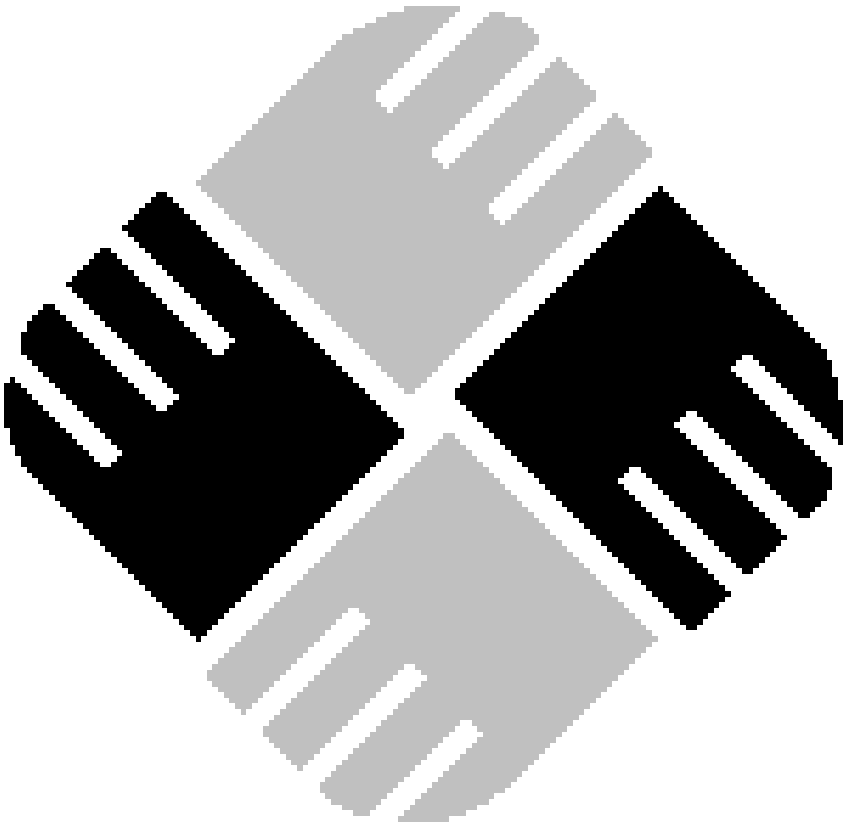
# JUNIOR MEDICAL OFFICER

# HANDBOOK



## BANKSTOWN HEALTH SERVICE

## DECEMBER 2003

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## ABBREVIATIONS

| Abbreviation | Description |
|---|---|
| JMO | Junior Medical Officer – refers to first two years after graduation – also known as Intern and RMO1 |
| PGY1/PGY2 | Post Graduate Year 1 (2 etc) |
| PMC | Postgraduate Medical Council |
| PAC | Primary Allocation Centre |
| RMO1/RMO2 | Resident Medical Officer First Year after intern (second year etc) |
| VMO | Visiting Medical Officer – specialist attending on a sessional basis |
| AMO | Attending Medical Officer – collective term for VMOs and Staff Specialists |
| ICU | Intensive Care Unit |
| CMO | Career Medial Officer – experienced salaried non-specialist medical officers |
| MO | Medical Officer – general term for any doctor |
| ED | Emergency Department |
| SWSAHS | South Western Sydney Area Health Service |
| ADO | Allocated Day Off – one day per month as additional leave |
| JAFA | JMO Attachment: Feedback and Appraisal form – used by JMOs to provide assessment and feedback on supervising senior staff |
| CIAP | Clinical Information Access Program – Library facility available on computer through the Intranet to access journals and texts on line |
| CIS | Clinical Information Service – includes medical records department and clinical data processing |
| PAS | Patient Administration System – computer system to record all patient identification and admission details |
| MRN | Medical Record Number – unique identification number for each patient used on medical record and patient identification labels |
| DRG | Diagnosis Related Group – grouping of diagnoses in similar broad groups for coding processes |
| ICD 10-AM | International Classification of Diseases version 10 Australian Modification – detailed coding system for all diseases and co morbidities |
| TMF | Treasury Managed Fund – provides indemnity cover for all staff and sources of funds payment in litigation payments |

## ACKNOWLEDGEMENTS

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Thank you also to Ailinh Chau, Medical Services Support Coordinator, for providing information and proof reading the text.

*Dr Geoff Westwood, Director Medical and Clinical Services*

# 1. WELCOME

## 1.1 Message From the General Manager

Welcome to Bankstown!!

I take this opportunity as General Manager of the Bankstown Health Service to thank you for coming to join us for the term of your new appointment. We look forward to you rapidly and smoothly becoming an effective member of one of our multidisciplinary teams that provide the range of clinical care to our community.

The Vision of the Bankstown Health Service is: **Committed to Excellence Through Collaboration**

Your stay and work at Bankstown offers an opportunity to participate actively with us in achieving our Vision. I trust that you will be an active contributor and at the same time find Bankstown-Lidcombe Hospital an institution that provides a breadth of experiences and resources that develop your clinical and professional skills in keeping with national best practice.

We endeavour to ensure that high quality service is provided that achieves the outcomes and expectations of our patients, their families/carers, and the Health Service. I encourage you to hone your communication skills – speaking and explaining, listening and writing – in order that your activities form a cohesive part of the care program; that patients and their families are aware of the program and its likely outcomes and that concerns they may have are expressed to us early and are promptly addressed by the Service.

Engage effectively with the patients, nursing, allied health, support staff and medical consultants to enjoy and benefit from your time at Bankstown.
Best wishes to you for a productive stay at Bankstown.

Andrew Bernard

## 1.2 Welcome from Director of Medical and Clinical Services

You have chosen or been allocated to work in a hospital that retains an air of being small and friendly while having a complex mixture of clinical work and sophisticated facilities as befits a Principal Referral Hospital. The senior clinicians are dedicated and enthusiastic teachers, meaning that the hospital is an excellent springboard into virtually any career.

The first few years following medical graduation are a challenging and stressful period. It is also a period of extraordinary development from student to independent medical practitioner. The aim of this manual is to help you negotiate this transition with a minimum of fuss by providing basic information about the hospital and the activities that you will encounter not only administrative matters but also in clinical areas and in your continuing medical education. Further information is available from the friendly staff in Medical Administration, the Director of Clinical Training and your individual term supervisors. The aim is to equip you for a successful future in medicine. Enjoy your time at Bankstown. We aim to equip you well for whatever career path you choose.

Dr Geoff Westwood

# 2. HOSPITAL ORGANISATION

The following section briefly outlines the structure of Bankstown Health Service and relationship to the Area Health Service

## 2.1 Hospital role and relationship to other health services

Bankstown Health Service consists of Bankstown Hospital (including Banks House, inpatient mental health), Bankstown Community health Service based in Raymond Street on the edge of the main Bankstown shopping area and a dental service conducted at Yagoona.

It is one of five sector health services in South Western Sydney Area Health Service (SWSAHS). The other four are Liverpool, Fairfield, Macarthur (Campbelltown and Camden hospital) and Wingecarribee Health Service. The overall governance of the Area is the responsibility of the Area Board that reports to the Minister for Health. A Chief Executive Officer is the senior Area manager and is supported by an Area Executive Team.

Liverpool Hospital is the major tertiary referral centre for SWSAHS providing the trauma referral centre and other service not available at Bankstown including cardio-thoracic and major neurosurgery, coronary angiography (catheter lab), MRI investigations and radiotherapy services for cancer treatment.

Bankstown Health Service has formal links with Macarthur Health Service, seconding interns and RMOs to Campbelltown Hospital for terms in Medicine, Surgery, Orthopaedics, Palliative Care, Psychiatry and Emergency Medicine. One Medical Registrar is also seconded to Campbelltown Hospital.

Pathology services including haematology are provided by South Western Area Pathology Service (SWAPS) based at Liverpool Hospital with a satellite laboratory in Bankstown Hospital for most routine office hours pathology. Anatomical pathology including an autopsy service is conducted from Liverpool Hospital, as are renal services with a satellite haemodialysis service conducted at Bankstown Hospital currently running 8 chairs five days per week.

## 2.2 Organisational Structure – Bankstown Health Service

Bankstown Health Service (BHS) introduced a revised organisational structure in March 2003. This clearly defines the structure and responsibility for corporate and clinical governance.

### 2.2.1 Corporate Structure

The senior officer is the General Manager who has responsibility for the entire operation of the health service and reports to the Area Director of Operations and to the Area Chief Executive Officer. A Health Service Executive consisting of the positions listed below supports the General Manager. Each of these individuals supports the clinical activities of the health service with responsibilities for defined activities. As at May 2003 these are:

- **General Manager (GM)** – Andrew Bernard
  The GM is the officer responsible for the operations of the entire health service. He is the major link between the health service and the Area Executive structure and has responsibility for both service provision and financial performance of the health service. All other executive members report directly to the GM.

- **Director of Medical Services (DMCS)** – Dr Geoff Westwood
  The Director of Medical Services has overall responsibility for medical recruitment and staffing within the hospital. The DMCS is supported by an Executive Assistant (Secretary) and a Medical Services Support Coordinator who has responsibility for JMO management including recruitment and rostering. Two Medical Services Support Assistants respectively look after day-to-day JMO issues including rosters, timesheets

and payroll issues, and managing issues to do with Staff Specialists and Visiting Medical Officers (VMOs).

The DMCS is on call at all times through the hospital switchboard and should be called in relation to:

- urgent administrative issues
- rostering problems and authorisation of the use of casual staff
- designated officer responsibilities (under the Human Tissue Act)

- **Director of Nursing and Clinical Services (DNCS)** – Margaret Brown
  The Director of Nursing and Clinical Services has a similar role to the DMCS with responsibility for nursing recruitment and staffing. Support is provided by the Deputy DNCS and several nursing administrators. Three categories of senior nursing staff are of vital importance to JMOs:
  - The After Hours Nurse Manager (AHNM) is the senior executive person in charge of the hospital outside normal working hours. This individual has responsibility for the smooth running of the hospital and effectively acts for the entire executive team. Should a JMO encounter any difficulty in terms of staffing, resources, theatre access or general problems of any nature, the first contact should be with the AHNM who is available through switchboard.
  - Nurse Unit Managers (NUMs) are located in each ward and clinical area and are responsible for the running of that area or unit. JMOs would be wise to get to know each NUM and cultivate their good will. Senior nursing staff are a valuable resource and can make life on the wards a much simpler and more pleasant experience. Doing small favours for nursing staff such as promptly responding when paged and completing medication orders, discharge summaries etc on time will reap great dividends.
  - Clinical Nurse Consultants (CNCs) are specialist nurses with extensive training and skills in specific clinical areas. They provide valuable advice on management of clinical problems and JMOs should get to know these nurses. CNCs are appointed in a range of areas including: cardiology, pain relief, wound care, emergency, respiratory medicine.

- **Director of Corporate Services (DCS)** – Leisa Rathborne
  The DCS has responsibility for managing the housekeeping side of hospital activities including car parking, catering, cleaning, stores and security

- **Human Resources Manager (HRM)** – Alan Schembri
  The HRM coordinates recruitment of staff, employment conditions, payroll issues and any other aspect of employment.

- **Director of Financial Services (DFS)** – Michael Henry
  The DFS overseas the hospitals financial management, allocates budgets for each department and service in consultation with the executive team, monitors performance against budget and produces regular financial reports for analysis of performance.

- **Director Community and Allied Health Services (DCAHS)** – Anthony Schembri
  The DCAHS has overall responsibility for all allied health staff in the hospital and also for the extensive community health services conducted outside the hospital.

### 2.2.2 Clinical Structure

The clinical structure has been established to enable clinicians in all disciplines a greater involvement in decision-making that affects the provision of clinical care to patients.

- **Clinical Advisory Council (CAC)**
  An eminent clinician working at BHS nominated by the General Manager and appointed by the SWSAHS Board chairs the CAC. The remaining membership consists of up to 8

highly regarded allied health, medical and nursing clinicians working at BHS together with a representative of the Bankstown Division of General Practice, the Chair of the BHS Medical Staff Council and two consumer/community representatives. The General Manager attends all meetings.

The CAC advises the Executive on:

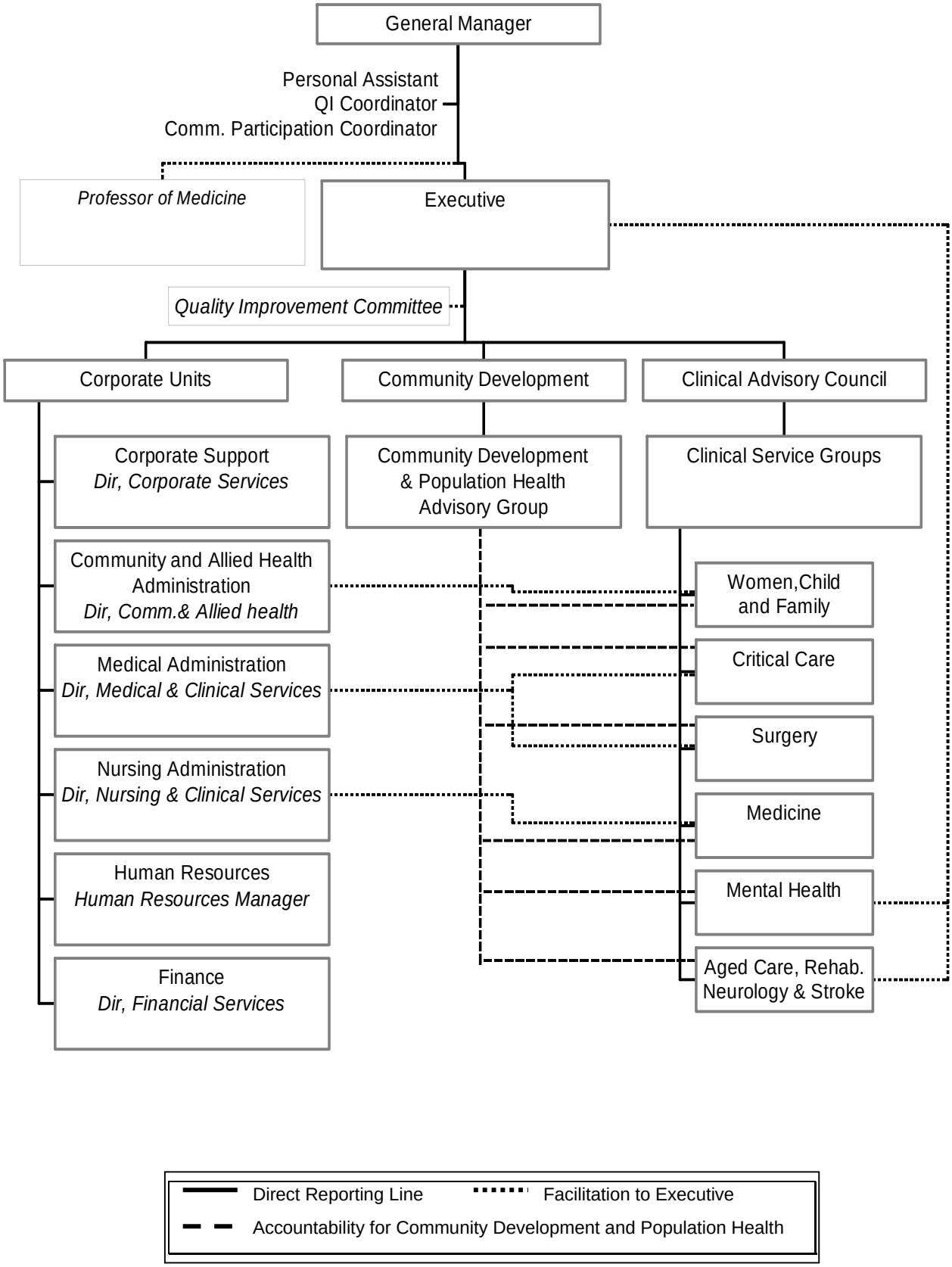
- Strategies to improve the health of residents of Bankstown and to evaluate and report on their effectiveness.
- Issues to improve quality of services.
- Strategies to improve equity of access to services.
- Purchasing of health services, equipment and service enhancements
- Key performance indicators to monitor the effectiveness of the health service and health outcomes.

- **Clinical Service Groups:**
  Multidisciplinary Clinical Service Groups (CSGs) have been established to manage the clinical activities of the BHS. There are six of these:
  - Women's, Child and Family Health (includes O&G, paediatrics)
  - Critical Care (ICU, Emergency, Anaesthetics, Acute Pain)
  - Medicine (all medical subspecialties)
  - Mental Health
  - Surgery (all surgical subspecialties)
  - Aged Care, Rehabilitation, Rheumatology, Neurology and Stroke

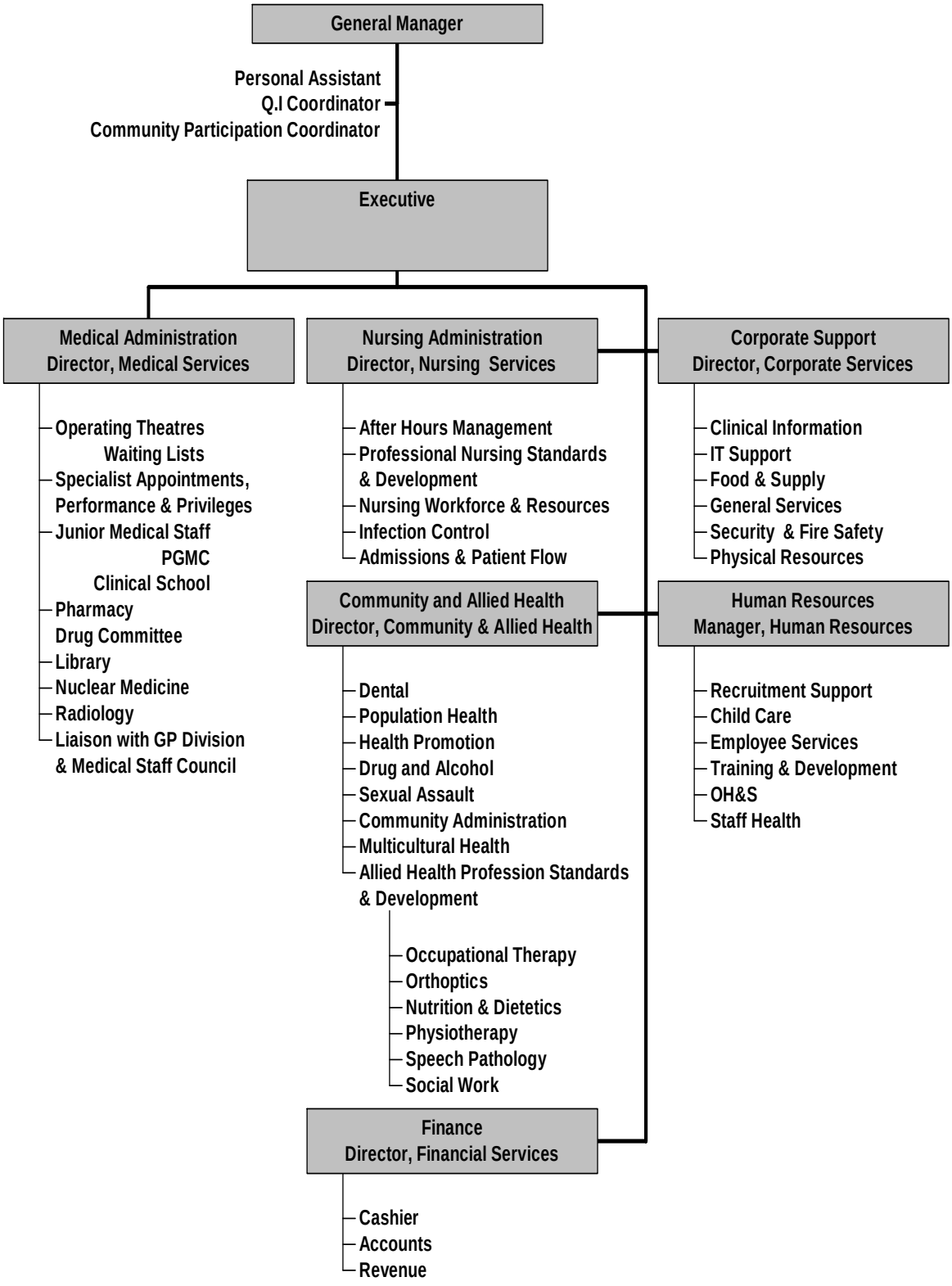
  These CSGs have delegated responsibility from the CAC and Executive for management of their relevant clinical activities. This includes:
  - Delivering effective, safe and efficient health services to meet activity targets within available resources.
  - Develop, implement and revise relevant clinical policies.
  - Conduct activities to review the clinical outcomes in their disciplines.
  - Investigate complaints.
  - Provide advice to the CAC on service enhancement, resource allocation and evaluation.

## 2.3 Organisational Charts

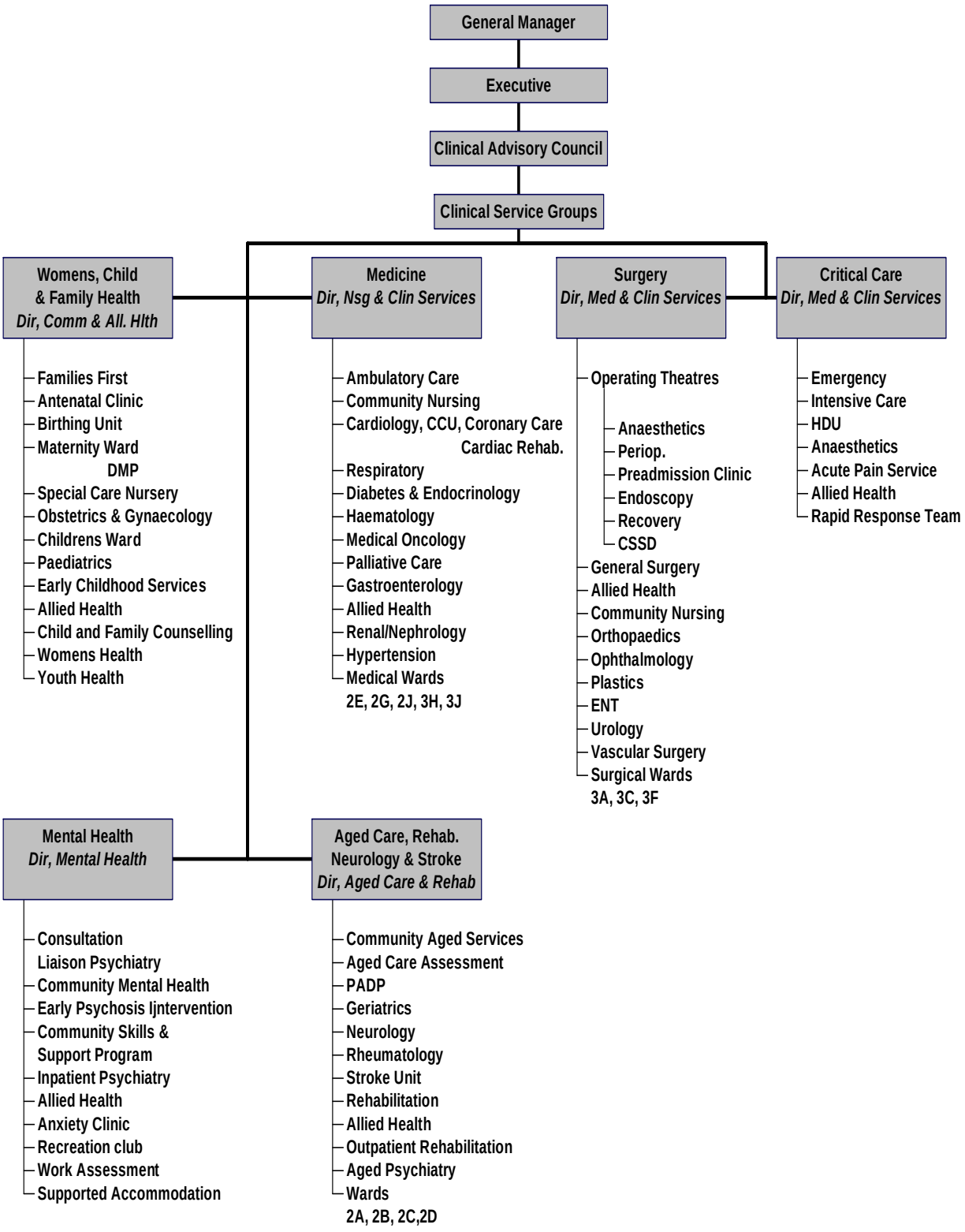
**BANKSTOWN HEALTH SERVICE**
**Organisation Structure**
**Chart 1**



# BANKSTOWN HEALTH SERVICE
## Corporate (Professional) Functions Structure
## Chart 2



# BANKSTOWN HEALTH SERVICE
## Clinical (Operational) Functions Structure
## Chart 3



## 2.4 Key Hospital Personnel (as at May 2003)

| Department | Name | Phone Extension |
|---|---|---|
| **Administration** | | |
| Director of Medical And Clinical Services | Dr. Geoff Westwood | 88554 |
| Medical Service Support Coordinator | Ms. Ailinh Chau | 88553 |
| Executive Assistant (Secretary) | Ms. Devika Munsami | 88554 |
| Medical Service Support Assistant (SMO) | Mr. Mosbah Taha | 88566 |
| Medical Service Support Assistant (JMO) | Ms. Betty Stojanovski | 88552 |
| Director of Clinical Training | Dr. Tram Bui | page via switch |
| **Directors Clinical and Diagnostic Departments** | | |
| Aged Care | A/Prof. Daniel Chan | 87556 |
| Aged Care Psychiatry | Dr. David Grace | 87247 |
| Ambulatory Care | Dr. Bin Ong | 88634 |
| Anaesthetics | Dr. David Gilbett | 88442 |
| Cardiology | Dr. Peter Kelleher | 88582 |
| Diabetes | Dr. Jeff Flack | 88350 |
| Emergency | Dr. Linda Dann | 87688 |
| Intensive Care Unit | Dr. Grant Bennett | 87970 |
| Nuclear Medicine And Ultrasound | Dr. Kien Lee | 88194 |
| Obstetrics And Gynaecology | Dr. Gamal Matthias | 87748 |
| Psychiatry | Dr. John Taylor | 88973 |
| Radiology | Dr. Brian Hammond | 88134 |
| **Chairs of Clinical Departments** | | |
| ENT | Dr. Patrick Bridger | 9707 3543 |
| Gastroenterology | Prof. Jeremy Wilson | 88284 |
| Ophthalmology | Dr. Phillip Myers | 9672 3055 |
| Orthopaedics | Dr. George Kalnins | 9790 5860 |
| Paediatrics | Dr. Phillip Emder | 9796 7113 |
| Plastic Surgery | Dr. Lionel Chang | 9744 6755 |
| Respiratory Medicine | Dr. Jonathan Rutland | 9745 4033 |
| Surgery | Dr. Robert Perrett | 9707 2428 |
| Urology | Dr. John Boulas | 9744 9555 |

# 3. JMO MANAGEMENT / CONDITIONS OF SERVICE

The Director of Medical Services has overall responsibility for administration of all JMO matters in the hospital supported on a day-to-day basis by JMO administrative staff and the Director of Clinical Training who has responsibility for JMO education.

