mater education

RMO FAMILY DOCTOR HANDBOOK

Revised 10.08.2020

mater.org.au

WELCOME FROM THE MEU

Please read this handbook in conjunction with the RMO Orientation Handbook, which is accessible on the MEU website via Zenworks
http://mededu.matereducation.qld.edu.au/handbooks/

MEU Contact Details

If you're experiencing difficulty with any aspect of the term, clinical or otherwise, please contact the term supervisor and/or PVMEO as early as possible.

Director of Clinical Training (DCT)	ext. 8229
Prevocational Medical Education Officer (PVMEO)	ext. 8431
Vocational Training Medical Education Officer (VTMEO)	ext. 1560
Medical Education Admin Officer	ext. 8272
Medical Education Manager	ext. 8114

INTRODUCTION

Family Doctor Role

The family doctor role is designed to improve the quality and experience of care, and the handover of care from hospital to community, by having a single doctor addressing the needs of both mother and baby on the postnatal floors. As a family doctor you will spend time working in) Birth Suite (BS), Special Care Nursery (SCN) and on the Postnatal Floors. It offers a unique opportunity to work in birthing and neonatal care for 6 months, and provides a learning experience for junior doctors interested in pursuing a career in either O&G, Neonatology or General Practice with a special interest in women's and babies 'health.

Mater Mothers' Hospital

Mater Mothers 'Hospital offers a number of services to assist women and their families before, during and after the birth. These include:

- Aboriginal and Torres Strait Islander Liaison Service
- Allied Health and Social Work Services
- Antenatal Education and Parenting Workshops
- Bereavement Support Service
- Breastfeeding Support Centre
- CHAMP Clinic and National Illicit Drug Strategy
- Early Pregnancy Assessment Unit
- Fertility Services
- Healthy Hearing Program
- Interpreter Service
- Maternal Fetal Medicine
- Maternity Homecare Program
- Midwifery Group Practice
- Neonatal Critical Care Unit
- Pregnancy Assessment Centre
- Pastoral Care and Chaplains
- Perinatal Outreach Education

Division of Neonatology

The Mater Mothers' Hospital is a University affiliated teaching hospital. Neonatal Critical Care Unit (NCCU) is a regional referral centre for premature, cardiac and surgical babies from Queensland and northern New South Wales. The hospital has just over 10000 births (public and private) of which 2000 visit us in our NCCU. NCCU has 79 cots of which 47 are intensive care equipped. NCCU is divided into 3 teams: Prem/Medical Intensive Care Nursery (ICN), Cardiac/Surg ICN and Special Care Nursery (SCN).

Neonatology has a multidisciplinary team approach to care, with nursing/midwifery/allied health/pharmacy involvement on the ward rounds. Junior and senior doctors are rostered to different areas and shifts. RMOs are involved with inpatients only, and are rostered to the postnatal floors or Special Care Nursery, alongside a Registrar or RMO.

Obstetrics and Gynaecology

The department comprises three general obstetrics and gynaecology teams (A, B, and C) each of which is headed by a cluster of consultants, as well as two registrars and a RMO. Each team undertakes both an obstetric and a gynaecology patient load. In addition to the general O & G teams there is an MFM team headed by the MFM consultants and an MFM fellow.

CASE MIX, CASE LOAD & MODEL OF CARE

The Family Doctor RMOs will divide their time between working on Postnatal Floors, Birth Suite and Special Care Nursery (SCN). They can also have the opportunity to be in Pregnancy Assessment Centre PAC

The Postnatal RMO reviews and discharges post-natal women and babies on ward M8, Birth Suite (BS) shifts entail working with other members of the BS team doing ward rounds, siting IVCs, taking bloods, perineal repairs (where appropriate) and assisting with Caesareans. While on PAC, you will gain experience managing common acute pregnancy presentations.

The RMO allocated to the Special Care Nursery (SCN) completes ward rounds daily (Mon-Fri) with the consultant/fellow rostered to SCN that week. The SCN has 32 cots and cares for public and private babies (private babies are seen by VMOs). On average, there are 25 public babies in the SCN. The condition of these babies varies from babies unable to be looked after on the postnatal floor (i.e. requiring NG feeds or iv fluids), premature babies that are not requiring respiratory support (mechanical ventilation or CPAP/high flow support) but can be on low flow oxygen, babies transferred down from the intensive care areas (cardiac/surgery or prem/medical ICNs).

It is anticipated working in these areas will provide good training and experience for the prospective GP with an interest in the care of pregnant patients and their newborns, as well as those wanting to head down the O&G or Paediatric training program.

ORIENTATION

Start of Term Orientation

All RMOs will complete an online Start of Term Checklist with their Term Supervisor during their first week, which is available on the Medical Education Unit website via Zenworks. Family Doctor RMOs will receive a specific orientation with input from the Neonatal and Obstetrics & Gynaecology teams.

The following areas will be covered:

- handover
- weekend rosters

- term learning objectives
- unit policies and procedures
- Babies on Board (BOB) Database and Matrix
- how daily clinical handover is conducted and
- miscellaneous (tour of the department, introductions to staff, location of resus trolley)

Orientation to Mater Maters Hospital

You will be taken on a hospital tour on your first day which will include the following areas:

M5:

- Main reception
- Conference rooms (5.1,5.2 and 5.3)
- Mother's café
- Vending machines
- Public elevators
- Stair access to all floors
- Pregnancy Assessment Centre (PAC) and the Early Pregnancy Assessment (EPA)
- Tea room
- Lockers – for use during shift only
- Birth Suite
- MMH Operating theatres and access to MAH Operating theatres.

M6: Special Care and Neonatal Intensive Care Unit

M7: ANC, Gynae clinic, MFM

M8: Postnatal Ward (public)

M9: Antenatal and Gynaecology Ward, with some postnatal women who have their baby in NICU/SCN or stillbirth babies (public)

M10: Private

M11: Private

M12: Private

Pagers/Phones

- Postnatal floor - DECT phone 8894 - located in the Neonatal Registrars Room (next to 6.1).
- SCN phone - located in the Neonatal Registrars Room (next to 6.1).
- Birth Suite – BS RMO has both a pager and DECT phone. You will receive these from the outgoing shift BS RMO.

