

## TERM DESCRIPTION

Term descriptions are designed to provide important information to prevocational junior medical officers (JMOs) regarding a particular rotation. They are best regarded as a clinical job description and should contain information regarding the:

- Casemix and workload,
- Roles & Responsibilities,
- Supervision arrangements,
- Contact Details,
- Weekly timetable, and
- Learning objectives.

The term description may be supplemented by additional information such as Clinical Protocols which are term specific. Term supervisors should have considerable input into the content of the term description and they are responsible for approving the content. In determining learning objectives, supervisors should refer to the Australian Curriculum Framework for Junior Doctors (ACFJD). The term description is a crucial component of orientation to the term, however it should also be referred to during the mid-term appraisal and end-of-term assessment processes with the JMO.

<b>FACILITY: The Canberra Hospital</b> <b>UPDATED: August 2019</b>	
<b>TERM NAME: Orthopaedic Surgery with Orthopaedic Geriatrics</b>	
<b>TERM SUPERVISOR: A/Prof Alex Fisher and Dr Igor Policinski</b>	
<b>CLINICAL TEAM:</b> <i>Include <b>contact details</b> of all relevant team members</i>	VMO Position: Prof Paul Smith – Pelvis and lower limb Dr Bryan Ashman – Fracture clinics Dr Sindy Vrancic – Upper limb Dr Chris Roberts – Upper limb Dr Damian Smith – Lower limb Dr Alexander Burns – Lower limb Dr Joe Lau – Lower limb Dr Joseph Smith – Shoulder and Lower limb Dr Gawel Kulisiewicz – Lower limb Dr Phil Aubin – Lower limb Dr Nicholas Tsai – Spine and general Dr Michael Gross – Lower limb Dr Igor Policinski – Upper limb  A/Prof Alex Fisher Dr Anil Paramadhathil (Alternative supervisor)

ACCREDITED TERM FOR :	<table><tr><td></td><td>Number</td><td>Core/Elective</td><td>Duration</td></tr><tr><td>PGY1</td><td>0</td><td></td><td></td></tr><tr><td>PGY2+</td><td>3</td><td>Non-Core</td><td>12 – 14 weeks</td></tr></table>		Number	Core/Elective	Duration	PGY1	0			PGY2+	3	Non-Core	12 – 14 weeks
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PGY2+	3	Non-Core	12 – 14 weeks										
OVERVIEW OF UNIT OR SERVICE  <i>Include outline of the role of the unit, range of clinical services provided, case mix etc.</i>	<p>There will be x3 PGY2s allocated to the Orthopaedic Surgery with Orthopaedic Geriatrics Term. At any one time, there will be x1 PGY2 rotating in the Ortho-Geriatrics term, and the other x2 PGY2s will be rotating through the Orthopaedic Surgery Term.</p> <p>Please refer to the Orthopaedic Surgery Term Description for start times, ward rounds, JMO tasks and responsibilities with regards to the x2 PGY2s rotating in this Unit.</p> <p>Please refer to the Orthopaedic Geriatrics Term Description for details pertaining to the Ortho-Geriatric x1 PGY2 component of this rotation:</p> <ul style="list-style-type: none"><li>• <b><u>Orthopaedic Surgery:</u></b></li><li>• To provide inpatient and outpatient care for traumatic and elective orthopaedic conditions</li><li>• To conduct clinical research on orthopaedic conditions</li><li>• To teach and train post-graduate surgical trainees, resident medical staff, medical students, nurses and allied health professionals in orthopaedic conditions</li><li>• The unit is one of the busiest in the hospital with 50-60 inpatients and daily outpatient clinics and operating lists</li></ul> <ul style="list-style-type: none"><li>• <b><u>Orthopaedic Geriatrics:</u></b></li><li>• To provide inpatient and outpatient management care for hip fractures pertaining to the geriatric community.</li><li>• To conduct clinical research on ortho-geriatric conditions</li><li>• To teach and train post-graduate surgical trainees, resident medical staff, medical students, nurses and allied health professionals in ortho-geriatric conditions and complications.</li><li>• The orthopaedic unit is one of the busiest in the hospital with 50-60 inpatients and daily outpatient clinics and operating lists. The ortho-geriatric component makes up a substantial proportion of patients with their own specific needs.</li><li>• The Fracture and Falls Prevention Clinic offers comprehensive assessment with targeted interventions to patients with unexplained recurrent falls or those who have suffered a fall injury and focuses on secondary prevention of osteoporotic fractures.</li></ul>												
REQUIREMENTS FOR COMMENCING THE TERM:  <i>Identify the knowledge or skills required by the JMO before commencing the term and how the term supervisor will determine competency</i>	Basic Clinical Training General Registration PGY2 level and above.												
ORIENTATION:  <i>Include detail regarding the arrangements for Orientation to the term, including who is responsible for providing the term orientation and any additional resource documents such as clinical policies and guidelines</i>	<p>Term orientation by the term supervisors and registrars during the first two days. Checklist for assessment and management of ortho-geriatric patients will be discussed (refer to <i>Checklist for Ortho-geriatric Patients</i>).</p> <p>JMO to arrange for meeting with Dr. Policinski’s PA. Prof. Fisher will also lead face-to-face orientation at the start of term.</p>												