## 3.1 JMO Management Unit

The JMO management unit is part of Medical Administration located on level 4 of the hospital. Two support staff who are the people that JMOs have most direct contact with for routine issues undertake Day to day management. A Medical Services Support Coordinator (extension 88553) looks after recruitment, term allocation, rostering, secondments and general administrative issues for JMOs. A Medical Services Support Assistant (extension 88552) is the person JMOs will have the most regular contact with about timesheets, pay issues, pagers and daily roster matters.

## 3.2 Workforce and Allocation Issues

The Postgraduate Medical Council of NSW (PMC) allocates final year medical students to hospitals for their intern year. Larger hospitals including Bankstown are known as Primary Allocation Centres (PACs). All PACs are associated with one or more other hospitals (often rural hospitals) in a secondment network and for Bankstown this is Campbelltown Hospital, part of Macarthur Health Service. Each Intern and RMO will spend one or two terms (10 or 11 weeks) at the secondment hospital. This is to ensure a fair allocation of JMOs to smaller hospitals and to provide experience for JMOs in a range of different clinical settings, particularly rural medicine.

The PMC also sets the schedule for advertising, interviewing and offering jobs for levels of medical officer from RMO 1 through to Registrar for each clinical year. This is published annually in June by the NSW Health Department. All hospital JMO positions are advertised simultaneously in NSW generally in July/August with interviews commencing in late August and throughout September. Verbal offers of appointment may be made at this stage.

A combined meeting of all hospitals (the “wash-up meeting”) is held, normally in early October, at which consensus on all positions is reached. This is to ensure that applicants are not offered positions at more than one hospital. Written offers are sent out immediately following this meeting, and never beforehand.

Each hospital voluntarily adheres to a quota system administered by the PMC for RMO1 positions. For most PACs the quota for RMO1s may be less than the number of intern positions. This means that RMO1 positions may not be offered to all of the interns in a PAC and offers to outside applicants seldom occur. Hence the majority of Interns also undertake their RMO1 year in the same hospital as the intern year. Most hospitals rely heavily on term assessments in decision-making at this time.

In accordance with the agreement between hospitals, once jobs have been offered and accepted, RMO1s are not allowed to subsequently move between PACs until the end of their RMO1 year, unless released by their employing hospital. Hospitals will refuse to negotiate with RMO1s who have not been released.

No restrictions are imposed on positions at RMO2 and above. The only restrictions imposed on registrars are those imposed directly by the colleges, or indirectly in relation to the number of accredited training positions.

All else being equal, Bankstown will preferentially offer positions to its own interns and RMOs for the following year assuming that satisfactory performance appraisals are received through the term assessments.

## 3.3 Term Allocations

The JMO year is broken into five terms of 10 or 11 weeks. The NSW Medical Board requires each intern to undertake a minimum of one term each in Medicine, Surgery and Emergency Medicine and these terms must provide general clinical experience. The remaining two terms at Bankstown Health Service will include one (or in some cases two) secondment term to Campbelltown Hospital and a relief term involving experience in a range of terms covering colleagues on leave including a share of night duty.

A similar arrangement applies for RMO1s (PGY2s) where the PMC stipulates a minimum of a Critical Care/Emergency Medicine term, a term providing medical experience and one providing surgical or further critical care experience. Secondment and relief terms apply as for interns at Bankstown.

Available terms at Bankstown include:
- Medicine – Aged Care, Stroke Unit, Cardiology, Paediatrics, Ambulatory Care, Psychiatry, Respiratory/Hypertension, Gastroenterology/Endocrine, Oncology/Haematology/Rheumatology, Renal/Neurology, Intensive Care, Obstetrics and Gynaecology.
- Surgery – General Surgery including subspecialties of upper and lower gastrointestinal surgery, plastic surgery, urology, neurosurgery, orthopaedics and otolaryngology.
- Emergency Medicine

Terms at Campbelltown include:
- Medicine, Psychiatry, Surgery, Orthopaedics Palliative Care and Emergency Medicine.

Each Intern and RMO is asked prior to commencement of the year to indicate any preference for the available terms. A term allocation is prepared by Medical Administration staff taking into account where possible individual preferences. It is not always possible to meet every individual's preferences depending on popularity of terms.

## 3.4 Term Supervisors and Term Descriptions

A senior clinician (Staff Specialist or VMO) is allocated as supervisor for each term. This individual is responsible for ensuring that the educational and training requirements for the term are achieved. The Term Supervisor is also responsible for the initial orientation and briefing for the term, mid term and end of term appraisals. JMOs should seek assistance from Term Supervisors at any time during the term regarding aspects of clinical experience, training and skill development that they feel need further development or with which they are having any difficulty.

## 3.5 Duty and Shift Rosters

Rosters are designed to provide appropriate experience to all JMOs, maintain adequate medical service cover for the hospital and to ensure that sufficient rest and recreation is available to JMOs to minimise fatigue. The principles outlined in the Safe Hours guidelines developed by the Australian Medical Association are followed where practicable. Absence from a rostered shift without prior approval from Medical Administration is a serious disciplinary offence. This is also the case for JMOs who are not not contactable when rostered oncall.

### 3.5.1 Normal Hours Rosters

JMO terms have normal rostered hours including rotating shifts in some terms as follows:
- Ward terms (medical & surgical): 0830 – 1700
- Paediatrics: 0800 – 1800 and 1600 – 2400
- ICU: 0800 – 2000 and 1930 – 0830
- Emergency: 0800 – 1800, 1400 – 2400, 2230 - 0830

### 3.5.2 Medical Cover After Hours, Weekends and Public Holidays.

As a general guide the minimum level of cover of medical staff after hours physically present in the hospital is:

- Registrars:
  - Emergency Department (CMO or Registrar) 1
  - Medical 1 - 2
  - Surgical 1
  - Anaesthetic 1
  - ICU 1 (to midnight then covered by Anaesthetic Registrar)
  - O&G 1 weeknights (on-call weekends)
- RMO/Intern:
  - Emergency Department 2
  - Medical wards 1 (2 till 2400)
  - Surgical wards 1
  - ICU 1
  - Paediatrics/O&G 1 (to 2400)
- Specialists/VMOs
  - A staff specialist or VMO is on call after hours for each major discipline.
- Ward allocation for after hours:
  This is not a specialties basis allocation; hence Medical Officers cover all patients in their allocated wards unless specialties are specified.

| Shift | Hours | Covers | Reports to |
|---|---|---|---|
| MO1 | Mon-Thu 1600-2400*<br>Fri 1700-0830<br>Sat 0830-0830<br>Sun, P/H 0830-2400 | • 3A, 3C, 3F<br>• Obstetrics and Psychiatry from 2400 | Surgical Registrar |
| MO2 | Mon-Fri 1600-2400*<br>Sat 0830-2400<br>Sun, P/H 0830-2400 | • 2A, 2B, 2C, 2D, Ambulatory Care<br>• 3J, 3H from 2100 Mon-Fri and from 1630 in weekend and public holiday<br>• Provide emergency cover for MO1 when MO1 is scrubbed in theatre (first on call) | Medical Registrar |
| MO3 | Mon-Fri 1600-2400*<br>Sat 0830-2400<br>Sun, P/H 0830-2400 | • 2G, 2J<br>• Respond to MET (Medical Emergency Team) call<br>• Provide emergency cover for MO1 when MO1 is scrubbed in theatre (second on call)<br>• Cover MO2 from 2300, Monday - Friday | Medical Registrar |
| Night Medical | Sat-Fri 2330-0830 | • 2A, 2B, 2C, 2D, 2G, 2J, 3J, 3H, Paediatric and Nursery<br>• Respond to MET (Medical Emergency Team) call | Medical Registrar |
| Night Surgical | Sun-Thu 2330-0830 | • 3A, 3C, 3F, Obstetrics and Psychiatry | Surgical Registrar |
| Cardiology MO | Mon-Fri 1700-2100<br>W/E, P/H 0830-1630 | • 3J, 3H | Medical Registrar |
| Paediatric Resident | Mon-Fri 1600-2400<br>W/E, P/H 0800-2400 | • Paediatric, Nursery, Obstetrics and Psychiatry | Medical Registrar |
| ICU Resident | Mon-Sun 1930-0830 | • ICU | ICU/Anaes Registrar |

* If it is an overtime shift, hour will be 1700-2400 for MO1 and MO3 and 1700-2300 for MO2.

- **Emergency Department Career Medical Officer /Registrar**
  The CMO on duty in the Emergency Department is the senior medical officer in the department and the nominated senior doctor in the event of a disaster situation until a more senior officer arrives at the hospital.

  The ED CMO/Registrar is responsible for:
  - Ensuring that adequate patient care is being carried out in the Emergency Department during the period of duty and supervising junior medical staff as required.
  - Determining those patients requiring admission to the wards and liaising with the After Hours Nurse Manager duty regarding emergency admissions and problems affecting patient care

- **Medical Registrar**
  The on-duty Medical Registrar is the senior doctor in the hospital with responsibility for patients admitted under the various medical specialities and is responsible for:
  - Care of all medical in-patients and is expected to review all unstable patients identified at handover or on request by JMOs or nursing staff.
  - Assessment all medical admissions in ED as soon as practicable and must discuss their assessment and ongoing management with the appropriate AMO.

- **Surgical Registrar**
  The Surgical Registrar on duty after hours is responsible for the care of all surgical patients both in wards and those in the Emergency Department likely to need admission. The Surgical Registrar should only go to the operating theatre for emergency cases and if so should assess emergency admissions between theatre cases as necessary.

- **JMOs**
  JMOs on duty after hours are assigned to geographical areas of the hospital according to their assigned shift as per the preceding table. They are expected to respond to all aspects of the care of their patients while on duty. After hours JMOs are expected to assist each other and to carry out any duties in any part of the hospital depending on workloads and clinical priorities as directed by relevant Registrars.

- **Ward Rounds**
  Registrars and JMOs on duty after hours are not expected to do routine ward rounds with their VMOs during the above-mentioned periods.

### 3.5.3 Sick Relief Roster

A roster is provided of JMOs for sick relief cover. An on-call payment is made to each JMO on sick relief and JMOs are expected to be available to work if required on this roster. The sick relief is used infrequently but may be required to cover an after hours shift of another JMO who is unwell and unable to work. JMOs who are unwell must notify Medical Administration as early as possible to enable the sick relief to be notified of the need to work an additional shift. Any JMO rostered for sick relief who also is unwell must notify Medical Administration the same as for any rostered shift.

## 3.6 Awards and conditions of service

This section outlines the major components of the award conditions under which JMOs are employed.

### 3.6.1 General Conditions

JMOs are employed under the terms and conditions of the Public Hospital (Medical Officers) Award 1999. Copies are available in Medical Administration, from the NSW Health website accessed through the SWSAHS Intranet or via Internet on
http://www.health.nsw.gov.au/er/human_resources/hs_awards/awards/awards_index.html#hrea
Current rates of pay are also accessible through the web site.

The Award covers all aspects of employment including working hours, penalty and overtime payments, leave provisions etc. In simple terms JMOs are employed on an annual contract with the hospital. The NSW Department of Health offers all medical graduates tenure within the NSW hospital system until completion of the third year after graduation in accordance with NSW Health Circular 88/86 (27 April 1988). This means that graduates are guaranteed three years of employment. It does not mean that an individual hospital is obliged to employ a doctor who wishes to remain at a particular hospital but that NSW Health has an obligation to find a vacant position somewhere in NSW.
The core elements of the Award include:

- **Hours of Work**
  - Ordinary hours are a maximum of an average of 38 hours per week. This is achieved by rostering either 40 hours in any consecutive seven days or 80 hours in any consecutive fourteen days and granting additional leave to the extent of one day per calendar month (ADOs see below).
  - Days off should be rostered of two days each week of four days in each fortnight as consecutive days where practicable.
  - No shift shall be less than eight hours in length on a weekday or less than four hours on a Saturday, Sunday or public holiday.
  - No broken or split shifts shall be worked.
  - All time worked in excess of 10 hours in any one shift shall be paid as overtime.
  - Two weeks notice should be given of rosters to be worked in relation to ordinary hours of work and where practicable in relation to rostered overtime. A hospital may change rosters without notice to meet any emergent situation.

- **Penalty Rates**
  Any ordinary hours worked between the following hours shall be paid at ordinary time plus the appropriate penalty rate:
  - 1800 to 2400 Monday to Friday – 12.5%
  - 2400 to 0800 from midnight Sunday to midnight Friday – 25%
  - Midnight Friday – midnight Saturday – 50%
  - Midnight Saturday – midnight Sunday – 75%

- **Meal Breaks**
  - Day shift – Monday to Friday
    There shall be a uniform meal break of 30 minutes
    Officers required to work during their meal break shall be paid for the time worked.
  - Other shifts – as per NSW Health Circular 83/250 (19 August 1983)

- **Overtime**
  - All overtime in excess of ordinary hours is paid at time and one-half for the first two hours and double time thereafter. All overtime on a Sunday is at double time.
  - On occasions additional time may be worked beyond rostered time to complete patient duties for example participation in operations running late due to unexpectedly complex surgery. Such “unrostered overtime” may be claimed on the

fortnightly time sheet (see 3.7.3 below). Justification for the unrostered overtime must be written on the time sheet.

- **Annual Leave**
  Four calendar weeks leave on full pay for each twelve-month's service plus one day for each public holiday worked.

- **Sick Leave**
  Full pay for 76 ordinary hours per year of service

- **Travelling allowances**
  Medical Officers seconded to another hospital may be granted a daily travel allowance for the difference in the distance travelled to the normal place of employment and the distance to the seconded hospital.

### 3.6.2 A.D.O (Allocated Day Off)

JMOs accrue ADOs by virtue of working a 40-hr week under a 38-hr/week award. This explains why payment is for 7.6 hrs per day, but the rostered ordinary shift is an 8-hour day and why overtime only starts (in normal circumstances) after 8 hours. One 8-hour day is accrued for each month worked and may be taken as time off work by mutual arrangement. A maximum of 12 days may be accumulated and any untaken ADOs will be paid out at ordinary rate of pay on termination of employment.

In general, no provision is made for relief when ADOs are taken. Therefore JMOs must ensure that their clinical team can accommodate their absence and that they are clear from the overtime roster. This is usually achieved by seeking permission from the team registrar. In addition Medical Administration must be advised and approval given by Medical Administration in advance of the ADO being taken.

ADOs can be rostered by Medical Administration and this will often be done in situations where the normal roster does not total 80 hrs in the fortnight. ADOs will not be approved for staff who have already worked 80 normal hours in the fortnight.

### 3.6.3 Timesheets and Salary Payment

Pay periods run fortnightly from Monday to Sunday. JMOs are paid at the end of the fortnight.

Timesheets are printed in Medical Administration based on published rosters. It is critical that Medical Administration is aware of any roster change prior to printing timesheets. Timesheets will be placed in JMO pigeonholes in the JMO room in Medical Administration and in the pigeonholes in the emergency department for JMOs working in that department. JMOs need to review, amend if necessary, and sign timesheets between Monday and Wednesday of the second week of the pay period.

In signing the timesheet JMOs are required to:

- validate that the shifts printed on the timesheet were actually worked or will be worked by the Sunday at the end of the pay period
- amend any rostered shifts which were swapped or changed at short notice (including details of any other parties involved)
- add in details of leave for which Medical Administration had not been notified in advance (this should rarely occur)
- add in details of unrostered overtime and call-backs (including justification)

Any changes which occur between signing the timesheet and the end of the pay period need to be documented on an ***"RMO adjustment Claim form"*** and submitted with the timesheet in the following pay period. These adjustments will be paid in the following time period. This

might include unrostered overtime in the last few days of the week, call backs over the weekend, sick leave or unanticipated roster swaps.

Adjustments must be submitted no later than the following fortnight. adjustments will not be accepted later than this.

## 3.7 Paging System

Communication is one of the most important aspects of the JMO role and critical to patient care. It is essential that all JMOs can be quickly located by their registrars, other JMOs for handover, nursing and other staff members when needed to respond to clinical issues. Pagers are allocated to all JMOs who require them, usually ward based JMOs. Those rostered to the Emergency Department will not normally be issued with pagers.

It is important that pagers are answered promptly. If you are unable to respond (e.g. in the middle of a procedure) ask for someone to respond and take a message. At the end of each term, pagers should be returned to Medical Administration and a new pager will be issued for the next term. This is because pagers are listed on the roster by position rather than name. This enables staff to memorise pager numbers for commonly called JMOs. The following after hours shifts have position specific pagers that should be collected from switch board at the start of the first after hours shift and either passed onto the night JMO or handed back to the switch board.

| Pager Number | Position | Night Position |
|---|---|---|
| 28376 | MO3 | Night Medical |
| 28058 | MO1 | Night Surgical |
| 28355 | MO2 | |
| 28016 | A/Hrs Medical Registrar | Night Medical Registrar |
| 28306 | Duty VMO Anaesthetist | |

The paging system is set up for user paging to reduce the load on the switchboard operators. Pager numbers are listed in the hospital internal phone book for many staff and on the JMO/RMO roster. To page someone the following steps are needed:

- Dial 77 and wait for the tone
- Enter the pager code (5 digits) and wait for the tone change
- Press *
- Enter the phone number or extension you want the person to contact (5 digits)
- Press * and hang up after hearing the confirming beeps.

Switchboard operators are able to enter messages to appear on pager screens. These are used as prompts for meetings such as lunchtime teaching sessions. The service is not available for individual pages.

## 3.8 Performance Review and Assessments

Ongoing performance review and assessment is a valuable means of gaining feedback on performance and identifying areas of knowledge or skill gaps where additional experience or effort is required. It is not a judgemental or punitive process but it is intended to be part of the educational program for JMOs. Performance review or performance management is now becoming a part of the normal annual process for all levels of medical staff including staff specialists and VMOs. The process established for JMOs enables feedback on both the JMO and the supervisors of each term.

### 3.8.1 Evaluation of the Junior Medical Officer by the Hospital

Junior Medical Staff assessment is both formal and informal and is undertaken by supervising Attending Medical Officers and Registrars. The formal component is completed using the “Junior Medical Officers Progress Review Form” which includes assessment of your history taking, physical examination, record keeping, clinical decision-making,

communication and procedural skills. Your clinical supervisors complete this at the end of each term. A mid-term assessment should also occur after 5 weeks in each term and must be documented by the Term Supervisor on the appraisal form. The aim is to identify areas of performance that need particular attention for improvement or areas in which the JMO wishes to gain additional skills or knowledge.

The reporting format is specified by the PGMC and is identical for all NSW hospitals. All information is currently being collated (in a de-identified format) by Newcastle University.

For interns, the Term Supervisor will be required to assess whether each intern is progressing satisfactorily towards unconditional registration. At the end of the year the hospital has to make a recommendation to the NSW Medical Board regarding registration. Clearly the end of term reports are critical in this regard.

It is in the best interest of each JMO to ensure that Term Supervisors discuss and complete the mid-term and end of term assessment by discussion with the JMO involved. This enables immediate feedback and for mid-term assessments enables action to be taken to address any concerns, skill development etc. Completed forms are reviewed by both the Director of Clinical Training and Medical Administration, and may be requested by hospitals that the JMO is applying to for future positions as part of the recruitment process.

### 3.8.2 Evaluation of the Hospital Experience by the Junior Medical Officer

Appraisal of the General Clinical Training Program by the JMO is just as essential a component of the evaluation process. Each term JMOs will be required to return a completed *JMO Attachment: Feedback and Appraisal* (or JAFA) form. Needless to say this form is orange. The document may also be completed on-line and sent directly to the PMC.

JMOs are asked to evaluate a number of facets of the term including the orientation, the education program, quality of experience gained, teaching offered by Staff Specialists and VMOs, level of supervision and the support from the Clinical Supervisor and Director of Clinical Training. This form will not be made available to Term Supervisors, however information is placed in a database by the PMC and can be accessed by Medical Administration in an aggregated and de-identified format. The aim is to enable Term Supervisors to be aware of aspects of the term that may require greater attention to fulfil the learning contract with JMOs.

### 3.8.3 Joseph Peukert Memorial Award

This Award is given each year, to the most outstanding Resident Medical Officer. Votes cast by all medical officers (JMOs and AMOs), nursing and other staff determine the winner.

## 3.9 Grievance Procedures

There are a number of options available for JMOs who wish to raise an issue, concern or grievance. The following individuals are available:

- Director of Clinical Training
- Director of Medical & Clinical Services
- JMO representative(s) on the General Clinical Training Committee
- Term Clinical Supervisor
- Employee Services Manager
- General Manager

Sometimes tensions arise between medical disciplines, between professional groups, or within the context of a training program. You may wish someone else to be aware of these tensions, but to act on this knowledge sensitively. These sorts of grievances, which you wish to be dealt with informally, should be raised with Medical Administration, or with the Director of Clinical Training. In either instance your grievance will be handled confidentially.

If a grievance demands a formal response it should be raised with Medical Administration and may require a written incident report. Written grievances will always be investigated and a written response provided. If the grievance is against Medical Administration, JMOs are encouraged to discuss this with the Director of Medical Services in the first instance but if not comfortable in so doing or feel the issue is not resolved then the matter should be raised with the Manager of Employee Services or the General Manager.

## 3.10 Employee Assistance Programs and Staff Health

A free program is available to help JMOs (and all staff) to manage their health and well being in the workplace and to improve their effectiveness, happiness and safety. If offers professional counselling for personal and work difficulties that may affect work performance such as:

- Stress
- Marital problems
- Sexual harassment and abuse
- Alcohol and drug dependencies
- Gambling
- Bereavement and grief
- Child and elder care
- Emotional and physical problems
- Referral of problems that are outside the expertise of the counsellor.

Two counsellors are employed by SWSAHS (one full time psychologist and one part time social worker) and an external contracted agency is engaged to provide additional services. The service is available 24 hours per day, 7 days a week and contact may be made through the Liverpool Hospital switch board on 9828 3000 by asking for the staff counsellor. You do not have to give your name to access this service and councillors are bound y strict codes of confidentiality.

