mater education

RMO OBSTETRICS & GYNAECOLOGY HANDBOOK

Revised 05/01/2021

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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 (MEO)	ext. 8431
Principal Medical Education Officer (PMEO)	ext. 1560
Medical Education Admin Officer	ext. 8272
Medical Education Manager	ext. 8114

INTRODUCTION

Mater Mothers' Hospital

Welcome to the Mater Mothers' Hospital, South Brisbane. Mater Mothers' Hospitals are renowned for providing high quality maternity services for women and families across Queensland, and beyond. Services are provided for women and families who do not have health insurance. These services are provided in partnership with the Queensland Government to ensure a high level, integrated tertiary service for women and babies which includes:

- Obstetrics
- Gynaecology
- Neonatology
- Maternal fetal medicine (MFM)

The hospital was designed with safety and the latest clinical technology in mind. It was built in close proximity to Mater Adult Hospital Critical Care Unit and boasts integrated technology to provide efficient monitoring for high risk pregnancies. The Neonatal Critical Care Unit provides 79 cot spaces including intensive care, high dependency and special care cots, making it one of the biggest neonatal critical care units in Australia

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

Mater Mothers' Private Hospital operates from within the same building as the Mater Mothers' Hospital and services privately insured patients. Obstetric care in this instance is offered by private visiting medical officers who will manage his or her patient's care

UNIT OVERVIEW

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 giving the RMO exposure to the various aspects of the speciality including clinics, birth suite, operating theatre and inpatient management. In addition to the general O & G teams there is an MFM team headed by the MFM consultants and an MFM fellow.

There is also a gynaecology which is housed on M9 (East). The gynaecology oncology team is located in the Mater Adult's Hospital as part of the Surgical Department and their RMOs come from the Mater Adults pool. .

Term Supervisors

Dr Alice Whittaker (Lead) & Dr Huda Safa	Contact via switch
Judy Edy Executive Support	X 1594

CASE MIX, CASE LOAD AND MODEL OF CARE

The General O&G RMOs (5-10 week position) rotate through several different roles within the department. At any one time, two RMOs will be rostered on to be the **Birth Suite Night RMOs**. The three **Team RMOs** do ward rounds for approximately 5-10 inpatients who are a mixture of Antenatal and Gynaecology. The Team RMOs will also perform post-natal reviews and discharges for some post-natal women an M9. Once ward-work is complete (approximately 9am), the RMOs are then rostered to attend unit activities with their team including Gynaecology OPD, OT, or Caesarean section list.

The **Family Doctor RMOs** (6 month position) rotate between the Postnatal ward, Birth Suite, Pregnancy Assessment Centre (PAC) and the Special Care Nursery (SCN). The Postnatal RMO reviews and discharges post-natal women on ward M8 and some on M9. Birth Suite 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. PAC entails assessing women presenting with acute pregnancy related issues.

Finally, the **Senior RMOs** (12 month position)will be rostered to antenatal clinic, caesarean section, Birth Suite, Early Pregnancy Assessment (EPA) and PAC. They also take it turns to be the RMO for the gynaecology team for a 5 week term, which offers unique learning opportunities.

UNIT ORIENTATION

RMOs participate in unit orientation together to receive a consistent message for the term. The following areas will be covered:

- handover
- weekend rosters
- term learning objectives
- unit policies and procedures
- how daily clinical handover is conducted and
- miscellaneous (tour of the department, introductions to staff, location of resus trolley)

Orientation to the MMH –you will be taken on a hospital tour on your first day

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

The Neonatal RMO Supervisor Dr Maureen Dingle will join the orientation and give a focussed orientation to the Special Care Nursery at the end of this tour. All family doctors will then receive on-the-job training in a neonatal discharge by a Neonatal Registrar.

Team Orientation

Your term supervisor will conduct a face-to-face team orientation with you within the first three days of the term. All RMOs are to complete the online Start of Term Checklist with their term supervisor during this orientation, which covers the following:

- reporting lines
- scope of practice
- expectations regarding RMO protected teaching time (Tuesday & Thursday 12.30pm to 1.30pm)
- discharge summary expectations
- daily roster and managing overtime- where to be & when, e.g. ward rounds
- discussion and documentation of your individual learning objectives for the term
- assessment
- research - opportunities within the unit
- identify 1-3 learning objectives
- pagers for each of the Team RMOs can be picked up from the M9 doctor's room
- Any mail sent to you (either internal or external) during your O&G term will be forwarded to the Resident Mail Tray in the Birth Suite Registrar Room or to the Medical Education Unit (L4 Duncombe Building). Please recycle envelopes used for internal mail.