Any mail sent to you (either internal or external) during your Family Doctor term will be forwarded to the Resident Mail Tray in the Birth Suite Registrar Room, Neonatal Registrar room or to the Medical Education Unit (L4 Duncombe Building). Please recycle envelopes used for internal mail.

LEARNING OPPORTUNITIES

Expected Opportunities	Examples
RMO as a Scholar and scientist: Opportunities to apply, consolidate and expand clinical knowledge and skills while taking increasing responsibility for providing safe, high-quality patient care.	• History taking and examination including performing an full examination of a newborn • Be able to identify signs of developmental delay whilst taking a history and during physical examinations • Develop expertise in using and interpreting growth charts • Speculum examinations • Recognition of gynaecological emergencies • Assist in labour and delivery • Recognition of deteriorating patients specific with obstetric considerations
RMO as a Practitioner: Opportunities to develop diagnostic skills, communication skills, clinical management skills (including therapeutic and procedural skills), evidence-based care approaches, and professionalism, all under appropriate supervision.	• Multidisciplinary teamwork with midwifery/nurse based care • Develop communication skills with parents and the team • Develop excellent time management skills and proactivity as a mindset; • Perineal suturing and repair with supervision; assistance with Caesarean section • Post-operative care • Correctly utilise and manage medications; • Develop procedural skills on babies, including capillary and venous blood sampling, intravenous line insertion, possibly lumbar punctures etc. Procedures are always to be undertaken with medical supervision/assistance until competency is obtained. • Develop neonatal resuscitation skills; code blue attendance

RMO as a Professional and Leader: Opportunities to further develop and reflect on skills and behaviours for safe professional and ethical practice consistent with the Medical Board of Australia's *Good Medical Practice: A Code of Conduct for Doctors in Australia*.	• Log book of procedures to document experience • Completing self-assessments at mid and end-term assessment meetings and discussing these with the Term Supervisor • Actively seeking regular feedback formal and informal from supervisors throughout the term
RMO as a Health advocate: Opportunities to participate in quality assurance, quality improvement, risk management processes, and/or incident reporting.	• Management of patient discharges / handover communication • Infection control / hand hygiene • Completion of the End-of-Term Unit Evaluation survey • Completion of the RMO Education Feedback survey following each education session

Individual learning objectives (ILOs)

Your Term Supervisor will discuss and develop learning objectives with you at your face-to-face orientation meeting, and evaluate your progress towards these learning objectives at your mid- and end-term assessment meetings. Learning objectives are to be documented on the Start-of-Term Orientation Checklist before submitting it to MEU and evidence of completing or progress towards these learning objectives are documented in your logbook and discussed with your term supervisor at mid- and end-term assessments.

You can have a look at various examples of individual learning objective, including appropriate procedural skills, in the RMO Obstetrics and Gynaecology Unit Handbook.

http://intranet.mater.org.au/cms/uploads/documents/store/resources/res_21083_RMOObstetricsandGynaecologyHandbook.pdf

SUPERVISION

Scope of Practice

RMOs are not permitted to perform any clinical procedure without direct observation, at least in the first instance. The clinical supervisor will then inform you what is to happen in future, with regard to whether or not direct supervision is required. This will be dependent on the skill itself and level of proficiency exhibited.

Term Supervisors

Dr Maureen Dingwall, Dr Alice Whittaker & Dr Huda Safa	Contact via switch
Judy Edy Executive Support	ext. 1594

Clinical Supervision

The team registrar and consultant will be your direct clinical supervisors. The level of supervision you are provided (level 1 or level 2) will be determined by the requirements of your role. You are

required to liaise regularly with your registrars and ask them for help if you are struggling to manage your workload or if you have clinical issues.

During and After Hours Supervision

Area	Who to contact	Pager #
Birth suite	Birth suite registrar	6610
PAC	PAC registrar	6609
Inpatient O&G	Team Reg, then 6611 registrar	6611
O&G registrars busy	On Call Consultant	6612
Postnatal Floors: Neonatal	Postnatal Floor Neonatal Reg OR	Phone 2214 (31632214)
Postnatal Floors: Neonatal	SCN Consultant (8am-4pm)	Cell phone via switch or located on Neonatal SMO roster
Postnatal Floors: Neonatal	After Hours: Neonatal Fellow	Direct Dial 77131 or 0423567273
Postnatal Floors: Neonatal	After Hours: Neonatal On call Consultant	Direct Dial 6910 or via switch
SCN	SCN Consultant	Cell phone via switch or located on Neonatal SMO roster

Escalation Policies

O&G

The 6611 On Call O&G Registrar is your supervisor after hours for questions regarding ward patients.

The 6611 On Call O&G Registrar manages Level 9 antenatal patients, PAC and ED.

If the 6611 O&G Registrar is unavailable, you are required to contact the O&G BS Registrar on 6610. If the 6610 O&G BS Registrar is unavailable, you may escalate to the On Call O&G Consultant on 6612.

Neonates

If you require after hours escalation please refer to the table above for the 'after hours'.

If you require escalation during business hours and not contacted the SCN Consultant please contact them or the Prem/Med ICN or Cardiac/Surg ICN Consultants via switch.

If the baby is clinically unwell and unable to contact the above and requiring further escalation call Neonatal Code Blue

RMO DUTIES & RESPONSIBILITIES

Birth Suite	0700 – 1900hrs
Postnatal Floors	0730 – 1530hrs (Monday to Sunday)
Postnatal Floors /PAC	0830 – 1630 start on the postnatal floors until discharges are completed. You can start next day's discharges or attend PAC
SCN	0800 – 1600

Birth Suite RMO

You will commence the shift with the BS handover in BS, perform a BS ward round and liaise regularly with your supervising Birth Suite registrar (6610)

Duties and Responsibilities

- Documentation and organisation
- Use RED stickers (available in each BS room) to indicate when a plan has changed.
- Liaise with the BS Team Leader (ph. 6580)
- Help organise a patient to go to theatre by calling:
    - MMH OT TL (ph. 1907)
    - Neonatology (ph. 77104)
    - Anaesthetics (ph. 6616)
- Assist with CS (public or private)
- Charting of medications e.g. IV antibiotics for fever in labour
    - IV access and appropriate blood tests
- Completion of VTE risk assessment tool for each patient prior to leaving the birth suite
- You are not required to attend morning handover for teams at 07:50
- The BS RMO will receive MET call pages for all levels of the MMH to your BS pager. Immediately inform the BS registrar of the MET call so you can attend together

- The BS RMO covers Obstetrics on the wards (M8 and M9) after 17:30pm on weekdays.The Postnatal Family Doctor and Obstetrics Team RMOs may hand over items to follow up.