## 3.11 Dress Code and Uniforms

There is no formal dress code or uniform. While on duty JMOs are required to dress neatly and sensibly as befits their position as a medical practitioner. There is no absolute requirement for male JMOs to wear a necktie and there is growing evidence that in fact it is better from an infection control perspective not to wear a tie. White coats are not provided but appropriate protective gowns, gloves, eye protection etc is available in all clinical areas and should be worn as required.

For infection control reasons, operating theatre clothing must not be worn outside of theatre (including the delivery suite) except for urgent clinical matters. This may include attending to a patient in the emergency department, diagnostic areas such as radiology or responding to an urgent request to attend a ward patient. Under these circumstances, the complete theatre attire MUST be changed on return to the operating theatre. Operating theatre attire must not be worn to the hospital cafeteria or non-clinical areas such as the kiosk near the front entrance or the kiosk in the medical centre.

## 3.12 Identity Badges

All JMOs will be issued with plastic magnetic coded photo ID badges on commencement. These should be worn at all times to identify the JMO. The badge has a dual purpose. It identifies the user as a bona-fide employee of the health service and enables other staff and patients to identify you by name. It also functions as a ‘swipe-card’ through the embedded magnetic code enabling access to areas such as operating theatres, ICU, delivery suite and car parks as well as after hour’s access to the hospital, Emergency Department etc. Increasingly areas of the hospital are controlled by swipe cards to limit access of the general public. Each ID badge is identified via approvals entered into the computer controller by staff in employee services. Authorisation is given on an as needed basis.

## 3.13 Personal conduct

All staff members are expected to abide by the SWSAHS Code of Conduct. This is based on NSW Health Guidelines and is common to all hospitals. A summary will be provided in the orientation pack for you to read and sign. The provisions on outside employment are probably the section most

pertinent to RMOs. Outside employment has to be approved but is not usually withheld unless the outside position conflicts with, or impairs the performance of your job at Bankstown.

JMOs are encouraged to identify their limitations, to acknowledge when help is required and to seek advice from more senior medical officers if in any doubt.

## 3.14 Personal and Professional Development

JMOs are expected to develop aspects of their personal and professional development including:

- An awareness of their limitation of knowledge and skills and when to seek help.
- Respect for patient autonomy and quality information sharing with patients and/or families.
- Participation in teaching and education activities.
- Maintenance of clear, comprehensive and accurate medical records as per guidelines in the RMO Handbook.
- Time management skills with good organisational skills and prioritisation to tasks.
- Demonstrating professional responsibility through punctuality, reliability and honesty.

# 4. JMO STAFF FACILITIES

This section covers issues loosely falling under housekeeping matters for JMOs.

## 4.1 Accommodation, lounge and dining facilities

A range of facilities are provided for rest and relaxation.

### 4.1.1 JMO Lounge and Facilities

A JMO lounge is provided for the exclusive use of JMO staff (Interns through to Registrars) on Level 3 adjacent to ward 3A. This is a private space for the use of JMOs and it is expected that all JMOs respect the privilege of access to this space by keeping the facility clean and tidy. Rubbish including left over food and disposal plates etc must be placed in the rubbish bins provided. Cups, glasses etc should be rinsed and placed on the bench by the sink or in the cupboard. If food is brought from the hospital cafeteria, this should be on disposable plates with plastic cutlery. A daily cleaning service is provided but JMOs are expected to maintain a reasonable state of tidiness and cleanliness.

Facilities include comfortable seating, television and video player, two computers with intranet and Internet access, microwave and tea and coffee facilities. Lockers are provided for safeguarding of personal effects.

A small doctors room is provided in Medical Administration for collection of mail and attending to formal correspondence such as completion of coroner's depositions, death certificates etc. A range of stationery is provided such as leave application forms and there are copies of most hospital manuals for reference purposes.

### 4.1.2 Overnight Accommodation

Duty rooms and overnight accommodation is provided as per the table below in single bedrooms each with an en-suite

| Position | Room No | Location |
|---|---|---|
| Medical Registrar | 1 (30478) | Level 3 adjacent to lift foyer |
| O&G Registrar | 2 (30475) | Level 3 adjacent to lift foyer |
| Surgical Registrar | 6 (30466) | Level 3 adjacent to lift foyer |
| Night Medical Officer | 7 (30465) | Level 3 adjacent to lift foyer |
| Night Surgical Officer | 8 (30462) | Level 3 adjacent to lift foyer |
| MO1 | 1 | Gallipoli Street (Above Child Care) |
| MO2 | 2 | Gallipoli Street (Above Child Care) |
| MO3 | 3 | Gallipoli Street (Above Child Care) |
| Anaesthetic/ICU Registrar | 30630 | Ward 3H |
| Orthopaedic Registrar | 30635 | Ward 3H |
| Paediatric Registrar | 30633 | Ward 3H |
| ICU Medical Officer | 30760 | ICU |

Only medical officers rostered to the above shifts are automatically entitled to accommodation. Other medical staff requiring a room will have to make a separate arrangement through Medical Administration.

Medical Officers using the above accommodation are reminded to collect their room key from Transport Department before closing of business at 1800 hours. Keys have to be returned to Transport Department no later than 0900 the following morning allowing the general service staff to change linen.

### 4.1.3 Meals and Allowances

Meals are served in the Staff Dining Room on level 1, which is open during the following times:

| | |
|---|---|
| Breakfast | 0630 - 0830 |
| Lunch | 1145 - 1345 |
| Dinner | 1630 - 1830 |

The Kitchen closes after 1830 hours, however, an Automatic Snack Machine is available. Tea and coffee facilities are also available at all times.

Under The Award, JMOs are entitled to a free meal when rostered to an overtime shift at short notice (i.e. less than 24hrs notice). In addition, South West Sydney Area Health Service has approved an above award entitlement to a free meal for any shift that exceeds 13hrs in duration, and two tickets for shifts that equal or exceed 24hrs

Free meals are claimed by presentation of a meal ticket to the dining room cashier. Tickets can be collected from Medical Administration during normal office hours in advance of rostered overtime shifts. Tickets are not available for collection at other times. Meal tickets are for personal use during the overtime shift worked. Tickets are not transferable to other RMOs or redeemable for cash.

Removal of crockery and cutlery from Staff Cafeteria is not allowed.

There is a private kiosk at the front entrance of the hospital open from 0830 to1830 each day serving hot and cold drinks, made to order sandwiches/rolls, cakes, a range of salads and snack foods. Newspapers and magazines are on sale also.

A second kiosk is located in the medical centre adjacent to the hospital and has a similar range of products plus hot foods.

## 4.2 Car Parking

The hospital provides about 600 car parking spaces with 185 underground spaces in the staff car park accessed from Artegal Street adjacent to the Emergency Department ambulance entrance. A further 375 car spaces are located at the front of the hospital via the Eldridge Road entry. There is also free street parking available in the immediate vicinity of the hospital.

A proportion of car parking spaces are allocated to JMOs and there is a waiting list for spaces. A fortnightly parking fee is deducted from salary payments for successful applicants and entry is gained by using your ID badge at the boom gate swipe card reader.

Parking in the front car park is available to all staff by payment of a fee at the boom gate.

## 4.3 Mail and Communication

Pigeon Holes are provided for JMOs in the doctor's room in Medical Administration. Any mail, notices etc will be placed in the individual pigeonhole. Separate pigeonholes are provided for in the emergency department, ICU and Banks House for JMOs working those terms. Mail for JMOs on secondment at Campbelltown will be sent to Medical Administration at Campbelltown.

A notice Board is provided in the doctor's room for display of general notices, significant events etc.

## 4.4 Professional Associations

The Health and Research Employees' Association of NSW (HREA) represents junior doctors industrially in NSW. Many JMOs also choose to belong to the Australian Medical Association (AMA) that has a role in representing the medical profession on a broader basis particularly in

lobbying government in respect of terms and conditions of remuneration for specialists and general practitioners.

Many JMO s may also choose to become subscribers to a medical defence organisation although this is not strictly necessary as salaried medical officers such as JMOs are covered for indemnity purposes for activities undertaken as part of their employment.

From time to time JMOs may wish to meet with representatives of professional associations to discuss topical issues. There is no restriction on such meetings other than gaining prior approval from Medical Administration and ensuring that an appropriate venue is booked in advance. In general such meetings should be held at lunch time or another convenient time outside the normal work hours.

## 4.5 Child Care Centre (Birralee)

This is a 55-place centre providing childcare services for staff and visitors of the Health Service. It is run by the Health Service and is open from 0630 to 1800 weekdays. The aim is to help to attract and retaining quality staff with children by providing care during normal working hours. A waiting list applies to obtain a place in the centre. The Child Care Centre has been recognised as a high quality facility by gaining 3-year accreditation under the Commonwealth Government National Child Care Accreditation scheme.

# 5. JMO EDUCATION

## 5.1 Postgraduate Medical Council of NSW (PMC)

The Postgraduate Medical Council (PMC) of N.S.W. was established in 1988 to promote and supervise the postgraduate education and training of Interns and RMO1s (PGY1s and PGY2s) in the N.S.W. Public Hospital system. Collectively these two groups are known as Junior Medical Officers or JMOs.

The Council has responsibilities for education, accreditation, workforce planning and allocation, and requires that all public hospitals employing Junior Medical Staff be accredited with the council. Bankstown-Lidcombe Hospital is fully accredited by the PMC for the maximum available three years.

The PMC sets and publishes standards and guidelines for training and education of JMOs that form the basis of accreditation. As a requirement under these standards the Hospital has established a General Clinical Training Program and appointed a Director of Clinical Training and a General Clinical Training Committee to oversee JMO education.

## 5.2 Director of Clinical Training (DCT)

The Director of Clinical Training is usually an experience clinician with an interest in JMO education and teaching. The DCT is independent from Medical Administration and hence is able to mediate in any dispute or misunderstanding that may occur between JMOs and Medical Administration.

The role of the DCT is to:

- assist in defining the needs of JMOs, establishing objectives for JMO training and the development and maintenance of education programs to ensure that objectives and needs of JMO training are met;
- act as a JMO advocate and to ensure that JMO terms are relevant and that teaching within the terms is satisfactory;
- maintain lines of communication between Medical Staff relating to training and education of JMOs;
- encourage Visiting Medical Officers, Staff Specialists and Registrars to include and supervise JMOs in all aspects of patient care, including decision making;
- provide career information and counselling;
- participate in the JMO orientation program;
- ensure that a term description is provided for every term rotation;
- ensure that individual contact occurs at regular intervals between the DCT and individual JMOs;
- facilitate feedback to each JMO about Medical Administration, and to Clinical Supervisors performance each term; and
- identify Junior Medical Staff with special needs or difficulties and to ensure that remediation occurs, where appropriate, for those demonstrating a deficiency in acquiring skills.
- Provide career development counselling and assist JMOs to obtain information necessary to make career development choices.

## 5.3 General Clinical Training Programme

A comprehensive program is provided for general JMO training designed to cover most aspects of patient care over the twelve-month period. The training program consists of:

- Monday and Friday lunchtime education program specifically targeted at Interns and RMO1s usually presented by Staff Specialists or VMOs. This is regarded as a compulsory session for JMOs. Pagers should be handed to respective registrars to carry for the session to ensure that pager calls do not disrupt the educational period.

- Grand Rounds each Tuesday lunch time. All medical staff are encouraged to attend and there is usually a presentation of one or more clinical cases of particular interest followed by discussion on diagnostic or management issues arising from the case. Grand Rounds are rotated through all speciality disciplines across the year.
- General Practice lunchtime session each Thursday.
- Other recommended departmental tutorials and/or meetings, a schedule for which is issued each 4 months.

## 5.4 General Clinical Training Committee (GCTC)

The General Clinical Training committee includes representatives from the Junior Medical Staff, Medical Administration, Medical Staff Council and Director of Clinical Training. The role of the Committee is:

- To determine the specific training and education needs of Junior Medical Staff.
- To develop, implement, monitor and evaluate the General Clinical Training Program.
- To ensure that Junior Medical Staff education at Primary Allocation Centres and Secondment Hospitals is of the standard required by the Postgraduate Medical Council.
- To regularly review and evaluate the training, education, experience and working conditions of each Junior Medical Officer.
- To ensure effective feedback to each Junior Medical Officer on his/her performance and progress.
- To provide regular reports on its activities to the management of the Hospital.
- To prepare for and maintain accreditation status.
- To advise on educational resource material needed to support the education program.
- To provide appropriate information on Junior Medical Staff matters, as required by the Postgraduate Medical Council

# 6. EDUCATIONAL RESOURCES

Bankstown Health Services has a range of facilities available to assist in medical education.

## 6.1 Medical Library

The Medical Library is located on the fourth floor of the main hospital building, adjacent to the auditorium. Library hours are 0830-1700 hours weekdays. A reference collection is also maintained in the Emergency Department for after-hours use.

The library has a comprehensive range of journals, major textbooks and other resources.
Services provided by the library include:

- Lending of books and audio-visual resources. Loan period for most items is three weeks.
- Document supply/inter-library loan service for journal articles and books not held by the library.
- Photocopying facilities.
- Access to publications held by other South Western Sydney Area Health Service libraries and listed in the area catalogue.
- Access to CIAP (Clinical Information Access Program)
- Assistance with reference enquiries/database searches
- Literature searches
- Internet access for work-related purposes.
- Access to MS Office applications for work-related purposes.
- Daily newspapers.
- Reading and study areas.

More specific information is located in the Library Guide (available in the Library at the Circulation Desk), the Bankstown Health Service Policy and Procedure Manual and the Library's Intranet site.

New staff members are welcome to visit the Library for an introductory tour. Enquiries should be directed to the Library on extension 88250.

## 6.2 Conference and Tutorial Rooms

There are 4 conference/tutorial rooms of varying capacity on level 4 of the hospital utilised for the various educational activities depending on number of participants. A schedule of meetings is placed in a clear viewing box on the door of each room on a daily basis. The weekly schedule is placed on the level 4 notice board adjacent to the Employee Service Department. Rooms may be booked in advance through the Education Centre on level 4 opposite the auditorium (extension 88057).

Next to the Library is the hospital Auditorium for large meetings. Grand Rounds are held in the auditorium. Note: food and drink are not permitted in the auditorium.

## 6.3 Audio-visualAids

The auditorium is equipped with permanently mounted slide, overhead and computer projection facilities. It is also set up for large screen projection and video-conferencing. Portable equipment is available for use in any of the conference rooms and several are also set up for video-conferencing. Equipment including a digital camera may be booked through the same contact as room bookings.

## 6.4 Internet and E-mail Access

All JMOs will be provided with e-mail access through the SWSAHS network computer system and SWSAHS Intranet (enables full access to educational facilities such as CIAP). Internet access is available for legitimate self-education or other activities. Under direction from the NSW Health Department SWSAHS is obliged to monitor Internet usage and has installed filtering software that

restricts access to sites deemed to be inappropriate for a health service and provides a detailed report log to the Manager ISD. Repeated attempts to access inappropriate Internet sites (e.g. pornography, gambling) will be notified to Medical Administration.

The SWSAHS Chief Executive Officer has issued a policy that staff who attempt to access such sites are to be issued with a first and final warning. An attempt to access the same or similar material on further occasions will be grounds for dismissal.

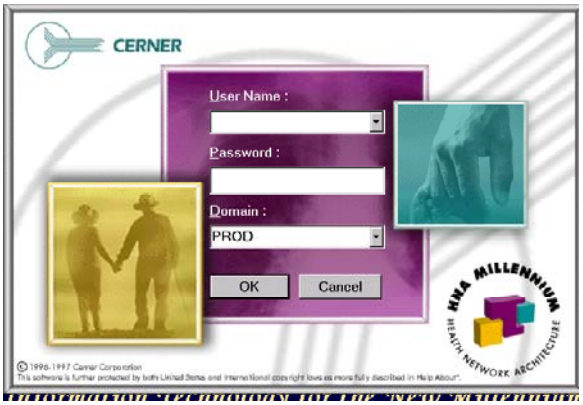
# 7. GENERAL JMO INFORMATION

This section covers a range of general issues of importance in daily activities for JMOs.

## 7.1 Inpatient List by AMO

This is one of the most useful computer applications for JMOs as it enables you to list where the patients are located in the hospital for the Attending Medical Officers (AMOs - VMOs and staff specialists) that are in your team.


Double click on the Explorer Menu Icon on the desktop.



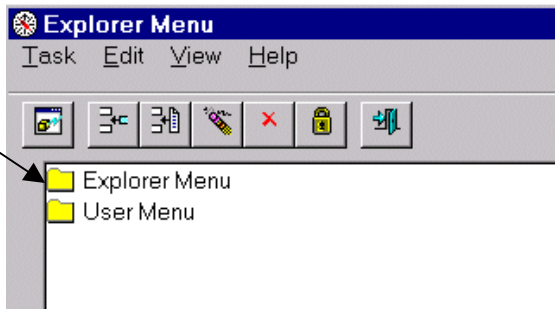

At the prompt enter your username and password. When you first log in, both your username and password will be your employee number. You will then be prompted to change your password.

Use your new password thereafter.

If the domain is blank, enter **PROD**.

Click **OK**.

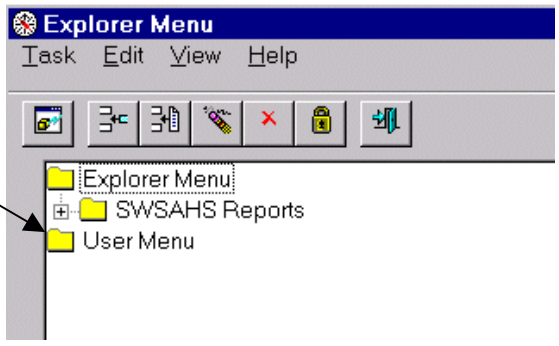
Double click on the Explorer menu.



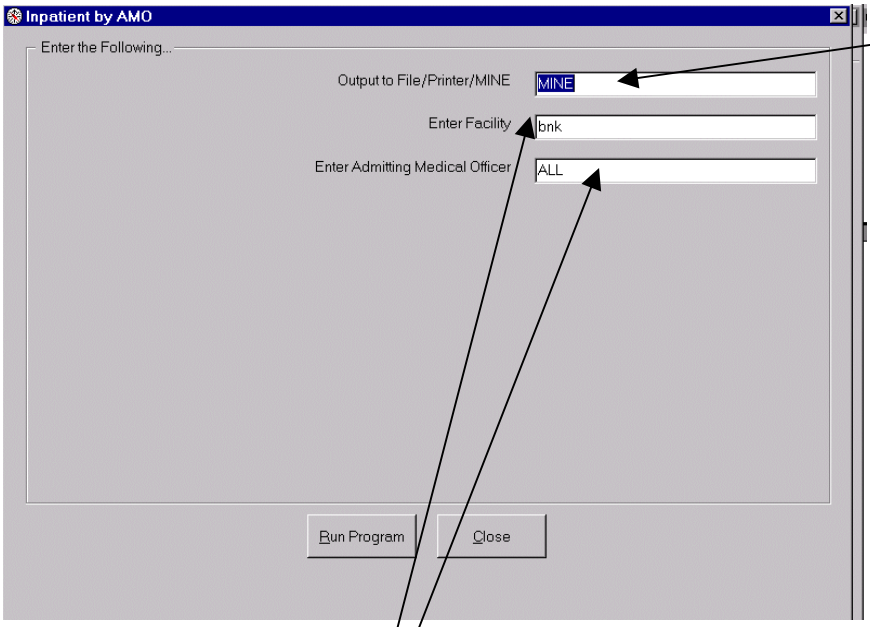

Click **once** on the plus sign [+]

beside the word SWSAHS Reports.

The reports available to you will then be listed.



Double click on the report called **Inpatient by AMO**.




Type in the printer name here. If you do not wish to print out the report, but just view it on the screen, leave the prompt as **MINE**.

(The printer name will be attached to the laser printer nearest you. It will start with the letters BK and then be followed by numbers eg. BK102, BK66 etc.)

Leave the facility prompt as bnk.

Enter the name of the AMO here. Type in the last name first, then a space then the first name. For example; **Gibian Thomas**. This prompt is case sensitive so you also have to type the name in Title Case (capitalised letter first then small letters thereafter).

Click on 

and your report should print out to the nearest printer (if you selected a printer) or to the screen if you left the printer prompt as **MINE**.

Once you have printed/run your report, close out of Explorer by clicking on the close window button on the top right hand side of the tool bar  or use the exit button  . Make sure you are completely out of Explorer when you have finished running reports.

| |
|---|
| If you have any problems running your reports, contact the Casemix & Statistics Unit in the Clinical Information Service on extension 88311 or come to the reception area between the hours of 8:30am to 5pm. |

## 7.2 Accessing Specialist Services

JMOs will be requested from time to time by their Registrar or consultant to arrange for a particular sub specialist to assess a patient. Generally Registrars arrange such consultations by phoning their respective colleague in the appropriate subspecialty and completing a written consultation referral from. The name of the appropriate Registrar is available on the term allocation roster.

## 7.3 Clinical Information Service & Medical Records

The Clinical Information Service (CIS) is located on level 2 opposite the Ambulatory Care Service on the right of the long corridor from the main lift foyer to the Emergency Department. It is open operates 24 hours per day, 7 days per week. The Service manages all functions related to medical records, clinical data collection and medico-legal correspondence (including FOI requests).

The Clinical information Service comprises the following) sections, each responsible for providing a service specific to their area. All areas are involved in assisting in the training of students from the University of Sydney, Faculty of Health Sciences.

### 7.3.1 Records Control and Processing (Medical Records)

This section encompasses the traditional management of medical records and undertakes the following functions:

- Provision of medical records for in-patient and outpatient care.
- Assembly and analysis of medical records to ensure complete and accurate information is available for data retrieval.
- Storage & Protection of Medical Records.
- Maintenance of the Patient Administration System (PAS) by updating record location using Medical Record Request and Tracking System (MRRT) and reconciliation of duplicate medical record numbers (MRNs).
- Provision of medical records for review/research purposes to authorised health professionals of South Western Sydney Area Health Service.

Under no circumstances must Resident Medical Officers take Medical Records from wards or clinical areas. If records are needed for clinical audit or any other purpose this can be arranged and records made available in the research room in the CIS department on level 2. Enquiries can be directed to extension 88305.

### 7.3.2 Casemix and Statistics Unit

This unit provides the data on clinical care of patients on which the management decisions of the hospital are based. Enquiries should be directed to extension 88321. It includes:

- Provision of routine and ad-hoc Health Service statistics.
- Casemix analysis and production of clinical/performance indicator data to support Health Service management and quality improvement processes.
- Development of statistical and other informative reports to reflect patient care and utilisation of hospital services and resources.
- Respond to requests for information.
- Maintenance of the Patient Administration System (PAS) to ensure all information contained is current and accurate. This includes updating patient details, financial details, admitting mothers and newborns, conducting data quality checks and reconciliation of duplicate Medical Record Numbers (MRNs).

### 7.3.3 Clinical Coding

All patient records are coded at discharge to enable analysis of the complexity of illness treated. This is a vital process as the funding of the hospital is largely dependent on the Casemix values determined from the coding. This gives a measure of the complexity of care needed for each patient and hence the resources (and funding) required to treat the patient. The more complex a patient's case is, the higher is the casemix value assigned and the funding allocated to the hospital. Clinical coders will largely take information from the discharge summary as well as other information recorded by clinical staff in the medical record. It is essential that all co-morbidities and diagnoses be listed on the discharge summary as this will increase the casemix value and more accurately reflect the true complexity of the care given. The coding process involves:

- Classification of diseases and procedures according to the "International Classification of Diseases. This enables each patient to be grouped into a Diagnosis Related Group (DRG).
- The tool used is the Tenth Revision Australian Modification (ICD-10-AM) in compliance with national coding standards and NSW Health Department Inpatient Statistics Collection (ISC) reporting requirements.

### 7.3.4 Forms Coordination

- All forms used for patient care are coordinated to ensure standardisation, compliance with ACHS standards and prevention of duplication. Should a new form be developed this must be discussed with the CIS staff (extension 88305).

### 7.3.5 Medico-legal and Clinical Typing

- Respond to medico-legal requests made by patients, clinicians and third parties (eg. legal representatives, insurance companies, etc) in accordance with relevant legislation and policies controlling the release of health information (eg: NSW Health Department policies and SWSAHS policies; Freedom of Information Act; Adoption Information Act,).
- Provision of information to General Practitioners, hospitals for on-going patient care.
- Preparation and processing of documents subpoenaed to court.
- Maintenance of the patient's right to privacy and confidentiality of the information contained in the medical record.
- Provision of transcription services to Outpatient Departments.
- Enquiries to extension 88335.

