mater education

RMO NEONATALOGY HANDBOOK

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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 or http://mededu.matereducation.qld.edu.au/handbooks/
Please refer to Mater Policy and Procedures Library for specific organisational policies and procedures.

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)	Ph. 8229
Prevocational Medical Education Officer (PVMEO)	Ph. 8431
Vocational Training Medical Education Officer (VTMEO)	Ph.1560
Medical Education Admin Officer	Ph. 8272
Medical Education Manager	Ph. 8114

INTRODUCTION

Division of Neonatology - Mater Mothers' Hospital

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).

The Division of Neonatology has close links with the Division of Obstetrics and Gynaecology (including the Maternal Fetal Medicine Unit) in providing comprehensive perinatal care.

From 2011, there have been interns (1-2) attached to Neonatology MMH. In 2015 residents have also joined our team. Interns will rotate every 5 weeks. Residents will rotate every 5-10 weeks or be involved in our 6 month rotation.

Model of Care and Case Mix

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 another RMO. For the resident on the 6 month rotation, our aim is to have you spending time in the Intensive Care Nursery as well.

The public postnatal floor has a turnover of 20-50% per day, there may be up to 20 families per day that our neonatal team need to see. The case mix consists of babies who require antibiotics, phototherapy, have congenital anomalies/abnormal antenatal scans, require follow up secondary to maternal illness/family history, small for gestation age/late preterm, or babies who may have neonatal abstinence syndrome (NAS).

The RMO allocated to the Special Care Nursery (SCN) completes ward rounds daily (Mon-Fri) with the consultant 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).

WHO DO I CONTACT PRIOR TO COMMENCING MY ROTATION?

Term Supervisor - Dr Maureen Dingwall (Maureen.Dingwall@mater.org.au)

An email from Dr Dingwall to you should occur prior to your rotation. This will include up to date information about your first day/week and what Tamika/Julia(secretaries) requires from you prior to commencing (contact email address, phone details).

You will be advised if another supervisor is covering Dr Dingwall.

Neonatal Secretary – Tamika Collins (Tamika.Collins@mater.org.au) and Julia Bosse (Julia.Bosse@mater.org.au) ext 8441

RMO roster -- Your roster is within our junior doctors/neonatal nurse practitioners' roster. It will be emailed to your Mater email address by our secretaries. See below under ROSTER for more information.

UNIT LEARNING OBJECTIVES

Learning Objectives

Interns work as part of a team involved with the assessment and management of babies. Primary responsibilities include patient care under supervision of registrars and consultants.

RMOs will have the opportunity to acquire greater decision making and problem-solving skills, refining their abilities to prioritize, participate in meaningful handovers, and provide high quality and safe patient care.

Throughout your time with us we hope you have gained/become more experienced in:

1. Dealing with a broad range of neonatal problems, medical & surgical, acute & non-acute, common & not so common;
2. Recognising a sick baby;
3. Clinical assessment of well babies by taking a good history (including Maternal history), performing a good examination including assessing growth, reviewing to see if our screening procedures have occurred;
4. Management of well and sick babies;
5. Being aware of the importance of infection control in a neonatal unit and education of parents with a newborn baby;
6. Dealing with parents or caregivers and ensuring that they are aware of their local community support;
7. Working as part of a multidisciplinary team;
8. The importance of infection control in a neonatal unit and education of parents with a newborn baby; and
9. Neonatal resuscitation through Neonatal Basic Life Support and if space permitted at our Advanced Neonatal Resuscitation course and/or via attendance at deliveries/neonatal code blue calls.

Opportunities may arise where you can attend birth of babies with Registrars. The department encourages you to attend

Medical BA Learning Objectives applied to Neonatology

Expected Opportunities	Examples	Log by End of Term
The intern as scientist and scholar Opportunities to apply, consolidate and expand clinical knowledge and skills while taking increasing responsibility for providing safe, high-quality patient care.	• Develop skills in taking a history and performing an 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 • Develop communication skills with parents and the team • Develop excellent time management skills and proactivity as a mindset;	
The 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.	• 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.	
The intern 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	
The Intern 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	

RMO Individual Learning Objectives

Your supervisor will discuss and develop learning objectives with you at your face-to-face orientation and evaluate progress towards them at mid- and end-of-term assessment. These individual learning objectives are to be documented on the *Start-of-Term Checklist* before submission.