Post-Natal Family Doctor (FD)

Family Doctor model of care is for the 8th Floor of MMH only. Outliers on a different floor will be seen by the Obstetric Team/Neonatal Floors Reg/SHO

Maternal review suitable for FD care (triggered prior to transfer to M8 –either BS or Obstetric Recovery):

- All elective CS (Enhanced recovery and standard recovery)
- PPH not requiring Bakri balloon (reg debrief)
- OASIS (reg debrief)

- Shoulder dystocia WITHOUT neonatal injury
- SVD with stable comorbidities
- Stable and well-controlled pre-eclampsia
- All other patients (emergency CS/fever in labour/Confluence patients and PPH requiring Bakri) will remain with the team

All Babies that required a medical review can be seen by a FD.

- Carry DECT phone 8894 if you are rostered for weekend or 0730-1530 shifts.
- Liaise with M8 Team Leader and review/ discharge patients as requested on M8 Journey board for Mum and Baby
- Attendance at the O&G morning handover at 0750 (5.1) if you are rostered for weekend or 0730-1530 shifts.
- Attendance at the postnatal multidisciplinary meeting at the journey board (8th floor) every day at 8.30 am, level 8, MMH
- Liaise with the Neonatal Floors medical officer/nurse practitioner after the 0830 Journey Board meeting so communication occurs with everyone on the postnatal floors team.
- Review of all mums and babies who are highlighted on the journey board that are requiring medial review/assessment and documentation into their medical records + baby's Personal Health Record (Red Book) re outcome. This will include all public postnatal mums and babies (excluding babies rooming in under NCCU care)
    - Mums requiring a medical review before discharge include all women who have had a LUSCS, instrumental birth, PPH, 3rd or 4th degree tear as well as women with complexities – see list in App xx
    - Remember to prioritise ERC LUSCS (Enhanced recovery LUSCS aim to be discharged 24hours post-caesarean)
- Updating the journey board so staff are aware of current status.
- Once daily discharges are complete it's a good idea to get ahead by commencing the following days discharges (time permitting)
- Refer to Appendix 2 for a breakdown of Neonatal column on the Journey Board.
- Completion of the baby's Personal Health Record (Red Book). This includes:
    - Neonatal examination
    - Recommended follow-up including GP reviews, Community Midwife Service and outpatient clinics - medical/allied health,
    - Investigations such as thyroid function tests, ultrasound of hips, head and renal tracts + appropriate follow up for that type of investigation
    - Please do not pull out the original pages the baby's health record book as this is done at time of discharge by the midwife/nurse. With appropriate identification stickers they are filed in the baby's medical records.
- Updating the journey board so staff are aware of current status.
- All newborns under 37 weeks gestational age and/or less than 2500g are to be discussed with the Postnatal Floors Neonatal Registrar prior to discharge

- If there are concerns after reviewing babies on the postnatal floor discussion to occur with the Postnatal floor Registrar /Neonatal Fellow or SCN SMO
- All babies requiring follow up by another specialty/to be seen in an outpatient clinic are to be discussed with the SCN SMO (Mon-Fri 0800-1600) or after hours Neonatal SMO
- Complete discharge summaries as required
    - See Appendix 3 (M8) for list of women requiring a medical discharge summary
    - If admitted to NCCU discuss with the relevant team if a baby discharge letter is required from Babies on Board (BOB).
- Once daily discharges are complete it's a good idea to get ahead by commencing the following day's discharges

SCN RMO

Special Care Unit Duties and Responsibilities

- Attendance at the 8am Medical Huddle - Location: 6.1 (level 6 MMH)
- Involvement with the multidiscipline Ward Round Team. Lists of these babies can be printed from babies on Board (BOB) database (Refer to appendix 3 for information regarding BOB)
    - Ward round starts at 8/8.30 am (or after the radiology meeting at 9 am). This may depend on if the consultant on for SCN has other commitments. Please find out at the beginning of the week when the ward rounds will start each day.
    - SCN has nurse led/multidisciplinary ward rounds.
    - Prior to the ward round, you should familiarise yourself with the patient's condition and progress, and ensure appropriate x-rays and investigation results are available.
    - During the round, transcribe the ward round findings and decisions into the chart.
    - Review Medication Sheets and cease unnecessary medications ;
- Adjust fluids/feeds appropriately.
- Organise investigations or referrals as discussed in the ward rounds, including follow up of the results.
- Review/assessment of babies and any concerns discussed with the SCN SMO.
- Weekly SHARED (Situation History Assessment Risk Expectations Documentation) medical summaries (via Babies on Board (BOB)) for all babies unless they are planning on being discharged or transferred that week. SHARED Medical Summaries are to be printed off from BOB and placed into progress notes in chronological order. It is important to fill in all the relevant areas, including subspecialties that are involved with the baby and follow up that will occur.
- Discharge examination/medications/letters when babies are known to be transferring/discharging home soon;
- Follow up arrangements to be organised once this has been discussed with the SCN SMO.