<p><i>required as reference material for the JMO.</i></p>	
<p><b>JMOs CLINICAL RESPONSIBILITIES AND TASKS:</b></p> <p><i>List routine duties and responsibilities including clinical handover</i></p>	<p><b><u>Unit Patients</u></b></p> <p><b><u>Orthopaedic Surgery:</u></b></p> <p>Under the supervision of the orthopaedic registrars, the JMO is responsible for the day-to-day management of the patients under their team. All patients under their care should be seen daily, usually with the team registrars. Medical students on rotation to the Unit should be encouraged to participate in the daily routine.</p> <p>Currently the consultants are divided into four teams in the orthopaedic unit with each team having a SET accredited registrar, a pre-SET unaccredited registrar and a JMO. The JMO will spend most of the term with one 'home' team but will rotate to other teams according to the roster.</p> <p>Between the teams the ward work and outpatient/operating sessions should be rotated between the JMOs to ensure everyone has an opportunity to get to clinics and surgical procedures.</p> <p>A medical case notes ward round is conducted each day by the ortho-geriatric team.</p> <p><b><u>Ward Rounds</u></b></p> <p>Consultant ward rounds are variable and usually occur either before or after theatre. Both VMOs and registrars will be encouraged to ensure that the JMO is involved in any individual ward rounds.</p> <p><b><u>Hours of Work</u></b></p> <p><b><u>Rostered hours of work are normally 7 am to 5pm or 12pm -10pm. JMOs work 9x10hr shifts in a fortnight period. On weekends there are two overlapping 7 hour shifts both days but these can be worked as one 14 hour shift by mutual agreement.</u></b></p> <p><b><u>Orthopaedic Geriatrics:</u></b></p> <p>Under the supervision of the ortho-geriatric registrar, the RMO is responsible for the day-to-day management of the patients under their team. All patients under their care should be seen daily, usually with the ortho-geriatric registrar and consultant. Medical students on rotation to the Unit should be encouraged to participate in the daily routine.</p> <p>Depending on the ward work demands, outpatient/operating sessions should be attended by the RMO to ensure an opportunity to get to clinics and surgical procedures of the ortho-geriatric patients.</p> <p>An Ortho-Geriatric admission is a comprehensive assessment that includes but is not limited to:</p> <ul style="list-style-type: none"> <li>• Medical and surgical history and physical examination</li> <li>• A full medication history and completion of the electronic medical reconciliation form</li> <li>• Detailed social history (education and work history, role of relevant family members, formal and informal care providers, presence of ACAT, Wills, powers of attorney or guardians)</li> <li>• Involves collateral history from family, carers and general practitioners.</li> <li>• Functional assessment pre and post op</li> <li>• Cognitive and psychological function pre and post op</li> <li>• Specific attention to continence, falls, osteoporosis</li> <li>• Perform a medication review</li> <li>• Screening blood tests which includes <u>FBC, U&amp;Es, LFTs, CRP, CK, Troponin I, B12, Folate, Iron studies, P1NP, <math>\beta</math>-CTX, Ca/Mg/PO<sub>4</sub>, 25-Hydroxy Vitamin D, PTH,</u></li> </ul>

	<p><u>Thyroid Function Test.</u></p> <ul style="list-style-type: none"> <li>• Goals of care and advanced care directives</li> <li>• Goals of admission for patient and family/carers</li> <li>• Formulation of a problem-oriented management plan</li> </ul> <p>The aim of the admission is to:</p> <ul style="list-style-type: none"> <li>• Identify and treat acute medical and surgical conditions or complications that may arise</li> <li>• Complete a comprehensive ortho-geriatric assessment</li> <li>• Optimise physical function</li> <li>• Prevent complications and functional decline</li> <li>• Formulate and action a comprehensive discharge plan</li> </ul> <p>Progress notes should be documented clearly as they are vital for:</p> <ul style="list-style-type: none"> <li>• Communication to other team members</li> <li>• Giving clear instructions to out of hours staff</li> <li>• Treating team reflection on diagnosis, investigations and progress</li> <li>• Used for medico-legal purposes</li> </ul> <p>Progress notes should detail:</p> <ul style="list-style-type: none"> <li>• Consultant and registrar ward rounds – new information gathered, issues list, examination findings, decisions made, plan for ongoing care</li> <li>• Investigation results</li> <li>• Changes in a patient's condition</li> <li>• Changes in a patient's management especially to a palliative approach</li> <li>• Discussions with patients, family members and GP</li> <li>• Issues list should be updated daily</li> <li>• Resuscitation Orders</li> </ul> <p><b><u>Hours of Work</u></b>  <b><u>Rostered hours of work are normally 7 am to 5pm or 12pm -10pm. JMOs work 9x10hr shifts in a fortnight period. On weekends there are two overlapping 7 hour shifts both days but these can be worked as one 14 hour shift by mutual agreement.</u></b></p>
<p><b>SUPERVISION:</b>  <i>Identify staff members with responsibility for JMO supervision and the mechanisms for contacting them, including after hours. Contact details</i></p>	<p><b>IN HOURS:</b></p> <p>Overall supervision is provided by the ortho-geriatric consultant A/Prof Alex Fisher and registrar, and by the orthopaedic consultant supervisor Dr Igor Policinski.</p> <p>Supporting surgical supervision is provided by the accredited and non-accredited orthopaedic registrars assigned to the individual orthopaedic teams. Medical problems are supervised by the ortho-geriatric team or specialty medical registrars.</p> <p><b>AFTER HOURS:</b></p> <p>After hours orthopaedic and medical registrar</p>
<p><b>STANDARD TERM OBJECTIVES:</b>  <i>The term supervisor should identify the knowledge, skills and experience that the JMO should expect to acquire during the term. This should include reference to the ACFJD. The term objectives should be used as a basis of the mid and end of Term assessments.</i></p>	<p><b><u>Orthopaedic Surgery:</u></b>  The JMO should strive to have undertaken the following by the end of this Term:</p> <p><b><u>Clinical</u></b></p> <ul style="list-style-type: none"> <li>• History and examination of orthopaedic patients, gaining an understanding of the clinical features of the orthopaedic conditions admitted under their care and a confidence in demonstrating the relevant physical signs</li> <li>• Assessment and management of: <ul style="list-style-type: none"> <li>○ fractures and dislocations</li> <li>○ soft tissue injuries</li> <li>○ other urgent orthopaedic conditions including infection</li> <li>○ elective orthopaedic conditions, in particular patients requiring joint</li> </ul> </li> </ul>