INTERN/RESIDENT DUTIES & RESPONSIBILITIES

Scope of Practice

Primary care of the patient is undertaken by the intern and resident, under the guidance and assistance of the Term Supervisor or Clinical Supervisor who is either a Registrar or a Consultant. A close working relationship with the nursing, administration and allied health staff is to be established.

All procedures are to be completed under supervision until assessed.

All skills (i.e., Newborn Examination) are to be completed under supervision until assessed.

Postnatal floor duties:

1. Attendance at the 8am Medical Huddle - Location: 6.1 (level 6 MMH)
2. Attendance at the postnatal multidisciplinary meeting at the journey board (8th floor) every day at 8.30 am, level 8, MMH
3. Review of all babies who are highlighted on the journey board that are requiring medial review/assessment (neonatal examination) and documentation into the medial records + baby's Personal Health Record (Red Book) re outcome.
4. 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.
5. Updating the journey board so staff are aware of current status.
6. All newborns under 37 weeks gestational age and/or less than 2500g are to be discussed with the Postnatal Floors Registrar prior to discharge
7. If there are concerns after reviewing babies on the postnatal floor discussion to occur with the Postnatal floor Registrar /Neonatal Fellow or SCN SMO
8. All babies requiring follow up by another specialty/to be seen in an outpatient clinic are to be discussed with the SCN SMO
9. Babies transferred to the postnatal floor from NCCU:
    - Handover for the NCCU team should have occurred and a transfer letter if they meet the criteria

- See 'Babies on Board' below re criteria for transfer letter.
- If this has not occurred please liaise with the Neonatal Team that they came from.

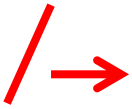
POSTNATAL FLOOR MMH8 JOURNEY BOARD MADE EASY

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

SPECIAL CARE UNIT

- 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;
    - 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.
    - All rounds are conducted as teaching 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 (excluding the first day of your rotation).
    - 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 examinations/reviews for all babies unless they are planning on being discharged or transferred that week. This includes updating our Babies on Board (BOB) database, especially the transfer/discharge section.
- 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.

Preterm/Medical or Cardiac/Surgical Intensive Care Nurseries (ICNs)

- Attendance at the 8am Medical Huddle - Location: 6.1 (level 6 MMH)
- If you have spent time with us before or been in another SCN you may also spend time in our 2 ICN areas. Both areas are well supported by nursing, consultant, fellow and registrars and would be a great way to learn about the different respiratory supports that we have, as well as attending deliveries with our registrars/fellows.
- Involvement with the multidiscipline Ward Round Teams. Lists of these babies can be printed from babies on Board (BOB) database. We have 2 ICN medical and nursing teams. Both have the same routine in the morning:
    - 8 am – Handover from the night staff
    - Ward round starts after handover (8.30 am)
- Same information as in SCN section applies, as well as reviewing the respiratory support and parental nutrition if the baby is requiring this.

- In the ICN areas. day and night summaries are completed in the progress notes and making sure that the BOB database is kept up to date so when the baby is transferred to SCN/Postnatal floors/local hospital or home the transfer/discharge letter is not time consuming.

Discharging Patients:

- 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.

- Liaising with patient carers and family members;
- Check adequate arrangements for care at home;
- Organise discharge medications;
- Organise appropriate follow-up;
- Complete discharge summary for babies prior to their discharged from our unit - see Babies On Board (BOB) Database Discharge Letters below for more information.

BIRTH SUITE/THEATRE

The RMO can attend deliveries with the Labour Ward (LW) MO.

SUPERVISION

Reporting Lines + Escalation of Care/Concerns:

- First contact person is the Registrar you are rostered with (in SCN this will be the consultant)
- If the Registrar is unavailable, contact the Fellow - ph 77131
- If both the Registrar and Fellow are unavailable, contact the SCN/ICN Consultant (depending on where you are rostered).

Any you have any concerns (especially if relating to staff/family behaviour or involvement in a neonatal code blue) that are not sorted out by the SCN consultant please contact your Term Supervisor.

UNIT ORIENTATION

Orientation Location and Time

Orientation will take place at 7.30 am in the NCCU registrar room, level 6, MMH (next to room 6.1).

Orientation begins early so that the majority can occur prior to the 8 am Medical Meeting/Handover in 6.1. If you are rostered to the postnatal floors the multidisciplinary meeting occurs at 8.30 am and you will be shown this as part of your orientation.

Unit Orientation Meeting

The Term Supervisor, Dr Maureen Dingwall, will conduct a face to face unit orientation with all RMOs. If Dr Dingwall is unavailable, a Fellow or SCN Consultant will provide the orientation.

