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.:	Respiratory Medicine	**Non-clinical experience:**	*(PGY2 only)*
PGY Level:	PGY2	**Prerequisite learning:**	*(if relevant)*
Term Descriptor:	*Respiratory medicine term involving the care acute and chronic care of respiratory conditions, including patients that need high acuity respiratory therapies- CPAP, NIC, High flow oxygen therapy. Attendance at word rounds, documentation, admissions of patients to the wards, discharges, attendance at clinics and participation in quality and safety program- weekly and CUSP0 comprehensive unit safety program. Experience in pleural procedures and arterial blood gases.*		

2. Learning objectives:		
EPA1: Clinical Assessment	Domain 1	Communicates accurately and effectively with the patient, carers and team members.
	Domain 2	Recognises their own limitations and seeks help when required in an appropriate way.
	Domain 3	Incorporates psychosocial considerations and stage in illness journey into assessment, acknowledging these factors can influence a patient's experience of illness and healthcare behaviours.
	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, where possible, patients' wishes and preferences about care, including CPR and other life-sustaining treatments (such as intubation and ventilation).
	Domain 2	Works effectively as a member of a team and uses other team members, based on knowledge of their roles and skills, as required.
	Domain 3	Recognises the importance of self-determined decision-making, partnership and collaboration in healthcare which is driven by the individual, family and community.
	Domain 4	Raises appropriate issues for review in quality assurance processes (such as at morbidity and mortality meetings).
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	Maintains patient privacy and confidentiality.
	Domain 3	Acknowledges and addresses individual racism, their own biases, assumptions, stereotypes and prejudices and provides care that is holistic, and free of bias and racism.
	Domain 4	Demonstrates knowledge of clinical pharmacology, including adverse effects and drug interactions, of the drugs they are prescribing.
EPA4: Team communication – documentation, handover and referrals	Domain 1	Produces medical record entries that are timely, accurate, concise and understandable.
	Domain 2	Maintains respect for patients, families, carers, and other health professionals, including respecting privacy and confidentiality.
	Domain 3	Includes relevant information regarding patients' cultural or ethnic background in the handover and whether an interpreter is required.

	Domain 4	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 (including Aboriginal Health Workers, practitioners and Liaison Officers).*	*☒ 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.*

4. Supervision details:			
Supervision Role	***Name***	***Position***	***Contact***
DCT/SIT	***Dr Chiu Kang***	Supervisor of HMO Training	Chiu.Kang@nh.org.au
Term Supervisor	***TBC***	Click or tap here to enter text.	Click or tap here to enter text.
Clinical Supervisor (primary)	***Allocated consultant on ward service***	Click or tap here to enter text.	Click or tap here to enter text.
Cinical Supervisor (day to day)	***Allocated 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. Katharine See	Head of Unit	Katherine.See@nh.org.au
Unit Consultants	Click or tap here to enter text.	Click or tap here to enter text
Respiratory CNCs	Click or tap here to enter text.	Click or tap here to enter text
Unit Registrars	Click or tap here to enter text.	Click or tap here to enter text
Peter Roberts	Lung Mass Coordinator	Click or tap here to enter text

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

6. Accreditation details *(PMCV use only)*		
Accreditation body:	Click or tap here to enter text.	
Accreditation status:	Click or tap here to enter text.	
Accreditation ID:	Click or tap here to enter text.	
Number of accredited posts:	PGY1: number	PGY2: number
Accredited dates:	Approved date: date.	Review date: date.

7. Approval

Northern Health

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

Appendix

Timetable example

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time
	Click or tap here to enter text.	Click or tap here to enter text.	11:00 – 12:00 Fortnightly unit education	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.
Afternoon	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time
	Click or tap here to enter text.	14:00 – 15:00 Monthly CUSP meeting	Click or tap here to enter text.	12:30 – 13:30 HMO Education 12:00 – 13:00 Unit Meeting	12:00 – 13:00 Audit Meeting & Journal Club General Resp Clinic	16:00 – 20:00 Neurology ward cover?	Click or tap here to enter text.
Evening	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time
	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Hours	Total	Total	Total	Total	Total	Total	Total