replacement

- Utilisation and interpretation of appropriate investigations, especially musculo-skeletal imaging
- Operating theatre experience, with an understanding of the principles of surgical exposure and wound closure
- Management of the surgical patient:
  - pre-operative:
    - pre-existing medical conditions
    - relevant investigations
    - informed consent
  - post-operative:
    - anticipation and prevention of complications, especially venous thrombosis and wound infection
    - wound care
    - pain control
- Medical problems in the surgical patient including an ability to decide on appropriate referral
- Rehabilitation including physiotherapy and allied professions

#### **Procedural**

- Venepuncture, IV cannulation, ABG, IDC insertion, joint aspiration
- Surgical assisting, knot tying, suture techniques
- Application of external casts

#### **Educational**

- Attend fracture clinics for instruction and supervision of cast application and management of ambulatory traumatic conditions
- Attend outpatient clinics for management of elective conditions
- Attend and participate in the weekly clinico-radiological review meeting
- Attend individual VMO tutorials on orthopaedic conditions

Participate in the General Clinical Training Program

#### **Orthopaedic Geriatrics:**

The JMO should strive to have undertaken the following by the end of this Term:

#### **Clinical**

- History and examination of ortho-geriatric patients, gaining an understanding of the clinical features of the ortho-geriatric conditions admitted under their care and a confidence in demonstrating the relevant physical signs
- Assessment and management of:
  - fractures and dislocations
  - soft tissue injuries
  - other urgent orthopaedic conditions including infection
- Fluid balance assessment and management in ortho-geriatric patients (refer to *Perioperative Fluid Management in Ortho-geriatric Patients Guideline*)
- Prevention of complications and optimisation of ongoing medical management with special consideration of:
  1. Pain
  2. Venous thromboembolism (in-hospital and post-discharge)
  3. Electrolyte status (hyponatraemia, potassium and magnesium abnormality)
  4. Anaemia
  5. Iron status
  6. High inflammatory response, possibly infections
  7. Delirium
  8. Infection
  9. Falls
  10. Osteoporosis

	<ol style="list-style-type: none"> <li>11. Polypharmacy</li> <li>12. Exacerbation of chronic conditions, such as CCF, COPD, diabetes</li> <li>13. Incontinence</li> <li>14. Functional assessment</li> <li>15. Wound management</li> <li>16. Prevention of pressure sores</li> </ol> <ul style="list-style-type: none"> <li>• Utilisation and interpretation of appropriate investigations, especially musculo-skeletal imaging</li> <li>• Operating theatre experience, with an understanding of the principles of surgical exposure and wound closure</li> <li>• Management of the ortho-geriatric surgical patient: <ul style="list-style-type: none"> <li>○ pre-operative: <ul style="list-style-type: none"> <li>▪ pre-existing medical conditions</li> <li>▪ relevant investigations</li> <li>▪ informed consent</li> </ul> </li> <li>○ post-operative: <ul style="list-style-type: none"> <li>▪ anticipation and prevention of complications, especially venous thrombosis and wound infection</li> <li>▪ wound care</li> <li>▪ appropriate pain control</li> </ul> </li> </ul> </li> <li>• Rehabilitation including physiotherapy and allied professions</li> <li>• Timely referral for rehabilitation and appropriate communication/ liaison with the Palliative Care Team</li> <li>• Discharge planning and participation in the weekly multi-disciplinary and/or family meeting</li> </ul> <p><b><u>Procedural</u></b></p> <ul style="list-style-type: none"> <li>• Venepuncture, IV cannulation, ABG, IDC insertion, joint aspiration</li> <li>• Surgical assisting, knot tying, suture techniques</li> <li>• Application of external casts</li> </ul> <p><b><u>Educational</u></b></p> <ul style="list-style-type: none"> <li>• Participate in the weekly <b>Geriatric Medicine Unit Education Meeting Tuesday 1200 hrs</b> and General Clinical Training Program</li> <li>• Attend relevant multi-disciplinary ortho-geriatric team meetings pertaining to their patients.</li> <li>• Attend individual VMO tutorials on orthopaedic conditions</li> <li>• Attend and participate in the weekly clinical-radiology review meetings</li> <li>• Attend fracture clinics for instruction and supervision of cast application and management of ambulatory traumatic conditions</li> </ul>
	<p><b>COMMUNICATION:</b></p> <p>All JMO's are expected to communicate effectively across: Patient interaction, patient information note taking, liaising with patient family members, working as member of a team, communicating with senior consultants, communicating with other health care professionals regarding longer term patient management.</p>
	<p><b>PROFESSIONALISM:</b></p> <p>Professional behaviour is a requirement for your continued employment, Professionalism is expected across all areas, including: Effective communication and participating in a multidisciplinary clinical team, develop skills in the setting of personal learning goals and their achievement through self-directed continuing medical education and supervised practice, skills in information technology relevant to clinical practice, collection and interpretation of clinical data, understand the principles of evidence-based practice of medicine and clinical quality assurance techniques, further understanding of medical ethics and confidentiality, and of the medico-political and medico-legal environment.</p>
<b><u>Orthopaedic Surgery Timetable:</u></b>	