## 7.4 Clinical Review and Quality Assurance

JMOs are encouraged to participate in the clinical review and quality assurance process undertaken in most disciplines at their regular meetings. In recent years the emphasis on assessment of clinical practice as shifted away from process to outcome review. Process review looked at the inputs such as staff, equipment and policies and procedures on the basis that if adequate inputs were in place, good clinical results should occur. Clinical outcome assessment now focuses on the result for the patient using a range of clinical indicators and key performance indicators. Establishing good clinical review habits as a JMO will set a pattern for future medical practice.

## 7.5 Medico-Legal Issues and Medical Indemnity

JMOs will face a number of issues related to deceased patients and general medic-legal issues. The commonest events are detailed in the following section. If there is any doubt about how best to deal with any such event Medical Administration should be contacted during office hours and after hours the After Hours Nurse Manager. The Director of Medical Services remains on-call to provide advice if necessary and can be contacted via the hospital switchboard.

### 7.5.1 Death and Cremation Certificates, Consent for Post Mortem Examination

When a patient dies both a Death Certificate and a Cremation Certificate must be completed immediately or the case reported to the Coroner if applicable. Copies of Death and Cremation Certificates attached at the end of this section (Appendix A, B and C).

The responsibility for completing the paper work (and in the case of a coroner's case, calling the police), belongs during normal working hours to the team JMO and after hours to the JMO who certified life is extinct.

**Death Certificate:** The correct title of the certificate is "Medical Certificate of Cause of Death" (Copy attached at the end of this section - Appendix A). You will often find that you cannot be 100% certain of the cause of death. This does not matter. The degree of certainty required is the same as for civil courts, i.e. you need to be convinced "on the balance of probabilities". If you do not have this degree of assurance, then the case will need to be reported to the coroner, unless another doctor can write the death certificate.

Please pay attention to the time sequence in completing Part 1 of the certificate. Conditions causing death must be recorded in ascending duration e.g cardiac arrest (minutes) due to coronary artery disease (years). Remember that what you write on this certificate will appear

on the certificate issued to the deceased's family by the Registrar of Births, Deaths and Marriages and is often of great significance to them. Accuracy is important.

The JMO completing the death certificate should notify the AMO of the death of the patient. The urgency with which this is done may vary depending on the extent to which the death was anticipated. Unless the AMO has left instructions to be notified at any time it is usually adequate if this is done early in the morning. If the cause of death is unclear from the notes the AMO should be consulted when informing of the death of the patient.

You can complete a Death Certificate even if you have not seen the patient prior to death providing there is sufficient information in the medical record to determine the cause of death. If so then simply write "not seen before death" instead of the date in the 'last seen alive' section of the certificate.

**Cremation Certificate:** The correct title of this certificate is "Attending Practitioner's Cremation Certificate" (Copy attached at the end of this section - Appendix B). You should always complete this certificate at the same time as completing the Death Certificate as you will be familiar with the death circumstances. The certificate must be collected by the Funeral Director before a cremation is permitted under the public health regulation. The funeral may be delayed if the certificate is not completed immediately. Many families do not wish cremation to occur for cultural, religious or other reasons. In such cases the certificate is destroyed.

**Post Mortem:** A post mortem (autopsy) may be requested by a family member or suggested by the treating AMO as a means of clarifying the cause of death. This can often give the family resolution of the death and can be instructive to the treating team. If the cause of death is unknown, a post mortem may be requested establish the cause of death. Alternatively the death may be reported to the Coroner as outlined in s 7.5.3 below, usually if the death is sudden and unexpected. It is not appropriate to report a case to the Coroner simply in order to obtain an autopsy when the family members will not give consent.

The performance of a post mortem examination is regulated by the Human Tissue Act 1983. A "Consent for Non-Coronial Post Mortem Examination" form must be completed along with a Death Certificate before the examination can be undertaken " (Copy attached at the end of this section - Appendix B). If you are unclear of the cause of death, you must record your best estimation of the cause. A revised certificate can be issued following the post mortem examination if this reveals a more accurate assessment of the cause of death. Please assist the family member completing 'Part A' of the consent as it is important that the non-applicable alternatives are deleted. You should complete 'Part B' of the form but do not complete 'Part C'. This is done by a "Designated Officer" gazetted under the Act. At Bankstown this is usually the Director of Medical Services during normal hours and the After Hours Nurse Manager at other times. Other staff can be identified by contacting Medical Administration.

### 7.5.2 Police Statements

All JMOs at some stage will need to complete a Police Statement. This is usually to provide clinical details for legal purposes of injuries sustained. A standard form is available in the JMO room in Medical Administration and must be used. The form contains the format to comply with the requirements of the NSW Evidence Act 1995, No.25 Expert Certificate Section 177. A copy is attached at the end of this section (Appendix C). Hard copies and an electronic version are available from medical administration.

The police will usually provide a written request for a statement together with a signed consent to release information from the patient. In some cases, usually where injuries have occurred to a person suspected of committing an offence, consent may not be available. A modified form is available noting that consent was not available. If there is any doubt over completion of a statement requested by Police, contact Medical Administration.

As a general rule only factual information should be recorded of clinical findings, results of investigations and treatment undertaken. This may include the fact that a more senior practitioner was consulted. It is sufficient to note that the injuries were consistent with the cause stated by the patient. JMOs should not guess or assume any causal relationship. JMOs are not regarded as forensic experts.

The final section calling for an opinion is usually completed along the lines that 'the patient should make a complete recovery with no loss of function' or some modifying statement. No opinion should be expressed regarding the cause of the injury.

### 7.5.3 Coroner's Cases

There are a number of circumstances where the death of a person must be reported to the NSW Coroner. Details of coronial reporting and related matters are covered by NSW Health Circular 99/57 issued on 24 June 1999 titled:

*Coroner's Cases and Amendments to Coroner's Act 1980*
*(1) Jurisdiction of Coroner*
*(2) Anaesthetic Deaths*
*(3) Obligation to Report Death*
*(4) Guidelines for Nursing Staff and Medical Officer's on Coroner's Cases Dying in Hospital*
*(5) Transfer of medical Records for Post Mortems*
*(6) Discharge Type Summaries for Coronial Cases in Hospitals*
*(7) Objections to a Post Mortem*

This circular contains answers to most common questions raised about Coronial matters. Briefly a death certificate must not be issued in the following circumstances and the death should be reported to the NSW Police or the Coroner. The person died:

- a violent or unnatural death
- a sudden death the cause of which is not known
- under suspicious or unusual circumstances
- having not been attended by a medical practitioner within the period of 3 months immediately preceding death
- while under, or as a result of, or within 24 hours after the administration of, an anaesthetic administered in the course of a medical, surgical or dental operation or procedure or an operation or procedure of a like nature, other than a local anaesthetic administered solely for the purpose of facilitating a procedure of resuscitation from apparent or impending death
- within a year and a day after the date of any accident to which the cause of death is or may be attributable

There are several other provisions concerning provisions of persons under Mental Health, Community Welfare, Youth and Community Services and the Children (Care and Protection) Acts. There are also provisions covering deaths related to police custody or prisoners.

When a death is reported to the Coroner a Form A "Report of a Death of a Patient to the Coroner" must be completed. This is similar to a Police Statement and details the events regarding history, examination and treatment. Where the death is associated with an anaesthetic a second document must also be completed. This is Form B "Report of Death Associated with Anaesthesia/Sedation". Both forms are available in the JMO room in Medical Administration and copies are attached at the end of this section (Appendix D & E).

Where a JMO is required to give evidence before the Coroner, legal assistance is usually available through the Health Service. Should you receive a summons to attend a Coroner's hearing, this should be notified to Medical Administration and assistance will be provided if appropriate.

### 7.5.4 Litigation and Medical Indemnity

At some stage all medical practitioners will probably be involved in litigation regarding medical treatment. JMOs are most likely to be required to provide statements and possibly give evidence in cases where the Health Service is sued or a Specialist or VMO is sued in respect of medical treatment. In such cases the JMO will usually have attended the patient at some stage during treatment and any evidence generally relates to observations of the patient's treatment, management carried out at the direction of a senior practitioner or communications made to other staff, patient or family. It is very unusual for JMO to be sued directly.

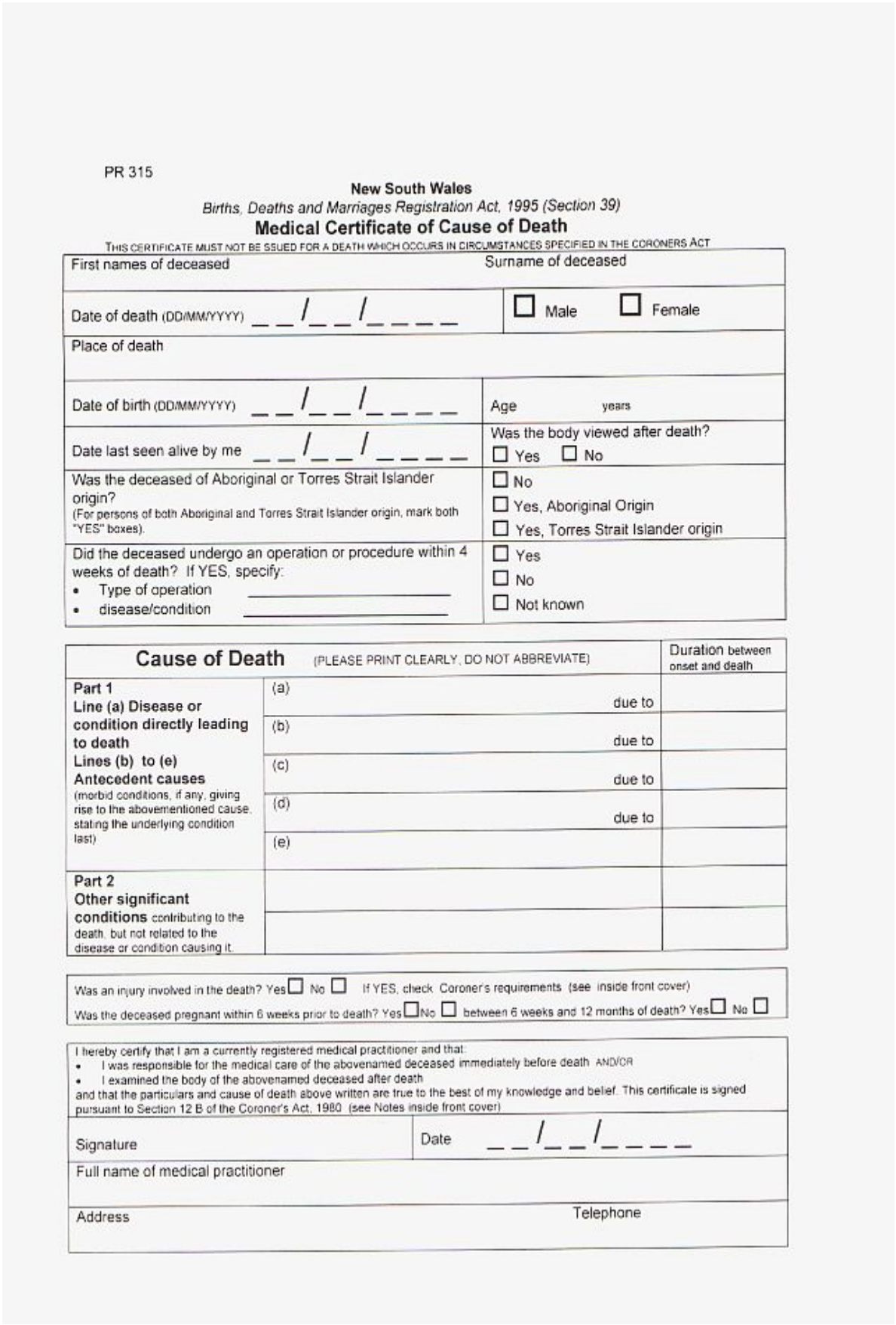
All JMOs are fully indemnified through the NSW Treasury Managed Fund (TMF) for actions related to their work with the Health Service. Membership of a separate medical defence organisation is not required I such instances. TMF indemnity does not cover actions performed outside paid employment (e.g. locum work).

### 7.5.5 Media Issues

You may be approached by a media representative for a comment on a topical issue or patient, such as a person sustaining a gunshot injury or following an assault. As a general rule staff at all levels are not permitted to speak to the media without the approval of the General Manager. If you are approached by a member of the media you should state that you are not at liberty to speak with them and direct them to contact the General Manager. If approval is given for the media to enter the hospital, you should make sure that patient confidentiality and privacy is respected and protected at all times. Patients should be asked in advance if they are willing to speak to the media and consent must be obtained before any images are taken of patients or staff members (photographs, video etc)

If you have any doubt about a media request refer the matter to the office of the General Manager, Medical Administration or after hours to the Nurse Manager on duty for the hospital.

# Appendix A: Death Certificate



PR 315

**New South Wales**

*Births, Deaths and Marriages Registration Act, 1995 (Section 39)*

**Medical Certificate of Cause of Death**

THIS CERTIFICATE MUST NOT BE ISSUED FOR A DEATH WHICH OCCURS IN CIRCUMSTANCES SPECIFIED IN THE CORONERS ACT

| | |
|---|---|
| First names of deceased | Surname of deceased |
| Date of death (DD/MM/YYYY) __ __ / __ __ / __ __ __ __ | ☐ Male ☐ Female |
| Place of death | |
| Date of birth (DD/MM/YYYY) __ __ / __ __ / __ __ __ __ | Age years |
| Date last seen alive by me __ __ / __ __ / __ __ __ __ | Was the body viewed after death? ☐ Yes ☐ No |
| Was the deceased of Aboriginal or Torres Strait Islander origin? (For persons of both Aboriginal and Torres Strait Islander origin, mark both "YES" boxes). | ☐ No ☐ Yes, Aboriginal Origin ☐ Yes, Torres Strait Islander origin |
| Did the deceased undergo an operation or procedure within 4 weeks of death? If YES, specify: • Type of operation _____ • disease/condition _____ | ☐ Yes ☐ No ☐ Not known |

| **Cause of Death** (PLEASE PRINT CLEARLY, DO NOT ABBREVIATE) | | Duration between onset and death |
|---|---|---|
| **Part 1** **Line (a) Disease or condition directly leading to death** **Lines (b) to (e) Antecedent causes** (morbid conditions, if any, giving rise to the abovementioned cause, stating the underlying condition last) | (a) due to | |
| | (b) due to | |
| | (c) due to | |
| | (d) due to | |
| | (e) | |
| **Part 2** **Other significant conditions** contributing to the death, but not related to the disease or condition causing it | | |
| | | |

Was an injury involved in the death? Yes ☐ No ☐ If YES, check Coroner's requirements (see inside front cover)

Was the deceased pregnant within 6 weeks prior to death? Yes ☐ No ☐ between 6 weeks and 12 months of death? Yes ☐ No ☐

I hereby certify that I am a currently registered medical practitioner and that:
- I was responsible for the medical care of the abovenamed deceased immediately before death AND/OR
- I examined the body of the abovenamed deceased after death

and that the particulars and cause of death above written are true to the best of my knowledge and belief. This certificate is signed pursuant to Section 12 B of the Coroner's Act, 1980 (see Notes inside front cover)

| | |
|---|---|
| Signature | Date __ __ / __ __ / __ __ __ __ |
| Full name of medical practitioner | |
| Address | Telephone |

## Appendix B: Cremation Certificate

NSW HEALTH
DEPARTMENT

**ATTENDING PRACTITIONER'S CREMATION CERTIFICATE**
PUBLIC HEALTH REGULATION 1991 Clause 49

My name is .....(full name in block letters). I am a registered medical Practitioner in New South Wales. I am informed that an application has been made or is to be made for the cremation of the remains of .....(Name of deceased) of .....
.....(Last address of deceased)

As (a) a member of the hospital medical team (cross out whichever not applicable)
(b) a general practitioner

I attended the deceased before death for .....((period of time: days, months, years)

**I have personally seen the body after death and am satisfied as to the identity of the body.**

1. State time and date of death.

2. State place where the deceased died.
(Give address and state whether own residence, lodgings, hotel, hospital, nursing home etc)

3. Are you a relative of the deceased? If so, state the relationship.

4. Have you, so far as you are aware, any pecuniary interest in or arising from the death of the deceased?

5. When did you last see the deceased alive?

6. How soon after death was the body examined? (hrs, days)

7. (a) Did you complete the Death Certificate for the deceased? (a) .....
(b) In your view, is the cause of death as is disclosed on the Death Certificate? (b) .....
(c) If not,
(i) State in your view what was the cause of death (i) .....
(ii) What was the duration of this condition in years, months or days? (ii) .....

8. (a) Has there been any operation/procedure performed on the Deceased within the last year before death? (a) .....
(b) If so,
(i) What was the nature of the operation, who performed it and when? (i) .....
(ii) In your opinion, did the procedure contribute to an acceleration of death? (ii) .....

9. Do you know, or have you any reason to suspect, that death of the deceased was due, directly or indirectly to:-
(a) violence (b) poison (c) abuse or neglect (d) drowning
(e) suffocation (f) burns (g) during custodial care (h) illegal operation

10. Have you any reason whatever to suppose a further examination of the body is desirable?

11. (a) Was any battery powered device attached to present in the body of the deceased? (a) .....
(b) If so, has it been removed? (b) .....

*Note:* This certificate must be handed to the Funeral Director, or sent by the medical practitioner who signs it to the medical referee.

I hereby certify that, to the best of my knowledge and belief and having sought where appropriate additional information, the answers given above are true and accurate and that no relevant information has been omitted.

Signature: ..... Date: .....

Address: ..... Registered Qualifications: .....

April 1995

## Appendix C: CR 17 - Consent for non – coronial post mortem examination

**SOUTH WESTERN SYDNEY AREA HEALTH SERVICE**

**CONSENT FOR NON-CORONIAL POST MORTEM EXAMINATION**

Affix ID Label Here

MRN | Surname | Given Names | Address - Street | Suburb | Postcode | Date of Birth | Sex | AMO | Hospital Name | Ward

**(A) POST MORTEM RELEASE INFORMATION OBTAINED FROM NEXT OF KIN**

Name of Medical Officer Obtaining Consent (Print name) _____

Senior Available Next of Kin (Print Surname) _____ First Name: _____

Address: _____

Relationship of Next of Kin to Deceased (Print) _____

1. **I consent to the following being carried out on the above named deceased:** ***(delete whichever is not applicable)***
   (a) a full post mortem examination of the deceased
   (b) a limited post mortem examination of the deceased (if limited permission given, state the part of the body to be examined on line below)

   _____

2. ***Delete whichever is not applicable:***
   (a) I consent to retention of tissue samples, organs and other body parts for diagnostic testing. The following organs are not to be retained _____
   (b) I consent to use of retained tissue samples, organs and/or other body parts for scientific, therapeutic, teaching and medical purposes
   (c) I do NOT consent to the retention of any tissue samples, organs and other body parts for diagnostic testing.

3. **I wish the tissue samples, organs and other body parts to be disposed of as follows:**
   ***(delete whichever is not applicable)***
   (a) in a lawful manner by the hospital
   (b) returned to me or a person nominated by me
4. **I have no reason to believe that the deceased had expressed any objection to this post-mortem examination**
5. **The nature of the post-mortem examination and the way that tissue from the deceased's body will be dealt with has been explained to me. I have had the opportunity to ask questions. I am satisfied with the explanation and the answers to my questions.**
6. **Please send a copy of the post-mortem report to Dr.** _____
7. **Please ensure the deceased is ready for release in time for the funeral arranged for:**
   **Date:** _____/_____/_____ **Time:** _____

**SIGNATURE OF THE SENIOR AVAILABLE NEXT OF KIN:** _____ **DATE:** ___/___/___

**SIGNATURE OF MEDICAL OFFICER REQUESTING PERMISSION FOR POST MORTEM:** _____

**INTERPRETER PRESENT: YES/NO** **SIGNATURE OF INTERPRETER:** _____

**(B) POST MORTEM INFORMATION TO BE COMPLETED BY MEDICAL OFFICER**

**CLINICAL SUMMARY** (*see Note 1 on page 2*):

_____

_____

**PROBLEMS FOR INVESTIGATION AT POST MORTEM:**

_____

_____

**CHECKLIST (SWAPS Policy requires an answer to all these questions):**

1. Is the death one which has been or is likely to be the subject of enquiry by the Coroner? (*see Note 2*) YES / NO
2. Has a Medical Certificate of the Cause of Death been signed? (*see Note 3*) YES / NO
3. To the best of your knowledge did the deceased, when alive, object to autopsy? YES / NO
4. To the best of your knowledge, has the body of the deceased been bequeathed for Anatomical studies? YES / NO
5. Does the body contain any radioactive material? (*see Note 4*) YES / NO
   If 'YES' please specify _____
6. Does the deceased pose a known infection risk? (*see Note 5*) YES / NO
   If 'YES' please specify _____

BINDING MARGIN - NO WRITING
FILE IN CLINICAL RECORD

REORDER - Oracle No. 6070651

CONSENT FOR NON-CORONIAL POST MORTEM EXAMINATION

CR 17

Mar 01 / Rev 3

**This form has a reverse side. Both sides MUST be completed**

## Appendix D: Police Statement

NSW Police Service
**EXPERT CERTIFICATE**
Section 177, Evidence Act 1995 No.25

**In the matter of:**
**Place Statement Taken:** Bankstown-Lidcombe Hospital, Eldridge Road, BANKSTOWN
**Date:**

**Name:**
**Work Address:** Bankstown-Lidcombe Hospital, Eldridge Road, BANKSTOWN, NSW 2200
**Work Telephone:** 02 9722 8000
**Occupation:**

**STATES:**

1. This statement made by me accurately sets out the evidence which I would be prepared, if necessary, to give in court as a witness. The statement is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable for prosecution if I have wilfully stated in it anything which I know to be false, or do not believe to be true.

2. I am _____ years of age.

3. I have a specialised knowledge based on the following training, study and experience.

   Qualification:

   Other Study/Experience:

4. At _____ hrs on ___/___/___ a male/female who is now known to me as

   _____ (Patient's name) attended the Emergency

   Department of Bankstown-Lidcombe Hospital

**Witness: ..... Signature: .....**

Page 1 of 2

Statement Re:_____ (continued)
(Patient's Name)

5. Upon examination, the injuries found were:

.....

.....

.....

.....

.....

.....

.....

.....

.....

6. The following investigations and treatment were given:

.....

.....

.....

.....

.....

.....

.....

7. I believe that the injuries exhibited are consistent with

.....

.....

.....

8. In my opinion the patient

.....

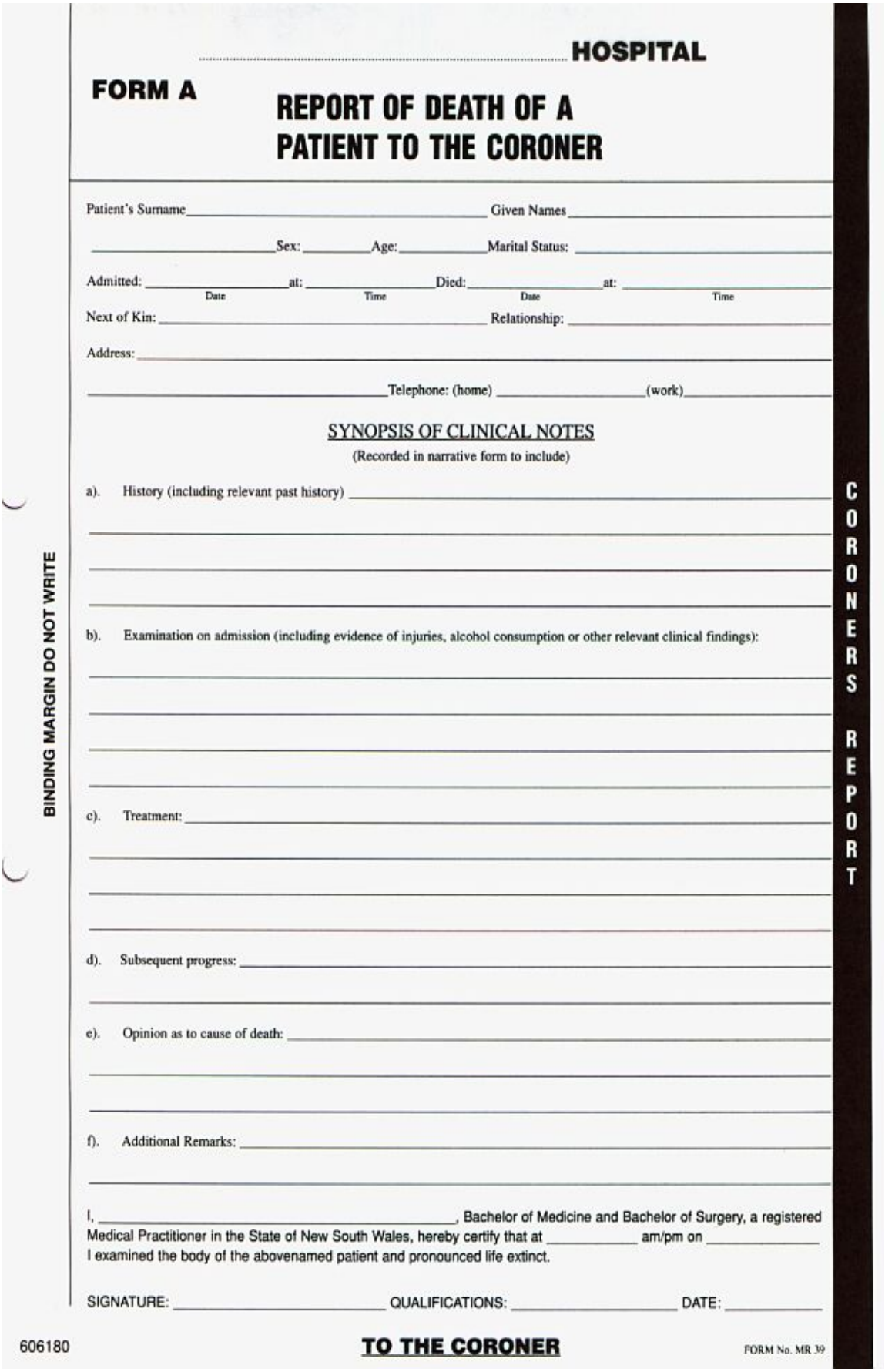
.....

