patients with weight <110kg undergoing minor procedures can be booked at peripheral sites- Broadmeadows Health service.
- Consent on NOA + provide bloods slips (some consultants like pre op FBE + G&H to be done if not already on the system)
- Call/Visit Jo Norris (gynae liaison nurse) x52220 to find a suitable theatre time for the patient
- Help her by calling consultants if needed, to place patient on their list
- If patient cannot be booked **within the week**, this should be flagged with consultant/gynae reg
    - DO NOT SIMPLY LEAVE NOA WITH JO

COMMON ABBREVIATIONS SPECIFIC TO UNIT

MOAH	**Medical obstetrics at home**	Monitor pregnant women with hypertension/COVID etc at home
DOM visit	Domiciliary midwife visit	Home visit by community midwife for early discharging patient (<48 hours post-partum)
MITH	Maternity hospital in the home	Home based care for mothers wanting early discharge (6-24 hours post-partum) *medicare eligible mums only
PNMH	Perinatal mental health	Referrals can be made via CPF internal referrals

Appendix 1.



Emergency surgery urgency categorization system

(2012 Framework for Emergency Surgery in Victorian Public Health Services)

Priority Level	Timeframe for surgery (time from booking to arrival in OT)*	Definition	Examples of cases in gynaecology
1	< 15 mins	**Immediate life-threatening** The patient is in immediate risk of loss of life, shocked or moribund, resuscitation not providing positive physiological response.	Moribund not responding to resuscitation: • Blood loss from ruptured ectopic or miscarriage • Gynae sepsis requiring surgical intervention
2	< 1 hour	**Life threatening** The patient has a life-threatening condition, but is responding to resuscitative measures.	Unstable patient with: • Blood loss from ruptured ectopic or miscarriage • Gynae sepsis requiring surgical intervention
3	< 4 hours	**Organ / Limb threatening / Obstetric morbidity** The patient is physiologically stable, but there is immediate risk of organ survival or systemic deterioration if left untreated	• Ovarian torsion* • Stable ruptured ectopic
4	< 8 hours	**Non-critical, emergent** The patient is physiologically stable but the surgical problem may undergo significant deterioration if left untreated.	• Stable incomplete miscarriage requiring D&C on ETBS
5	< 24 hours	**Non-critical, non-emergent, urgent** The patient's condition is stable. No deterioration is expected.	• Stable ectopic without rupture
6	< 48 hours	**Semi-urgent, not stable for discharge** The patient's condition is stable. No deterioration is expected but the patient is not suitable to be discharged	• Stable septic miscarriage (as soon after 24hrs IV antis) • Vulval abscess / Bart's without sepsis

*Delay to OT beyond these timeframes may be needed when managing competing demands for safe access to theatre for emergency obstetric cases, particularly after hours. Clear documentation required in these cases.

Appendix 2. USEFUL TEMPLATES

- **Antenatal clinic**
- **EPAS clinic**
- **PAC**

ANTENATAL CLINIC

On EMR, input data under *Interactive View* **BEFORE** creating a note for antenatal clinic, so that the data is autopopulated onto the note. (see appendix 3)

Khalid Collab ANC - O&G HMO Low

30F G2P1 EDD 3/9/22
30+2 today

1xCS/NVD 2020 3.4kg

O pos nil antibodies
Serology neg (or state any abn)
Rubella immune (or NON immune)
GTT neg / GDM diet / GDM insulin
NIPT/FTCS/MSS low risk (or high risk or declined)
BMI 40
GBS positive/neg (if > 36weeks + planning for vaginal delivery should have this done)

S28: EFW 1500g (80%) AC 80% N DVP dopplers

S20: N morph, placenta location (anterior/posterior/fundal) COO (clear of os?) Cx Long + Closed

#BMI 40
#GDM insulin - xx units
#prev CS - wanting VBAC/repeat CS

On review
- Fetal movements: is patient happy
- PV loss/bleeding?
- abdo pain ?contraction
- if GDM - hows their BSL at home

On examination:
BP
SFH
Cephalic, 5/5 palpable
Pitting oedema?
Weight
Urine dipstick

Plan (dw with Dr Standen)

EPAS Clinic

EPAS Telehealth – O&G HMO
Review/First appointment
30F
GXPX
Referred from ED with
HOPC:
Ix:
Blood group:
HCG:
USS:

Call to patient (review pain, pv bleeding, infective symptoms)
Imp:
Plan

Useful phrases (for copy and paste to notes)
Discussed with Gynae reg
Patient aware of when to come to ED – large PV bleed >1 pad/hour. Severe abdominal pain, lightheadedness/dizziness.

