Surviving the first month of internship

October 2017

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1. Introduction

Congratulations on graduating from Medical School and obtaining an internship in South Australia! Your internship will be both exciting and challenging, representing a key formative experience in your medical career.

This guide has been produced by trainee medical officers to assist those commencing internship in South Australia. The guide is very much focussed on providing advice for those first few weeks of internship because this is the period we feel is most daunting. Our experience is that once you have survived the first month or two, you will transition from 'surviving' to 'thriving'.

We hope this document is helpful for you. We will be conducting an evaluation later in 2018 to assess how we can improve it in the future. Please take the time to complete the evaluation process so that things can be improved for the cohort following you.

South Australian Medical Education and Training (SA MET) has purview over prevocational medical training in South Australia and its Doctors-in-Training Committee exists to receive feedback from trainee medical officers on relevant education and training matters. Please feel free to contact SA MET and / or the Doctors-in-Training Committee at any time via contact details displayed on the website (http://www.samet.org.au/).

2. Pre-internship checklist: hit the ground running!

The following checklist represents some of the key things that you should have in order (or at least have thought about) prior to starting internship. Not all areas are essential, but considering these things in advance should make your start to internship as smooth as possible.

Handover

Most hospitals will arrange for you to have a formal handover with the intern you are taking over from when you start on the wards. If this does not occur then you should take it upon yourself to arrange a handover to ensure you can hit the ground running.

Prepare to look after yourself

This might sound silly, but it is worth spending a little time thinking about how you are going to look after yourself during the stressful first few weeks as an intern. Questions to consider:

- Have I got enough food and clean / ironed work clothes for a couple of busy weeks?
- When do I need to wake up / leave home to get to work a bit ahead of time?
- What is my roster like for the coming term? Can I use any weekends off to my advantage?
- What awesome thing (apart from debt…) am I going to spend my first pay check on?
- When is my leave and what am I looking forward to doing with it?
- Who am I going to call if I am struggling at work or just need to debrief?

App yourself up

There are many useful medical applications for smartphones. You may already have some favourites from Medical School. Some which we feel are particularly useful for interns are listed below. Some of these applications are relatively expensive so you may want to wait until you start working before purchasing them in order to determine how useful you may find them:

- **Oxford Handbook of Clinical Medicine**: costs the full price of the book, but more portable!
- **UpToDate**: as an SA Health employee, you can get the UpToDate app (full functionality) free!
- **Mediquations**: useful list of automated clinical scores to assist patient management
- **Convert**: useful for when elderly patients give you height / weight in Imperial measures
- **VoCal**: useful audio reminder application for the 16:30 gentamicin level you can't forget
- **AMH**: the subscription does cost the full price, but it is useful when you can't find a desktop
- **Dropbox**: some cohorts of interns create extensive lists of cheat-sheets / guides and local clinical guidelines on a shared Dropbox folder, which can be very useful on busy cover shifts
- **CommDoc**: a very useful consultation language application that can significantly assist with local Indigenous language communication in communities across the Northern Territory
- **EyeChart**: this is but one of many available Snellen chart applications, and trust us, you'll never be able to find a Snellen chart when you need one
- **BugDrug**: this somewhat rough but useful application demonstrates which antibiotics are likely to cover different types of bacteria (although it should not replace the Therapeutic Guidelines or an Infectious Diseases consult!)
- **Medscape**: this can be a helpful resource, although regular data-heavy updates can be irritating
- **Evernote/Onenote**: if you haven't already got a note taking app, it's time to start
- **Essential anatomy**: this can be useful for demonstrating relevant anatomy to patients
- There are a range of other medical applications available on many topics, some of which may be more or less applicable to you depending on the rotations you conduct and your vocational training intentions (e.g. NIHSS stroke severity grading applications, microbial resistance and antibiotic selection applications, and more)

Decide how you're going to roll

Are you a bag or a clipboard person… perhaps neither? It may not be a bad idea to decide this before your first day. There is no 'ideal' method for having everything you need at your fingertips and you will probably improve your system after the first few weeks.

Some things you want to have in easy reach at all times include a couple of black pens, your pager (with battery cover taped down… sigh), stethoscope (with name tag), stamp (with name, pager and provider number for pathology forms), and identification card.

Other things that are useful to keep in your locker / bag include: spare pager batteries, more pens, long-life food, a few blank time sheets (for when you inevitably forget) and a change of clothes (you never know what bodily fluids may be encountered).

AHPRA Registration / Provider and Prescriber numbers

There are often significant delays in receiving provider and prescriber numbers from the Department of Human Resources which creates major headaches for new interns and their supervising residents / registrars. If you do not have your provider number, you may be unable to order radiology or pathology services which are key intern duties. Similarly, although you will be able to prescribe in inpatient medical charts, you will be unable to write discharge scripts without a prescriber number (another key duty for interns); the lack of a prescriber number may cause issues in prescribing for inpatients via the Enterprise Patient Administration System.

Therefore we **strongly encourage you** to ensure you have your provider and prescriber numbers before you commence internship.

The steps involved in getting your provider and prescriber numbers are as follows:

- Obtain registration with the Australian Health Practitioner Regulation Agency (AHPRA): https://www.ahpra.gov.au/
- Once you have an AHPRA registration number, you can apply for a provider and prescriber number with the Department of Human Resources: https://www.humanservices.gov.au/

It may be necessary to hassle the above organisations to ensure you are at the front of the queue (your internship will prove to you that the squeaky wheel gets the grease in all things from radiology to consults to official Government registrations, and it is often your solemn duty to be that squeaky wheel for the benefit of your patients).