.....

**Witness: ..... Signature: .....**

Page 2 of 2

## Appendix E: The Coroner: Form A "Report of a Death of a Patient to the Coroner"



.....HOSPITAL

**FORM A**

**REPORT OF DEATH OF A PATIENT TO THE CORONER**

Patient's Surname_____ Given Names_____

_____Sex:_____Age:_____Marital Status: _____

Admitted: _____ (Date) at: _____ (Time) Died: _____ (Date) at: _____ (Time)

Next of Kin: _____ Relationship: _____

Address: _____

_____Telephone: (home) _____(work)_____

SYNOPSIS OF CLINICAL NOTES

(Recorded in narrative form to include)

a). History (including relevant past history) _____

b). Examination on admission (including evidence of injuries, alcohol consumption or other relevant clinical findings):

c). Treatment: _____

d). Subsequent progress: _____

e). Opinion as to cause of death: _____

f). Additional Remarks: _____

I, _____, Bachelor of Medicine and Bachelor of Surgery, a registered Medical Practitioner in the State of New South Wales, hereby certify that at _____ am/pm on _____ I examined the body of the abovenamed patient and pronounced life extinct.

SIGNATURE: _____ QUALIFICATIONS: _____ DATE: _____

606180

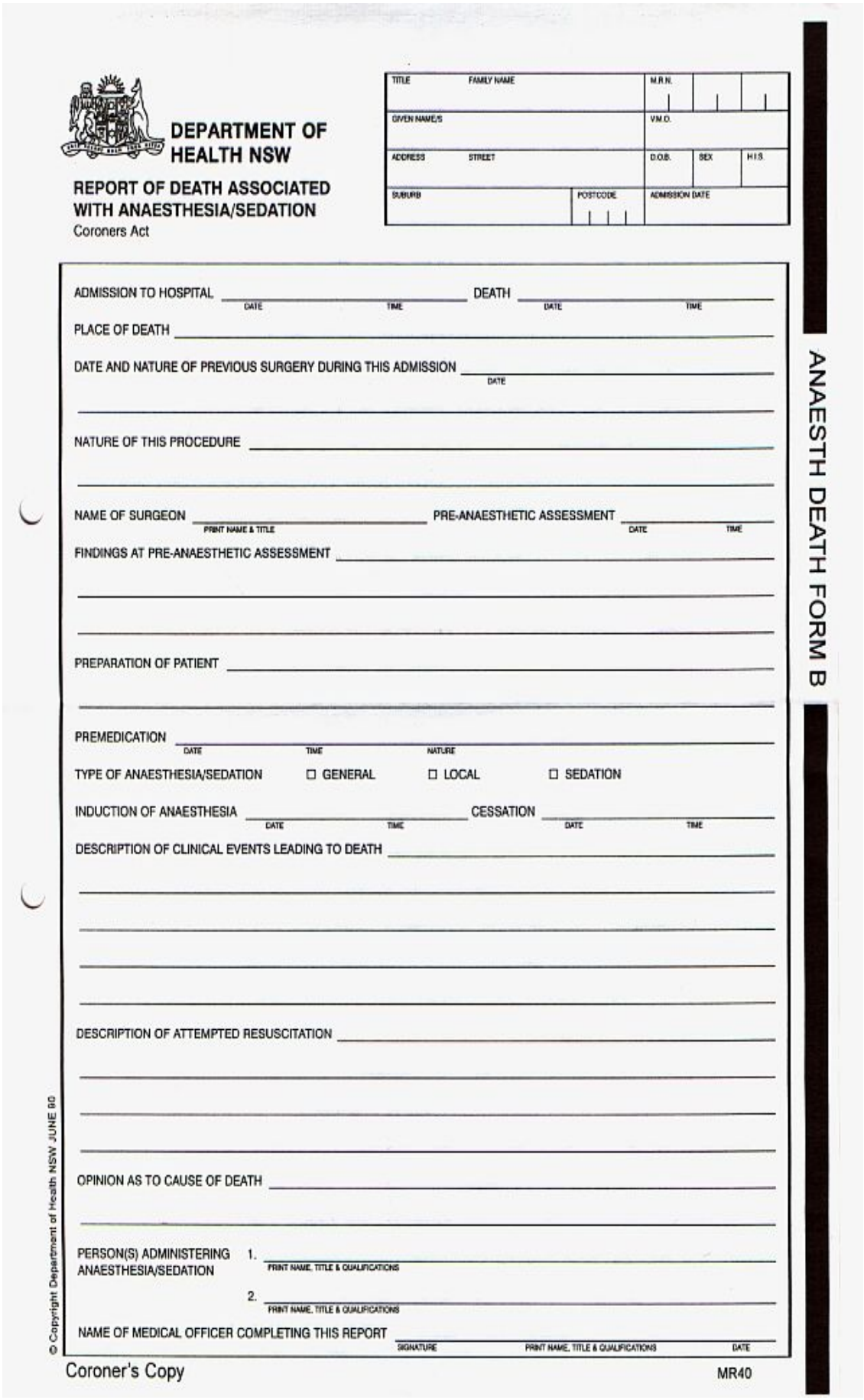
**TO THE CORONER**

FORM No. MR 39

BINDING MARGIN DO NOT WRITE

CORONERS REPORT

## Appendix F: Anaesthetic Death Form B



DEPARTMENT OF HEALTH NSW

REPORT OF DEATH ASSOCIATED WITH ANAESTHESIA/SEDATION

Coroners Act

TITLE | FAMILY NAME | M.R.N. | GIVEN NAME/S | V.M.O. | ADDRESS STREET | D.O.B. | SEX | H.I.S. | SUBURB | POSTCODE | ADMISSION DATE

ADMISSION TO HOSPITAL _____ DATE _____ TIME _____ DEATH _____ DATE _____ TIME _____

PLACE OF DEATH _____

DATE AND NATURE OF PREVIOUS SURGERY DURING THIS ADMISSION _____ DATE _____

NATURE OF THIS PROCEDURE _____

NAME OF SURGEON _____ PRINT NAME & TITLE PRE-ANAESTHETIC ASSESSMENT _____ DATE _____ TIME _____

FINDINGS AT PRE-ANAESTHETIC ASSESSMENT _____

PREPARATION OF PATIENT _____

PREMEDICATION _____ DATE _____ TIME _____ NATURE _____

TYPE OF ANAESTHESIA/SEDATION ☐ GENERAL ☐ LOCAL ☐ SEDATION

INDUCTION OF ANAESTHESIA _____ DATE _____ TIME _____ CESSATION _____ DATE _____ TIME _____

DESCRIPTION OF CLINICAL EVENTS LEADING TO DEATH _____

DESCRIPTION OF ATTEMPTED RESUSCITATION _____

OPINION AS TO CAUSE OF DEATH _____

PERSON(S) ADMINISTERING ANAESTHESIA/SEDATION 1. _____ PRINT NAME, TITLE & QUALIFICATIONS

2. _____ PRINT NAME, TITLE & QUALIFICATIONS

NAME OF MEDICAL OFFICER COMPLETING THIS REPORT _____ SIGNATURE _____ PRINT NAME, TITLE & QUALIFICATIONS _____ DATE

ANAESTH DEATH FORM B



Coroner's Copy MR40

# 8. PATIENT CARE ISSUES

The following sections provide advice and guidance on management of common issues relating directly to patient care.

## 8.1 Admission, Transfer and Discharge Policies

The efficient movement of patients through the hospital system from admission to discharge is essential to maximise the available resources such as available beds. JMOs have a significant role to play in such activities.

### 8.1.1 Responsibility For Patients

Most JMOs will be attached to a clinical team (usually ward based inpatient care) consisting of several Staff Specialists and/or Visiting Medical Officers (VMOs), collectively referred to as Attending Medical Officers or AMOs, one or more Registrars and one or more JMOs. This means that JMOs are responsible to the AMOs for the clinical care of the patients admitted under each of the AMOs. For day-to-day purposes, supervision of JMOs is delegated by the AMO to the Registrar. In some teams (e.g. orthopaedics), responsibility for the team's patients is shared between two JMOs. In this case the JMOs have responsibility for all of the patients and need to be familiar with their clinical management plan. This is particularly relevant if one JMO is in theatre or on an ADO.

### 8.1.2 Admission

All new patients admitted to a clinical team need to be promptly assessed, investigations initiated, or if already commenced, the results collated, a provisional and differential diagnosis recorded and the management plan documented. The last aspect is possibly the most important as it provides a record for other staff involved in the care of the patient of the intended pathway for the care of the patient. These activities will normally occur at the direction of the team Registrar and the patient should be discussed with the Registrar following assessment by the JMO. It is vital that each JMO has a clear understanding why each patient under their care is in hospital and what the details are of the management plan. If there is any uncertainty, the Registrar or AMO should be contacted.

On occasions, disagreement may occur as to who is responsible for "doing the admission" of patients who enter the hospital via the emergency department. The JMO for the AMO or team under which the patient is admitted is responsible for undertaking this role. Attending Medical Officers must be notified of the admission, unexpected deterioration or death of any patient under their care. JMOs should consult with the relevant Registrar to determine who will contact the AMO.

In many instances the preliminary investigation and treatment will have commenced in the Emergency Department, but this does not relieve the JMO from the responsibility of ensuring that all elements of the admission have undertaken and documented. The team JMO must make sure that each new patient is personally seen and assessed. Patients who have been accepted for admission but remain in the Emergency Department because of lack of hospital beds are the responsibility of the admitting team and the JMO attached to the team should give these patients the same priority as patients on the ward.

JMOs need not assess surgical patients admitted on the day of surgery unless specifically requested by the nursing staff.

### 8.1.3 Overnight Admissions

Each JMO with inpatient team responsibilities must each morning on first assuming duty check the Admission Book at the Emergency Department desk or look up on the E-Pass computer system to note any additional patients under their care. They will then be in a position to ensure continuation of treatment, including further notification of the Registrar and appropriate AMO.

After hours (nights, weekends and public holidays) RMOs rostered for ward duty should adopt the procedure outlined above and ensure that each new admission is reviewed without delay and necessary action initiated.

### 8.1.4 Ward Work

The responsibility for the welfare of each inpatient rests on the JMO during the absence of the AMO from the hospital. Each JMO is expected to have a detailed knowledge of all patients under their care and if the JMO has any doubt or difficulty regarding management of a patient the team or after hours duty Registrar should always be consulted. JMOs must ensure that all patients under their care are seen every morning. This will often be with the Registrar on a formal ward round.

### 8.1.5 Case Notes

All entries in to the medical record must be written legibly and must include the date, time and JMO's printed name, signature and designation. This is important in allowing the time frame and sequence of investigation and treatment to be assessed by any other practitioner who sees the patient (particularly after hours). It can also be vital in dealing with a complaint or medico-legal claim where a delay in management is claimed. In Coroner's cases the time sequence of treatment is often of great significance. Clearly identifying who wrote the entry assists subsequent staff in determining the significance of management plans and who to consult if there is any doubt or change in the condition of the patient.

E.g. 12/11/99 22:30
A. JMO (Intern)

A complete history and physical examination must be recorded on the day of admission. Progress notes should be written daily and/or when a significant change occurs in the patient's condition. In particular, the JMO must record in the notes the fact that the patient was seen by the AMO on a ward round, any instructions arising from the round (including no changes in instructions) and any update to the management plan.

The RMOs case notes should give an accurate picture of the patient's progress for the purpose of communication with other staff involved in the patient's management (e.g. nursing, allied health) and also in order to be of value in the future, where they may be needed for clinical investigations, research or medico-legal purposes.

Remember that medical records are frequently requested under subpoena for medico legal reasons and may be released to the patient under the freedom of information legislation. All entries should be written on the basis that a third a third party or the patient will read them at a future time.

### 8.1.6 Discharge Summary

No patient is to be discharged WITHOUT a discharge summary. Discharge summaries must be legible and succinct and must contain sufficient information to be of value to the patient's General Practitioner (GP), and to other medical officers should the patient be readmitted.

The discharge summary forms the basis of continuity of care between the hospital and the GP. If it is not done well patient care will be compromised.

It must contain at minimum the final diagnosis, major complications during admission, changes to management (especially medications) and instructions for ongoing care.

The format for completion of discharge summaries is as follows: -

- Forms are to be completed by the JMO (self-carbonised and in groups of three [3]).
- The original is placed in patient's file.
- Copy to AMO - document is placed in pigeonhole in AMO Room.
- Copy placed in sealed envelope for GP and handed to patient on discharge.

Discharge summaries for elective day only and short stay surgical patients may be entered on a combined operation report/discharge summary sheet, which is completed at the time of operation.

Electronic discharge summaries are progressively being developed with formats specific to specialities. Examples include aged care and neurology. Obstetric discharge summaries will be produced from the obstetric database.

### 8.1.7 Patient Transfer

Any patient transferred to another hospital must have a comprehensive accompanying letter from the JMO that includes details of history, clinical findings, results of investigations, response to treatment and reasons for the transfer.

### 8.1.8 Handover

It is essential that JMOs formally handover at the end of each shift to the JMO responsible for ongoing care details of any patients with particular problems who may need close attention during the following shift. Clear instructions should be noted in the medical record to guide subsequent staff if any issues are anticipated.

JMOs finishing normal rosters should notify the relevant after hours JMO of any anticipated problems and any outstanding calls. If the evening RMO/Intern still has outstanding tasks to complete at midnight, they must be discussed with the Night RMO.

The After Hours Nurse Manager should be notified of any likely problems in terms of difficult patients, issues with family members or need for special nursing or other care.

At the end of each term JMOs should hand over to their replacement by meeting with the new team JMO (if possible) or by phone or in writing and discussing current patients and team processes.

### 8.1.9 Notification of Specialist/VMO

When a patient's condition changes significantly or dramatically worsens, the responsible Staff Specialist or VMO should be notified as soon as practicable. Usually the appropriate Registrar will contact the Specialist/VMO but may delegate this to a JMO. Most Specialists/VMOs will issue instructions as to how they wish to be notified and in some cases this includes waking during the night. Discretion should be used if waking a Specialist/VMO at night. The commonest reason to do so is a situation where the changing patient condition requires advice or a decision from the Specialist/VMO.

Similarly they should be notified of the death of one of their patients at a reasonable hour. This can usually be deferred until early morning but it is important that the Specialist/VMO is aware of the death before attending the hospital as contact may be made with a grieving family member.

## 8.2 Prescriptions and Medication Charts

The commonest errors in patient management (apart from errors in communication) occur in respect of orders and dispensing of medications to patients whilst in hospital. This section outlines some of the basic principles to ensure that medication issues are handled professionally and responsibly. As medical officers, JMOs occupy a special position in the hospital structure in that they are able to prescribe medications and hence initiate the sequence for patients to receive drugs of varying potency and efficacy. All other categories of staff such as nursing staff are able to administer medications but not initiate drug orders (with the exception of a few nurse initiated specific medications).

### 8.2.1 Principles for Prescribing for Hospital Patients

To ensure that errors in prescribing or administering medications are minimised, careful attention should be given to checking the dosage of each drug to be given, especially if a

calculation is required (e.g. mg/ml, or mg/kg). If in doubt, consult with Pharmacy Staff who is available at all times to offer advice and service in education and prescribing of drugs. Alternatively, JMOs should consult with their Registrar, AMO, and the product information or use any of the common references including on line MIMs and other electronic pharmacy reference.

- The first prescriber must endorse the patient details when commencing a medication chart (if a sticky label has been used this should be signed, to avoid the possibility of the wrong sticky label going on the chart and the medications dispensed to the wrong patient).
- The patient's name and MRN should be written on the first page of the medication chart before affixing a patient label. This is to ensure the name is recorded on the duplicate carbonised page in case a label is not fixed to that page.
- When ordering medication, write the generic name and dosage of the drug legibly to avoid errors.
- When changing orders the original prescription must be ceased and a new order written.
- If ordering a dose that could be regarded as being unusual JMOs should confirm their intention by UNDERLINING and INITIALLING the dose.

### 8.2.2 External Prescriptions

The hospital will provide up to 3 days supply of medication for patients discharged to nursing homes. Other patients will need to obtain medications from external pharmacies either by visiting their GP or by provisions of a prescription on discharge. Prescription pads are available on all wards for writing external prescriptions for patients about to be discharged. JMOs should become familiar with the basic requirements of the Commonwealth Government Pharmaceutical Benefits Scheme (PBS). The key elements in writing a PBS prescription are:

- There should be no more than 3 items on a PBS prescription and amounts in NHS quantities, is preferred.
- The same item cannot be prescribed for the same patient more than once on the same day.
- If the patient is to receive a specific brand of medicine prescribed by the doctors, the "brand substitution not permitted" box must be ticked.
- Many items prescribed as pharmaceutical benefits are restricted to specific conditions. The prescribing medical officer is responsible for ensuring that the medication is prescribed in accordance with these restrictions. For example, pethidine injections may only be prescribed as a PBS item for "short term treatment of acute pain".
- Write only one item per prescription when prescribing narcotics.
- Some medications require specific authority from the Health Insurance Commission to enable prescription. JMOs are not entitled to utilise authority prescriptions and patients should be referred to their GP for such prescriptions.

Each PBS prescription should be completed with the following information:

- Name, address and contact telephone number of the prescribing doctor.
- Prescriber number of the doctor
- Patient's name and address
- Tick box for: 'PBS' or 'Restricted PBS' and 'Brand Substitution not permitted'
- Name and strength of drug
- Quantity and number of repeats (as per PBS guidelines)
- Adequate directions
- Place a line across any remaining empty space on the prescription
- Signature of prescribing doctor
- Date prescription is written

### 8.2.3 Medication Safety

Medication incidents can occur from a range of factors not all of which are preventable. Most medications are associated with predictable side effects and unpredictable adverse reactions. However there are a number of strategies that will help to minimise medication errors and incidents. These all constitute good medication practice and should be followed at all times. They include:

- Use generic drug names in medication orders and reserve brand names for combination products.
- Avoid abbreviations in prescribing and use simple English.
- Write all drug orders in clear legible form.
- Ensure that previous adverse drug reactions (including allergies) are clearly documented on the medication chart.
- Check with a pharmacist or look up appropriate references if unclear about any aspect of a prescription.
- Ensure that medication details are clearly written on discharge summaries, letters to GPs and are communicated to the patient and/or carer.
- Report all adverse drug reactions on the medication incident form.

### 8.2.4 Prescriber and Provider Numbers

These are numbers issued by the Commonwealth Health Insurance Commission that identify each doctor and will be needed by JMOs. Forms are available from Medical Administration and will be provided in the orientation pack.

- **Prescriber Number:** This number is issued once to a medical graduate and remains the same throughout your practicing life no matter where you move in Australia. It identifies the individual doctor and must be written or printed on a prescription written for dispensing in a community retail pharmacy.
- **Provider Number:** This number is specific to the practice location of each doctor. It is used to identify where the doctor practices and is used by the Health Insurance Commission to track the billing practices of doctors. Hence doctors with multiple practice addresses require a new provider number for each location. JMOs will have a number specific to Bankstown Health Service. This is needed for writing referrals to outside private doctors usually for patients treated at the hospital who require a specific private specialist referral directly from the hospital. In most cases the patient's GP will provide this.

### 8.2.5 ADRAC Reports

The Adverse Drug Reports Advisory Committee collates reports of adverse reactions to medications to collect evidence of known responses to enable alerts to be sent out to prescribers to avoid future adverse responses. This relies on accurate reporting of adverse events. All RMOs are encouraged to report the following:

- ALL suspected drug interactions
- Reactions to other drugs which are suspected of significantly affecting a patient's management, including reactions suspected of causing
  - Death
  - Danger to life
  - Admission to hospital
  - Prolongation of hospitalisation
  - Absence from productive activity
  - Increased investigational or treatment costs
  - Birth defects

Reports of suspected adverse drug reactions are best made by using a prepaid reporting form ("blue card"), which is available from the Pharmacy Department.

### 8.2.6 Chemotherapy

Chemotherapy at Bankstown Hospital may only be administered by medical officers and nurses who have received special training. This takes place in either the Oncology Unit or Ambulatory Care Unit.

The Pharmacy Department will arrange supply for other patients requiring injectable formulations of cytotoxic agents such as Methotrexate for rheumatoid arthritis and the Oncology Unit will arrange administration.

## 8.3 Consent

The following information is a summary of NSW Health Circular 99/16 issued 8 February 1999 "*Patient Information and Consent to Medical Treatment*".

### 8.3.1 Background

All patients need to give consent in broad terms before undergoing a procedure or treatment – this is to avoid a legal action for assault or battery.

All patients need to be informed of the material risks associated with a procedure or treatment – this is good practice and a practitioner who fails to provide this information before a patient undergoes a procedure risks an action for negligence.

### 8.3.2 Responsibilities

Responsibility for informing and ensuring consent is obtained from the patient belongs to the medical officer recommending and responsible for the performance of the procedure, usually the Visiting Medical Officer or Staff Specialist responsible for treating the patient.

### 8.3.3 Informing

- This is the process of providing a patient with information on which to base consent. Information provided must be:
  - sufficient and material to allow the patient to have a genuine understanding of the nature of the operation or treatment.
  - about the condition, investigation and treatment options, benefits and possible adverse effects or complications of treatment (including no treatment)and the likely result if treatment is not undertaken.
  - provided in person to enable the practitioner to assess how well the patient understands the risks involved in the procedure.
- Written information can supplement but not replace verbal information.
- The informing medical practitioner has a legal duty to warn the patient of a material risk inherent in the proposed treatment, which might influence the decision of the patient to consent. A risk is 'material' if, *in the circumstances, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it, or if the medical practitioner is or should be reasonably aware that the particular patient, if warned of the risk, would be likely to attach significance to it (Rogers* v Whitaker).
- When an investigation, procedure or operation is recommended by an AMO and another medical officer is performing the investigation, procedure or operation, then both the AMO and other medical officer are responsible for informing the patient and ensuring consent.

### 8.3.4 Consent

- Consent is the exercise of choice by a patient about undergoing a proposed procedure operation or treatment after receiving sufficient information.
- A patient has a legal right to refuse treatment.
- For consent to be valid the following criteria must be met:
  - The patient must have the **capacity** to give consent, that is, to be able to understand the implications of treatment.

- Consent must be **freely given** and the patient must not be pressured by staff or family into making a decision
- Consent must be **specific** to the procedure to be performed.
- The patient must be **informed** about the procedure.

### 8.3.5 Delegation

In some circumstances the task of informing a patient and seeking consent may be delegated to another medical practitioner. The AMO in delegating this task to another medical officer must be satisfied that the other medical officer is competent to undertake the task. To be competent the other medical officer must have sufficient knowledge concerning:

- the nature of the illness
- the proposed approach to the investigation or treatment including expected benefits, common side effects and material risks, whether the procedure is conventional or experimental, and who will undertake the investigation or treatment
- other options for diagnosis and treatment
- the degree of uncertainty of the diagnosis and therapeutic outcome
- the likely outcome of not having the procedure
- any possible psychosocial outcomes
- the time and cost.

Junior Medical Officers usually do not have sufficient knowledge, skills or experience to 'inform' patients. In all situations **interns should not inform** nor seek the **consent** of patients.