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Respiratory Advanced Trainee	Mon	Tues	Wed	Thur	Fri	Sat	Sun	Mon	Tues	Wed	Thur	Fri	Sat	Sun
Reg	0800-1730	0800-1730	0800-1730	0800-1730	0800-1300			0800-1730	0800-1730	0800-1730	0800-1730	0800-1300		
								OnC PoC Onca ll Resp	OnC PoC Onca ll Resp					
RESPIRATORY REGISTRAR 1														
Reg	0800-1730	0800-1730	0800-1730	0800-1300	0800-1730			0800-1730	0800-1730	0800-1730	0800-1300	0800-1730		
	OnC PoC Onca ll Resp	OnC PoC Onca ll Resp								OnC PoC Onca ll Resp	OnC PoC Onca ll Resp			
Respiratory Registrar 2														
Reg	0800-1730	0800-1730	0800-1300	0800-1730	0800-1730	0800-1300	0800-1300	0800-1730	0800-1730	0800-1300	0800-1730	0800-1730		
					OnC PoC Onca ll Resp Weekend	OnC PoC Onca ll Resp Weekend	OnC PoC Onca ll Resp Weekend							
Respiratory Pleural Fellow														
Fellow	0830-1606	0830-1606	0830-1606	0830-1606	0830-1606			0830-1606	0830-1606	0830-1606	0830-1606	0830-1606	0800-1300	0800-1300
			OnC PoC Onca ll Resp	OnC PoC Onca ll Resp								OnC PoC Onca ll Resp	OnC PoC Onca ll Resp Weekend	OnC PoC Onca ll Resp Weekend
Respiratory HMO1														
HMO 1			0800-2030	0800-2030	0800-2030	0800-2030	0800-1600	0800-2030	0800-1700	0800-2030				
Respiratory HMO2														
HMO 2	0800-2030	0800-1700	PayC onHr 12.50								0800-2030	0800-2030	0800-2030	0800-1600
Respiratory Intern														
Intern	0800-1700	0800-1700	0800-1200	0800-1700	0800-1700			0800-1700	0800-1700	0800-1200	0800-1700	0800-1700		

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

10. Unit Orientation	
Unit Orientation occurs at the beginning of each term. Attendance is mandatory and paid time. Orientation that occurs outside of your rostered hours should be submitted as overtime on the overtime reporting portal.	
Location	Ward 20 and Respiratory Lab
Facilitator	Ward Consultant/registrar and NUM Pleural team will arrange practical pleural procedure training.
Date	First week of rotation
Start	08:00

11. Unit Overview	
Department	Respiratory
Location	Ward 20 and Respiratory Function/Fit Testing Lab
Inpatient Beds	4 RCU (Respiratory Care Unit) Beds and remainder Ward 20
Outpatients Clinics	Nil mandatory. Monday AM/PM, Tuesday AM, Thursday AM/PM, Friday PM
Day Procedures	SURC (Transit Lounge B) for day pleural procedures. Theatre for bronchoscopy/EBUS.
Virtual Unit	Ambulatory Pleural Service

12. Safety

Unit Specific Safety & Risks

- Safe medication prescribing
    - Minimise aerosol generating procedures. MDI inhalers, rarely if ever use nebulisers.
- Respiratory failure- Type 2 respiratory failure patient predominantly in RCU. Type 1 respiratory failure patients only if there is a clear limit of care/plan for escalation.
    - Non invasive ventilation (BiPAP, CPAP), HFNP
- COVID screening. All community referrals require COVID clearance to be completed by Reg/Resident prior to accepting admission.
- TB precautions. To be discussed with ward registrar/consultant and infection control as required.
- Falls
- Pressure injuries
- Delirium
- DVT prophylaxis
- Standardised documentation
    - Autotext proformas- respiratory and pleural
    - RCU care plans

- Intravenous lines
- Procedural safety
    - All procedures performed under ultrasound
    - Procedure matching
    - Anticoagulation status

13. Communication	
Medtasker	Residents, Inpatient Registrar, Pleural Registrar, Consults Registrar
WhatsApp	N/A
Pager	Residents only
MS Teams	Respiratory Junior Doctors, Pleural Medicine Unit, Respiratory Unit Meeting, Respiratory Radiology Meeting

14. Handover Process	
Morning	Respiratory Office (behind RCU Ward 20)
Afternoon	Respiratory Office (behind RCU Ward 20)/ MS Teams Pleural Handover to Respiratory team for after hours cover.
Night	Tuesday and Sunday- Handover Neurology Resident Wednesday and Saturday- Handover from Neurology Resident Handover RCU patients to on call registrar. All other days handover to night cover