CLINICAL AREAS

M8

- Level 8 is the main postnatal floor, providing care for women once they have delivered. It is a 41 bed postnatal ward with an average daily turnover of 18 admissions and 18 discharges.
- The ward is divided into 2 sections, beds 1-19 and beds 20-41 to improve patient management and to try to decrease clinical risk. Please note that medical records for beds 1-14 are housed in the western end of the floor and the records for beds 15-41 are at the eastern end. There is an **ALS/neonatal resuscitation trolley** as well as the Store Room (IV cannulation trolley/medications) located near the journey board in the centre of the ward.
- **Journey Board** – Located in the centre of the floor, the Journey Board outlines patient management and progress. You will need to view the M8 VOLT to familiarise yourself with the O&G Journey Board system and ask the floor TL if you need help interpreting the board. You should start your day at the journey board with a ward list and identify which patients need to be seen. The M8 team leader will help you prioritise

PAC

The PAC is obstetric specific emergency department that accommodates antenatal and postnatal patients who are:

- brought in by QAS
- referred by the GP
- booked for review appointments (usually referred from their antenatal appointments or GP)
- self-present with Obstetric-related conditions/concerns

For more information regarding common PAC presentation please review the PAC section the RMO

O and G Unit Handbook.

http://intranet.mater.org.au/cms/uploads/documents/store/resources/res_21083_RMOObstetricsandGynaecologyHandbook.pdf

SCN

SCN makes up part of our NCCU. It contains 32 cots located in 4 pods of 8 cots (648-679). SCN is located on level 6 MMH and is to the right if entering NCCU from the main doorway (next to the Main NCCU reception). SCN has a reception area which contains a discharge planning journey board. SCN looks after babies that are not requiring our intensive care nursery (respiratory support, central venous or arterial access or requiring cardiac/surgical care that do not qualifying for transfer to SCN) but unable to have care with Mum on the postnatal floor (<35 weeks gestation, <2200g at birth, requiring NG feeding/closer monitoring)

Education Location Key	
5.3, 5.1	Conference room level 5 MMH
6.1	Conference room level 6 MMH
ICN	Intensive Care Nursery
MFM	Maternal Fetal Medicine MMH Level 7
Des O'Callaghan	Des O'Callaghan auditorium
NCCU	Neonatal Critical Care Unit

EDUCATION

Timetable

WHEN	TIME	WHAT	WHERE
MON	7.30am – 7.50am 7.50-8am	Non-mandatory O&G Morning Education O&G Medical Huddle	5.1 MMH 5.1 MMH
	8am	Brief (5min) Neonatal Medical Huddle (night and day staff)	6.1 MMH
	8.30am - 9am	Neonatal Radiology Review	6.1 MMH
	8am - 12pm	Growth & Development Clinic	L 4 Salmon Building
	12.30pm-1.30pm	Perinatal Mortality Meeting	5.3 MMH
	1.30pm - 3.30pm	MFM Clinic	L7 MMH
TUE	7.30am – 7.50am	Non-mandatory O&G Morning Education	5.1 MMH
	8am	Brief (5min) Neonatal Medical Huddle (night and day staff)	6.1 MMH
	8am - 12pm	Growth & Development Clinic	L 4 Salmon Building
	8.30am 2.30 - 3pm	Prem/Med ICN Multidisciplinary Team Meeting SCN Multidisciplinary Team Meeting	6.1 MMH 6.1 MMH
	12.30pm–1.30pm	**RMO Education – Protected Teaching Time**	**L4 Duncombe Building**
WED	7.30am – 7.50am	Non-mandatory O&G Morning Education	5.1 MMH
	8am	Brief (5min) Neonatal Medical Huddle (night and day staff)	6.1 MMH
	8am – 12pm	Short Term Follow-up Clinic	L 4 Salmon Building
	8.30am – 9am	Neonatal Radiology Review	6.1 MMH
	9am	ROP Clinic	L 4 Salmon Building
	1pm – 2pm	Simulation scenarios (can occur at other random times)	NCCU
	2pm – 4pm	Neonatal Teaching & Journal Club (to include monthly Grand Rounds Session)	6.1 MMH
THUR	7.30am – 7.50am	Non-mandatory O&G Morning Education	5.1 MMH
	8am	Brief (5min) Neonatal Medical Huddle (night and day staff)	6.1 MMH
	8.30am	Cardiac/Surg ICN Multidisciplinary Team Meeting	6.1 MMH
	12.30pm – 1.30pm	**O&G Department RMO Education – Protected Teaching Time**	5.3 MMH
	2pm – 4pm	Monthly Joint NCCU/Surgical Teaching	6.1 MMH
FRI	7.30am – 7.50am	Non-mandatory O&G In hours (Mon – Fri)	5.1 MMH
	8am	Brief (5min) Neonatal Medical Huddle (night and day staff)	6.1 MMH
	8.30am – 9am	Neonatal Radiology Review	6.1 MMH
	12.30pm - 1.30pm (monthly)	Campus wide grand rounds	Des O'Callaghan
	1.15pm – 2pm	MFM Meeting	5.1 MMH
	Fortnightly 1.30pm – 5pm	O&G Registrar teaching (Family Doctor RMOs welcome to attend)	

(Please refer to the Key on the following page).

Courses and Modules

O&G - K2 CTG Learning Package

RMOs have free access to the K2 CTG learning package which is accessible via 'clinical resources' on the intranet.

Neonatal Basic Life Support

At (or prior to) the beginning of our time with us please complete the online basic life support module in MyMater learning. The Face-to-Face part can occur with one of the neonatal facilitators at any stage while you are at work.

Advanced Neonatal Resuscitation Course

MMH Neonatology runs a multidisciplinary full day advanced neonatal resuscitation course. Attendance during your rotation will hopefully occur. If you have not heard via email about a date, please contact our secretary Julia Bosse (ext 8250, or julia.bosse@mater.org.au). The Neonatal Division covers the registration fee for the course.

Newborn Examinations: Assessment of the Well Newborn on MyMater Learning

RMOs may wish to enrol in the 'Assessment of the Well Newborn 'online module on My Mater Learning.This competency was designed for midwives, previous RMOs have found this useful.