### 8.3.6 Age of Consent

- For patients under the age of 14 years the consent of a parent or guardian is necessary.
- Patient aged 14 to 16 years may consent provided they adequately understand and appreciate the nature and consequences of the procedure. It is prudent in this group to also obtain the consent of a parent or guardian unless the patient objects.
- Patients over 16 years can give valid consent.
- Where the patient is not mentally competent, or unconscious, the provisions of the Guardianship Act apply. This specifies a hierarchy of people able to give consent, usually starting with a person who has the care of the patient.

## 8.4 Confidentiality and Privacy

The easiest approach to confidentiality of patient information is to work on the basis that all patient information is confidential and that the only people with a right to access to it are the patient and other members of the treating clinical team. Confidentiality of clinical information is essential. You must take care not to discuss patient matters in locations where you may be overheard by members of the public or by staff who have no involvement in the management of the patient.

Medical records must be placed where they are not available to unauthorised persons. As a JMO you only have a right to look at records of patients that you are directly managing. You do not have a right to review cases that you feel might be of interest but in which you have no clinical involvement. The exception is where you are undertaking a retrospective clinical review or audit of particular cases and need to review medical records. Patients have a right of privacy

There are a number of circumstances in which external people have a legislative right to confidential information or when conditions need to be reported. These are covered in NSW Health Circular 99/18. '*NSW Health Information Privacy Code of Practice*' issued 15 February 1999. If in doubt, contact Medical Administration and where uncertain, always err on the side of not releasing information.

## 8.5 Freedom Of Information and Release of Information

The Freedom of Information Act allows patients to apply for copies of any information held by the hospital concerning them. Access is usually granted unless reasons for exemption, specified under the act apply. The most common reason for exemption is in situations where it is considered that release of the information may be damaging to the patient's health. This usually only applies to Mental Health patients.

Interpreting the FOI Act is not part of the JMO role and requests to access medical records should be referred to the medical record department.

## 8.6 Management of Aggression

Bankstown Health Service has a policy to help recognise and deal with workplace aggression. A copy is found in the General Policy and Procedure Manual available in all departments. Basic training in the Minimisation and Management of Aggression is provided during orientation or as needed throughout the year.

Aggressive incidents are defined as:
- Simple assault (i.e. verbal abuse/threats). This is the most common.
- Assault and battery (physical contact and/or minor injury)
- Threats with an offensive weapon without physical injury
- Aggravated assault requiring medical assistance

Aggression can be found to come from the following three key sources:
- External aggression caused by persons outside the organisation, such as during an armed hold-up.
- Client-initiated aggression that is inflicted on workers by their customers or clients.
- Internal aggression that occurs between employees within an organisation, such as between management and other staff (vertical aggression) or between employees (horizontal aggression).

The SWSAHS Policy looks at three main areas:
- Risk identification and control.
- Management of an aggressive incident.
- Post-management of and aggressive incident.

No staff member should tolerate aggression and incidents should be reported to your department manager or Medical Administration.

## 8.7 Child Protection

Under the provisions of the Children and Young Person's Care and Protection Act 1998 all NSW Health staff are required to have training and understanding of their responsibilities for child protection.

All staff are required to undertake mandatory Child Protection/EnAct Training. This is provided as part of orientation to the hospital or as required should you join the hospital part way through the year. There are five categories of child abuse, emotional, physical, sexual, neglect and domestic violence. The training will enable you to recognise and report children and young people at risk of harm. Reporting is mandatory under the Act to enable families who may need additional support to minimise the harm to children or young people. It is not aimed at removing children from families.

Information is available on the SWSAHS Intranet Child Protection site. This has relevant documents including SWSAHS Policy and Protocols for the protection of children and young people.

## 8.8 Interpreter Services

A comprehensive interpreter and translation service is provided with trained health interpreters. These should be utilised whenever necessary to ensure that a full history has been obtained from the patient and that the patient understands what is wrong and the intended management. As a general rule family members and staff untrained as interpreters should not be used as interpreters. The service can be contacted through the following numbers:

- Normal working hours: 9828 6088
- After hours: 9616 8111
- Fax: 9828 6090
- Email: Interpreters.Bookings@swsahs.nsw.gov.au

### 8.8.1 Interpreters

- Access is available to a comprehensive Health Care Interpreter Service (HCIS). This provides a 24 hr multilingual and sign interpreter service using qualified and health trained interpreters.
- Onsite (face to face) including signing services and telephone interpreting (conference calls up to 6 people) services are available 0830 to 1700 Monday to Friday.
- An after hours service (24 hrs; 7 days per week) is provided for obstetric services, emergency services, sexual assault, mental health teams, intensive/coronary care units and consent for emergency surgery.
- Block booking of interpreters for regular clinics such as antenatal clinics.
- It is important when booking an interpreter to have the following information available:
  - Language required
  - Date, time and duration needed
  - Hospital/department location
  - Name and contact number of health care professional who will be speaking with the patient
  - Patient's last name, gender and first name

### 8.8.2 Translation Services

The Health Translation Unit (HTU) provides free translations of written documents of up to 50 words and competitive rates for translations over 50 words.

### 8.8.3 Backup Services

Should the interpreter service not be available in an emergency a backup service is provided by Telephone and Interpreting Service (TIS). This should be used as a last resort when HCIS is not able to provide the required service.

Hospital priority only phone: 1300 655 030

Have the following information available:

- Client Code C024379
- Hospital that you are calling from (Bankstown)
- Department
- Your name and contact number.

# 9. SPECIAL DEPARTMENTAL PROTOCOLS

## 9.1 Nuclear Medicine and Ultrasound

The Department is located adjacent to the Radiology Department on Level 2.

### 9.1.1 Hours of operation

- Monday to Friday 0800 - 1800.
- Routine bookings 0830 – 1700 Inpatient studies performed after 5.30 p.m. must be discussed with the consultant in charge as these often extend past 1800.
- Saturday 8.30 a.m. – 4.30 p.m. for Ultrasound only. In-patient studies performed after 4.00 p.m. must be discussed with the consultant in charge.
- Sunday & Public Holidays – CLOSED
- Please note there is no on-call service.

### 9.1.2 Booking requirements

- Department must be notified if:
  - an interpreter is required,
  - patient has any special needs such as physical or intellectual disability.
- Patients should be informed of the procedure and indicate a willingness to proceed prior to booking the procedure. For patients unable to give informed consent, this should be obtained from next or kine or other responsible person and documented in on the request slip.

### 9.1.3 Range of services

- A full range of adult and paediatric nuclear medicine and ultrasound is available, including bone mineral densitometry

### 9.1.4 Request forms

- These are to be completed by Medical Staff ONLY. Please complete all sections of the form, as all this information is essential and use patient labels if possible. Of particular importance is the clinical question, ward or exact location, and whether the patient has been previously studied at the hospital. Relevant clinical information MUST be provided. Sign the form and PRINT YOUR NAME AND PAGER NUMBER. Incomplete forms will be returned and the examination will be delayed or cancelled.
- Do not request unnecessary examinations and NEVER complete a request form without first examining the patient and NEVER sign a blank request form or one completed by someone else.
- To make an inpatient appointment, send the completed form to the department. The ward staff will then be notified as to the time of the study and preparation. Patients who are to have the study performed as an outpatient will need to have the form given to them to take to the department.

### 9.1.5 Films and Reports

- After an examination, films are kept in the Department for reporting. A copy of the report will be forwarded to the ward as soon as possible.
- Please do not remove films from the department without the permission of departmental administrative officers.

### 9.1.6 Interventional Procedures

- A full range of ultrasound guided interventional procedures are available. These should first be discussed with a Staff Physician

### 9.1.7 After Hours

- There is no on-call service. There are sessional ultrasound services on weekends as described earlier in "Hours".
- For after hour's radiation safety advice (eg. radiation accidents, iodine therapy) call switchboard to contact the Hospital Radiation Safety Officer.

## 9.2 Radiology

The department is located adjacent to Accident and Emergency on Level 2.

Useful Telephone Numbers:

- Reception 88131/34
- Typing/Reports 88143
- CT & Procedure Bookings 88168

### 9.2.1 Hours

- Radiography staff are on duty 24 hrs 7 days a week.
- Clerical staff are on duty 0800hrs – 2300hrs Monday to Friday.
- Only Emergency Department and URGENT inpatient examinations will be performed after 1700hrs and on weekends.

### 9.2.2 Radiologists

- The department is staffed by both full time Staff Radiologists and Visiting Medical Officer Radiologists. A Radiologist is available in the Department between 0900hrs and 1700hrs Monday to Friday. Staff Radiologists can be contacted through the Radiology Department Reception or through switch.
- A Staff Radiologist is on call at all times for urgent consultation and may be contacted through switch. The Radiologist on call should only be contacted by a JMO after discussion with the appropriate Registrar or AMO.

**Range of Services**

- All routine plain film and contrast examinations are available. In addition, Multi-slice CT, myelography, digital subtraction angiography, OPG and a full range of interventional procedures are available. These should be discussed with a Radiologist on a case need basis.

### 9.2.3 X-Ray Request Forms

- These are to be completed by medical staff ONLY. Please complete all sections of the form, as all this information is essential and use patient labels if possible. Of particular importance is the ward or exact location in casualty, the mode of transport and whether the patient has been previously x-rayed at the hospital. Relevant clinical information MUST be provided. Sign the form and PRINT YOUR NAME and PAGE NUMBER. Incomplete forms will be returned and the examination will be delayed or cancelled.

- Do not request unnecessary examinations and do not complete a request form without first examining the patient and NEVER sign a blank request form or one completed by someone else. All request forms should be forwarded to the Department. Appointments for routine examinations and contrast studies will not be made until the request form has been received.

### 9.2.4 X-Rays And Reports

- After an examination, x-ray films are usually kept in the Department for reporting and filed by MRN adjacent to reception where they are available for viewing or may be collected. If the films are required on the ward immediately, please indicate this on the request form. A copy of the report will be forwarded to the ward as soon as possible.

- After reporting, typed reports are available through the hosrep Computer System. Reports waiting typing can be accessed via the phone line by ringing 88144 and following the recorded voice instructions.
- Please do not remove x-rays from the department without informing the clerical staff as this makes the films difficult for others to find.
- If unreported x-rays are taken from the Department, the accompanying request forms must NEVER be removed from the Department.
- X-rays are not to be given to patients or loaned outside the hospital without the authorisation of Radiology Staff.

### 9.2.5 Mobile X-Rays

- Request of urgent mobile examinations can be made by phoning the Department on 88189. Mobile examinations are often of inferior quality and it is preferable for the patient to come to the Department where possible.

### 9.2.6 Procedure Bookings

- A range of interventional procedures is available including fine needle biopsy, abscess drainage, percutaneous nephrostomy and biliary drainage. These should first be discussed with a Staff Radiologist. Requests for CT, contrast examinations, myelography and angiography should be directed to the Nursing Staff in CT who will make bookings.

### 9.2.7 After Hours

- No routine inpatient examinations will be performed after 1700hrs and on weekends. Angiography, Interventional radiology can only be performed during office hours due to lack of trained staff after hours. CT procedures are covered by call on weekends and after hours Mon to Fri by staff on duty or call.

## 9.3 Emergency Department (ED)

The Emergency Department provides an Orientation Program and Manual to all new staff, prior to the commencement of each term.

All Medical Officers are under the direct supervision of the Director of Emergency, Emergency Department staff specialists and the senior CMO on each shift.

### 9.3.1 Emergency Department Case Notes

All ED patients are subject to Triage (initially by a senior nurse) to ascertain the severity of the condition and to allocate a priority of medical attention.

- All ED notes must be legible and must include the following:
- Name of doctor and time seen
- Time of expected discharge (home or to ward)
- Appropriate documentation of history, examination and investigations.
- Treatment and disposal plan
- VMO/Ward Registrar contacted where appropriate
- Discharge Letter/referral where appropriate.
- Details of medical certificates/medications on discharge etc.

### 9.3.2 ED Staffing

- Staffing is as per a roster with numbers on each shift varying to cope with anticipated workloads. The minimum number is on the overnight shift where there is always a CMO as the senior in-charge doctor plus two RMOs or one RMO and one Intern. Hence if you are going to be significantly late or are unable to attend due to illness, you must ring and advise the duty CMO.

- All ward staff are expected to attend the Emergency Department, on request, at times of crisis. This is an extremely rare event, so if you are called you must respond.
- The Emergency Department is not to be left unattended at any time. Meal breaks should be taken after discussion with the duty CMO. In general, staff do not leave the department during their shift for any length of time as meal breaks are incorporated into the shift.
- Swapping of shifts is only permissible between doctors of the same level of training or higher (i.e.) intern to intern. Permission is required from the director, staff specialist or duty CMO to change shifts.
- Annual leave will not be approved during your ED term except under special circumstances.
- Handover: at the end of every shift, each medical officer is responsible for handing over his or her patients to one of the on-coming shift doctors. This must be documented on the white board. A formal hand-over is held daily at 0800hrs.

### 9.3.3 Documentation and Diagnostic Tests

- All Medical Records, x-ray packets and any other documentation relating to the patient are confidential and should not be left lying around on desks or in examination bays.
- All Staff are responsible for maintaining the medical record and x-ray packet in good order - returning all information to its proper place.
- Laboratory and Radiology Requests must have the *correct* patient label and information. Only essential diagnostic tests should be performed in ED. Available results should be confirmed prior to discharge. Other results can be obtained directly from the laboratories by the LMO or ward staff.
- Patients must not be asked to ring in for results. They should be advised to attend their LMO who can obtain the results directly from the laboratory.
- The Medical Officer in ED must complete medical Certificates and Workcover Certificates *prior to discharge*, either home or to the ward. All Workcover certificates should be a First Certificate as Progress and Final Certificates are obtained from the LMO or specialist

### 9.3.4 Complaints

- The Director or a Staff Specialist is available Monday to Friday from 8am to 5pm.
- Do not engage your colleagues in unpleasantries in front of the patients.
- All problems should be directed to either the Duty CMO, ED Staff Specialist or the Director.

### 9.3.5 Disaster Plan

- Copies of the Plan are distributed throughout the department. All staff should make themselves aware of the requirements of the plan and of the equipment available in ED.

### 9.3.6 General Protocols

Protocols for other services are available in the department including:

- Admission Policy
- Referrals outside the hospital and interhospital transfers
- Sexual assault/Child Abuse

### 9.3.7 Orthopaedic Referrals And X-Rays

- Patients should be given their private x-rays to take home. Hospital x-rays can be collected on the day of appointment.

### 9.3.8 Medication/Scripts

All medications prescribed or external prescriptions written must be documented in the medical record.

As a general principle in the Emergency Department as a JMO you are not expected you to know everything, HOWEVER, YOU ARE EXPECTED TO ASK if in any doubt about medications!

### 9.3.9 Orientation for new Interns/RMOs and Registrars

- New staff in ED will be asked to attend the Department on the Friday before the new term commences. An orientation program of approximately one hour will be held and will include a tour of the department.

## 9.4 Pathology Services

Pathology services are provided by the South Western Area Pathology Service (SWAPS) based at Liverpool Hospital. Service provided include:

- Anatomical pathology including cytology
- Clinical chemistry including toxicology
- Haematology including blood transfusion
- Microbiology including serology

Cytogenetics and a few other uncommon tests are provided only by reference laboratories.

Most routine pathology tests are done in the laboratories at Liverpool Hospital. However the SWAPS laboratory on Level 2 of Bankstown-Lidcombe hospital undertakes:

- Common "*stat*" and "urgent" tests in Haematology and Chemistry
- All Blood Bank testing, except the routine antenatal screening.
- Frozen Sections and Fine Needle Aspirations on site, but only by appointment.
- Haematology Clinics, by one of SWAPS Haematologists.

### 9.4.1 Hours Of Operation

- The Area Pathology service operates 24 hrs a day, 7 days a week including public holidays but not all services are available at all times.
- The laboratory at Bankstown Campus is open from 0730 hrs to 2400 hrs.
- Between 2400 and 0730hrs, specimens for "*Stat* and Urgent" tests are sent to the Area laboratory at Liverpool by courier pick up form the Emergency Department. The only exception is for blood transfusion services. If "Group and Hold" or "Cross Matching" is required laboratory staff "on-call" are called in to the Bankstown laboratory.

### 9.4.2 Specimen Collection

There are two components to every request - the specimen collection and identification

- **Specimen collection**
  This can be blood, urine, any other normal or abnormal body fluid or a specimen of tissue. The appropriate tube or, if necessary, a larger container must be selected for each type of specimen. In some instances several different tests on the same type of specimen, e.g. blood, may require several different specimen tubes. Ward staff will normally be familiar with the containers. These are listed in the pathology menu on ward terminals or by telephone enquiry to the individual laboratories or to SWAPS Specimen Reception on 85045.

  Note: Blood for grouping and/or cross-matching must be collected in a 7ml EDTA tube specifically labelled for this purpose.
- **Specimen / Patient Identification**
  When collecting any specimen always check patient identity by asking patients to state their name, without prompting; then check their wrist label. Both should match the information on the request form. If the patient is unconscious, confused or cannot speak English you may need to consult with relatives or nursing staff. The specimen label should, as a minimum state:
  - the patient's full name
  - medical record number

- date and time of collection and,
- if other than blood or another body fluid, the site from which the specimen was collected. should also be specified.

Specimen containers should be labelled *immediately* after collection. If using a pre-printed label always check this against the patient's identity. Labels for a specimen for cross match should be *hand written.*

Always complete specimen collection and labelling on one patient at the bedside, before proceeding to the next. Incorrectly labelled specimens will be rejected by the laboratory staff.

### 9.4.3 The Request Form

In SWSAHS, a single "universal" request form can be used for all pathology requests except for blood grouping and/or cross-matching which require a special form. Multiple tests can be requested on a single form even if these are done in different departments of SWAPS. For this reason, and because the request forms are to be photocopied or scanned, it is important that they are filled in adequately and legibly, preferably in black ink. Usually when tests are required on more than one day a separate request should be required for each day. There are a few exceptions e.g. repeat INR testing for monitoring anticoagulation can be requested over a period of 6 months on a single form.

- **Patient identification data**
  These include name, medical record number, address, sex, and date of birth. SWAPS receives 800,000 requests annually and names may recur commonly, addresses change but the date of birth is consistent is a highly specific discriminator as the probability of coincidence of name and date of birth for more than one patient at any time is very low. A patient identifying label may be applied.
- **Medical Officer data**
  - Senior Medical Officer/Admitting Medical Officer (AMO) - This is the senior medical officer in charge of an inpatient, either a Visiting medical Officer (VMO) or a Staff Specialist
  - "Requested by" - this means the JMO. Please print your name; medical staff signatures are almost invariably illegible.
  - The Health Insurance Commission allocates provider numbers. Arrangements should have been made for you to obtain one. This must be quoted on all private patient requests. If in any doubt always include it.
  - Signature - this is your authority for the test(s) requested.

**NOTE: Never sign a form hoping another person will later stick the label on it. Never provide any person with request forms that are blank except for your signature.**

- **Test related data - Collection time and date**
  This is important because some specimens deteriorate with time and this must be assessed. This section should be completed by the person collecting the specimen if this has not done before the request is written.

- **Test related data - Clinical details**
  There is not much room for details however there are *two essential elements:*
  - The principal clinical features, e.g. vomiting, jaundice, right iliac fossa pain and
  - The working diagnosis, e.g. (respectively for the above) small bowel obstruction, viral hepatitis, acute appendicitis.

  In addition a past history of malignancy is always relevant in any histopathology request and antibiotic treatment, current or in the recent past must be included in microbiology requests.

- **Tests requested - What you want done**
  Write the request in plain English. A few abbreviations are approved by the Health Insurance Commission a few others by local policy. Unauthorised and particularly "self-generated" abbreviations are not acceptable. Handwriting must be legible.

- **Specimen priority**
  **Routine**: done in the order in which it joins the queue for the test requested.
  **Urgent**: put to the head of the queue, accelerated processing where appropriate, e.g. short cycle in histopathology.
  **'Statim'**: Latin = 'immediately' abbreviated to '**stat**' - taken literally - result as soon as test can be done - competition only from other tests with the same status.
  *NB: Avoid "stat abuse" - if everything is "stat", nothing is Stat!*

- **Blood grouping and cross-matching**
  Special tubes and request forms are used to maximise the certainty of patient identity. Where blood is required for emergency transfusion it will be supplied as requested. For elective procedures the provisions of the maximum blood order schedule (MBOS) of the Red Cross Blood Transfusion Society apply. Under this schedule blood is not cross-matched for many procedures but can be provided within 10 minutes if required.

- **"Add on" tests**
  From time to time a need arises to add additional tests to a request that has been made previously. To avoid having to collect another specimen from the patient the laboratory may be phoned with the additional request. A written request must be submitted to confirm the telephone request with the comment "add on" written on the subsequent request form.

### 9.4.4 Obtaining Pathology Results

All laboratory results are and printed and available electronically. Common automated tests, e.g. electrolytes, creatinine and urea, routine blood counts even with a routine priority should be available within 2-4 hours. Histopathology as a rule requires a minimum of two working days but a more rapid result can be provided with prior consultation with the Department of Anatomical Pathology. Complex tests, e.g. chromosome analysis, which are sent out to a reference centre may take one to two weeks.

If a printed result is not available or from the computer, a telephone enquiry may be made to the laboratory.

### 9.4.5 Obtaining Advice About Pathology Tests

- The computer system offers a wide range of advice and information about the pathology service and should be your resource. If the issue is a technical one that cannot be resolved with the aid of the computer the relevant laboratory should be contacted.
- Where it relates to a result it is important that the enquiry be directed to the laboratory performing the test. If the result is improbable ask:
  - For the result to be checked to ensure that it corresponds to the result in the laboratory work list and, if this is correct ask;
  - For the test to be repeated giving your reasons.
- If the issue is one of interpretation in relation to the patient's clinical condition, consultation with a pathologist may be required if it cannot be solved by discussion with senior colleagues. In the case of a histopathology or cytology report enquiries should, wherever possible, be directed to the pathologist signing the report.
- General information about most common tests and their significance is contained in the "Manual of Use and Interpretation of Pathology Tests" by the Royal College of Pathologists of Australasia, which is available in all laboratories of SWAPS and can be accessed from the RCPA Website on: http://www.rcpa.edu.au.

### 9.4.6 Consent For Postmortem Examination

- Post-mortem examination is a valuable means of confirming the cause of death if there is any uncertainty. A family member may also request an autopsy. Post-mortems are not arranged locally for cases referred to the Coroner.
- You or another medical officer who attended the patient during their final illness must complete a medical certificate of the cause of death.
- Consent for post-mortem examination in NSW is regulated by the Human Tissue Act (1983) and by administrative instructions from the NSW Health Department. For a post-mortem examination to be lawful the following need to be satisfied:
  - Either the deceased had consented during life to such an examination, or
  - Had not expressed any objection and consent to post-mortem has been given by senior available next of kin. If a person objects before death this must be recorded prominently and over-rides any consent from next of kin.
- Custom and usage in NSW require that consent by next of kin is recorded in writing.
- NSW Health Department policy requires specific consent regarding the use, retention and disposal of organs obtained at autopsy and that these issues are addressed specifically in the course of obtaining permission for an autopsy from the next-of-kin. Consent for autopsy should be sought by a more senior medical member of the patient care team than the intern but you are likely to be involved in ensuring effective arrangements are made for the interview with the next of kin and for completion of the necessary documents. Form CR17 *Consent for Non-Coronial Post Mortem Examination* must be completed (copy attached at end of this section).
- Even though a post mortem may be required to determine accurately the cause of death, a Medical Certificate of the Cause of Death must be completed before the post mortem can performed. The cause of death recorded should be the best estimate based on the clinical and diagnostic evidence. An amended certificate can be issued if necessary following the post mortem.
- The Medical Certificate of the Cause of Death and the relevant signed consent form together with the patient's medical record must be submitted for final authorisation by a Designated Officer authorised under the Human Tissue Act. In office hours this is usually the Director of Medical and Clinical Services. At other times there are a number of Designated Officers available and if necessary the After Hours Nurse Manager may act in this role. The Department of Anatomical Pathology of SWAPS (Ph: 9828 5383) should then be contacted to make arrangements for the autopsy and a clinical summary of the history should be attached for use by the pathologist drawing attention to any issues of particular interest.

## 9.5 Intensive Care Unit (ICU) and High Dependency Unit (HDU)

Bankstown-Lidcombe hospital has a 14 bed combined ICU and HDU facility with capacity (May 2003) for 7 ventilated patients

### 9.5.1 Admissions

- The admission policy and procedure for both ICU and HDU patients is the same. The capacity of the unit is to accept another admission at any given time varies according to the patient mix and staffing level in the unit at the time of the request, rather than the absolute number of patients in the unit.
- Following a request for admission, the ICU Registrar or duty ICU consultant will discuss the request with the Team Leader for that shift prior to accepting the patient, as the ability of the unit to cater for another patient must be assessed, and, if necessary, arrangements made to transfer out patient(s).