The following areas will be covered:

- Daily roster
- Term roster (your hours each day) and how to access it
- Unit policies and procedures
- Babies on Board (BOB) database and Verdi
- Term learning objectives
- Discussion and documentation of your individual learning objectives for the term
- assessment
- Handover with the previous RMO
- How daily clinical handover is conducted and
- Miscellaneous - tour of the department, introductions to staff, location of resus trolley etc.
- Start of Term Checklist

Start of Term Checklist

All RMOs complete the Start of Term Orientation Checklist with their Term Supervisors within the first week of a new term. The checklist is completed online and the link is available on the Medical Education Unit website (http://mededu.matereducation.qld.edu.au/cpd-requirements/all-forms/).

Where will I be rostered to?

SCN or Postnatal Floors. Mon-Fri 8 am – 4pm

ICN areas if you have had experience in SCN

Who will I be roster with?

You will have a Registrar/Resident with you. Their contact numbers are:

SCN Resident	ph 77128
Postnatal floors Registrar/SHO (QCH)	ph 2214
Prem/Medical ICN Registrar	ph 77127

Card/Surg ICN Registrar ph 77126

SCN Consultant - covers both SCN and the postnatal floors.

Their contact number: see consultant roster for their cell phone (also applies to the ICN consultants)

POLICIES AND PROCEDURES

All Mater policies, procedures and forms are located electronically on the intranet in Mater Policy and Procedures Library. This resource is continually being updated and will contain the most up to date management of a wide range of neonatal conditions. If you identify one that you are aware of more recent evidence please let us know, and become involved in our ongoing improvement of our service.

The following are relating to commonly seen issues in Neonatology:

- Examination, assessment and discharge of newborn babies - Document ID MPPL-04169
- Jaundice and phototherapy for newborn babies - Document ID MPPL-04016
- Hypoglycaemia management for newborn babies - Document ID MPPL-04073
- Temperature management of newborn babies - Document ID MPPL-02553
- Developmental Dysplasia of Hip in newborn babies - Document ID MPPL-04394
- Cerebral ultrasound of the newborn baby- Document ID MPPL-02549
- Conjunctivitis and sticky eyes in babies - Document ID MPPL-02524
- Hydration status of well newborn babies - assessment and management - Document ID MPPL-03381
- Iron and vitamin supplements for babies - Document ID MPPL-03338
- Subgaleal Haemorrhage - assessment and management of babies Document ID MPPL-04198
- Hypoxic Ischemic Encephalopathy (HIE) Trigger Tool - Document ID - MPPL-00895
- PIVC insertion and Blood Sampling for babies - Document ID PR-CLN-800075
- Code Blue neonate- Document ID MPPL-03584
- Neonatal outpatient clinics for post-discharge care procedure- Document ID MPPL-03432
- Congenital renal anomalies of the kidney and urinary tract - Document ID MPPL - 02994
- Pregnancy and Newborn care
    - Hepatitis B positive - Document ID MPPL-03189
    - Hepatits C - Document ID MPPL-02572
    - HIV - Document ID MPPL-02882
    - Syphilis infection - Document ID MPPL-03298
    - Herpes simplex virus - Document ID MPPL-03203
    - Thyroid disease - Document ID MPPL-02491

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 the Medical Education Unit, early. The MEU will send out a reminder email with instructions to all RMOs one week prior to all due dates. The assessment forms 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.

BABIES ON BOARD (BOB) DATABASE: DISCHARGE LETTER

Discharge Letter 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 letter 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 letter on leaving the hospital.

Babies transferring to the postnatal floor require a transfer letter if they meet the criteria:

- Requiring respiratory support
- >24 hours in NCCU (excluding border babies that are on all suck feeds)
- Requiring iv fluids
- Having significant investigations

- HIE Trigger Tool
- Subgaleal haemorrhage Tool

The transfer/discharge letter includes:

- Active Problems + relevant Past Problems
- Dates of admission and transfer/discharge
- Discharge Weight, Head Circumference & Length must be included.
    - The weight obtained just prior to rooming in requires 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
- Outstanding/Outpatient Investigation
- Follow up (including if referrals have been made (or not)

Print 3 copies 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.

Babies discharged to foster care or adoption.