	Monday	Tuesday	Wednesday	Thursday	Friday
<b>AM</b>	<b>7.00</b> Handover meeting <b>7.30</b> Ward round <b>8.00</b> Elective/Trauma Theatre <b>9.00</b> Outpatients	<b>7.00</b> Handover meeting <b>7.30</b> Ward round <b>8.00</b> Elective/Trauma theatre <b>9.00</b> Outpatients	<b>7.00</b> Handover meeting <b>7.30</b> Ward round <b>8.00</b> Elective/Trauma theatre	<b>7.00</b> Handover meeting <b>7.30</b> Ward round <b>8.00</b> Elective/Trauma theatre <b>9.00</b> Fracture clinic (paediatric)	<b>7.00</b> X-ray meeting at John James Hospital <b>7.30</b> Ward round <b>9.00</b> Outpatients
<b>PM</b>	<b>1.00</b> Fracture clinic	<b>1.00</b> Outpatients	<b>1.00</b> Fracture clinic	<b>1.00</b> Outpatients	<b>1.00</b> Fracture clinic
		<b>2.30-4.00pm</b> Intern teaching		<b>2-3pm</b> RMO teaching	

#### Orthopaedic Geriatrics Timetable:

	Monday	Tuesday	Wednesday	Thursday	Friday
<b>AM</b>	<b>8.00</b> Ward round	<b>8.00</b> Ward round  <b>10.00</b> Multi-disciplinary meeting	<b>8.00</b> Ward round  <b>10.00</b> Consultant ward round	<b>8.00</b> Ward round	<b>7.00</b> Ward round
<b>PM</b>	<b>2.30</b> Consultant paper round and medication review	<b>12.00</b> Geriatric medicine unit education meeting  <b>2.30</b> Consultant paper round and medication review	<b>12.30</b> Internal medicine grand rounds  <b>2.30</b> Consultant paper round and medication review	<b>2.30</b> Consultant paper round and medication review	<b>2.30</b> Consultant paper round and medication review
		<b>2.30-4.00pm</b> Intern teaching		<b>2-3pm</b> RMO teaching	

#### PATIENT LOAD:

Average number of patients looked after by the JMO per day

10- 20 Orthopaedic Geriatrics

Varies from 5-50 depending on-take teams for Orthopaedic Surgery

#### OVERTIME

Average hours per week

**ROSTERED: 8**

**UNROSTERED: 0**

<p><b>EDUCATION:</b></p> <p><i>Detail education opportunities and resources available to the JMO during the term. Formal education opportunities should also be included in the unit timetable.</i></p>	<p><b><u>Registrar Teaching</u></b> Registrar teaching occurs informally on ward rounds and during hand-over sessions.</p> <p><b><u>General Clinical Training</u></b> A list of common geriatric syndromes is listed in the practical guide. Further reading is also included. The Australian and New Zealand Society for Geriatric Medicine (ANZSGM) website at: <a href="http://www.anzsgm.org/vgmtp/">http://www.anzsgm.org/vgmtp/</a> covers the following topics:</p> <ul style="list-style-type: none"> <li>• Delirium</li> <li>• Falls and Balance</li> <li>• Osteoporosis treatment</li> <li>• Dementia</li> <li>• Continence</li> </ul> <p><b><u>On-call rosters</u></b></p> <p><b><u>Registrar Roster</u></b> <b><u>Monday to Friday one works to 10.30pm and another stars at 10pm for overnight. On weekends two registrars cover theatre and ED calls during the day.</u></b></p> <p><b><u>Consultants roster (Ortho-geriatric)</u></b> Any issues related to the ortho-geriatric patients can be discussed with the ortho-geriatric consultant (A/Prof Alex Fisher) on the weekdays between 8:00 am and 5:00 pm. After hours and on the weekends, if necessary, the ortho-geriatric consultant (A/Prof Alex Fisher) can be contacted via switch (except when he is not in Canberra).</p> <p><b><u>Consultants roster (Orthopaedic)</u></b> VMOs are on-call for one week at a time, commencing 8:00am Friday, but often split the week with another VMO. Roster swaps between VMOs often mean that one team receives patients more than others.</p>
<p><b>ASSESSMENT AND FEEDBACK:</b></p> <p><i>Detail arrangements for formal assessment and feedback provided to JMO during and at the end of the term. Specifically, a mid-term assessment must be scheduled to provide the JMO with the opportunity to address any short-comings prior to the end-of-term assessment.</i></p>	<p>Term Supervisors will provide formal assessment and feedback using the online 'one45' at mid-term and at the end of term. In completing the assessment, the Term Supervisors will consult with Consultants, Registrars, Nursing Staff and any other staff members, who have had extensive contact with you.</p> <p>Please contact Dr. Policinski's PA to arrange appointments for both mid-term and end of term assessments.</p>
<p><b>ADDITIONAL INFORMATION:</b></p>	<p><b><u>Communication with General Practitioners</u></b> A hospital discharge referral form should be completed prior to discharge and a copy given to the patient at discharge. Specific instructions for follow-up should be discussed with the registrar and consultant prior to discharge. Notify the patient and document in the notes. A telephone call or facsimile to every patient's family practitioner should be made for every patient who has stayed overnight. A Unit or VMO card, detailing contact phone numbers and with space for both follow up appointments and patient specific discharge instructions should be given to every patient or responsible next of kin.</p> <p><b><u>Discharges / Discharge Documentation</u></b> Patient discharges should be planned at least one day in advance, in consultation with the registrar and clinical nurse consultant. The Discharge Referral must be completed for all inpatient discharges before discharge and after discussion with the registrar about the follow-up plan. All deceased patients must have a Discharge Referral completed. The discharging specialty is responsible for the completing the Discharge Referral within 48 hours of discharge. If you have never seen the patient please make a note of this on the</p>