The Start of Term Checklist is available on the Medical Education Unit website via Zenworks or http://mededu.matereducation.qld.edu.au/cpd-requirements/all-forms/

All RMOs should take time to peruse this handbook before presenting for work and discuss any concerns with the Term Supervisor.

O & G Intranet homepage and Video On Line Tutorials (VOLTs)

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. Video On Line Tutorials (VOLTs) are the O&G Department's preferred way of orientating new doctors to different aspects of the job. Please familiarise yourself with the content, particularly the "essential VOLTs" so as to improve your own efficiency and knowledge of things both department specific and for general O & G clinical management.

RMO LEARNING OBJECTIVES

MBA Learning Outcomes for Interns Applied to O&G:

Expected Opportunities	Examples
Intern as Scholar and scientist: Opportunities to apply, consolidate and expand clinical knowledge and skills while taking increasing responsibility for providing safe, high-quality patient care.	• Antenatal history taking and examination • Speculum examinations • Recognition of gynaecological emergencies • Assist in labour and delivery • Recognition of deteriorating patients specific with obstetric considerations
Intern as 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 based care • Perineal suturing and repair with supervision; assistance with Caesarean section • Post-operative care
Intern as 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
Intern as health advocate:	• Management of patient discharges / handover communication

Opportunities to participate in quality assurance, quality improvement, risk management processes, and/or incident reporting.	• 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.

UNIT EDUCATION & TRAINING OPPORTUNITIES

Unit Learning Opportunities

The list of learning opportunities in O & G are extensive however, RMOs will have the opportunity to acquire a broad general understanding of medicine, and develop skills in the diagnosis and management of the following common disorders and conditions, medical procedures and tests, and develop confidence in interpreting the tests.

RMOs have free access to the K2 CTG learning package which is accessible via 'clinical resources' on the intranet and can work through this package if they have an interest. However RMOs are not expected to interpret CTGs.

Interns: Knowledge

- Recognise that most obstetric patients have uncomplicated antenatal care and confinement
- Identify high risk pregnancies by history and clinical examination
- Suggest initial investigation of women with pregnancy complications
- Gain knowledge of the management of complications in pregnancy and appreciate the need for appropriate consultation/referral
- Understand principles of resuscitation and management of antepartum, intrapartum and postpartum haemorrhage
- Become familiar with the features of both normal and abnormal labour
- Know indications for continuous fetal heart rate monitoring and have some understanding of features of a CTG
- Gain clinical skills in the antenatal and gynaecology clinics, pregnancy assessment units, wards, delivery suite, operating theatre
- Order appropriate first line investigations and be able to interpret results
- Develop and understand the management of first trimester complications, including threatened miscarriage and hyperemesis

- Become familiar with management of common gynaecological pathologies

Interns: Skills

- Develop skills in
    - Performing abdominal and pelvic examinations, including speculum examination and cervical smear
    - IV cannulation
    - Urinary catheter insertion
    - Assessment of the gravid abdomen (lie, presentation, SFH, engagement, liquor volume, FHR)
- Assist with normal vaginal delivery and instrumental deliveries
- Assist at caesarean sections
- Provide post-operative assessment and suggest management of patients
- Prescribe and administer medication safely under supervision
- Communicate with patients, relatives and other health professionals appropriately
- Demonstrate ability to work as a team member
- Maintain accurate, comprehensive, legible records

PGY2/3: Knowledge

All of the above plus

- Manage complications in the first trimester, including threatened miscarriage and hyperemesis

PGY2/3: Skills

All of the above plus

- Conduct normal vaginal delivery under supervision, observe, and where possible assist at instrumental deliveries
- Repair vaginal and perineal lacerations/episiotomies
- Manage infections including Group B Streptococcus
- Perform minor procedures such as dilation and curettage, insertion of Mirena IUCD under supervision
- Provide post-operative management of patients
- Prescribe and administer medication safely.