UNIT POLICIES & PROCEDURES

Sick Leave

In hours (Mon – Fri): Call Judy Edy, Executive Support on 07 3163 1594, available from 07:30am – 16:00pm. Judy Edy will then communicate to the team you are rostered to

Outside of hours: please communicate directly with the team you have been rostered to

- Neonatal - Rostered to SCN or Postnatal Floors: Neonatal Consultant On Call
- O&G - Rostered to PAC, BS and Postnatal Floors: Delivery Suite Registrar 07 3163 6610
- Call or email the Medical Education Manager 07 3163 8114 or email mededu@mater.org.au

****Please note**** If you have taken more than 2 days of sick leave a medical certificate will be required.

Injured/Sick While at Work

- Notify your supervisor and complete an incident report form
- In an emergency, attend the Emergency Department
- Contact the SHAW unit (X 8190) who manage work cover claims

O & G Intranet homepage

The department's intranet homepage is a valuable source of information. Its content is updated regularly, making it a reliable mode of communication between all members of the department. Please familiarise yourself with the content so as to improve your own efficiency and knowledge of things both department specific and for general O & G clinical management.

Protocols

Guidelines for most clinical situations are available on the Mater Document Centre (MDC). MDC is available on all computers via the intranet and is located in ZEN works.

A shortcut to commonly used protocols can be found on the O&G departmental home page under Policies, Procedures and Guidelines.

The following are policies relating to commonly seen issues in Neonatology:

- Examination, assessment and discharge of newborn babies- Document ID WI-CLN-800075
- Jaundice and Phototherapy – newborn babies - Document ID PR-CLN-800056
- Hypoglycaemia in newborn babies - Document ID PR-CLN-800073
- Developmental Dysplasia of Hip - Document ID GD-CLN-800044
- Cerebral Ultrasound of the newborn baby- Document ID GD-CLN-800001
- Thyroid Disease – pregnancy and newborn care - Document ID GD-CLN-800093
- Conjunctivitis and sticky eyes in babies - Document ID PR-CLN-800102
- Hepatits C – pregnancy and newborn care - Document ID PR-CLN-800110
- Hydration Status of the well baby- assessment and management - Document ID PR-CLN-800082
- Pentavite – supplementation and vitamin D deficiency - Document ID PI-CLN-430212
- Subgaleal Haemorrhage assessment and management of babies- Document ID GD-CLN-800091
- Blood specimen collection - babies- Document ID PR-CLN-800075
- Code Blue - neonate - Document ID PR-CLN-900059
- Neonatal outpatient clinics - Document ID PR-CLN-800092
- Congenital anomalies of the kidney and urinary tract - Document ID PR-CLN-800101
- Syphilis infection – pregnancy and newborn care- Document ID GD-CLN-800098

UNIT ROSTER & TIMETABLES

For specific rosters & timetables please see the appendices attached to this document

Hours

RMO hours are as per a rolling roster templates which are on the O & G and Neonatal intranet. Its your responsibility to regularly check the roster for updates on the intranet. If you have any queries about the roster please contact the AO (x1594).

Your regular working hours need to add up to 76 hours / fortnight under the current Resident Medical Officers (RMO) Enterprise Agreement.

If you wish to swap shifts with another RMO on the roster, you need to:

- Approach the other RMO regarding the swap
- Ensure that the swap will comply with the award for both parties and is within the same pay period i.e. do not exceed 76hrs/week
- If the swap is approved, AO will notify switchboard and clinical areas involved to confirm the change in an email to the affected doctors.

Weekends

The Family Doctor RMOs and Neonatal Registrar will cover weekend Postnatal floor activities. Roles, responsibilities, timetables and information on supervision for these activities are listed under the relevant sections above.

Kronos

Changes to timecards in Kronos must be completed by 10am on the Monday after the end of each fortnight pay period for authorisation. It is your responsibility to enter your hours into Kronos by the cut off.

- Check your rostered ordinary hours, this column must total 76 hours per fortnight
- Use the 24 hours clock
- You have 30 mins of unpaid meal breaks each day

Mater is committed to safe working hours for all of its employees, particularly fatigue management in MMH as we run a 24hr service. Shift work can be disruptive to your body clock and to your personal/family life. We have therefore added additional junior doctors in recent years, and we frequently rework roster patterns to ensure you are working as close to 76 hours per fortnight and that you can handover and go home at the end of your rostered shift.

The roster is designed to protect your rostered hours and facilitate timely handover of jobs from outgoing to oncoming medical officers. As such un-rostered overtime is discouraged. Try to finish your rostered shift on time and hand over to a colleague. The Team will endeavour to get you home on time also. In the exceptional circumstance where un-rostered overtime is necessary e.g. called to theatre, obstetric emergency etc, it must be approved prospectively by a consultant. This approval, patient URN and reason for overtime must be supplied to the AO so it can be documented in Kronos.

The Postnatal RMOs should finish at 17:30pm each weekday and 19:00pm on weekends. If they can foresee they will not complete all of the day's required reviews/ discharges by this time, they should alert the AO or the LBS Consultant as early in the day as possible, and another RMO (usually the BS RMO) will attend Post-natal floors to assist them. If despite this, you still need to stay back beyond their finish time, again please alert the LBS Consultant or Dr Paul Bretz and they can approve this.

If you are keen to pursue a career in Obstetrics and Gynaecology,or Paediatrics you may choose to stay back to watch or assist in complex surgery, to follow a woman's care in labour, watch neonatal team with complex/premature babies or to attend educational activities beyond your rostered shift. To be clear, these activities that you choose to attend fall outside of your rostered hours and are not remunerated.

Quick Summary:

- You will always be paid your rostered hours
- You will always be paid penalties
- If staying beyond rostered hours to conduct additional work, please ask your relevant consultant (O&G or Neonatal). If your consultant is not available please contact Dr Paul Bretz via switch, for approval if related to O&G. Contact SCN or the after-hours Neonatal Consultant if related to Neonatology.
- If it is agreed that you will be staying back, overtime will be paid without questions as long as the approving consultant's name is in KRONOS as a comment.

ASSESSMENT & FEEDBACK

Assessment

The Family Doctor RMOs will have formal assessments at 5 weeks, 3 months and 6 months.

Assessment meetings will consist of the O&G and Neonatology Term Supervisors, and the RMO. Supervisors will notify residents of their assessment meeting date and time. The assessment form can be accessed at any time from the Medical Education Unit website via Zenworks or http://mededu.matereducation.qld.edu.au/cpd-requirements/all-forms/

If you're experiencing difficulty with any aspect of the term, clinical or otherwise, please contact the term supervisor and/or the Medical Education Unit, early.