15. Shift Structure			
	Intern	HMO	Registrar
Day	N/A	0800-2030 (week on week off)	0800-1700 On call 1 in 4. 1x half day per week
Afternoon	N/A	Handover to evening resident 2000 Handover to Neurology resident at 1700 on Tuesday. Covering Neurology from 1700-2000 Wednesday.	
Night	N/A	N/A	
Weekend	N/A	0800 – 2030 on Saturday (covering neuro/stroke from 1600) 0800 – 1600 on Sunday (handover to neuro/stroke HMO)	

		Handover to N Tower HMO covering resp/neuro/stroke via MedTasker at end of evening shift	

16. Shift Roles & Responsibilities			
	Intern	HMO	Registrar
Day	N/A	Login to medtasker. Respiratory and Pleural. Receive handover from night resident. Print EMR lists. Confirm CLDs. Ward Rounds (RWR/CWR) • Respiratory Assist with pleural procedures (as required) Wednesday 10am- Long stay meeting (Ward 20)	As per individual registrar role ROVER. Inpatient Consult EBUS Pleural
Afternoon	N/A	Chase bloods Ward round jobs Prepare discharges Ward MDT meeting daily- 3pm Assist with admissions Update EMR lists. Cover Neuro- Wednesday PM	
Night	N/A	Handover to evening resident- 8pm.	
Weekend	N/A	Login to medtasker. Receive handover from night resident. Print EMR lists. Confirm CLDs.	

		CLDs for Sunday and Monday are almost impossible with limited pharmacists All scripts to be completed before 12 pm Ward Rounds (RWR/CWR) • Respiratory and pleural. Assist with consults as required. Cover Neuro- Saturday PM	

17. Common Conditions

Guidelines available for admission and management of:
Asthma exacerbation
COPD exacerbation
Bronchiectasis exacerbation
Community acquired pneumonia
IPF exacerbation
Lung masses
Pleural effusions
Pneumothorax

18. Common Procedures

NGT insertion
IDC insertion
IVC insertion +/- venesection
Arterial bloods gas
Pleural aspirate
Pleural catheter 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/

S: Drive
S:\Respiratory Medicine\Registrar Education\NH guidelines for Respiratory\Respiratory
Access can be granted by respiratory lab staff.

Pleural medicine handbook- Please contact Kirstin (Pleural CNC). Will be available on S: Drive

20. Routine Orders	
Pathology	EMR order sets exist for common respiratory presentations. FBE, UEC, CRP, LFT ABG, VBG Sputum MCS Extended viral PCR Urinary streptococcal antigen, urinary legionella antigen LDH and Coagulation profile (prior to pleural procedures)
Radiology	CXR, CT Chest
Pharmacology	Short acting bronchodilators: Salbutamol, Ipratropium Long-acting bronchodilators • LAMA: Tiotropium (e.g. Spiriva) • LAMA/LABA: Tiotropium/Oladaterol (e.g. Spiolto) • LABA/ICS: Budesonide/Formoterol (e.g. Symbicort) • ICS/LABA/LAMA: Budesonide/Formoterol/Glycopyrrolate (E.g. Breztri), Beclometasone/Formoterol/Glycopyrronium (E.g. Trimbow) Prednisolone Anxiolytics: Ordine, Lorazepam Mucolytics: Bromhexine Antibiotics: Ceftriaxone, Amoxycillin, Augmentin, Cefuroxime, Metronidazole, Azithromycin, Doxycycline, Moxifloxacin (Penicillin allergy only)