RMO DUTIES & RESPONSIBILITIES

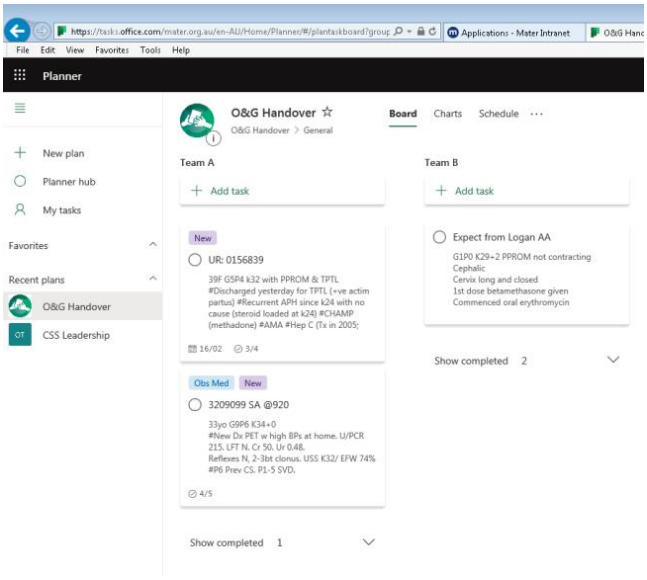
There are several types of O&G RMO terms.

O&G Team RMO (Team A-C)

Timetable

- Most days Mon- Thurs 0750 – 1620 (half days sometimes)
- One day a week Birth Suite 0700 - 1900
- Friday: 0750 – 1230

Refer to the 'Education' heading to view the learning opportunities available.



Duties and Responsibilities

- Print your team's inpatient list from Verdi
- Attend morning handover at 0750 weekdays in conference room 5.1. New admissions will be discussed via the Microsoft Planner app. Sign in to app, choose "O&G Handover" on the Planner Hub; new admissions will be listed in the respective team buckets and flagged as "New"

  Please note: inpatient referrals to Obstetric Medicine should be flagged on planner, after consultation with team registrar and verbal request for review by the Obs Med Registrar.
- Participate in the team ward round with consultant and registrar
- On Friday ward rounds (or before a public holiday) document plans with the WE-SHARED stickers available on M9 nurses station.
- Action patient plans from ward round (e.g. MFM scans, pathology requests)
- Discharge/ review post-natal women on M9 who will go home without their babies (e.g. pregnancy loss or extremely premature baby who is in the NICU). Women on M9 who will go home with their babies will have their discharge done by the Family Doctor. Perform a CHaT discharge summary to those women who require them.
- Attend rostered role for that day as per the roster (e.g. clinic by 0900, gynae theatre by 0900 unless requested earlier, CS list by 0830).
- Report throughout the day to your team registrar on progress of inpatient management
- On BS days, do the job of the BS RMO (see below in BS RMO section)
- Acknowledge your team's Verdi results
- Complete Gynaecology patient's discharge summaries promptly, ideally on the day of discharge: check book in M9 doctor's room for any patients missing a discharge summary

- Perform your Buddy RMO's role when they are on a half day (Team A buddies with the Gynae RMO, Team B buddies with Team C)

When your team is on for Birth Suite, it is still necessary to undertake your ward duties, M9 discharges and participate in a ward round of your team's inpatients.

Please note you have a rostered role and you attend to that role as promptly as possible. You may be called away from the wards to assist sooner than indicated on the roster.

BS RMO

Timetable

The BS RMO timetable comprises

- Birth Suite nights 1900 – 0700
- Birth Suite days 0700 – 1900

Refer to the 'Education' heading to view the learning opportunities available.

Duties and Responsibilities

You are an essential part of the BS team. 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)

- 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 0750
- 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 the wards (M8 and M9) after 1730 on weekdays and after 1900 on weekends. The Postnatal RMO and Team RMOs may hand over things to follow up.
- You will receive calls from the M8 and M9 floors for advice and patient reviews. (Most reviews of antenatal patients should be directed to the 6611 registrar in the first instance). Any questions can be directed to the 6611 registrar and all antenatal patients need to be discussed with them.

- On weekends, you will be asked to be the RMO for the ward round on M9 (antenatal and gynaecology) with the 6611 Registrar
- If you are rostered to work at night, you are not permitted to sleep. Please use this time to learn and use resources such as Up-To-Date and the KS CTG package
- You are required to take meal breaks at night (total ½ hour)

Senior RMO (SRMO)

As a senior RMO you will be rostered as either the Gynaecology SRMO or as a General SRMO. The General SRMO roster involves a mixture of Elective CS lists, Birth Suite, Antenatal Clinic (ANC), Early Pregnancy Assessment (EPA) and PAC shifts. There will be one SRMO doing the gynaecology job at time, usually for 5 weeks. There will be three SRMOs on the General SRMO roster at any one time.

This role is designed to see Senior RMOs "step up". We encourage RMOs to become credentialed for certain procedures. (See the **Assessment of Obstetric Procedures for Senior RMOs** form, accessible via the intranet/departments/Obstetrics and Gynaecology/Credentialing.) Refer to the 'Education' heading to view the learning opportunities available.