There is also an optional self–assessment section located at the beginning of the assessment form, which you are encouraged to complete and discuss with your supervisor. However if you wish to complete this separately you can complete the RMO form Self-Assessment Form which is located on the Medical Education Unit Website under 'Assessment Forms'.

Feedback

Your clinical supervisor/s will provide regular written feedback regarding your progress via your assessment forms, and verbal feedback on a daily basis. If you have concerns or would like more regular feedback, speak to your supervisor in the first instance and the MEU if required. At the end of your rotation, you are required to complete the end-of-term unit evaluation survey and provide valuable feedback on your supervision.

For more information regarding assessment and feedback, please refer to the RMO Orientation Handbook.

APPENDIX 1: BIRTH SUITE PROCEDURES

IV Cannulation and Venepuncture

NOTE: a phlebotomy service (including IV cannulation) is available 6am -9pm weekdays, 7am - 5pm Sat/Sun. A Verdi request form is required for IVC insertion. All samples sent from BS are sent in red bags and received as urgent. Group and Hold tubes must be hand labelled. In other clinical areas, when you want urgent processing, send specimen in a red bag, and if the result is not received promptly, please call Pathology on 8500. Urgent requests for X-match should be done over the phone 8149.

Not all labouring patients require intravenous access. Patients who may need IV access include:

- IV infusion e.g. Oxytocin (Syntocinon), Insulin infusions
- Previous Caesarean section
- Previous significant PPH
- Patients going to theatre for emergency procedures
- Heavy blood loss, requiring fluid resuscitation
- Epidural anaesthesia
- Pre-eclampsia
- Haemoglobin less than 10 g/dL
- Grand-multiparity

16G IV access should be preferentially obtained in the patient's non-dominant arm using local anaesthetic. When the cannula has been inserted, consider if you also need to send blood specimens thus avoiding venepuncture later. Not every patient in BS requires FBC and Group and Hold.

Commonly Prescribed Medications in Birth Suite

- Syntocinon infusion is prescribed on the IV fluid chart for labour augmentation/induction and is titrated by the midwife and registrar in accordance with the MMH Syntocinon infusion policy. The registrar must authorise a Syntocinon infusion prior to being prescribing.
    - 30 units syntocinon in 500mls Hartmann's at rate "as per protocol"

- Post-partum analgesia
    - Paracetamol 1g QID PRN (max 4g/24hrs)
    - Ibuprofen 400mg TDS PRN (AVOID WITH PET)
    - Opiods rarely required

- Perineal repair
    - Paracetamol 1g PR once only predication

- Diclofenac 100mg PR once only medication
- Consider charting regular simple analgesia for episiotomies as these women experience more pain. Small second degree tears usually only require PRN medications.
  - Paracetamol 1g QID
  - Ibuprofen 400mg TDS for 3 days
- Endon/Codeine PRN (rarely required)
- Stool softener of choice (lactulose, movicol, Coloxyl) PRN

- Antibiotics for PPROM>18 hrs, GBS positive or preterm labourers
  - See Policy **"Group B streptococcal disease—antenatal and intrapartum management – procedure"**

- Antibiotics for fever in labour
  - See Policy **" Infection and sepsis in pregnant and postpartum women"**

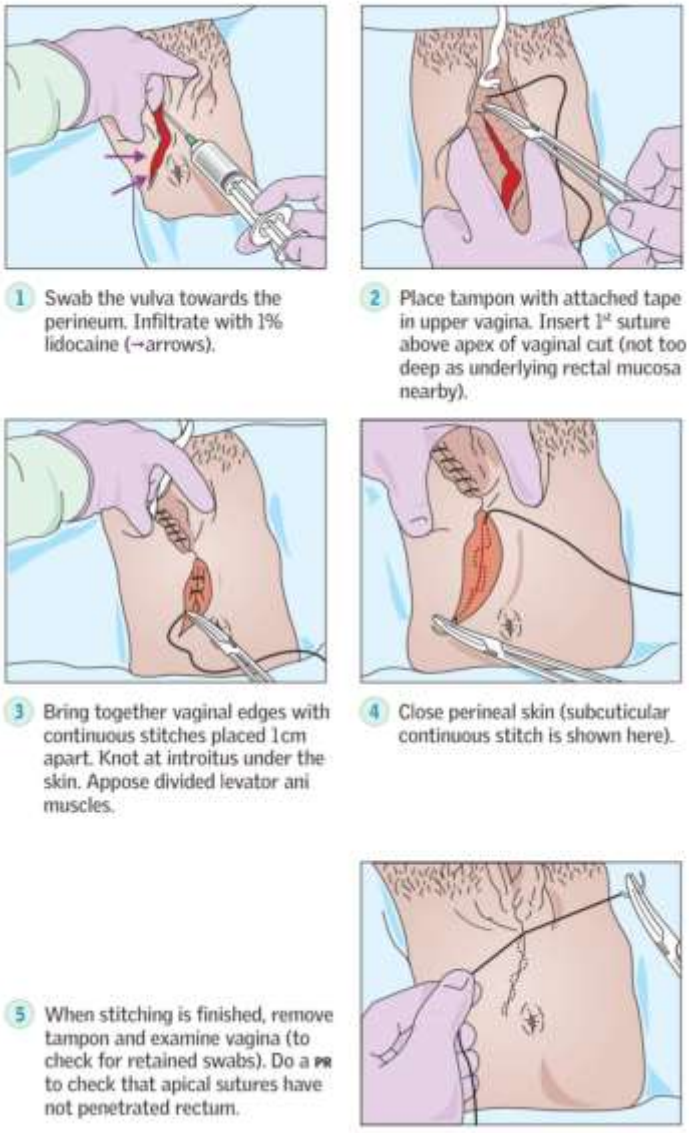
- Neonatal medications prescribed on the Neonatal medication chart. Midwife caring for that patient will discuss these with the parents and consent obtained prior to charting
  - Vitamin K (Konakion) 1mg IM
  - Hepatitis B vaccination 5mcg IM