### 9.5.2 Elective surgical admissions

- Elective surgical admissions to ICU and HDU must be "booked" in advance by the surgical team looking after the patient, and noted on the white board at the ICU end of the unit. If approached by one of the surgical team, you should ask them to discuss the

need for admission with the ICU Registrar or one of the ICU Consultants before the patient is "booked in". The team should be advised to check again on the day of surgery as to whether a bed will be available post-operatively, as Emergency admissions may have occurred since a bed was "arranged".

### 9.5.3 Emergency admissions from the Wards or Emergency Department

- The ICU Registrar must review these patients, and an assessment made as to whether ICU or HDU admission is required. If admission is required, the availability of a bed must be discussed with the Team Leader. The ICU Consultant on call should be notified prior to accepting any patient into ICU or HDU.
- The medical officer requesting ICU or HDU admission is responsible for notifying the consultant looking after the patient of the transfer to the unit, in the case of a ward patient. In the case of a patient from the Emergency Department, the CMO or Registrar admitting the patient should inform the consultant under whose care the patient will be admitted. Always check with the doctor referring the patient that this has been done.

### 9.5.4 Transfers from other hospitals

- Admitting calls from other hospitals are directed to the ICU Registrar, who will then discuss these with the Team Leader to determine bed availability, and the duty ICU consultant. The ICU Registrar will then call the other hospital back to accept the patient. These patients will normally be admitted directly to ICU. In such cases, the Duty Medical or Surgical Registrar should be notified and requested to review the patient and to contact the admitting physician or surgeon.
- It is imperative that the consultant under whose care the patient is admitted is notified of the admission at the time of admission, and unacceptable if this is not done. It is the responsibility of the duty ICU registrar at the time of the patient's admission to ensure that the consultant has been informed.

## 9.6 Mental Health Services

An integrated mental health service provides adult inpatient and community-based mental health services to the residents of Bankstown. Infant, child and adolescent service development is expected within the next twelve months. The service is committed to developing and providing high-quality and accessible mental health care that is consistent with the National Standards for Mental Health Services. The staffing establishment is approximately 90 FTE's.

Mental Health Services comprise a number of service units, based on the hospital campus, at Bankstown Community Health Centre, or at one of several other community-based sites. The main components of the mental health service include:

- Banks House, a 30-bed acute adult mental health unit attached to Bankstown-Lidcombe Hospital
- Consultation-Liaison Psychiatry Service
- Emergency Department Clinical Nurse Consultant, provide mental health consultation to the hospital's Emergency Department
- Outpatient psychiatry clinics at the Bankstown Community Health Centre
- Early Psychosis Intervention Program
- Case Management & Extended Hours Team providing case management and community-based treatment and follow-up
- Community-based Rehabilitation Service, comprising a Work Assessment & Retraining Unit, a Community Skills & Support Program, and a Recreation Club
- Bankstown Anxiety Clinic, providing outpatient assessment and treatment for anxiety disorders using cognitive-behavioural therapies
- GP/Mental Health Shared Care project, aimed at strengthening collaboration between general practitioners and the mental health service to improve the management of mental health problems and disorders

### 9.6.1 Banks House (Inpatient Mental Health Unit)

Banks House is a 30-bed acute mental health unit that accepts both voluntary and involuntary admissions under the provisions of the NSW Mental Health Act. The Unit sees a diverse range of clinical problems, including the major psychotic and mood disorders, organic brain syndromes (acute and chronic), and a range of anxiety and personality disorders. A significant percentage of the clientele serviced by the Unit have concomitant alcohol and/or other drug dependence syndromes.

### 9.6.2 Consultation-Liaison Psychiatry Services

Consultation-liaison psychiatry services are provided to the Emergency Department and wards and units of Bankstown-Lidcombe Hospital. The Consultation-Liaison Psychiatry team comprises Consultant and Registrar level medical staffing, as well as Clinical Psychologist and Clinical Nurse Consultant support. The team is available to provide ward-based consultation or advice in relation to patients presenting with intercurrent mental health symptoms or disorders. A Clinical Nurse Consultant has a specific brief to provide consultation to the hospital's Emergency Department.

### 9.6.3 Referrals to the Mental Health Service

- Consultation-Liaison Psychiatry Service or Personnel within the Division of Mental Health

  The Bankstown Health Service switchboard maintains a comprehensive directory of the contact details of services and personnel, including, duty, on-call and senior staff. This number should be used in any circumstances where difficulty in making contact with the relevant service has been encountered, or where circumstances might require contact with an on-call clinician (e.g. on-call Consultant Psychiatrist) or other senior member of the Health Service personnel.

- Community Clients

  During business hours referrals or enquiries in relation to community clients or patients requiring post-discharge follow-up or assessment can be directed to the community mental health team on 9780 2777 (the general number for Bankstown Community Health Centre), or via 1300 787 799.

- Banks House - Current Inpatients

  The main number for Banks House is 9722 8996, and all matters relating to current or recently discharged Banks House inpatients should be directed to this number.

## 9.7 Operating Theatre Protocols (Peri operative Suite)

Bankstown-Lidcombe Hospital has an integrated peri operative suite that includes:

- 8 Operating theatres with associated anaesthetic bays
- 16 Bed main recovery
- 2 Endoscopy rooms
- 8 Bed stage 2 recovery
- Admission and pre-admission area
- Discharge Lounge
- Central Sterilising and Supply department

### 9.7.1 Access to Theatres

Access to the theatres is via the male and female change rooms located in the CSSD corridor on level 3. For security reasons a swipe card reader is fitted to each door and entry is by personal ID badge. Your ID badge should be worn at al times so that theatre staff know who you are.

### 9.7.2 Key Personnel

Each of the major areas operates under the direction of a Nurse Unit Manager (NUM) and a Nurse Manager supervises the whole peri operative service. Contact persons (as at May 2003) and telephone extensions are:

- Nurse Manager Peri operative Services - Colleen Mole - 88435
- NUM Theatre - Pat Naidu - 88439
- NUM Periop - David Wong - 88440
- NUM Recovery/Anaesthetics - Rhonda Cloughessy - 88430
- NUM CSSD - Jan Howard – 88045
- Clinical Nurse Educator – Theatres - Cheryl Swamy - 88423

### 9.7.3 Operating Suite Attire

The Peri operative Suite is regarded as a sterile area and operating suite attire must be worn at all times. The exception is that normal clothing may be worn up to the plastic doors in recovery and to the red line in OT main corridor. Clean operating suite attire (blues) that replaces all outer garments must be worn when entering the theatre suite. The correct attire consists of:

- Dress or pants suit (separate top and bottom)
- Hair must be completely covered with a beret, hood or balaclava.
- Footwear is to be clean separate shoes worn only in the theatres or external footwear covered by overshoes
- All jewellery must be confined or removed.
- Fingernails should be are clean, short and free of nail polish and artificial nails.
- High filtration masks are to be worn when entering the operating room during a procedure
- Personal protective equipment (PPE) such as gloves, masks, goggles, face shields, aprons and gowns, are provided and must be worn to meet standard precautions.

To reduce the risk of transmission of infection throughout the hospital, staff leaving the operating suite should change into normal clothing. If it is essential to leave theatres to assess a patient elsewhere in the hospital and it is impractical to change into normal clothing theatre attire may be worn. This includes attendance to patients in ICU and Labour Ward, emergencies or urgent matters in the other wards or to assess patients in the emergency department. In such cases:

- Hats, boots and masks must be removed before leaving theatre
- It is not necessary to wear a gown over OT attire but any contaminated clothing is to be changed before leaving the unit.
- On return to the Operating Suite, a complete change of OT attire is required.

Theatre clothing must not be worn to the staff cafeteria, coffee shop or to administrative areas.

### 9.7.4 Standard/Universal precautions in the Perioperative Suite

The standard infection control precautions outlined in section 10 of the JMO manual apply at all times in the peri operative suite. A few additional precautions are recommended:

- The peri operative suite is a major risk area for sharps injury. To minimise the risk of sharps injury within these environs:
  - Use retractors when assisting in surgical procedures, not your hands.
  - Pass and receive sharp instruments in designated sharps container eg. Yellow dish.
  - Pick needles up with needle holders or forceps only, not your fingers.
  - Cut needle off when tying knots if possible.
  - Needles lying in the surgical field not in use need to be protected, by turning sharp point inside a needle holder.
  - Avoid use of sharp instruments eg. catspaw retractors.
  - Double gloving is highly recommended

### 9.7.5 Surgical Scrubbing

At all times, remember: Above the nipple line, below the waist and above the elbows are unsterile areas.

- **Scrubbing**

The surgical scrub is the process of effectively reducing the number of micro-organisms on the skin by mechanical washing with anti-microbial soap or detergents. The objective is to:

- To remove dust, skin flakes and oil from hands and lower arms.
- To reduce the microbial count to as near zero as possible.
- To leave an anti-microbial residue on the skin to prevent growth or microbes.

- **Preparation**
  - Operating room attire must be worn including hair covering and face masks.
  - Nails must be short, clean and free of nail polish and false nails.
  - All jewellery, including wedding rings, should be removed.
  - Ensure sleeves are above the elbows.
  - Adjust the water to a comfortable temperature and even flow.

- **Method**

1. The surgical scrub must be a timed concentrated effort.
2. Open the surgical scrub brush without contamination at commencement of wash.
3. Pump 2mls of solution onto the scrub brush, scrub nails and any grossly contaminated areas on hands and arms. Scrub for 30 seconds each hand and then rinse from fingers to elbows.
4. Lather each hand for one minute paying attention between the digits and then continue to lather the arms in a circular motion finishing at the elbows. Rinse off the solution.
5. Pump 2mls of solution and wash hands thoroughly. Wash up the arms thoroughly in a circular motion finishing at the midpoint of the forearms for a total of 2 minutes. Rinse off the solution.
6. Pump 2mls of solution and wash hands thoroughly for 1 minute. Rinse off solution.
7. Turn taps off with elbows, remembering to keep hands higher than elbows at all times. Walk to gown trolley keeping hands away from body and above waist height.
8. If contamination occurs, re-scrub.

Note: When re-scrubbing after the first scrub for the operating list, follow the method as stated above from 5 to 8.

- **Drying Hands and Arms**
  - Pick up the sterile towel. Ensure that bare hands do not touch the sterile field.
  - Step back from the gown trolley and allow the towel to open out fully.
  - Use one corner only to dry the left hand, and the second corner to dry the arm to the elbow, using a slow circular motion.
  - Use the dry end of the towel and repeat the above procedure on the right hand and arm. Care must be taken to avoid the towel coming into contact with the scrub clothing.

Note: If you have a cut on your hands:

- Cover with Opsite dressing.
- Scrub as above.
- Change Opsite between cases.

### 9.7.6 Gowning and Gloving

Sterile gown and gloves must be applied before scrubbed personnel can touch sterile equipment or the sterile field. This prevents micro-organisms on hands and clothing being transferred to the patient's wound during surgery. The sterile gown and gloves also protect

the hands and clothing of scrub personnel from micro-organisms present in the patient or the atmosphere. Gown and gloves should be donned using aseptic technique

- **Gowning Method**
  - Remove the gown from the sterile field by picking it up at the neck edge, lift up and towards you.
  - Step back and check that you have sufficient space to don gown without touching another person or furniture.
  - The gown has been folded so that you are touching only the inside surface with bare hands. Allow the gown to unfold and work both arms into sleeves simultaneously.
  - Do not allow your hands to go through the stockinette cuff. Hold the sleeve from the inside so that the scout nurse cannot pull gown over hands whilst adjusting and typing the tapes. Keep the elbows bent and hands above waist level.

- **Gloving - Closed Method**
  - The hands must not be pushed through the stockinette cuff of the gown.
  - Using the right hand, pick up the left hand glove and place it against the left hand, thumb to thumb, cuff of glove at the finger edge and glove fingers pointing toward the elbow.
  - The thumb of the right hand is inserted under the glove cuff and the cuff is stretched over the right hand gown stockinette cuff.
  - The right gown cuffed hand then pulls the glove into position.
  - Repeat the procedure with the right hand glove.
  - Adjust the gloves on both hands.
  - Wash off glove powder for abdominal, pelvic, prosthetic surgery.

- **Gowning and gloving by other team members**
  - In most cases a scrub nurse will be available to assist with gowning and gloving and will hold the garments for you to push your arms and hands into the sleeves.
  - Once gloves are donned the back panel of the gown is closed by undoing the tie and passing the back tie to another scrubbed person, pivot and then tie both sides at the front.

- **Removal of gown and gloves for immediate re-scrubbing**
  - Undo the front wrap around tape and have the scout nurse untie the back tapes. The scout nurse pulls the gown off from the shoulder.
  - The scout nurse then grasping the cuff of the glove, removes each glove separately without touching the skin.
  - Do not touch anything and proceed to scrub.

- **Removal of gown and gloves at the end of the operative procedure**
  - Undo the front wrap around tape and have the scout nurse untie the back tapes.
  - Remove the gown without touching clean operating room attire. Discard the gown into a linen bag.
  - Remove glove by grasping the palm surface of the contaminated side of the glove and pull off.
  - Insert clean hand under the glove onto the palm and pull the other glove off.
  - Gloves are discarded into the garbage bag.

## 9.8 Ambulatory Care Unit

The Ambulatory Care Unit is located on level 2. The current opening hours are 8 am to 8 pm Mondays to Fridays, and 8 to 6pm on the weekends. It has two main functions.

### 9.8.1 The Ambulatory Care Program

The Ambulatory Care Program refers to a course of treatment for patients with acute or subacute conditions who are sufficiently medically stable to be treated as an outpatient or at home. Patients have to fulfil specific clinical, functional and social criteria prior to admission into the program. The Unit accepts referrals from general practitioners, specialists, Emergency, outpatient clinics and hospital wards. All patients on the program must have a principal consultant or ambulatory care specialist responsible for the patient.

- Common conditions treated in the Ambulatory Care Program include:
  - Deep venous thrombosis and pulmonary embolism
  - Other conditions requiring anticoagulation
  - Over anticoagulation
  - Cellulitis
  - Uncomplicated urinary tract infections and other genito-urinary tract infections.
  - Uncomplicated pneumonia and exacerbations of CAL
  - Acute tonsillitis and other upper respiratory tract infections
  - Osteomyelitis
  - Septic arthritis

### 9.8.2 Ambulatory Day Hospital

The Ambulatory Day Hospital provides and coordinates various day procedures and treatments. Medical teams may be required to manage their patients directly in the unit with the support of the nursing staff.

- **Common services provided at the Day Hospital include:**
  - Blood transfusion
  - Venesection
  - Chemotherapy/intravenous immunotherapy
  - Intravesical BCG
  - Catheter changes
  - Changes of P.E.G.
  - Team medical reviews (acute and post acute only)

### 9.8.3 JMO Role

This term will give you exposure and experience with clinical management of medical and surgical conditions in an outpatient setting, and allow you to develop your procedural skills.

As a JMO allocated to the term, you are stationed in the unit. You are an integral member of the team and should be easily accessible to the nursing staff. Approximately 30% of the unit referrals occur on the same day, and thus prompt efficient management is required. You should also familiarise yourself with the standard protocols in the unit. The unit is committed towards quality improvement, and you will have an opportunity to participate in a project during this term.

- **Basic Term Objectives**
  - Foster a caring, professional attitude towards patients and relatives
  - Encourage a team approach towards patient care.
  - Provide experience in the in-hospital and out-of-hospital phases of the management of patients.
  - Provide experience in the identification of patients suitable for Ambulatory Care programmes.
  - Encourage utilisation of Ambulatory Care services as appropriate.

- **Specific Term Objectives**
  - Develop the ability to assess the suitability of an acute patient for management in an Ambulatory Care setting.
  - Gain understanding of the conditions suitable for an Ambulatory Care programme.

- Gain experience and develop skills in the management of these conditions, and in the techniques and devices used.
- Ability to liaise effectively with other health professionals including general practitioners, and the Unit caring for the patient treated in Ambulatory Care.
- Ability to manage a patient as part of a multidisciplinary and extended team, both within the hospital sector and outside the hospital, with the community sector.

- **Skills Attained**
  - Intravenous cannulations including placement of midlines and PICC lines.
  - Drainage procedures for pleural effusions and ascites
  - Change of PEG tubes.

# 10. INFECTION CONTROL

The importance of adherence to basic infection control principles cannot be overstated. JMOs should establish lifetime habits as a matter of routine practice. The single most common source of infection is from person to person by direct contact. Much of this can be prevented by the simple procedures outlined below.

## 10.1 Standard Infection Control Precautions

Standard precautions protect staff from exposure to potential infection and protect patients from cross-infection carried by staff members. All body fluids must be treated as potentially infectious irrespective of the patient's perceived infectious status. This includes blood, all other body fluids, secretions & excretions (excluding sweat) regardless of whether they contain visible blood, intact skin & mucous membranes.

## 10.2 Handwashing

Handwashing is the single most important procedure for preventing infection. It is simple and cost effective. Skin that is intact (without cuts, abrasions or lesions) is a natural defence against infection. The basic principles of handwashing are:

- Hands must be cleaned immediately before and after direct patient/client care.
- If hands or other skin surfaces become contaminated with blood or body substances, they must be washed immediately or as soon as practicable.
- Gloves may be an acceptable alternative in urgent situations but are mainly intended to protect the health care worker rather than the patient/client.
- Hands must be washed and dried after removal and disposal of gloves.
- Hands may be protected from chafing by the regular use of hand creams.
- Hands should be washed with liquid soap solution and running water using a thorough cleansing action (friction), covering all surfaces and then drying thoroughly with either paper towels or single use cloth towel.
- Appropriate disinfecting solutions/gels such as those containing alcohol/chlorhexidine may be used between patients as an alternative to handwashing.

## 10.3 Protective Attire

Protective attire provides a barrier and reduces opportunities for transmission of pathogens in health care settings. Protective attire must be worn during procedures that are likely to cause splashing of blood or body fluids, contamination of clothing or skin contact. Protective attire includes:

### 10.3.1 Gloves

Must be worn when soiling of hands with body fluid is anticipated. Single use disposable gloves should not be re-used, but disposed of after use. Gloves must be changed and discarded:

- if torn or punctured during a procedure;
- after contact with one individual patient is complete and before care is provided to another; and
- when performing separate procedures on the same patient and there is a risk of transmitting infection from one body part to another.

The use of gloves does not eliminate the need for hand washing or cleaning. Hands should be washed or cleaned immediately after removal and disposal of gloves.

### 10.3.2 Mask/goggles or face shields

Masks are worn as a protective device for the mouth and nose and must not be touched by hand while being worn and be removed after 20 minutes continuous exposure to aerosols or as soon as practicable after becoming moist or visibly soiled. A mask is removed by

touching the ties only and should not be worn around the neck but discarded as soon as practicable after use.

Protective eye-wear (glasses, goggles or face shields) is worn to prevent contamination of the eyes when splattering with body fluids is anticipated. (Always use for patients with productive cough & tracheotomy). They must be discarded once worn and not used again unless reusable and have been cleaned according to the manufacturer's instruction prior to reuse.

### 10.3.3 Gowns

Can protect the skin and clothing from exposure to blood and body substances. Fabric gowns are sufficient to protect against small sprays of blood but they cannot protect the wearer from large amounts of blood. A plastic apron must be worn when soiling of clothing is anticipated. Gowns that cover the shoulders should be worn when lifting patients who are bleeding.

## 10.4 Sharps in Theatres

Sharps' are pointed instruments/implements capable of causing injury to staff, patients and members of the community. Examples of sharps are syringe needles, scalpels, suture needles and broken ampoules.

The potential for transmission of blood-borne diseases is greatest when sharp instruments or devices are used. Special care must be taken to prevent injuries during procedures, when cleaning used sharp instruments and during disposal of used sharps. Accidental injuries incurred from the incorrect handling or disposal of 'sharps' are painful, potentially dangerous to the health of the individual and costly to the health care system in terms of treatment and loss of the staff member to the system.

### 10.4.1 Safe Work Practices for use of Sharps

The hospital has a responsibility to ensure adequate and accessible resources for the disposal of sharps. Each staff member who uses sharps is responsible for their management and disposal. The following practices should be observed in handling sharps:

**Needles:**

- Dispose of a used needle and syringe as one item.
- Do not carry unguarded needles. Carry in an injection tray with a 'sharps' container to facilitate immediate disposal of 'sharps' after use.
- Blunt drawing-up needles to be used where possible.
- Needles must not be removed from disposable syringes for disposal, or be purposely broken or otherwise manipulated by hand, except:
  - when it is necessary to remove the needle for technical reasons; or
  - when performing procedures where needles must be bent. In such cases needles must not be bent after contamination with blood or body substances.
- Needles must not be resheathed except in special circumstances. When resheathing is required:
  - the needle must be properly recapped;
  - the sheath must not be held in the fingers; and
  - either a single-handed technique, forceps, or a suitable protective guard designed for the purpose must be used.

**Other Sharps:**

- Disposable razors are single use items to be disposed of into 'sharps' container immediately after using.
- Broken glass contaminated with blood or body fluids to be disposed of into a 'sharps' container.

**Passing of Sharps:**

- 'Sharps' must not be passed from the hand of a health care worker to another person. However, this requirement does not apply in a case involving an invasive procedure, if the proper conduct of the procedure would be adversely affected.
- A puncture resistant tray must be used to transfer 'sharps'.

**Sharps Containers:**

- 'Sharps' containers should be placed as close as practical to the point of use to limit the distance between use and disposal.
- 'Sharps' containers should be placed so visitors, particularly children, do not easily access them.
- Immediately after use, non-reusable 'sharps' must be disposed of in a puncture resistant container.
- Immediately after use, reusable 'sharps' must be placed in a puncture-resistant 'sharps' container specially kept for that purpose and labelled as such.
- 'Sharps' containers should:
  - be puncture-resistant, waterproof and leakproof;
  - have an opening that is wide enough to allow 'sharps' to be dropped into the container by a single hand operation;
  - be designed so that the opening is small enough to prevent insertion of a person's hand:
  - be clearly labelled with black lettering on yellow background with the biohazard symbol printed on the container;
  - never be overfilled, only fill to the marked line on the container; and
  - be securely sealed with a lid before disposal.
- 'Sharps' should never be forcibly placed into a 'sharps' container and the level of 'sharps' in a 'sharps' container must never be pushed down by hand. Never place your hand into a waste paper bin or gar-bag.
- 'Sharps' containers are available in:
  - all patient rooms
  - on all IV trolleys
  - on all blood collection trays
  - all department areas where sharps are in use

### 10.4.2 Reporting of "Sharps" and "Body Fluid Exposure"

- Report all exposures, no matter how trivial they appear.
- Read instructions on the yellow card attached to your identification card.
- After exposure to blood or body fluid particularly injuries by "sharps"
  - Clean wound immediately as practicable
  - Skin: Wash with soap and water - not antiseptic,
  - Mucous membrane: wash with water or saline,
  - Mouth - spit out and rinse with water numerous times,
  - Sharp injury: wash with soap and water.
  - Report injury immediately to Dept Head/After Hours Nurse Manager
  - Fill out Accident & Incident form
  - Attend Emergency Department - Immediately within 1-2 hours for major exposure to blood
  - Confidential testing, treatment & counselling available from Infection Control Clinical Nurse Consultant 8am - 5pm Mon - Fri (Ext 88633 or page 28230**)**

## 10.5 Infectious Disease Issues

Infectious diseases are one of the potential hazards faced by JMOs both in terms of potential for infection of the JMO by contact with infected persons and the risk of transmission of disease from the JMO to another person.

### 10.5.1 Screening and Vaccination against Infectious Diseases

JMOs as health care workers have a duty to take reasonable steps to be aware of their own infectious disease and vaccination status and minimise the risk of transmitting infectious diseases to patients or other staff. The Bankstown Health Service as an employer provides a service for screening and vaccination where employees are not able to provide evidence of their status. The Infection Control Clinical Nurse Consultant through the Bankstown Medical Centre adjacent to the hospital arranges this. For more details see NSW Health Circular 2002/97 "Occupational Screening and Vaccination against Infectious Diseases" issued 18 October 2002.

### 10.5.2 Protocol for Immune Status

- All medical practitioners who undertake exposure-prone procedures have a professional responsibility to be aware of their infective status in relation to blood-borne viruses (Hepatitis B, C and HIV).
- Medical practitioners who become aware that they are infected with a blood-borne virus must not undertake exposure-prone procedures. To do so constitutes unsatisfactory conduct and will cause the doctor to be subject to disciplinary proceedings by the NSW Medical Board.
- Infected medical practitioners may continue to practise medicine, provided that public safety is not endangered by their impaired health or their performance of exposure-prone procedures.