Gynaecology SRMO

Timetable

- Most days 0750 – 1620 (with some half days)
- Once a fortnight 0700 – 1900 (Birth Suite)

Duties and Responsibilities

- Attend handover at 0750 in 5.1
- Participate in team ward round with consultant and registrar
- You may be asked to see the MFM patients with the MFM Fellow or Registrar. You will be required to do the discharge checks and discharge summaries for M9 MFM post-natal women who will go home without their babies (any post-natal MFM patient on M8 will get seen by the Postnatal RMO).
- Action patient plans from ward round (e.g. scans, pathology requests/ book post-operative outpatient appointments in clinic.
- Assist in theatre and clinic as per roster
- Report throughout the day to your team registrar on progress of inpatient management
- Acknowledge your team's Verdi results
- Complete discharge summaries promptly, ideally on the day of discharge – check book in M9 doctor's room for any patients missing a discharge summary
- Perform your Buddy RMO's role when they are on a half day (your Buddy RMO is the Team A RMO)

General SRMO

Timetable:

Varied but includes

- Day shifts for CS/ EPS/ ANC Varied
- BS night shift (weekends) 1900 – 0700
- PAC day/weekends 1230 – 2230/ 0900 – 2000 (Saturday and Sunday)

Duties and Responsibilities

- ANC
    - Attend antenatal clinic (ANC) as rostered
    - You will need to complete Matrix training to use Matrix (ANC software) prior to your first clinic
    - Discuss each patient seen with consultant &/or registrar for that clinic
- CS
    - Prompt arrival at CS list 0830/ 1300
    - Score VTE risk and Chart VTE prophylaxis and regular medications
- BS nights (weekend)
    - See list of duties in previous section
- PAC
    - See list of duties on next page
    - You are not expected at PAC until 1330 on Tuesday and Thursday to allow you to attend education.
- EPA
    - See patients in EPA as required and discuss with the 6611 or PAC registrar
- Offer assistance to fellow RMOs if time allows
- Liaise with Dr Alice Whittaker to complete VTE and hand hygiene patient safety audits and attend inpatient services meetings when rostered to this.

If you are interested in undertaking the Certificate of Women's Health or the RANZCOG Diploma you should discuss this with Dr Tal Jacobson via email talj@evehealth.com.au

PAC RMO

Roles and responsibilities

- Carry the 8105 DECT phone and Pager
- See patients in PAC as required and discuss with 6611 or PAC registrar.
    - You may need to source investigation – the PAC AO can help
    - Registrar supervision required for speculum examinations if preterm (<37), low lying placenta or presentation for APH. (unless SRMO has completed credentialing for this)

- IV cannulation and venepuncture (most midwives will undertake this if possible). Use the Lamson tube station in Birth Suite to send specimens to Pathology by dialling 5-5-0.
- Order investigations including blood tests and MFM scans (call if urgent)
    - You must ensure follow up of results ordered if a stable patient is discharged prior to results being finalised – you may need to handover and leave a note in the RMO review box to check it the next morning
    - Some women **with reduced FM will require a MFM scan that day. To ensure they can go home from MFM if the scan is normal, please ensure:**

        1. Referring doctor states in notes and on MFM request "patient may go home from MFM if ultrasound requires no immediate actioning"

        2. Follow up appointment is made BEFORE patient goes down for scan and appointment details noted on request - "next appointment made for...."
- Results acknowledgement daily for PAC patients
    - To find the unacknowledged results, login to Verdi; select Patient list > Unacknowledged Results > MMH Unacknowledged. Then in the popup window choose "Unit: Obstetric teams A, B & C Episode Type: Emergency, Referred to Registrar: No". The Search results will then appear in the Search Results tab at the bottom of the screen. Select a patient one at a time and acknowledge the pathology results. Any result about which you are uncertain, you should refer to the Registrar, using the prompt.
- Prescribe medications as required
    - You may be asked to prescribe domperidone to augment lactation. There is a Consent form (on the Mater Document Centre) you must have the patient sign prior to prescription as this is off-label use.
- Facilitate admission process for patients being admitted from PAC (including IV cannulation, IV fluids, medications and completion of the VTE risk assessment tool)
- Ensure follow up appointment (in PAC or ANC) is booked for patients being discharged
- Document PAC visit in Matrix. You may need to add "issues" as a result of the PAC presentation, e.g. a new diagnosis if PET. Your registrar will be able to assist with this if you are not familiar with Matrix.
- New admissions need to be entered on Microsoft Planner. The registrar can assist with this.
- Each patient who presents to PAC is required to sign a green Medicare form prior to discharge.