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	Admission workflow on EMR. Every RCU patient requires a daily RCU care plan, complete during the ward round as they expire in the morning. NIV/CPAP/High flow order (always d/w reg). Mandatory documentation. GOPC VTE prophylaxis SpO2 target range - Either 88-92% or 92-96% Regular puffer (type and dose) Tips Cautious use of ordine (1-2mg q2h PRN) for managing breathlessness – only give to people in whom you are comfortable supressing their respiratory drive. Bromhexine for sputum clearance problems. Pholcodine for bothersome cough. Pneumonia – SMART-COP score, sputum MCS, consider urine strep/legionella antigens. IV antibiotics as per Northern Guidelines or eTG. Some need repeat CXR 6 weeks post discharge to assess for underlying mass. Asthma exacerbations – usually viral, smoking, or puffer technique/non-compliance. Pred 50mg, usually no antibiotics, PRN bronchodilators +/- regular. COPD exacerbations – non-infectious vs infectious (2 of 3: fevers, Δsputum colour, Δsputum volume). Prednisolone 25–37.5 mg daily (~0.5mg/kg), regular preventers +/- bronchodilators. Antibiotics if infectious. Patients for bronchoscopy +/- lavage +/- biopsy: fast from midnight, check for blood thinners, coags, consent (risks include anaesthetic, bleeding, infection, pneumothorax, non-diagnostic sample). Patients for radiological biopsy: must be discussed with radiologist and approved on request form, consent, check for blood thinners and withhold accordingly, drop off forms to procedure booking office and take the yellow checklist with you back to the ward and ensure the nurse is aware.

Ward Rounds	Prior to round • Receive handover from night HMO, note issues requiring early flag to registrar/consultant • Ensure list updated with new admissions; include on the list patients who are admitted under other teams but are in RCU beds for ventilatory support (e.g. HFNP, NIV) as the inpatient respiratory team sees these patients as part of the round. • Ensure WOWs battery fully charged • Check with NIC if any issues with the planned CLDs for that morning During round • HMOs are encouraged to present patients on ward rounds. • Use ward round workflow on EMR. • Order of round: sick patients -> Discharges and RCU patients -> other • Every RCU patient requires a daily RCU care plan (as they expire each morning) as an additional documentation to the ward round note – can be completed from EMR shortcut • Update Resp CNCs on patients that need their input: RCU patients, ABGs, puffer education, COPD/asthma/dyspnoea action plans, home oxygen, CPAP initiation.
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 Please ensure private physicians are also receiving a copy. Phone handovers to GPs for complex patients. Tips On the round, confirm the following: duration of antibiotics/steroids, follow-up plan, outpatient investigations, planned date of discharge and are they a CLD? Ensure discharge summaries are copied to any private physicians' rooms (explicitly request this under the discharge plan and provide the details of the rooms). ARC referrals are through MedTasker + complete the top part of the ARC referral form. Inform the NIC as the back will need to be filled out. DC summary needed. Respiratory function tests: most will need spirometry + TLCO, lung volumes if restrictive pathology, some asthmatics need FeNO + skin prick testing. Test off inhalers where possible. Can email through to Resp lab or dropped off in person. OPC referrals through CPF. Please clarify which clinic with ward registrar if unsure. Urgent referrals (<4 weeks) can be facilitated by ward registrar (e.g. lung mass follow up, ILD) Pulmonary rehab is 'Community Access > SACS > Pulm Rehab.' Elective bronchoscopy – notice for admission form to be completed, consented and given to office near anaesthetics department. Ensure they have recent coags prior. Home O2: Need ABG off O2 for 15 min – as per home oxygen referral form on PROMPT. Takes time to organise so pre-empt patients that will need this prior to discharge. Follow-up at oxygen clinic **in >30 days** with repeat ABG off oxygen and/or 6MWT prior to appointment (both of these can be requested on the RFT forms and faxed through in addition to giving the patient an ABG path slip).

Outpatient Clinics	Outpatient clinics, prescriptions and investigations remain on CPF
CDI Queries	Good documentation is critical to provide an accurate record of the patient's stay in hospital, decision making processes and rationale and handover between the multiple clinicians engaged in the patient's care. Remember - "if it is not documented, it didn't happen". Your documentation is also vital for 'clinical coding', which is necessary for Department of Health data reporting and hospital financial reimbursement. To ensure accurate and comprehensive documentation in real-time, the Clinical Documentation Specialist (CDS) will identify any deficiencies in documentation in the healthcare record and will query these via Medtasker. These will show up as "CDI Query". Please action these queries by documenting in the healthcare record. This can be done by documenting: • on the next progress note (paper format), or • on an electronic progress note in CPF by noting "CDI query response", and/or • on the discharge summary in CPF
Death Certificates	Print 2 copies, sign them and put them in the file. The discharge summary should still be completed in a timely fashion, as should any communication required with outside providers. Death certificates are completed online. https://www.bdm.vic.gov.au/medical-practitioners Hard copies are to be printed out for the patient file/funeral director, in addition to the electronic submission.
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 clinic are made electronically via e-referrals on CPF. If you think referral to the clinic is indicated, please discuss with your supervising consultant/registrar prior, as availability is limited. Inpatient: Referrals for admission go through the inpatient registrar via Medtasker or phone. Referrals made from external or other teams go through the consults registrar via Medtasker or phone via switch. Pleural referrals are made electronically via e-referrals on CPF. Please confirm with the pleural team on the Pleural Medicine Unit MS teams application on timing and discharge plan.
External	External clinic referrals are made electronically through the northern e-referrals. Urgent external referrals can be made by contacting the consults or pleural registrar directly through switch.