- **Standing Orders** now exist for midwives in birth suite. They are authorised to prescribe and administer the following without medical officer approval
  - Metoclopramide 10mg IM once only
  - Morphine up to 10mg IM once only
  - Syntometrine 1ml (5 units syntocinon + 500mcg ergometrine) IM once only
  - Syntocinon 10 units IM once only
  - Terbutaline 250mcg S/C once only for hyperstimulation

Perineal Repairs and Suturing

Repair of uncomplicated perineal tears and episiotomies is a skill that should be learnt during the term. Midwives may do this for their women, but you will be asked to do this for women where the midwife is not competent or has other clinical tasks which take priority. Ask to be supervised by the registrar until confidence has been gained or credentialed as competent. Seek help if there are problems. Third and fourth degree tears are repaired by the registrar in OT. For further reading, preview the perineal repair packages saved on the birth suite handover room computers. You

can also attend the perineal repair workshops run by midwifery facilitators – enrol on MOVES, search for: **CE-PSUT : Perineal Suturing Workshop**



1 Swab the vulva towards the perineum. Infiltrate with 1% lidocaine (→arrows).

2 Place tampon with attached tape in upper vagina. Insert 1st suture above apex of vaginal cut (not too deep as underlying rectal mucosa nearby).

3 Bring together vaginal edges with continuous stitches placed 1cm apart. Knot at introitus under the skin. Appose divided levator ani muscles.

4 Close perineal skin (subcuticular continuous stitch is shown here).

5 When stitching is finished, remove tampon and examine vagina (to check for retained swabs). Do a PR to check that apical sutures have not penetrated rectum.

Graphic taken from the Oxford Handbook of Clinical Specialties

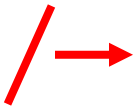
APPENDIX 2: POSTNATAL FLOOR MMH8 JOURNEY BOARD MADE EASY FOR NN (NeoNatal) COLUMN

A triangle is the aim as that indicates that the baby has been assessed, Red book completed and clear to be discharged. If a baby becomes unwell after this stage the midwife will call about this acute change.

Documentation onto the Journey Board:

= Newborn has been seen on the postnatal Floor by a medical doctor.

If a newborn becomes unwell on the postnatal floor the neonatal registrar will be paged by the midwife regarding their concerns. Once the assessments have been done then write this side of the triangle onto the Board.



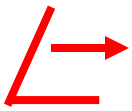
= Newborn has been seen on the postnatal Floor AND requires ongoing medical review.

The arrow will be added by the medical officer (or midwife) if further medical input is needed

= Newborn has been seen on the postnatal Floor AND' Red Book' has been filled out.

The 'Red Book' means that the full newborn exam has been completed and the 'Personal Health Record' has been filled out as well as documentation into their clinical notes.

This can be completed by a Medical officer/midwife/registered nurse



= Newborn has been seen on the postnatal Floor + 'Red Book' has been filled out AND requires ongoing medical review

= Well Newborn Examination has been completed and no further review is needed

ICN or SCN = Admitted to the NCCU

APPENDIX 3: BABIES ON BOARD (BOB) DATABASE (DISCHARGE SUMMARIES)

Discharge Summaries are generated using BOB. Writing a good discharge summary is an art form, and you will become much better at it as you gain more experience

The summary produced by BOB depends absolutely on the completeness and accuracy of data entered. You will receive an initial training session when you start. It is not completely intuitive, and if you need further help, please contact one of our Registrar/Fellow/SMOs or our date officer, as they have many trouble shooting tips. It your responsibility to ensure, that the clinical data is accurate and complete.

BOB database on all babies are to be updated when changes/new problem occurs or procedure has been performed. If the Database is updated regularly, when the baby is ready for discharge it is a relatively simple step to generate a comprehensive summary. If little information has been put in prior to discharge, it can be a mammoth task (e.g. completing information on a 24 weeker with >100 day stay). Babies transferred to SCN from ICN teams should have had BOB updated and this includes the discharge letter. If this has not occurred please inform your consultant.

All babies transferring to another hospital or being discharged home must have a completed discharge summary on leaving the hospital.

The discharge letter includes:

- Active Problems + relevant Past Problems
- Discharge Weight, Head Circumference & Length must be included.
    - This can be the weight obtained just prior to rooming in – with a date added. Monitoring of growth post discharge won't be an issue if there is a date corresponding to the growth parameters prior to discharge.
- Discharge Medications
- Referrals
- Investigation results pending (or to occur)
- Follow up

Confirm that you have entered the correct receiving GP/Speciality names into BOB before printing the transfer/discharge letters.

Print 3copies if baby is being discharged home or 4 copies if being transferred to another hospital. A printed version is not required for medical records as the BOB discharge letter automatically identified in Verdi under discharge letter.

The copies are for:

1. Mother,
2. Family Doctor,
3. Community Liaison,

4. Receiving Hospital (for transfers)

Further copies may be required if other sub specialists have been involved in the baby's care .

The copy for the receiving hospital goes with the baby in an envelope along with various photocopied documents which the Ward Clerk/nursing staff organise. Put the other copies in the front of the baby's medical record. One copy will be passed onto the parents/carer and Child Health nurses by the SCN staff.

Discharge summaries can be printed out by you at any time of day or night! It is great to have an updated version in BOB when the baby looks close to being transferred or discharged. If there are any omissions or inaccuracies which you can't correct you can give the SCN consultant a call. For complex babies, and those being transferred to another hospital please find out from your consultant if they also wish to see the summary.

Remember that an accurate discharge summary is an essential component of good patient care. Your diligence in keeping the record of your allocated babies up -to-date and accurate, and your discharge planning in completing BOB and making follow-up arrangements is important, and your performance in this area forms part of your end-of-term assessment.