Family Doctor RMO

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 floor . As a family doctor you will spend time working in Pregnancy Assessment Centre (PAC), Birth Suite (BS), Special Care Nursery (SCN) and on the Postnatal Floors. For more details, please see the Family Doctor Handbook.

Postnatal RMO (done by one of the Family Doctor RMOs, although other RMOs may be called to help)

Duties and Responsibilities

- Attend 7:50am Medical Huddle – Location 6.1
- Liaise with M8 Team Leader and review/ discharge post-natal patients as requested on M8/M9
- Carry DECT phone 8894
- Discharge post-natal patients as required: see M8 journey board for medical discharges, expected date and time of discharge
    - Patients requiring a post-natal discharge check include all women who have had a LUSCS, instrumental birth, PPH, 3rd or 4th degree tear. These women will not all necessarily need a CHaT discharge summary.
    - Remember to prioritise ERC LUSCS (Enhanced recovery LUSCS aim to be discharged 24hours post-caesarean)
- Complete discharge summaries as required
    - Women requiring a medical discharge summary on CHaT include women with medical disorders complicating their pregnancies, women with obstetric complications, women with unplanned pregnancy outcomes and re-admissions - see list in Appendix 2.
- Once daily discharges are complete it's a good idea to get ahead by commencing the following days discharges (time permitting)
- Attend education on Tuesday and Thursday, even if workload is busy (ask for help)
- Ask for help early if discharges won't get done by your finish time of 1330
- The Family Doctor who usually performs the Post Natal RMO job will also perform neonatal checks of babies. **Non-family doctor RMOs called to help out on the post-natal floors should not do reviews on babies** – please call the Family Doctor RMO or the Neonatal registrar to do these.
- See Appendix 2 for details of the Post-Natal RMO job.

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/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 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

M9

- M9 is predominantly the ward for public antenatal patients and gynaecology patients but some post-natal women stay here also. These are either "overflow" patients from M8, or else they are women who cannot be with their babies, either as their baby is in the nursery and is not expected to go home with them from hospital, or because they have had a pregnancy loss.
- The ward is divided into 3 sections, beds 1-14 (Western End), beds 15-25 (Central) and beds 26-41 (Eastern). Antenatal patients are usually in beds 1-25, and Gynaecology and overflow post-natal 26-41.

Gynaecology clinics

- Gynaecology clinics are held on Level 7 MMH
- The Gynaecology SRMO will do a Paediatric and Adolescent Gynaecology (PAG) clinic once a fortnight in the Salmon Building
- Ask for assistance with examinations if you are unfamiliar with what is required as there may be information or an intervention necessary which you may not be able to achieve without help (e.g. endometrial pipelle sampling of the endometrium, polypectomy or preoperative assessment of uterine suitability for route of hysterectomy, or a prolapse repair).
- If the patient requires surgery, a registrar or consultant must consent the patient; the back of the consent is the booking form which needs to be completed. Finally, a care path needs to be completed, relevant to the type of surgery planned. If the patient is a Category 1 or 2, she needs to see the Gynaecology Case Managers before they leave for the day. Their office is on Level 7 opposite the reception desk.
- A letter must be dictated for all new consultations. Please follow the prompts to registrar with Ozescribe and when dictating, ensure you mention which Gynaecologist's clinic it is. Please refer to the laminated template available in the clinic as a guide for a structured yet brief letter that conveys the essentials of your consultation to the referring medical practitioner.
- Chart Reviews are ideally done by Registrars or Consultants, but you may be asked to help. Please discuss each chart review. If you are unable to contact a patient on the phone, please DO NOT rebook the chart review; instead, follow the laminated flow chart and check with your registrar/consultant. Remember you can ask the patient to call you back on the Gynaecology Clinic phone number (3163 3000) or dictate a letter asking her to make an appointment via this phone number, at a more appropriate time.

Birth Suite

- All shifts are 0700 – 1900 or 1900 – 0700

- Formal birth suite handover is at 7am and 7pm each day (coincides with birth suite registrar shift change) and all obstetric staff members are required to attend their shift's handover. NOTE: This is different to the morning handover for O & G teams which is at 0750 weekdays in room 5.1.