#### Discharge Referral.

Discharge Referrals not completed by the end of each financial quarter will be brought to the attention of the Directors and the SMT leaders.

In accordance with Policy 0113:001 Record Completion and Casemix Summaries the Medical Record Department will refuse to sign you out (for your final pay) unless you have completed all Discharge Referrals/Discharge Summaries you are responsible for.

#### Tips for good discharge summaries

- Clearly document the following issues:
  - DVT prophylaxis
  - Appropriate treatment of osteoporosis
  - Optimisation of medications associated with falls and fractures
- Address issues dealt with and what was done about each rather than a chronological summary
- Limit investigation results to the most important ones and relevant to ongoing care and recent basic blood tests at time of discharge
- Include cognitive assessment (MMSE)
- Include allied health input and their recommendation
- Include functional( ADLs) and mobility changes at the time of the Discharge
- Comment on any medication changes made and why
- For drugs requiring authority (e.g. Olanzapine, Alendronate, Donepezil) ensure provisions for ongoing prescribing are included
- Clearly document plans for medication (e.g. Oxycotin – wean as pain improves)
- Make note of any medication NOT started (e.g. Warfarin in a patient with AF and risk of bleeding) or not to be restarted.
- Include Resuscitation orders, advanced directives and details of Enduring Power of Attorney
- Include discharge destination( home, rehabilitation, other hospital or nursing home

#### **Death Certificate Documentation**

The details of the diagnosis of patients who are receiving end of life care, should be documented in the progress notes and handed over to afterhours JMOs.

The hand over should include the diagnosis of the death and issues leading to the death. Causes of death of patient should be discussed and confirmed with the ortho-geriatric consultant (A/Prof Alex Fisher) and registrar.

The copy of the death certificate should be handed over by the JMOs to the treating team for the review.

Discharge summary for each death should be completed.

A phone call to the patient's GP is essential on discharge from hospital especially

- In the event of a patient's death, as relatives will usually consult the GP and will expect them to be fully aware of the circumstances.
- If you would like the GP to see the patient within a week
- If there are complex or significant issues to be followed up on
- If there have been significant changes to medications

#### **Medical Record Documentation**

All in patients should have a brief note written following each review i.e. at least daily.

To maintain the integrity of the record and ensure the best optical disc image possible, the following must be adhered to:

- All entries must be legible, clear, relevant and objective.
- Every entry must include date, time, signature, designation and printed name.
- All entries must be written within the boundaries of the form. Do not write in the margins.

- Only approved, barcoded forms should be used.
- Use black ballpoint pen only. Do not use blue pen, pentel, rollerball, felt pens, highlighter pens or liquid paper.
- Only approved hospital abbreviations should be used.
- Student entries must be countersigned by their supervisor.
- Entries written in error must have only one line ruled through the incorrect entry; have "Written in Error" entered above or beside the incorrect entry and the entry must be dated, timed, signed and designated.

#### **Care Type Change**

Care type change (also known as Change of Clinical Intent) is a change in the phase of treatment or change in acuity during a patient's admission, for example from Acute Care to Rehab. In some situations a patient may have several Care Type changes during the course of their admission.

For each Care Type change the medical officer must:

- assess the patient
- document patient history, status and expected goals on the Notification of Care Type Change form
- document the new care type, the reason for care type change, goals of current treatment and patient's current status in the progress notes

Once all sections of the form have been completed it should then be signed and handed to the Ward Clerk for action on CareSys.

For more details see Policy number 0117:001 Care Type Policy.

Term Supervisor  
A/Prof Alex Fisher  
July 2019



Term Supervisor:  
Dr Igor Policinski  
July 2019



## Clinical Management

### Patient Assessment

#### Patient identification

Follows the stages of a verification process to ensure the correct identification of a patient

Complies with the organisation's procedures for avoiding patient misidentification

Confirms with relevant others the correct identification of a patient

#### History & Examination

Recognises how patients present with common acute and chronic problems and conditions

Undertakes a comprehensive & focussed history

Performs a comprehensive examination of all systems

Elicits symptoms & signs relevant to the presenting problem or condition

#### Problem formulation

Synthesises clinical information to generate a ranked problem list containing appropriate provisional diagnoses as part of the clinical reasoning process

Discriminates between the possible differential diagnoses relevant to a patient's presenting problems or conditions