Counselling provided to pt about miscarriage, that they are common and often no cause is found. Nothing she did caused it to happen and unable to be prevented. Discussed likely success of future pregnancies not determined by previous miscarriage.
Discussed management options for missed miscarriage, including expectant, medical and surgical. Risks and benefits of all discussed.

Preadmission Clinic
Surgery:
Date
Indication

O&G hx
PMHx
Meds (include dose and frequency)
Past surgical hx

Smoking
Alcohol
Allergies

Exercise tolerance
Issues with anaesthetics in the past

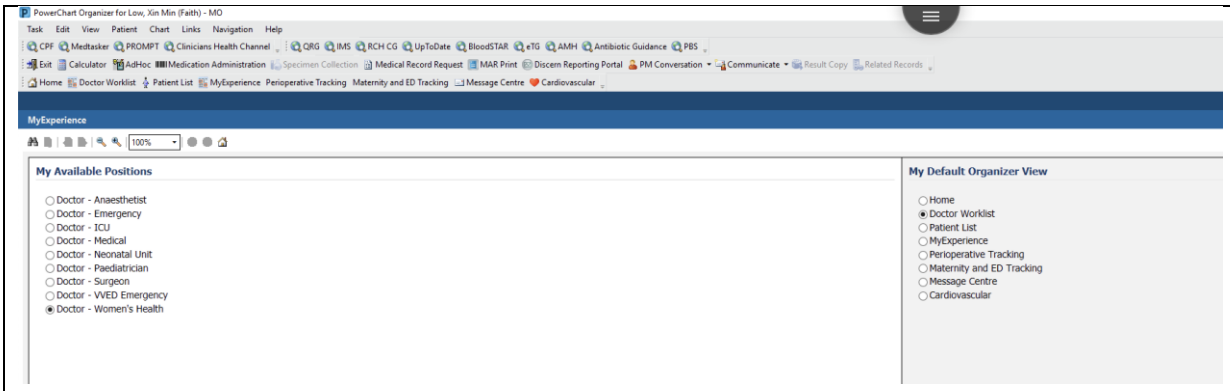
OE
Heart: HSDNM
Lungs: clear
LL: no oedema
BMI

PLAN
1. Does any of the med need to be withheld - anticoagulant, hypoglycemics
2. Do you need to speak to anaesthetics about this lady because she is comorbid
3. What blood test does she need preop/ has she done it?

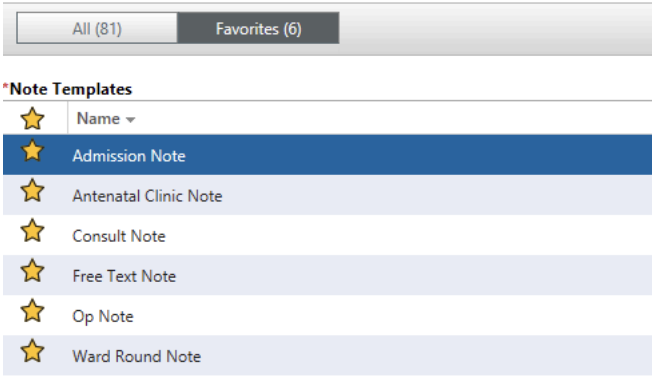
APPENDIX 3. O&G and EMR

Prior to starting the rotation in O&G it is essential that you change *MyExperience* to Women's Health (as seen below)