APPENDIX 4: M8 OBSTETRICS

Important contacts

Postnatal Family Doctor DECT phone	ext. 8894
Midwifery Unit Manager	ext. 8030
Team Leader 1	ext. 6323 or
Team Leader 2	ext. 1504

Postnatal Checks

Please try to complete a discharge check the day before the expected discharge day. Expected day and time of discharge depends on date, time and mode of delivery. Women requiring a medical Post Natal Check will be indicated on the Journey Board with a coloured magnet. This list includes, but is not exclusive to, women who had an elective or emergency caesarean section, an instrumental birth, a 3rd or 4th degree tear, or a PPH, Babies requiring a medical discharge will be indicated on the Journey Board by an Orange magnet. If there is any question as to why a patient is for O&G or Paediatric review, discuss with the TL.

Maternal Discharge Summaries on CHaT

Whilst midwives complete a discharge summary in Matrix for postnatal women, **all complex women should also have a medical discharge summary completed on CHaT**.

Conditions requiring Medical Officer Maternal Discharge summary

1. Patient with medical disorders complicating pregnancy
    - Hypertensive disorders of pregnancy, including PET/HELLP
    - Pre-existing DM
    - Pre-existing cardiac/respiratory disorders /peripartum cardiomyopathy
    - VTE during pregnancy OR planned to discharge on anticoagulation
    - AFLP/HUS/CKD/ ICU admission
    - Any patient requiring ongoing Obs Med input
2. Obstetric complications requiring "debrief" prior to discharge
    - Complicated CS like classical/ placenta praevia/CS hysterectomy/ surgical complication sustained
    - Shoulder dystocia with neonatal complication
    - OASIS
    - MROP/PPH requiring surgical management OR blood transfusion
3. Unexpected pregnancy outcome like IUFD/early NND/HIE
4. All unplanned re-admissions

You will note that women who have had a standard Emergency or Elective CS or instrumental delivery do not require a medical discharge summary, although you will be required to see them to do their discharge check.

Average inpatient length of stay: use the discharge calculator:

MM8 Discharge Calculator	Type of Birth		
Time of Birth	Vaginal Birth	Enhanced Recovery Caesarean	Caesarean Birth or Special Cots on MM8 (eg Abx)
Midnight – 6am	Tomorrow 9am-11am	Tomorrow 9am-11am	Day after tomorrow 9am-11am
6am – 12 noon	Tomorrow 11am-1pm	Tomorrow 11am-1pm	Day after tomorrow 11-1 pm
12 noon – 6pm	Tomorrow 1-4pm	Tomorrow 1-4pm	Day after tomorrow 1-4pm
6pm - Midnight	Day after tomorrow 9am-11am	Day after tomorrow 9-11am	In 3 days 9-11am

Maternal Care paths

Please ensure you document in the care path. The sections requiring medical officer completion are coloured orange. The care paths guide you through the important aspects to your postnatal reviews. Any variances MUST be documented in the progress notes. Any concerns/questions the midwives or ward clerk will be happy to assist.

Debriefs

Patients who have unplanned or adverse circumstances surrounding their delivery, (e.g. PPH, Emergency LSCS, 3rd or 4th degree tear), require a 'debrief 'from the treating team's registrar. This is communicated on the Journey Board and in the Care path. It is recommended the team RMO highlights the required debriefs to the O&G team Registrar so as to facilitate timely debriefing in relation to patient discharge. Wherever possible debriefs should be completed the day before discharge to speed up the discharge process. If the patient has questions or concerns about the birth process or wasn't satisfied with the initial debrief, please alert the O&G team Registrar.

Postnatal Medications

It is best to discuss all medication questions with your registrar (O&Gor neonatal), particularly in the first instance or if there are any concerning features with the patient's clinical state:

- Please ensure patients with PET are not prescribed NSAIDS (e.g. ibuprofen) for pain relief.
- Patients (Maternal)who have a temperature in labour will usually be prescribed 24 hours of IV antibiotics. If the patient remains afebrile, IV antibiotics can be ceased. If chorioamnionitis was suspected, please change them to oral antibiotics. Please see policy **"Infection and sepsis in**

pregnant and postpartum women". Babies are reviewed re ceasing antibiotics at 36 hours of age.

- Patients with a Bakri Balloon in place will receive IV and an oxytocin infusion while the balloon is in situ. Only a registrar should deflate and remove a Bakri balloon. Please see policy "Postpartum haemorrhage (including use of Bakri balloon and B Lynch suture)"
- Patients with gestational hypertension may require antihypertensives postnatally. Often they will be changed to enalapril in this instance. Please discuss this with the Team Reg +/- the Obs Med Reg.
- Patients who had gestational diabetes (GDM) will have BSLs checked 24 hours postnatally and have their diabetic medication ceased as usually, the high BSLs associated with GDM should normalise after birth. If however, there are ongoing BSL control issues, you should discuss this with the Team Reg +/- the Obs Med Reg.. GDM patients are also required to have a repeat OGTT at 6-12 weeks post-natally (this can be followed-up via their GP)

Patients (Maternal) with medical issues

The Obstetric Medicine (Obs Med) team operates on a consultation basis within the MMH. Patients with complex medical issues may require a consultation with the Obs Med registrar (pager #0030). This is at the discretion and request of the treating team registrar and consultant. There is a formal referral process for requesting an Obs Med review. If you are concerned about a patient's management in view of medical issues, liaise firstly with your treating team registrar who will then devise an appropriate course of action which may include Obs Med or other speciality referral, outpatient clinic, PAC or GP follow up. After hours contact with the Obs Med team needs approval by the registrar or consultant.

Phlebotomy Service and Specimens for Pathology

The phlebotomy service operates two rounds in the morning. Leave your Verdi request forms in the wall mounted Perspex Phlebotomy tray located next to the Lamson Tube station. If you have collected your own specimens send to Pathology by dialling 5-5-0 on the Lamson tube station. The on call phlebotomist is available for bloods and IVC's.

Criteria for Midwifery Care – maternal and baby

Uncomplicated women who have had an SVD with no antenatal or intrapartum issues are suitable for midwifery led care and discharge. There is also a work instruction re' Examination, assessment and discharge of newborn babies 'which includes criteria Discuss with the M8 team leader if you have and questions or concerns.

Brief Guide to Maternal discharge checklist

To improve efficiency performing a postnatal check, you are strongly encouraged to watch the short video "postnatal check" accessed via the O and G website:

https://www.screencast.com/t/9MfzrZV5