Regularly re-evaluates the patient problem list

#### Investigations

Judiciously selects, requests and is able to justify investigations in the context of particular patient presentation

Follows up & interprets investigation results appropriately to guide patient management

Identifies & provides relevant & succinct information when ordering investigations

#### Referral & consultation

Identifies & provides relevant & succinct information

Applies the criteria for referral or consultation relevant to a particular problem or condition

Collaborates with other health professionals in patient assessment

### Safe Patient Care

#### Systems

Works in ways which acknowledge the complex interaction between the healthcare environment, doctor & patient

Uses mechanisms that minimise error e.g. checklists, clinical pathways

Participates in continuous quality improvement e.g. clinical audit

#### Risk & prevention

Identifies the main sources of error & risk in the workplace

Which may contribute to patient & staff risk

Explains and reports potential risks to patients and staff

#### Adverse events & near misses

Describes examples of the harm caused by errors & system failures

Documents & reports adverse events in accordance with local incident reporting systems

Recognises & uses existing systems to manage adverse events & near misses

#### Public health

Knows pathways for reporting notifiable diseases & which conditions are notifiable

Acts in accordance with the management plan for a disease outbreak

Identifies the key health issues and opportunities for disease and injury prevention in the community

### Infection control

Practices correct hand-washing & aseptic techniques

Uses methods to minimise transmission of infection between patients

Rationally prescribes antimicrobial / antiviral therapy for common conditions

#### Radiation safety

Minimises the risk associated with exposure to radiological investigations or procedures to patient or self

Rationally requests radiological investigations & procedures

Regularly evaluates his / her ordering of radiological investigations & procedures

#### Medication safety

Identifies the medications most commonly involved in prescribing and administration errors

Prescribes, calculates and administers all medications safely mindful of their risk profile

Routinely reports medication errors and near misses in accordance with local requirements

### Acute & Emergency Care

#### Assessment

Recognises the abnormal physiology and clinical manifestations of critical illness

Recognises & effectively assesses acutely ill, deteriorating or dying patients

Initiates resuscitation when clinically indicated whilst continuing full assessment of the patient

#### Prioritisation

Applies the principles of triage & medical prioritisation

Identifies patients requiring immediate resuscitation and when to call for help e.g. Code Blue / MET

#### Basic Life Support

Implements basic airway management, ventilatory and circulatory support

Effectively uses semi-automatic and automatic defibrillators

#### Advanced Life Support

Identifies the indications for advanced airway management

Recognises malignant arrhythmias, uses resuscitation/drug protocols and manual defibrillation

Participates in decision-making about and debriefing after cessation of resuscitation

#### Acute patient transfer

Identifies when patient transfer is required

Identifies and manages risks prior to and during patient transfer

### Patient Management

#### Management Options

Identifies and is able to justify the patient management options for common problems and conditions

Implements and evaluates a management plan relevant to the patient following discussion with a senior clinician

#### Inpatient Management

Reviews the patient and their response to treatment on a regular basis

#### Therapeutics

Takes account of the actions and interactions, indications, monitoring requirements, contraindications & potential adverse effects of each medication used

Involves nurses, pharmacists and allied health professionals appropriately in medication management

Evaluates the outcomes of medication therapy

#### Pain management

Specifies and can justify the hierarchy of therapies and options for pain control

Prescribes pain therapies to match the patient's analgesia requirements

### Fluid, electrolyte & blood product management

Identifies the indications for, & risks of, fluid & electrolyte therapy & blood products

Recognises and manages the clinical consequences of fluid electrolyte imbalance in a patient

Develops, implements, evaluates and maintains an individualised patient management plan for fluid, electrolyte or blood product use

Maintains a clinically relevant patient management plan of fluid, electrolyte and blood product use

#### Subacute care

Identifies patients suitable for & refers to aged care, rehabilitation or palliative care programs

Identifies common risks in older and complex patients e.g. falls risk and cognitive decline

#### Ambulatory & community care

Identifies and arranges ambulatory and community care services appropriate for each patient

#### Discharge planning

Recognises when patients are ready for discharge

Facilitates timely and effective discharge planning

#### End of Life Care

Arranges appropriate support for dying patients

Takes account of legislation regarding Enduring Power of Attorney and Advanced Care Planning

### Skills & Procedures

#### Decision-making

Explains the indications, contraindications & risks for common procedures

Selects appropriate procedures with involvement of senior clinicians and the patient

Considers personal limitations and ensures appropriate supervision

#### Informed consent

Applies the principles of informed consent in day to day clinical practice

Identifies the circumstances that require informed consent to be obtained by a more senior clinician

Provides a full explanation of procedures to patients considering factors affecting the capacity to give informed consent such as language, age & mental state

#### Performance of procedures

Ensures appropriate supervision is available

Identifies the patient appropriately

Prepares and positions the patient appropriately

Recognises the indications for local, regional or general anaesthesia

Arranges appropriate equipment

Arranges appropriate support staff and defines their roles

Provides appropriate analgesia and/or premedication

Performs procedure in a safe and competent manner using aseptic technique

Identifies and manages common complications

Interprets results & evaluates outcomes of treatment

Provides appropriate aftercare & arranges follow-up

## Skills & Procedures

Venepuncture

IV cannulation

Preparation and administration of IV medication, injections & fluids

Arterial puncture in an adult

Blood culture (peripheral)