24. Clinical Deterioration	
Escalation Process	Check GOPC and contact registrar

PreMet	Resident and registrar review
Code	Resident and registrar review

25. Night Shift Support	
Unit	On call registrar
RCU	All changes to NIV/HFNP or other settings must be approved by on call Respiratory registrar/consultant
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.
- Credentialing for pleural procedures will be based upon completion of the pleural practical session and performance of procedures under supervision. There are defined requirements listed within the pleural unit handbook.

28. Unit Education

Topic presentations- Fortnightly on Thursday meeting. Either long or short depending on radiology meeting.
Journal club- Fortnightly following on from weekly audit at Friday meeting.
Ward consultant teaching- Wednesday post round on second week of consultant ward service.

Pleural education and practical session- start of rotation.

29. Unit Meetings

Lung Mass MDM – Thursdays 8-9am, prior to lung mass clinic that afternoon
- Can sometimes expect direct admits for patients discussed at MDM if a decision was made for inpatient management

Audit Meeting – Fridays 12-12:30pm
- HMO to present the discharge audit spreadsheet from previous week (details later in document) and whether KPIs were met.
- Registrars to present any prolonged admissions (>5 days) or readmissions.

Radiology Meeting – Thurs/Fri 12:30-1pm
- Document impressions/plans from meeting.
- Have patient URNs ready if presenting a case
- To add pts: Team chat and add to excel document uploaded by Registrar each week.

Journal Club/Topic Presentations – Thursday 12-1pm/Friday 12.30-1pm
- Roster made at the start of the year. Journal club for shorter ½ hour sessions. Larger topics for full 1 hour sessions.
- Maximum 1 presentation per resident per rotation.

CUSP Meeting – 4th Tuesday every month 2-3pm (check emails)
- Use discharge audits to tally readmissions over the previous calendar month and reasons why - into 1 slide. You talk to the readmissions slide. Registrars talk about reasons why.
- For reference: S:\Respiratory Medicine\Respiratory CUSP\Presentations

30. Research and Quality Improvement

Research Meeting Wednesday 11am (monthly) – run by Dr Sanjeevan Muruganandan
- Opportunity to get involved with research as required.

Pleural research – please contact the pleural team in regards to ongoing research projects.

DISCHARGE AUDIT
Every Friday at the discharge audit meeting, you are to present the spreadsheet from the week prior (Mon-Sun). While you are on ward duty you should update the discharge spreadsheet with details of patients you discharged for your week.

S:\\Respiratory Medicine\Discharge Audits\Discharge Audits 2023\...\
Copy the spreadsheet from the week prior and change the dates
Note there are now two separate tabs for gen resp and pleural patients!
Fill in patient details according to columns and the stats at the bottom should automatically complete. Double check the formula fields include all patients.
For readmissions within 28 days, include the team they were previously admitted under, and a brief reason why they were readmitted.
Ensure that discharge time is counted as time leaving the ward, not time leaving transit lounge.

This information can be found in iPM > search patient > Inpatients > Inpatient history > then see all bed updates for relevant encounter

Data can be collected from iPM > Reports > Inpatient Reports > Discharge Reports >> Parameters > Health organisation (1280 for TNH) > Start date/End date as per Audit dates >

Group by “S” >> Jump to “N Respiratory” and “Pleural Medicine Unit” to gather data for: Patient name/URN, LOS, time of discharge, destination, transit lounge or not. NOTE that day bronchoscopies also come on this list – DO NOT include them in the audit.

NOTE that CLD/RCU LOS/ICU LOS can’t easily be found after discharge and it takes a long time for notes to be uploaded to CPF, so keep track of these things prior to d/c.