Public and public obstetric care is undertaken in the same birth suite (BS) with 15 rooms for birthing (Rooms 2-16). Each shift there is:

  - Midwife team leader (TL) who coordinates BS for that shift
  - Team of midwives (usually one midwife = one patient in labour) divided into public and private
  - Obstetric consultant on call
  - Registrar
  - Birth suite RMO
  - Obstetric anaesthetic registrar
  - Neonatology registrar

Each birth room is stocked with equipment to perform:

  - IV cannulation and venepuncture
  - Perineal repair/suturing
  - Speculum and vaginal examinations

An ALS resuscitation trolley and obstetric emergency trolley is kept in the corridor between rooms 510 and 511.

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

Common PAC presentations include:

- Spontaneous rupture of membranes (SROM) at term
- Pre-term pre-labour rupture of membranes (PPROM)
- Antepartum haemorrhage (APH)
- Decreased fetal movements (FM)
- Pain (usually abdominal/lower back)

- Early pregnancy problems
    - These women will be seen by the EPA registrar and midwife during weekdays, but by the PAC RMO and PAC midwives after hours.

Booked appointments

Common reasons for booked appointments:

- Gestational HTN and pre-eclampsia monitoring
- Fetal growth concerns (SGA, LGA) for CTG
- Expectant management of PPROM patients requiring regular monitoring
- Cholestasis

- Please note that once a plan has been made for regular follow up appointments in PAC, most women are no longer seen in Antenatal Clinic.
- At 8am each day, the BS consultant will attend a "huddle" with the PAC RMO and midwife to discuss the day's booked appointments

The PAC has a comprehensive series of care pathways tailored to the above common presentations. These care pathways are designed to streamline management of PAC patients. All documentation is to be made on these pathways, negating the need for progress note documentation. Additional documentation or admissions should still be recorded on progress notes.

The midwife will undertake the initial review, normally including a history of presenting complaint, examination and a set of observations. The midwives will manage the patient without RMO involvement if the patient presents with

- early labour/SROM at term or
- a low risk pregnancy

RMO (and Registrar) involvement is then required to finalise an appropriate management plan if the patient presents with

- an acute medical presenting complaint,
- a complex antenatal history
- a high-risk pregnancy (including pre-term)
- a GP referral or
- a history of recurrent presentations for the same complaint

PAC can be a busy place and patient flow is important. Team work, communication and appreciating length of stay are important factors to maintain appropriate patient flow. **The goal for PAC length of stay is two hours.**

- As soon as the need for obstetric review has been identified following midwifery assessment, the RMO will be asked to review and discuss the plan with the PAC Reg (6609) or the 6611 Reg
- At 30 minutes without 6609 or 6611 On Call Registrar advice or review or if clinically urgent, contact 6610 BS Registrar for management advice and review
- At one hour without Registrar review, contact 6612 BS On Call Consultant for management advice and review

EDUCATION

There are numerous structured and informal opportunities to learn during your time in O&G.

- Non-mandatory Morning Education Session Monday to Friday mornings at 0730-0750 in Rm 5.1 (Behind the level 5 Café). Please sign the attendance sheet for your RMO CPD record
- RMO Education Tuesday 1230 – 1330 – protected teaching time
- O&G resident Education Thursday lunchtime 1230-1315 (in room 5.3). Please sign attendance sheet for MEU's record

You have free access to the K2 CTG learning package which is accessible via 'clinical resources' on the intranet and all RMOs are encouraged to work through this package during your time with us.

- Fortnightly O & G Department Friday afternoon education session which the residents are welcome to attend.
- SimTEACH sessions – once a month for the Gynae Senior RMO. This is the opportunity to practice your laparoscopic skills in the simulation centre.

SUPERVISION

Supervisors

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.

After Hours Supervision

Area	Who to contact	Pager #
Birth suite	Birth suite registrar	6610
PAC	PAC registrar	6609
Inpatient	6611 registrar	6611

Both registrars busy	On Call Consultant	6612

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.

Escalation Policy

Support escalation policy:

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

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

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

UNIT POLICIES & PROCEDURES

Sick Leave

- In hours (Mon – Fri)
- Call Judy Edy, Executive Support on 07 3163 1594, available from 0730 – 1600 Mon- Fri
- Judy Edy will then communicate to your team
- Outside of hours, please communicate with the BS Registrar (07 3163 6610)

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

Injured/Sick 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

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. These are updated periodically and therefore it is wise to review the relevant document online rather than printing it off for future use. A shortcut to commonly used protocols can be found on the departmental home page under Policies, Procedures and Guidelines.