IV infusion including the prescription of fluids

IV infusion of blood & blood products

Injection of local anaesthetic to skin

Subcutaneous injection

Intramuscular injection

Perform & interpret and ECG

Perform & interpret peak flow

Urethral catheterisation in adult females & males

Airway care including bag mask ventilation with simple adjuncts such as pharyngeal airway

NG & feeding tube insertion

Gynaecological speculum and pelvic examination

Surgical knots & simple suture insertion

Corneal & other superficial foreign body removal

Plaster cast/splint limb immobilisation

## Clinical Symptoms, Problems & Conditions

### Common Symptoms & Signs

Fever

Dehydration

Loss of Consciousness

Syncope

Headache

Toothache

Upper airway obstruction

Chest pain

Breathlessness

Cough

Back pain

Nausea & Vomiting

Jaundice

Abdominal pain

Gastrointestinal bleeding

Constipation

Diarrhoea

Dysuria / or frequent micturition

Oliguria & anuria

Pain & bleeding in early pregnancy

Agitation

Depression

### Common Clinical Problems and Conditions

Non-specific febrile illness

Sepsis

Shock

Anaphylaxis

Envenomation

Diabetes mellitus and direct complications

Thyroid disorders

Electrolyte disturbances

Malnutrition

Obesity

Red painful eye

Cerebrovascular disorders

Meningitis

Seizure disorders

Delirium

Common skin rashes & infections

Burns

Fractures

Minor Trauma

Multiple Trauma

Osteoarthritis

Rheumatoid arthritis

Gout

Septic arthritis

Hypertension

Heart failure

Ischaemic heart disease

Cardiac arrhythmias

Thromboembolic disease

Limb ischaemia

- ☒ Leg ulcers
- ☒ Oral infections
- ☒ Periodontal disease
- ☒ Asthma
- ☒ Respiratory infection
- ☒ Chronic Obstructive Pulmonary Disease
- ☒ Obstructive sleep apnoea
- ☒ Liver disease
- ☒ Acute abdomen
- ☒ Renal failure
- ☒ Pyelonephritis & UTIs
- ☒ Urinary incontinence & retention
- ☐ Menstrual disorders
- ☐ Sexually Transmitted Infections
- ☒ Anaemia
- ☒ Bruising & Bleeding
- ☒ Management of anticoagulation
- ☒ Cognitive or physical disability
- ☒ Substance abuse & dependence
- ☒ Psychosis
- ☒ Depression
- ☒ Anxiety
- ☒ Deliberate self-harm & suicidal behaviours
- ☐ Paracetamol overdose
- ☒ Benzodiazepine & opioid overdose
- ☒ Common malignancies
- ☐ Chemotherapy & radiotherapy side effects
- ☐ The sick child
- ☐ Child abuse
- ☐ Domestic violence
- ☒ Dementia
- ☒ Functional decline or impairment
- ☒ Fall, especially in the elderly
- ☒ Elder abuse
- ☒ Poisoning/overdose

## Professionalism

### Doctor & Society

#### Access to healthcare

- ☒ Identifies how physical or cognitive disability can limit patients' access to healthcare services
- ☒ Provides access to culturally appropriate healthcare
- ☒ Demonstrates and advocates a non-discriminatory patient-centred approach to care

#### Culture, society healthcare

- ☒ Behaves in ways which acknowledge the social, economic political factors in patient illness
- ☒ Behaves in ways which acknowledge the impact of culture, ethnicity, sexuality, disability & spirituality on health
- ☒ Identifies his/her own cultural values that may impact on his/her role as a doctor
- ☒ Indigenous patients
- ☒ Behaves in ways which acknowledge the impact of history & the experience of Indigenous Australians
- ☒ Behaves in ways which acknowledge Indigenous Australians' spirituality & relationship to the land
- ☒ Behaves in ways which acknowledge the diversity of indigenous cultures, experiences & communities

#### Professional standards

- ☒ Complies with the legal requirements of being a doctor e.g. maintaining registration
- ☒ Adheres to professional standards
- ☒ Respects patient privacy & confidentiality

#### Medicine & the law

- ☒ Complies with the legal requirements in patient care e.g. Mental Health Act, death certification
- ☒ Completes appropriate medico-legal documentation
- ☒ Liaises with legal & statutory authorities, including mandatory reporting where applicable

#### Health promotion

- ☒ Advocates for healthy lifestyles & explains environmental lifestyle risks to health

- ☒ Uses a non-judgemental approach to patients & his/her lifestyle choices (e.g. discusses options; offers choice)
- ☒ Evaluates the positive & negative aspects of health screening and prevention when making healthcare decisions

#### Healthcare resources

- ☒ Identifies the potential impact of resource constraint on patient care
- ☒ Uses finite healthcare resources wisely to achieve the best outcomes
- ☒ Works in ways that acknowledge the complexities & competing demands of the healthcare system

### Professional Behaviour

#### Professional responsibility

- ☒ Behaves in ways which acknowledge the professional responsibilities relevant to his/her health care role
- ☒ Maintains an appropriate standard of professional practice and works within personal capabilities
- ☒ Reflects on personal experiences, actions & decision-making
- ☒ Acts as a role model of professional behaviour

#### Time management

- ☒ Prioritises workload to maximise patient outcomes & health service function

#### Demonstrates punctuality

#### Personal well-being

- ☒ Is aware of, & optimises personal health & well-being
- ☒ Behaves in ways to mitigate the personal health risks of medical practice e.g. fatigue, stress
- ☒ Behaves in ways which mitigate the potential risk to others from your own health status e.g. infection