Two versions **of the discharge summary** are **need to be produced**;

- First version is for the Department of Child Safety and Maternal GP that can contain any relevant clinical and Maternal details, and then
- Second version is for the adoptive or foster parents and their GP with the following completed to ensure **maternal privacy**:
    - The mother's name and date of birth removed (if CPU Team is able to change this in iPM)
    - Baby's address has been changed to Dept of Child Safety by our CPU/Admin
    - Clarifying who their GP will be and amending this (initial transfer, of GP details, into Babies on Board (BOB) would be of the Mother's)
    - The whole section on maternal problems, especially including the maternal drug history and serology.

Details of care and follow-up investigations are still required, e.g. "xxx had neonatal abstinence syndrome and is discharged on phenobarbitone x mg twice daily" or "xxx needs follow-up testing as follows for risk of hepatitis C exposure…..".

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.

PERSONAL PROPERTY

Please be warned that personal items go missing very regularly at the Mater. It is strongly recommended that you lock away your bag at all times. The registrar room does have a lock and the combination is **1965** if the door if closed.

STAFF TEA ROOM

A staff tea room is located on the 6th floor back corridor. Fridges, microwaves, toasters and tea/coffee/milk are provided for your use. Swipe card access is required to enter this room. There are no tea room fairies to facilitate cleaning.

UNIT EDUCATION & TRAINING OPPOTUNITIES

When	Time	What	Where
MONDAY	8 am	Brief (5min) Medical Huddle (night and day staff)	6.1 MMH
	8.30 am – 9 am	Neonatal Radiology Review	6.1 MMH
	8 am – 3 pm	Growth & Development Clinic	L 4 Salmon Building
	12.30 pm-1.30 pm	Perinatal Mortality Meeting	5.3 MMH
TUESDAY	8 am	Brief (5min) Medical Huddle (night and day staff)	6.1 MMH
	8 am - 12 noon	Growth & Development Clinic	L 4 Salmon Building
	8.30 am	Prem/Med ICN Multidisciplinary Team Meeting	6.1 MMH
	12.30 pm–1.30 pm	RMO Education – Protected Teaching Time	L4 Duncombe Building
	1.30 pm - 3.30 pm	MFM Clinic	L7 MMH
	2.30 pm - 3 pm	SCN Psychosocial/Discharge Planning Meeting	Quite Room L6 MMH
WEDNESDAY	8 am	Brief (5min) Medical Huddle (night and day staff)	6.1 MMH
	8 am – 12 noon	Neonatal Babies Clinic	L 4 Salmon Building
	8.30 am – 9 am	Neonatal Radiology Review	6.1 MMH
	9 am	Retinopathy Of Prematurity Clinic	L 4 Salmon Building
	2 pm – 4 pm	Neonatal Teaching & Journal Club (to include monthly Grand Rounds Session)	6.1 MMH
THURSDAY	8 am	Brief (5min) Medical Huddle (night and day staff)	6.1 MMH
	8.30 am	Cardiac/Surg ICN Multidisciplinary Team Meeting	6.1 MMH
	12.30 pm – 1.30 pm	RMO Education – Protected Teaching Time	L4 Duncombe Building
	2 pm – 4 pm	Monthly Joint NCCU/Surgical Teaching (1st Thursday of the month)	6.1 MMH
FRIDAY	8 am	Brief (5min) Medical Huddle (night and day staff)	6.1 MMH
	8.30 am – 9 am	Neonatal Radiology Review	6.1 MMH
	12.30 pm – 1.30 pm	PIP (Interns only) – Protected Teaching Time	MMSS
	12.30 pm - 1.30 pm (monthly)	Campus wide grand rounds	Des O'Callaghan
	1.15 pm – 2 pm	MFM Meeting	5.1 MMH

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

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
MMSS	Mater Medical Study Space, Level 4, Duncombe Building
NCCU	Neonatal Critical Care Unit

Perinatal Mortality meeting

Reviews the case -histories of stillbirths and neonatal deaths and can be a worthwhile discussion of obstetric and neonatal management.

MFM Meeting

Reviews the ultrasounds and case -histories of all currently diagnosed fetal abnormalities. This can be a worthwhile meeting to discuss the implications of ultrasound findings, and discuss prognosis and management of antenatal diagnosed fetal abnormality. (It's also useful to know what problems are coming up!)

Neonatal Teaching

The topics and format will vary according to the domain and subject matter. However, four major domains will account for most of the sessions.

1. **Clinical Teaching**

   This will involve presentations from staff of the department, as well as other subspecialty areas, relevant to the clinical practice of neonatal and perinatal medicine. For example, there may be presentations on genetics, paediatric respiratory medicine etc and the topics will be dependent on availability of speakers.