UNIT ROSTER & TIMETABLES

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

Hours

RMO hours are as per the roster templates which on the O & G intranet. The best way to read the roster is to look down each day column, find your name and then look to see what rostered role has been allocated to you. NB: Team RMOs are rostered Monday to Friday regardless of whether your name is allocated to a specific rostered role. It is your responsibility to regularly check the roster for updates on the intranet. If you have any queries about the roster please contact Judy Edy, Executive Support (x1594).

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

There may be some slight variation in your rostered hours from fortnight to fortnight (some weeks slightly less than or more than 76 hours) which is where ADO Flex comes in. If you work more than 76 hours, and these are rostered hours, these will get added to your ADO Flex balance. Fortnights where you work less than 76 hours, you will get paid your full salary, drawing down on your ADO Flex balance. Your ADO Flex Balance should never exceed the equivalent of 6 days' work. When you finish your rotation with the O&G department, you should leave with the same number of hours you started with – you may be given ADOs to facilitate this. Overtime hours worked due to last minute requests (e.g. a colleague off sick) will get paid as overtime.

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, the Birth Suite RMOs as well as the General SRMOs will cover weekend activities. Roles, responsibilities, timetables and information on supervision for these activities are listed under the relevant sections above.

Public and Private Caesarean Sections

After hours, private obstetricians may request assistance for emergency Caesareans sections. The 6611 registrar should be contacted first but they may delegate to the BS or PAC RMO. All requests for assisting private caesarean delivery must be approved by your registrar or consultant. If there are public clinical patients requiring your attention these should take priority. Please ask your registrar or consultant to speak to the private obstetrician in the event there is a conflict between private and public responsibilities. If you do attend OT to assist with a private caesarean please inform the Team leader of BS/PAC.

Please note that during your rostered shifts you are remunerated for the clinical work you undertake, and this includes assisting for urgent unplanned private emergency CS. Whilst you are employed to work 'publically', Mater Health Services does indemnify you for this 'private' unplanned/emergency activity. You are however not permitted to receive an additional payment for this activity because:

a) Private income is not a provision of the Medical Officer agreement for junior doctors;

b) You are already being remunerated for this activity which is occurring during your rostered shift; and

c) receiving a specific income implies you have entered into a private agreement with the woman and/or her private specialist, an activity for which you are neither indemnified nor credentialed

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.

Team A, B and C RMOs and Gynae SRMO

- Check your rostered ordinary hours, this column must total 76 hours per fortnight
- Use the 24 hour clock
- A regular week day shift from 0750 to 1620 is 8 hrs of rostered ordinary as 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 hrs/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 O&G 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 O&G Team and Gynae RMOs should finish at 1620 each day. Often you will need to attend to some tasks on the ward prior to going home, so you may need to ask to leave your clinical activity (theatre or clinic) early. Please discuss with your registrar as soon as possible in the afternoon.

The Postnatal RMOs should finish at 1730 each weekday and 1900 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, you may choose to stay back to watch or assist in complex surgery, to follow a woman's care in labour 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
- When working on a rolling roster, there are sometimes alternating heavier and lighter fortnights

- Additional hours are banked and then repaid to ensure you always receive at least 76 hrs pay (ADO Flex)
- You will always be paid penalties
- If staying beyond rostered hours to conduct additional work, please ask your consultant. If your consultant is not available please contact Dr Paul Bretz (Director) via switch, for approval.
- 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 AND FEEDBACK

Assessment

It is the responsibility of the RMOs to seek a mid-term and end-of-term assessment with their term supervisor. If you're experiencing difficulty with any aspect of the term, clinical or otherwise, please contact the term supervisor and/or medical education, early. The MEU will send out a reminder email with instructions to all RMOs one week prior to all due dates. 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/

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.

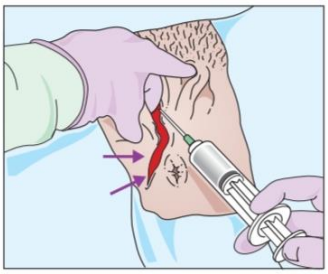
Commonly Prescribed Medications in Birth Suite

- 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.