#### Ethical practice

- ☒ Behaves in ways that acknowledge the ethical complexity of practice & follows professional & ethical codes
- ☒ Consults colleagues about ethical concerns
- ☒ Accepts responsibility for ethical decisions

#### Practitioner in difficulty

- ☒ Identifies the support services available
- ☒ Recognises the signs of a colleague in difficulty and responds with empathy
- ☒ Refers appropriately

#### Doctors as leaders

- ☒ Shows an ability to work well with & lead others
- ☒ Exhibits leadership qualities and takes leadership role when required

#### Professional Development

- ☒ Reflects on own skills & personal attributes in actively investigating a range of career options
- ☒ Participates in a variety of continuing education opportunities
- ☒ Accepts opportunities for increased autonomy and patient responsibility under their supervisor's direction

### Teaching, Learning & Supervision

#### Self-directed learning

- ☒ Identifies & addresses personal learning objectives
- ☒ Establishes & uses current evidence based resources to support patient care & own learning
- ☒ Seeks opportunities to reflect on & learn from clinical practice
- ☒ Seeks & responds to feedback on learning
- ☒ Participates in research & quality improvement activities where possible

#### Teaching

- ☒ Plans, develops & conducts teaching sessions for peers & juniors
- ☒ Uses varied approaches to teaching small & large groups
- ☒ Incorporates teaching into clinical work

- ☒ Evaluates & responds to feedback on own teaching

#### Supervision, Assessment & Feedback

- ☒ Seeks out personal supervision & is responsive to feedback
- ☒ Seeks out and participates in personal feedback and assessment processes
- ☒ Provides effective supervision by using recognised techniques & skills (availability, orientation, learning opportunities, role modelling, delegation)
- ☒ Adapts level of supervision to the learner's competence & confidence
- ☒ Provides constructive, timely and specific feedback based on observation of performance
- ☒ Escalates performance issues where appropriate

## Communication

### Patient Interaction

#### Context

- ☒ Arranges an appropriate environment for communication, e.g. privacy, no interruptions & uses effective strategies to deal with busy or difficult environments
- ☒ Uses principles of good communication to ensure effective healthcare relationships
- ☒ Uses effective strategies to deal with the difficult or vulnerable patient

#### Respect

- ☒ Treats patients courteously & respectfully, showing awareness & sensitivity to different backgrounds
- ☒ Maintains privacy & confidentiality
- ☒ Provides clear & honest information to patients & respects their treatment choices

#### Providing information

- ☒ Applies the principles of good communication (e.g. verbal & non-verbal) & communicates with patients & carers in ways they understand
- ☒ Uses interpreters for non-English speaking backgrounds when appropriate
- ☒ Involves patients in discussions to ensure their participation in decisions about their care

#### Meetings with families or carers

- ☒ Identifies the impact of family dynamics on effective communication
- ☒ Ensures relevant family/carers are included appropriately in meetings and decision-making
- ☒ Respects the role of families in patient health care

#### Breaking bad news

- ☒ Recognises the manifestations of, & responses to, loss & bereavement
- ☒ Participates in breaking bad news to patients & carers
- ☒ Shows empathy & compassion

#### Open disclosure

- ☒ Explains & participates in implementation of the principles of open disclosure
- ☒ Ensures patients & carers are supported & cared for after an adverse event

#### Complaints

- ☒ Acts to minimise or prevent the factors that would otherwise lead to complaints
- ☒ Uses local protocols to respond to complaints
- ☒ Adopts behaviours such as good communication designed to prevent complaints

### Managing Information

#### Written

- ☒ Complies with organisational policies regarding timely & accurate documentation
- ☒ Demonstrates high quality written skills e.g. writes legible, concise & informative discharge summaries

- ☒ Uses appropriate clarity, structure and content for specific correspondence e.g. referrals, investigation requests, GP letters
- ☒ Accurately documents drug prescription, calculations and administration

#### Electronic

- ☒ Uses electronic resources in patient care e.g. to obtain results, populate discharge summaries, access medicines information
- ☒ Complies with policies, regarding information technology privacy e.g. passwords, e-mail & internet, social media

#### Health Records

- ☒ Complies with legal/institutional requirements for health records
- ☒ Uses the health record to ensure continuity of care
- ☒ Provides accurate documentation for patient care

#### Evidence-based practice

- ☒ Applies the principles of evidence-based practice and hierarchy of evidence
- ☒ Uses best available evidence in clinical decision-making
- ☒ Critically appraises evidence and information

#### Handover

- ☒ Demonstrates features of clinical handover that ensure patient safety & continuity of care
- ☒ Performs effective handover in a structured format e.g. team member to team member, hospital to GP, in order to ensure patient safety & continuity of care

### Working in Teams

#### Team structure

- ☒ Identifies & works effectively as part of the healthcare team, to ensure best patient care
- ☒ Includes the patient & carers in the team decision making process where appropriate
- ☒ Uses graded assertiveness when appropriate

- ☒ Respects the roles and responsibilities of multidisciplinary team members

#### Team dynamics

- ☒ Demonstrates an ability to work harmoniously within a team, & resolve conflicts when they arise
- ☒ Demonstrates flexibility & ability to adapt to change
- ☒ Identifies & adopts a variety of roles within different teams

#### Case Presentation

- ☒ Presents cases effectively, to senior medical staff & other health professionals