Term Description – Handbook – ROVER

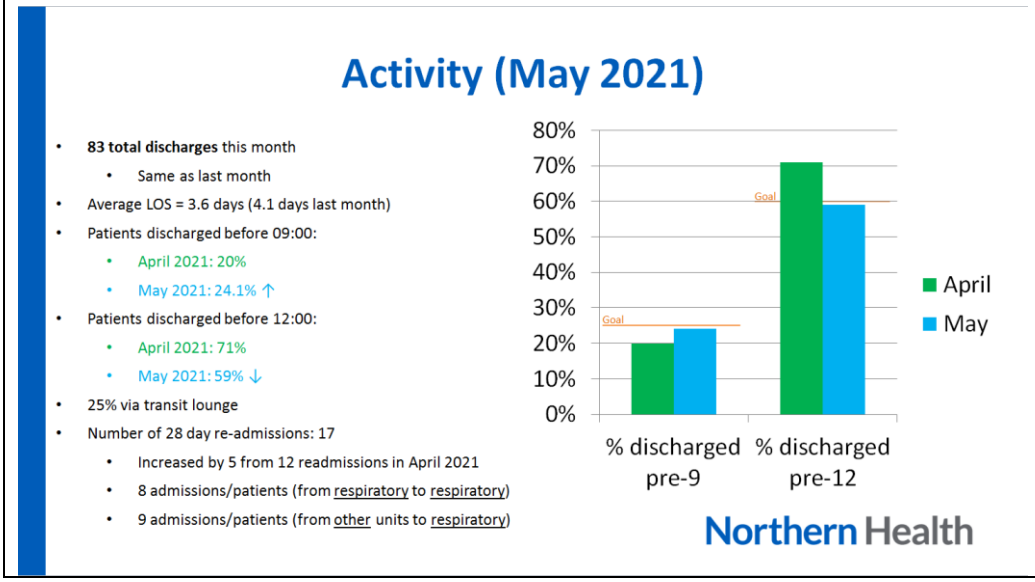
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
1	Patient	UR	Discharge Date	LOS	DC <12	DC <9	Diagnosis	Destination	RCU LOS	ICU LOS	Via TL?	CLD?	Readmit (28 days)	Reason	Resp F/u	Pleural F/u
2	[redacted]		7/06/2021	1	Y	-	Bacterial exacerbation of bronchiect	Home	-	-	-	-	-	-	Y	-
3			7/06/2021	5	Y	-	T2RF 2' secondary to bacterial pneun	Home	3	-	-	Failed	-	-	Y	-
4			9/06/2021	2	Y	Y	NIE asthma	PCU	-	-	-	-	Y (resp)	-	Y	-
5			9/06/2021	4	Y	-	Exac ILD	Home	-	-	Y	Y	-	-	Private	-
6			9/06/2021	5	Y	-	Sepsis secondary to bacterial pneum	Home	-	-	Y	Y	-	-	Y	-
7			9/06/2021	2	Y	-	Exac asthma	Home	-	-	Y	-	-	-	Y	-
8			9/06/2021	1	-	-	Haemoptysis	Home	-	-	-	-	-	-	Y	-
9			9/06/2021	2	-	-	Exac likely COPD	DC AMA	-	-	-	-	-	-	Y	-
10			10/06/2021	1	Y	Y	Social admit post bronchoscopy	Home	-	-	-	-	-	-	Y	
11			11/06/2021	1	N	N	U/S guided biopsy LN	Home	-	-	-	-	-	-	Y	
12			11/06/2021	7	N	N	Exac ILD + sarcoidosis	Home	-	-	-	-	-	-	Y	
13			11/06/2021	2	Y	N	NIECOPD	Home	2	-	-	Y	-	-	Y	
14			12/06/2021	1	Y	Y	IECOPD	Home	-	-	-	Y	-	-	Y	
15			12/06/2021	4	Y	Y	?EGPA	Home	-	-	-	Y	-	-	Y	
16			13/06/2021	3	Y	N	IECOPD/Asthma	Home	-	-	-	-	-	-	y	
17																
18																
19																
20																
21	Total Patients:	15														
22																

23	Average LOS =	2.7	Avg RCU LOS =	2.5
24	Median LOS =	2	Avg ICU LOS =	#DIV/0!
25	DC pre 12: (>60%)	73.3%	Via TL: (<30%)	20%
26	DC pre 9: (>25%)	26.7%	Readmissions	1
27	IF CLDs all left pre-9:			