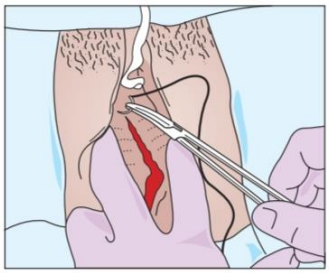
        - Paracetamol 1g QID
        - Ibuprofen 400mg TDS for 3 days
    - Endone/ Codeine PRN (rarely required)
    - Stool softener of choice (lactulose, movicol, Coloxyl) PRN
- Antibiotics for PPROM>18 hrs, GBS positive or preterm labourers
    - See Policy **"Group B streptococcal disease—antenatal and 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

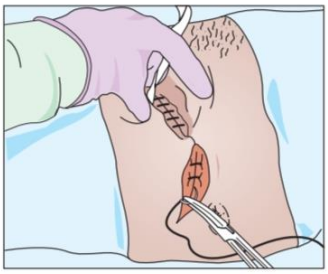
Repair of uncomplicated perineal tears and episiotomies is a skill that should be learnt during the term. Midwives may do this for their women, but you will be asked to do this for women where the midwife is not competent or has other clinical tasks which take priority. Ask to be supervised by the registrar 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**



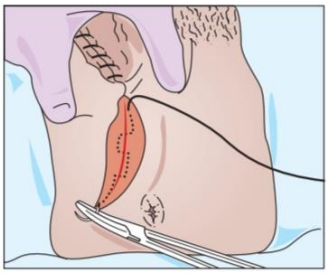
1 Swab the vulva towards the perineum. Infiltrate with 1% lidocaine (→arrows).



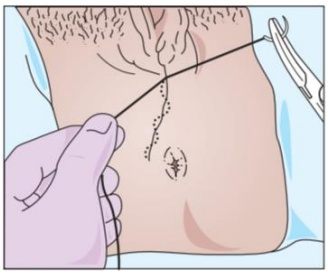
2 Place tampon with attached tape in upper vagina. Insert 1st suture above apex of vaginal cut (not too deep as underlying rectal mucosa nearby).



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: M8

Important contacts

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

Post-natal 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, If there is any question as to why a patient is for O&G review, discuss with the TL.

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 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 Post-Natal 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

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 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 team Registrar.

Post-natal medications

It is best to discuss all medication questions with your registrar, 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 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"**

- 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 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

Uncomplicated women who have had an SVD with no antenatal or intrapartum issues are suitable for midwifery led care and discharge. Discuss with the M8 team leader if you have and questions or concerns.

Brief Guide to discharge checklist

- Ensure Full Postnatal check performed as per care pathway
  - If anaemic
    - Hb 90-110 – prescribe FGF / Vit C once daily.
    - Hb <90 - Consider Ferrinject
    - if Hb <70g - Consider transfusion (see policy and discuss with Registrar)
  - If Rhesus negative, check baby's blood group (within 24 hours)
    - If cord blood positive, consent for Anti-D (625IU) and Kleihauer. Kleihauer will determine whether more Anti-D is required
    - If cord blood negative, no action required
  - If non-immune to Rubella, MMR recommended with whooping cough vaccination via GP
  - If mother is Hep B positive, ensure that baby receives Hep B IgG at MMH

- If mother found to be GBS positive and she wasn't given IV antibiotics in labour, please notify the neonatal registrar due to the risk of delayed onset GBS sepsis
- If 3rd/4th degree tear
    - not discharged until bowel opens.
    - oral antibiotics for 5 days
    - aperients for 10 days post repair (Lactulose, Movicol and Coloxyl are all appropriate choices)
    - Follow up with Physio +/- postnatal clinic at 12 weeks
- Cervical screening test
    - If due, with GP at 6 weeks post-partum
    - If abnormal, needs follow up in colposcopy Clinic (speak to Registrar)

- Discuss need for contraception and options available to them but that we can't prescribe or administer at MMH. GP to discuss further and prescribe.
- Discuss need for pertussis vaccination with the GP for the mother (if not received that pregnancy) and for close family members. MMR also to be obtained from GP if rubella non immune.
- Baby check if required (if you are not a Family Doctor trained to do a neonatal discharge, and there is no Family Doctor available, please call the Neonatal Registrar to do their discharge)
    - Follow check list in Health Record
    - Heel prick Day 3 (Home midwives if discharge earlier)
    - Check with Neonatology registrar if concerns
- Follow Up
    - 1 week baby check with GP
    - 6 week postnatal and baby check with GP
- Ensure education completed as per care pathway particularly giving advice and point of contact if unwell (PAC or GP)
    - blood loss
    - signs of infection (endometritis, mastitis, wound infection)
    - signs of a DVT
    - post-natal depression
- Ensure care pathway outcomes are signed off and Transfer to Midwifery care completed
- Place a white magnet on Journey board to indicate patient transfer to midwifery care.
- See Postnatal Discharge VOLT for a comprehensive guide to performing a postnatal discharge check.