### 10.5.3 Exposure-Prone Procedures

In NSW exposure-prone procedures are defined as those procedures where there is potential for contact between the skin (usually finger or thumb) of the health care worker and sharp surgical instruments, needles or sharp tissues (splinters/pieces of bone/tooth) in body cavities or in poorly visualised or confined body sites including the mouth. Procedures that lack these characteristics are unlikely to pose a risk of transmission of blood-borne viruses from infected health care workers to patients.

Full information on exposure-prone procedures and infectious status are available in NSW Health Circular 99/88 "Health Care Workers Infected with HIV, Hepatitis B or Hepatitis C" issued 22 October 1999.

### 10.5.4 Notifiable Infectious Diseases

A number of specific diseases have been proclaimed under the NSW *Public Health Act 1991* as notifiable infectious diseases. As soon as a diagnosis is made or strongly suspected the disease must be notified:

- Normal Hours Monday to Friday – Infection Control CNC (Ext 88633 or page 28230**)**
- After hours – Page Hospital After Hours Nurse Manager or
- Ring Liverpool Hospital switchboard on 9828 3000 (ext 83000) and page the on-call Public Health Officer.

# 11. OCCUPATIONAL HEALTH, SAFETY & REHABILITATION

The Bankstown Health Service has an OHS&R Policy that is committed to providing, maintaining and improving a place of work that is healthy and safe and without risk to you, patients, clients and visitors. This policy complies with the Occupational Health and Safety Act (2001) and Regulation (2000).

The OHS&R Policy and Procedure Manual can be found in each department. It covers things like manual handling, personal health, aggression, security, workers' compensation and rehabilitation.

## 11.1 Employer responsibilities

As an employer Bankstown Health Service is committed to providing a work place, which is safe, and without risk to staff, clients and visitors. This commitment includes:

- Complying with all relevant Occupational Health & Safety Legislation.
- Maintaining local workplace Occupational Health & Safety Committees.
- Preventing injury and illness to staff and visitors.
- Allocating staff certain Occupational Health & Safety responsibilities.
- Maintaining workplaces which are safe and without avoidable risk.
- The development of safe work practices and procedures.
- Providing information and training, concerning the workplace, to all staff.
- Assisting staff who incur a work related injury and illness to return to work as safely and quickly as possible
- Reducing work related injury and illness costs.

## 11.2 Employee responsibilities

As employees of the health service, JMOs are expected to:

- Comply with Occupational Health & Safety legislation.
- Cooperate with managers and supervisors to provide a workplace that is safe and without risk to staff/clients and visitors.
- Take reasonable care for their own safety and for the health and safety of all persons in the workplace.
- Not intentionally or recklessly interfering with, or misusing, anything provided in relation to Occupational Health & Safety in the workplace.
- Report to supervisors all unsafe conditions, equipment, hazards or practices.
- Notify supervisors of all accidents, mishaps and near misses.
- Practice safe work practices following appropriate training, eg - manual handling, dangerous goods, etc.
- Ensure that they are aware of and can access their local Occupational Health & Safety Committee.

## 11.3 Workplace Injury And Rehabilitation

Workplace injury management is an important part of health service management. If you have an accident, injury or incident at work:

- Tell your supervisor after any work related occupational injury or illness as soon as possible but before leaving the workplace or at least within 24 hours of the incident occurring. In most cases this is the clinical departmental head or the Nurse Manager of the clinical area in which the incident occurred. Medical Administration should also be notified, particularly if you need to take sick leave.
- If required your supervisor will contact the OH & S practitioner who will arrive at the worksite within 30 minutes (with the exception of incidents on the weekends and between 5:30pm - 8am. In these cases the OH & S Practitioner will contact you and your manager the next day);

- The OH & S Practitioner will assess you, arrange support and treatment (if needed) and investigate the accident;

Occupational injury management and rehabilitation of injured workers is a central feature of the workers compensation system. Its significance is based on the following principles:

- Early intervention.
- The workplace, in the majority of cases, is the most appropriate and effective place to rehabilitate injured workers.
- Maintenance at work or an early and appropriate return to work, consistent with medical opinion, is generally in the best interests of injured workers who have suffered a work related injury or illness.
- The Area Health Service and injured workers have a social and economic interest in ensuring that injured workers return to work safely and as soon as possible following a work related injury or illness.

## 11.4 Manual Handling

Manual Handling is:
*"Any activity requiring the use of force exerted by a person to lift, push, pull, carry or otherwise move, hold or restrain any person, animal or object"*.

It is your responsibility to look out for, then reduce or remove manual handling hazards and risks. JMOs should be aware of any risk to their own safety in handling patients or equipment. This is particularly so when assisting with patient handling, for example sitting a patient up in bed. If you have any doubt of the correct technique ask another staff member. Most nursing staff are well trained in lifting techniques and lifting equipment is available in all clinical areas.

## 11.5 Security Service

JMOs should always be conscious of their personal security issues such as always wearing identity badges, securing vehicles and personal belongings, and securing confidential material such as patient information.

Security staff are available at the hospital 24 hours per day, every day. They are able to assist in situations of aggression such as where a family member becomes agitated with staff. They are also able to escort JMOs to parked vehicles after hours or to the JMO accommodation in Birralee adjacent to the hospital.

Security staff may be contacted through the hospital switchboard (ext 90) or via pager 28072. In an emergency requiring urgent assistance dial extension 666 or activate a duress alarm if one is located in your area. A security officer may also be contacted on radio by dialling extension 88692. For routine enquiries the office number is Ext 87692.

# 12. ALLIED HEALTH SERVICES

## 12.1 Physiotherapy

Physiotherapy services are provided in several settings to assist people to recover from injury or illness that decreases mobility.

### 12.1.1 Inpatient Physiotherapy

Services are provided for Medical and Surgical wards, ICU/HDU, CCU, Orthopaedics, Paediatrics, Rehabilitation and Aged Care wards

**Contact Process:** Referrals are made by completing the Allied Health referral form, **except** in the case where there is an integrated team referral process in ICU/HDU, the Rehabilitation and Orthopaedic wards.

To notify Physiotherapists working on the acute wards that a written referral has been made, they can be paged. Physiotherapists on the Rehabilitation/Aged care wards do not carry pagers.

### 12.1.2 Outpatient Physiotherapy

The Outpatient Physiotherapy service is provided for people presenting with musculoskeletal problems such as back/neck pain; problems with peripheral joints (eg shoulder, knee, ankle); uncomplicated fractures for plaster changes (acute fractures are initially dealt with by MO); minimal paediatric follow up (eg of talipes or torticollis); follow up after orthopaedic surgery (eg knee reconstruction); and minimal respiratory follow-up

The service caters for patients who live or work in the Bankstown LGA. Primarily an adult-based service with some services for children. Referrals are made by completing the Allied Health referral form. Written referrals are accepted from external referrers eg GP's.

An Assessment Clinic is in operation to ensure all patients are assessed within a 2-week period of referral to ensure patient's with the greatest clinical needs receive treatment first. Group programs are also conducted for people with chronic low back pain and for people with knee problems

**Contact Process:** Phone internally 98, externally 9722 7200

### 12.1.3 Outpatient/Community Physiotherapy

This service is as part of the **Outpatient Rehabilitation Team** (a multidisciplinary team consisting primarily of Occupational Therapy and Physiotherapy). Short-term intensive Physiotherapy and Occupational Therapy Rehabilitation programs are provided to adults who require a team approach.

The service caters for adults who live or work in the Bankstown LGA, who require rehabilitation and meet the following criteria:

- Recent discharge from Hospital after a stroke, amputation or orthopaedic surgery; or
- Resident in the Bankstown community and require rehabilitation following an acute episode and are being managed in the community rather than being admitted to Hospital eg Parkinson's Disease

Referrals are made by completing an Allied Health referral form, or by receiving written referrals from external referrers eg GP's, discharging Hospitals.

**Contact Process:** internally phone 98, externally 9722 7200

### 12.1.4 Emergency Department - Rapid Response Service

This is a multidisciplinary team consisting of Occupational Therapy, Physiotherapy, Primary Health Nursing and Social Work. Assessment and treatment is provided for people over 16 years of age who present to the Emergency Department, who would benefit from short-term intervention to assist them to safely return to and remain in the community and as such prevent an admission to Hospital.

Referrals are made to the Service by the attending medical officer or Triage Nurse in the Emergency Department. A Rapid Response multidisciplinary assessment is then made.

**Contact Process:** Telephone internally on 87702, by paging the relevant staff member or if the referral is 'after hours', leaving a message in the Social Work After Hours book in the Emergency Department.

## 12.2 Occupational Therapy

Occupational therapy services are available to address physical and medical problems that may interfere with a person's needs, home management tasks, and work, leisure and community activities. Occupational Therapists are concerned with:

- Teaching clients new ways to manage daily tasks such as dressing, bathing and cooking.
- Recommending ways to improve a person's safety and independence in their home and community environment by providing equipment and/or arranging home modifications. Home visit assessments are arranged if required. Discharge home visits are not carried out.
- Providing ideas on how to save energy.
- Making custom splints for clients with various hand injuries and arthritis.

### 12.2.1 Inpatient Wards

Assessment and treatment is available to all inpatients admitted to acute medical/surgical wards, rehabilitation wards and a variety of clinics (orthopaedic, oncology). Allied Health referral forms are available on all wards – check Allied Health Referral Chart.

### 12.2.2 Outpatient Services

Home and community assessments are provided, and splinting and various health promotion groups are offered (arthritis education, carpal tunnel). A Specific Outpatient Rehabilitation Services is also available. To refer, phone 9722 7200 or send Allied Health referral form to the Occupational Therapy department.

### 12.2.3 Rapid Response Service

Assessment of patients presenting to the Emergency Department with the aim of preventing hospital admission. Operates 7 days a week, including Public Holidays. The team is located in the Emergency Department, phone, 9722 7702.

### 12.2.4 Driver Assessment and Rehabilitation Service

Aimed at promoting independent and safe driving for individuals with a range of disabilities or medical conditions. A medical RTA referral is required. For further details contact 9722 7200.

## 12.3 Speech Pathology (Hospital Based)

Speech Pathologists are involved in the assessment and management of communication and swallowing disorders. As well as direct intervention services provided include patient and family education; and community, staff and student consultation, education and health promotion. Speech Pathology services are provided to all adult inpatients and to neonates with feeding difficulties. There is a limited outpatient service for adults.

### 12.3.1 Who To Refer

By carefully discerning the appropriateness of the referral you can improve the efficiency of the response and improve patient care.

| Appropriate Referrals ✓ | Not Appropriate X |
|---|---|
| Communication or swallowing disorders resulting from stroke, dementia, hypoxic brain damage, progressive neurological disease | Gastroenterology or surgical patients who have been on a fluid diet for management of gastro or surgical issues |
| Suspected aspiration pneumonia, including patients with respiratory illness where some component of aspiration is suspected. | Difficulty due to poor or missing dentition |
| Patient coughing or choking on oral intake | Behavioural eating disorders |
| Oral or pharyngeal dysphagia suspected, includes patients who have had oral or pharyngeal cancer | Lower oesophageal or git problems |
| Communication and swallowing management for patients with tracheostomy | Unconscious patients |
| Neonates with feeding difficulties | |
| *** Patients who fit into "not appropriate" column but have signs or symptoms mentioned above. | |

### 12.3.2 How to Refer

- Page the therapist allocated to the ward on which the patient is admitted to ensure prompt attention. Each ward has the contact details for the therapist covering that ward.
- Complete the Allied Health referral form including information about the patient's diagnosis, relevant background information, and the reason for the referral. Good information assists the speech pathologists in prioritising assessments.
- Referrals must be received before 4.00pm to be considered for assessment on that day.

For after hours and weekend assessments there is a JMO Swallowing Protocol available on all wards. This is a guide to a step by step screening of a patient's swallowing function.

## 12.4 Social Work

Social Work is provided for both inpatients and outpatients of the hospital.

### 12.4.1 Inpatient Service

Social Work provides assistance with social, psychological and emotional issues that patients and their families may have as a result of their illness and hospitalisation. Particular issues may be around coping with the illness, separation from home and family, bereavement and loss, drug and alcohol issues, financial worries and concerns regarding discharge home, need for community supports or for alternative care such as hostel and nursing home.

### 12.4.2 Aged Care Placements

Within the hospital Social Workers coordinate Aged Care Placements. As part of this medical staff are asked to complete part of a form applying for approval to place a person in a nursing home or hostel. It is a priority for this form to be completed, and approved by a delegate from the Aged Care Team. Please give this form priority as any delay could delay a patient's discharge. A patient cannot be discharged to a Nursing Home or hostel without this form being completed and approved.

### 12.4.3 Outpatient Service

Social Work has only a very limited general outpatient service that provides initial assessment and referral on to other community based services. Other outpatient services are attached to specific units and clients are usually seen as part of a clinic visit rather than in the community (eg Oncology, Antenatal).

### 12.4.4 Groups

Social Work is also involved in a number of group programs including:

- Antenatal Young Parent's Group
- Cardiac Rehabilitation Education Group
- Oncology Education and Support Group

### 12.4.5 Referrals

Early referral of patients assists in timely discharge planning

Social Workers can be contacted via page (usually listed on the ward) or via Allied Health Reception Ph "98" (internal) or 9722 7200.

Some wards require written referrals to Allied Health – check with the ward NUM, ward clerk or Allied Health Referral Chart.

## 12.5 Nutrition And Dietetics Service

(including the Community Nutrition Team)

The goals of the nutrition and dietetics service are:

- To provide clinical nutrition services for inpatients including provision of therapeutic diet meals and nutrition education.
- To work with Food Service and The Nutrition Link to ensure the nutritional adequacy of the hospital menu and therapeutic diet menu.
- To provide clinical nutrition services for local residents, including individual nutrition counselling and/or group education programs.
- To plan, implement and evaluation nutrition promotion activities responsive to the needs of local residents, with the aim of reducing diet related diseases.

### 12.5.1 Inpatient Services

Dieticians are responsible for assessing the nutritional needs of inpatients, and providing their nutritional care and education while in hospital.

### 12.5.2 Outpatient Services

Regular general outpatient clinics for individual dietary assessment and education are held in the Allied Health Building. Children can also be referred to paediatric die titian clinics. A medical referral is required. To book phone 9722 7200.

Dieticians are also involved in outpatient clinics and group education as part of the Diabetes Centre and Oncology Unit. Bookings are taken through the unit involved.

### 12.5.3 Community Nutrition Team

The Community Nutrition Team conducts nutritional health promotion projects that aim to improve the Bankstown community's access to safe and nutritious food supply, and reduce diet related disease. The team can be contacted at Bankstown Community Health Centre on 9780 2792, by other groups and organisations who want nutritional input into their projects. Specific programs are offered on a regular basis:

- **Eating for a Health Heart:** A workshop is held at Bankstown Community Health Centre once every six weeks on a Tuesday 9-30am - 12noon. A fun morning learning about cholesterol, fats, fibre, reading food labels, shopping tips, modifying recipes. To book contact the Secretary of the Department of Cardiology, Bankstown Hospital, on 9722 8491.

- **Moving Forward with Your Weight:** A 6 session programme for people wishing to lose weight Information is provided on healthy eating, stress management and increasing activity levels.
  **Contact:** Phone 9722 7200 Fax 9722 7125

## 12.6 Orthoptics Service

### 12.6.1 Services provided

- Vision screening
- Assessment and treatment of visual function (including post stroke)
- Strabismus/double vision
- Ocular muscle disorders
- Visual field testing

Refer to Allied Health Referral Chart for guidance regarding making referrals.
**Contact:** Phone 97227873
**Hours:** 9am -5.30pm Monday-Friday

## 12.7 Allied Health Services Chart (May 2003)

| | Allied Health Services | | | | | |
|---|---|---|---|---|---|---|
| | Occupational Therapy | Physio-therapy | Speech Pathology | Nutrition & Dietetics | Social Work | Orthoptics |
| **Ward/Unit** | | | | | | |
| 2J | Routine | Routine | On Call | Routine | Routine | On Call |
| 2G | Routine | Routine | On Call | Routine | Routine | On Call |
| 2A | Integrated Team | Integrated Team | On Call | Routine | Integrated Team | Integrated Team |
| 2B | Integrated Team | Integrated Team | Integrated Team | Routine | Integrated Team | Integrated Team |
| 2C | Routine | Routine | On Call | Routine | Routine | On Call |
| 2D | Routine | Routine | On Call | Routine | Routine | On Call |
| 3A/3B | Routine | Routine | On Call | Routine | Routine | On Call |
| 3C | Integrated Team | Integrated Team | On Call | Routine | Routine | On Call |
| 3F | Routine | Routine | On Call | Routine | Routine | On Call |
| 3H / CCU | Routine | Routine | On Call | Routine | Routine | On Call |
| ICU / HDU | On Call | Integrated Team | On Call | Routine | Integrated Team | On Call |
| 3E Maternity | On Call | Routine | On Call | On Call | Routine | On Call |
| 3D Nursery | On Call | Routine | On Call | On Call | Routine | On Call |
| 2F Paeds | On Call | Routine | On Call | Routine | On Call Cover | On Call |
| Emergency/ Ambulatory Care (Rapid Response Service) | Integrated Team | Integrated Team | On Call | On Call | Integrated Team | On Call |

**Chart Definitions**

- **Integrated Team:** In those units where the Allied Health professional is part of the daily ward routine and able to monitor needs closely, ***no written will be required***.
- **Routine:** The Allied Health professional routinely visits the ward but is not able to monitor needs closely - ***An Allied Health Form must be completed*** for all s unless the is made during a ward conference with the relevant Allied Health professional present. Forms will often be collected, however the relevant Allied Health professional should also be contacted (paged/phoned) for urgent referral.
- **On Call:** The ward is not routinely visited by the Allied Health professional staff - ***An Allied Health Form must be completed*** for all referrals, the Allied Health professional will also need to be contacted (paged/phoned) for urgent referral.

## 12.8 Community Health Services

A range of services is provided to meet the needs of the Bankstown Local Government Area community. These are provided from a number of sites with the main office location being at 36-38 Raymond Street, Bankstown. The Community Health Service aims to empower people to manage health better in a community setting. The service is committed to improving the health of the people of Bankstown through providing comprehensive, accessible and accountable health services that address the social, emotional, physical, cultural and environmental aspects of health in the community.

The services include:

- Primary Health Nursing Early Childhood Centres
- Palliative Care
- Health Promotion
- Women's Health Service – including health promotion and Well Women's Clinic
- Sexual Assault Services
- Youth Health Service – including Adolescent Services
- Ethnic Health Services – including Ethnic Aged Health Service and Mereki Cottage
- Child and Family Service – including counselling, parentcraft, child development, speech and occupational therapy, physiotherapy, and physical disabilities.
- Drug and Alcohol Service – including needle and syringe exchange, counselling and health promotion
- Dental Service – including adult and children's services to eligible residents plus school dental screening, SOKS program, relief of pain clinic, and dentures for pensioners scheme
- Multicultural Day Care Centre and four general Day Care Centres

# 13. DISASTER AND EMERGENCY PROCEDURES

The hospital has detailed plans for dealing with a range of internal and external disaster responses contained in the Disaster Response Manual. This is a bright red coloured vinyl covered ring binder located prominently in all departments and wards throughout the hospital. JMOs should become familiar with the location and contents of these folders. The Manual has detailed instructions for each response including action sheets for each level of staff member. The action sheets outline the specific role of each staff member and in a declared emergency JMOs should refer to the action sheet to determine their role.

The Director of Medical Services is the Health Service Disaster Controller and has the authority to commit hospital resources to deal with the emergency. The Director of the Emergency Department is the Health Service Medical Commander with responsibility for organising the clinical management of patients.

JMOs and other hospital staff will be advised should an emergency arise by a series of voice alerts through the hospital public address system. These are:

- Alert: Provides early warning of the impending disaster response.
- Stand-by: At this stage specific staff are contacted
- Activate: The hospital response is implemented
- Stand down: The response is completed and activities scale back to normal. Debriefing is arranged.

The prime role of JMOs in a disaster will either be to help discharge patients in order to free beds for incoming casualties, or to be deployed elsewhere (usually ED) to help assess and mange the incoming casualties. Medical administration or the senior medical and surgical registrars will advise JMOs regarding deployment.

## 13.1 Emergency Contact Number

The Bankstown Hospital **internal emergency number is extension 666**. This number is used for all internal emergencies including MET (see below), fire, bomb or security emergencies. This extension is a priority line to the switchboard and operators will answer this line ahead of all other calls. Only genuine emergencies are to be notified via this extension.

## 13.2 Fire

The following procedures apply to all areas of the Bankstown-Lidcombe Hospital:

- The Staff members discovering fire door/alarm activated must implement the **RACE** procedures:
  - **R** Remove any patients and staff from the immediate fire/danger area
  - **A** Alert Switchboard extension 666 and nearby staff
  - **C** Confine fire and smoke, if practicable close windows and doors
  - **E** Extinguish or control fire but do not take any unnecessary risks

- When implementing the "RACE" procedures the following issues should be considered:
  - Fires are considered too large to contain if they exceed the size of a waste paper bin.
  - Keep low in a smoke filled environment.
  - Control the fire with appropriate fire fighting equipment (If you are trained and it is safe to do so)
  - Implement evacuation plan if necessary refer to Evacuation Procedures in this Plan or Internal Emergency Procedures in Flip Manual.
  - The patient's medical records should accompany each patient (if possible)
  - If the automatic alarm system should fail to be activated the alarm can be manually activated by breaking glass on the break glass panel situation in the warden intercom point (WIP)
  - Ask Nursing Unit Manager to isolate oxygen.

## 13.3 Bomb Threat

If you receive a bomb threat:

- DO NOT PANIC
- Let the caller continue the conversation
- Attract the attention of a second person if possible
- The second person is to report the threat by calling extension 666 and state location of the call
- Prolong the conversation to obtain as much information as possible and make notes of
  - Where the bomb is placed and when it is timed to explode
  - Distinguishing background noise (e.g. traffic)
  - Distinguishing voice characteristics
  - Whether the caller has knowledge of the hospital
- Use the bomb threat checklist when the call is terminated.
- If what appears to be a bomb is found:
  - Do not touch it
  - Dial 666 and state location of the suspected bomb
  - Report to Supervisor of the area if possible
  - Follow instruction of persons in charge of the area
  - Evacuate the immediate area

## 13.4 Medical Emergency Team (MET)

A Medical Emergency Team (MET) system operates at Bankstown Health Service to provide prompt intervention and stabilisation of compromised patients 24 hours a day as well as responding to cardiac arrests. The prevention or reduction of adverse outcomes is achieved through the intentional, early identification of common antecedents associated with life-threatening events. The effect is measured by Key Performance Indicators (KPI) including:

- A reduction in adverse patient outcome rate
- A reduction in cardiorespiratory arrest rate
- A reduction in unanticipated ICU admission rate
- A reduction in unexpected death rate

Any staff member may place a MET call by dialling extension 666 and it is not necessary to first consult with a more senior colleague.

### 13.4.1 Indications for MET calls

A MET call can be placed if any one or more of the following criteria are present:

| **Acute changes in:** | **Physiology** |
|---|---|
| Airway | Threatened |
| Breathing | ALL RESPIRATORY ARRESTS<br>Respiratory rate <5<br>Respiratory rate >36 |
| Circulation | ALL CARDIAC ARRESTS<br>Pulse rate <40<br>Pulse rate >140<br>Systolic Blood Pressure <90 |
| Neurology | Sudden fall in level of consciousness<br>(Fall in GCS of >2 points)<br>Repeated or prolonged seizures |
| Other | Any patient who you are seriously worried about, who does not fit the above criteria |

### 13.4.2 Roles and Responsibilities of the MET

The Medical Emergency Team (MET) is composed of advanced clinicians including at least one Registrar and one ICU Registered Nurse (RN). One member of the MET must be trained in advanced resuscitation and acute hospital medicine. RN's who have completed an Advanced Resuscitation Course may act as MET Team Leader.

The minimal MET response team consists of an ICU RN and either the ICU, Anaesthetic or Medical Registrar, depending on the time of the MET activation and the availability of the medical resources.

- **MET: 0800 - 2300 hours**
  - ICU RN.
  - ICU Registrar - Team Leader
  - Advanced Trainee Cardiology Medical Registrar (unless detained elsewhere).
  - In the event of two concurrent MET calls, the Advanced Trainee Cardiology Medical Registrar (0800-1700) attends as Team Leader. After hours Medical Registrar attends as Team Leader (1700-2300).

- **MET: 2300 - 0800 hours**
  - ICU RN
  - Anaesthetic Registrar covering ICU overnight - Team Leader during these hours.
  - After hours Medical Registrar will also respond unless detained elsewhere
  - In the event of two concurrent MET calls, the After hours Medical Registrar attends as Team Leader