PASID	Patient Name Sex	Age	Discharge Date Time Financial Classification	LOS	Discharged Clinician Admit Date Time	Disch Code	Health Oraganisation ACAS Status	Discharged Unit	Discharged Ward
Specialty: N Respiratory									
[redacted]			21/06/2021 11:38	3	Chen, Dr Y	H		N Respiratory	N Ward 20
			Public - Eligible		18/06/2021 19:23		Not Specified		
			22/06/2021 10:21	1	Chen, Dr Y	H		N Respiratory	N Transit Lounge
			Public - Eligible		21/06/2021 19:51		Not Specified		
Total: 2									

CUSP Audit Slide

Cumulative data for the CALENDAR month (1st to last day of each month).
Collate the data in excel then put the data in the slide proforma (S:\\Respiratory Medicine\Respiratory CUSP\Pro forma slides)– tell the registrar when you've completed it so they can add it into the slideshow. You can save the slide to the respective Discharge audit folder for that month.



31. Career Support
Discuss with Head of Unit - Katharine See Deputy Head of Unit- Liam Hannan Ward Consultant Research Pleural/Research Lead- Sanjeevan Muruganandan

32. Medical Students on the Unit
MD2 and 4: Follow resident and registrar. Can be divided between registrars.

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.

	In hours Monday to Friday 0730 - 1630	Step 1: Medical Workforce Reception 8405 8276	Step 2: Notify unit	Please ensure you notify both MWU & your unit
	After hours Monday to Friday Between 1630 – 2200 After hours Monday to Friday Between 2200-0730	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)	Step 2: Notify unit (at a suitable time)	Please ensure you notify both MWU or After Hours (depending on the time) & your unit at a suitable time.
	In hours Weekends & Public Holidays 0700 - 2200	Step 1: Medical Workforce On-call Phone 0438 201 362	Step 2: Notify	Please ensure you notify both MWU & your unit
	After hours Weekends & Public Holidays 2200-0700	Step 1: Hospital / After Hours Coordinator (8405 8110 or via switch)	Step 2: Notify unit	Please ensure you notify both MWU & your unit
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. Overtime is approved by consultant on ward service.			

34. JMO Rover

Respiratory Care Unit (RCU)

- Beds 7 - 10 – Staff Station 4
- 2:1 patient:nurse ratio, specially trained nurses
- Continuous sats monitoring, frequent obs
- Required for most NIV, CPAP or high-flow nasal prongs
- Nurses can do ABGs
- Require daily RCU care plan
- Resp consult on all non-resp patients in RCU and complete ALL RCU care plans
- Patients can be *physically* in an RCU bed but not an RCU patient

Discharge goals

- Aim discharge **>50% before 12pm** and **>25% before 9am**
- Aim for Criteria Led Discharges (CLD) – flag these early with ANUM and pharmacy
- Complete CLD form and leave in purple folder
- Complete **CLD scripts before 4pm** the day before so pharmacy can process them
- CLD patients should have discharge summary completed the day before and ticked off first thing early morning when confirmed patient has satisfied criteria
- There may not be a nurse able to sign off the CLDs, so you may have to do this yourself first thing in the morning

Contacts
Respiratory Consultants
Katharine See, Liam Hannan (Tues fortnightly), Megan Howden (Thurs), Jibin Thomas, Bassem Dawood, Naomi Atkins, Yan Chen, Melissa Yang, Angus Husband, Kanishka Rangamuwa, Sanjeevan Muruganandan, Victor Duong, Susana Mu.

Respiratory Registrars
Billy Robinson, Redita…

Respiratory CNC's
Claire Ristovski- Team Leader (RCU, CPAP, O2 and General Respiratory). 0488789187
Priya Varghese- RCU, O2 and General Respiratory. 0457486811
Sharon Rukavina- Asthma & Allergy. 0459948184
Veena Radha- CPAP and General Respiratory.
Clarissa Fleming- EBUS. 0436672060
Peita Roberts- Lung Cancer. 0428630825
Kirstin Tirant- Pleural. 0428630825

Respiratory Lab
Respiratory Office 8405 2444
Nicholas Romeo- Head of respiratory Lab. 0411 068 210
RFT Lab 84052406

35. Document Status		
Updated by	Dr Kai Chaivannacoopt- Respiratory AT	31/01/2024
Reviewed by	Dr Natina Monteleone	01/02/2024
Next review date		April 2024