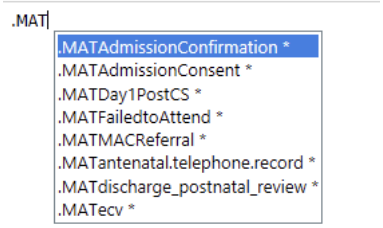
Term Description – Handbook – ROVER



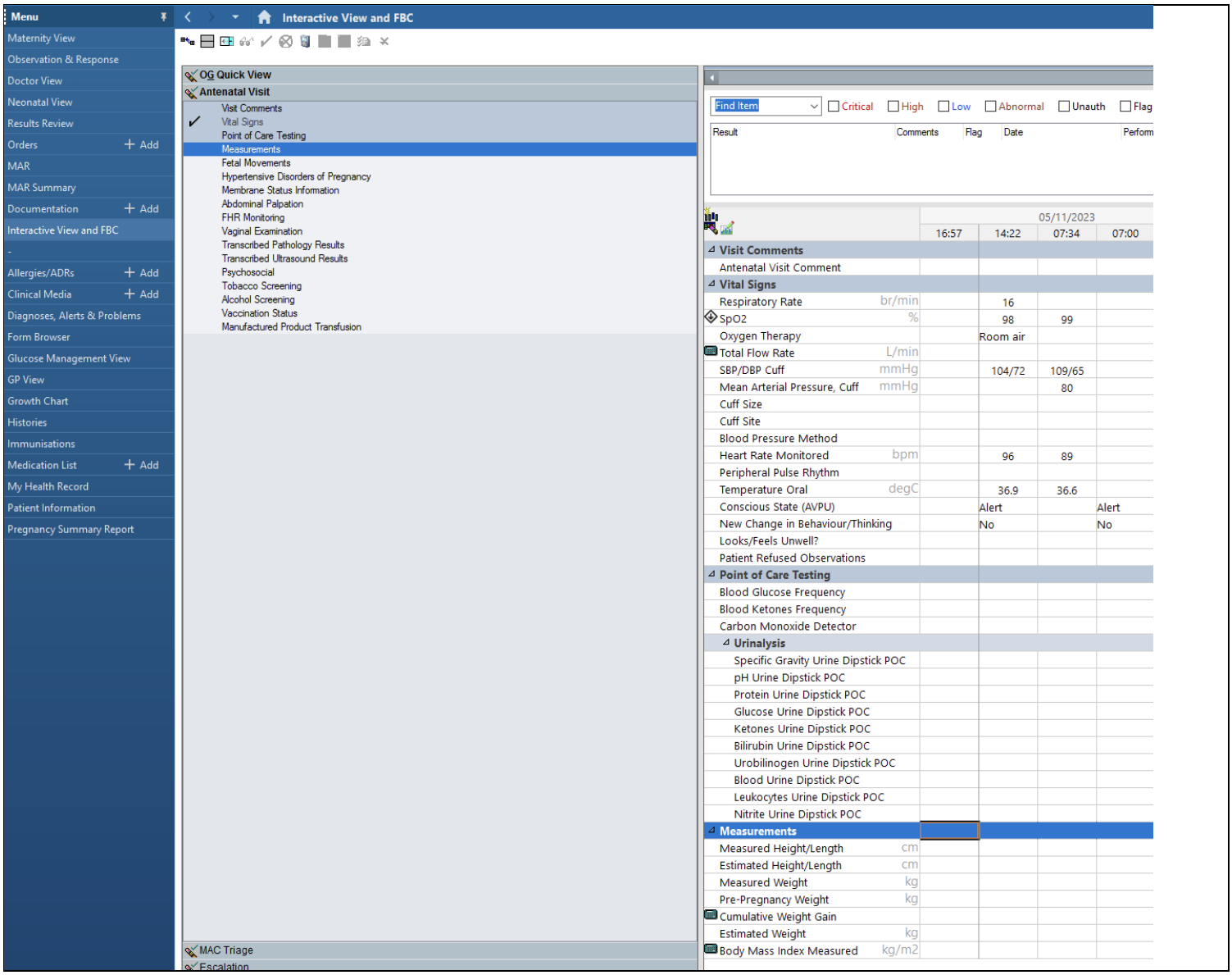
This is a list of templates that you will use, adding them to your *Favourites is advised.*



.MAT is a handy shortcut for most obstetrics paperwork



Interactive view (use this during antenatal clinic)



35. Document Status		
Updated by	O&G unit	December 2023
Reviewed by	Dr Natina Monteleone	01/02/2024
Next review date		April 2024