2. **Professional Qualities Curriculum**

   This involves subject matter and themes as outlined in the handbook of the R.A.C.P. Briefly, the PQC "outlines the broad concepts, related learning objectives and the associated theoretical knowledge, clinical skills, attitudes and behaviours" which are required by a Paediatrician, regardless of specialty area. The topics that will be presented will include communication, ethics, quality and safety, and cultural competency.

3. **Journal Club**

   The journal club component of the teaching program will involve the presentation of recent or clinically relevant medical literature. The emphasis will be upon appropriate literature searching, critical appraisal skills, and clinical relevance and applicability.

4. **Case Presentations**

   As well as the presentation of instructive cases, this will also be an opportunity for trainees to present research plans or results. We may also take the opportunity to undertake morbidity review and clinical audits that can be presented in this session.

The consultant staff will provide protection of the time for the teaching, and attendance will be expected from all rostered staff. There are many other teaching opportunities available on the Mater campus. The MMRI Research Support Centre offers teaching in evidence-based practice, critical appraisal and statistical methods.

Simulations

In 2014, MMH NCCU started a multidisciplinary in-situ simulation program. This is coordinated by the Neonatal Simulation Fellow and the Neonatal Practice Development team. During your term you may become involved with these simulation sessions and debriefing following this. The times/days are random but often occur around the Neonatal Teaching times.

Neonatal Resuscitation

Basic Life Support

All junior doctors rotating to Neonates are to complete the 'Basic Life Support – Neonatology' eLearning on LEAP. Following completion of this online module, junior doctors are to request a face to face assessment, which can occur in the neonatal unit with a facilitator at any time.

Advanced Life Support

MMH Neonatology runs full day neonatal resuscitation course which may occur, depending on the available of space as priority goes to the Registrars and Fellows as they hold the labour ward phone.

Our secretary organises all of the bookings and will email you if a spot is available during your time with us.

The multidisciplinary course comprises of online education and multiple-choice questions prior to the workshop, short slide presentations, video clips and practical workstations/scenarios on the day of the workshop and multiple-choice questions post the workshop.

Newborn Examinations: 'Examination of the Well Newborn' on LEAP

'Examination of the Well Newborn' program on LEAP is for midwives to obtain competency in performing the full newborn examination and able to discharge babies without needing medical assistance. The online module is now available to all medical staff. Feedback from previous Interns/JHOs has been that they have found this useful. Please feel free to look up 'Examination of the Well Newborn' in LEAP.

ROSTERS

Rosters

Roster will be emailed to your Mater email address. The roster can also be seen via Yammer (NCCU Registrar, fellow, NNP Roster)

Any requested changes to the roster - please email our generic address (NCCUmedicalroster@mater.org.au)and include your supervisor as well so they are aware if you have PDL or existing appointments. We are very flexible at changing the length of time at work if required.

Both junior doctors and consultant rosters are shift based and are also available on the Neonatal SharePoint site (Intranet - Departments - Neonatology - Left hand column under Documents contains Medical Rosters). It is also an excellent source of contact details (consultants cell phone number for direct contact rather than via switch). The advantage of a shift system is that, while you should make every effort to complete your workload by the end of your shift, any uncompleted work should be handed over to the next Registrar.

All breaks are the RMOs responsibility to organise.

We expect you to keep to your rostered hours and not stay on to complete unfinished work as overtime is extremely expensive and unnecessary with a shift system. Generally, unrostered overtime will not be paid. On rare occasions, it may be appropriate to stay behind as an extra pair of hands. In such a case, please contact the consultant in charge to explain the situation and obtain his/her permission.

In the majority of cases something can be arranged to ensure you are able to take your break and leave work on time.

Please also note that the consultants are happy for there to be some "give & take" with hours. If you require being late /leaving early because of a reason we can organise 'make up' of the hours after discussion with the consultant you will be rostered with.

SICK LEAVE

In the event of unplanned sick leave please ensure the following staff are aware:

- Call the on call Neonatal consultant before 8am (via switch if you do not have their contact number)
- Email Tamika Collins (Tamika.Collins@mater.org.au), Olivia Paton (Olivia.Paton@mater.org.au) and the MEU 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

HANDOVER

1. Postnatal Floors – to your Postnatal floor RMO as they will be on a 12 hour shift.
2. SCN - hand over babies of concern/ pending results or ceasing antibiotics to Card/Surg Registrar (ph 77126)
3. Prem/medical or Cardiac/Surg ICNs – hand over all babies to the Registrar or Fellow rostered on for the 12 hour shift
4. At end of rotation – to the incoming intern/JHO