Insurance and financial matters

- **Medical indemnity insurance:**

  SA Health indemnifies you for your work as an intern. However, various medical defence organisations also provide free medical indemnity insurance for interns and their cover may be more expansive than that provided by SA Health. You can also sign-up with multiple different organisations, some of which have different perks, so there is no reason not to sign-up and ensure you are fully covered (and it also makes sense to gain 'low risk' exposure to different medical defence organisations so that when you need to select one in the future you have some personal experience to base this decision off).

- **Income protection insurance:**

  Your future salary is now your biggest asset: it makes perfect sense to insure it, just as you would insure your car. SuperSA provides some income protection insurance packages which can be financially effective as the cost is taken from your superannuation, not your post-tax salary. However, income protection insurance with a different insurer is also tax deductible; furthermore, it can be far more flexible in terms of commencement date after injury, level of cover and other specific clauses. We encourage you to look into what income protection insurance arrangements will work best for you. It is something you want to see a professional about. Do not forget to review your policy annually (or as required) as your income changes.

- **Professional development allowance:**

  Interns are permitted a professional development allowance which is currently $4,000 per annum. The amount for each year rolls over into the following year if you are still employed in SA Health, but after that is lost. Professional development can be utilised to attend educational courses, purchase textbooks, purchase electronic equipment for study or work purposes and other things. Approval is at the discretion of your manager (usually but not always the Director of Clinical Training and / or Director of Medical Services).

  It is worth planning how you want to spend your professional development to maximise the benefit you receive and, if you intend to stay within SA Health, cast your mind forward to what you may want to use the allowance for in the following year. Ensure you keep detailed and backed-up records of all expenses because these are required for making claims. Claims can take months to be processed so ensure that you do not rely on prompt reimbursement for cash flow purposes. There are professional development administrative staff at each hospital to field questions.

- **Salary sacrificing arrangements:**

  Salary sacrificing basically refers to the process whereby Government employees are able to divert some of their pre-tax income towards specific other things. Basically what this does is lowers your income tax obligations, as you are taxed against the income remaining *after* the deduction of the 'salary sacrifice' amount. Maxxia is the monopolised provider of salary sacrificing for SA Health employees and specific questions about the details of salary sacrificing are best directed there.

  Organising your salary sacrificing arrangements is important to ensure you receive the maximum benefits for your work. These can take some time to sort out, so getting on to it as early as possible is highly recommended. Errors do occur so we recommend keeping things simple, avoiding unnecessary changes, and asking for (and writing down) reference numbers for all calls to Maxxia.

  Note that the fringe benefit tax year runs from April to March rather than in the financial year or the calendar year. As interns start employment in January / February, this means that you have your full annual quota of maximal salary sacrificing ($9,000) available to you for use before the end of March, at which time any unused salary sacrificing capacity will be lost and a new fringe benefit tax year will commence. Therefore many interns take out a loan of about $9,000 and then salary sacrifice 100% of their salary into that loan until the end of March to make the most of this situation. After that time, you can re-arrange things with Maxxia to adjust to a more normal salary sacrificing arrangement. Many employees use the Maxxia credit card, whereby approximately $350 per fortnight of pre-tax income is transferred on to the card for the entire year (e.g. around $350 by 26 fortnights equals your $9,000 maximum allowable salary sacrifice in the fringe benefit tax year).

  Note that from mid-2016 onwards, in addition to the approximate $9000 maximum previously applied to salary sacrificing, a meals and entertainment card was introduced by Maxxia. This allows an additional $2550 in salary sacrifice per annum over and above the previous maximum, but only

for holders of a meals and entertainment card. Further information can be found on the Maxxia website and we would strongly encourage prospective interns to explore this option so you can ensure you are receiving the maximum benefit for your hard work.

- **Tax returns and tax optimisation:**

  Tax returns, depending on your prior employment and the complexity of your financial arrangements, typically get more complex as you enter internship. There are many accounting firms that are eager to enrol young doctors and they will offer free / cheap tax returns. We think it is highly advisable to seek advice from a professional, especially when advice is offered for free, about how you can optimise your tax obligations as a junior doctor. They can advise on what you can and cannot claim against tax as well as what paperwork you need to keep in order to ensure that claims can indeed be made when it is 'tax time'. Accounting firms may offer to provide advice about income protection insurance, salary sacrificing and other matters. Unlike salary sacrificing, accountancy is a proper marketplace so there are lots of options out there; make sure your cast a discerning eye over the choices and make an informed decision.

- **Banking:**

  It is worth revisiting your bank as an intern because some major banks have relationships with the Government / SA Health whereby they may be willing to waive certain bank fees. Your new salary may also qualify you for superior credit card offers or other options of interest. As with accounting, there is competition in the banking market and shopping around is advisable.

References

Applications for positions after internship open surprisingly early, and ideally you should identify two consultants to provide references for you within the first two rotations of the year. It is worthwhile thinking about this early so that you are prepared when applications open.

3. Ensuring you are safe, learn and achieve general registration

There are some important basics which, as an intern, you should know to expect on each rotation during your internship. This information is additional to your facility orientation and hospital-based tutorial program. If you do not receive this information at the beginning of each rotation, take it upon yourself to find these things out. Often colleagues who have done the rotation as an intern previously will be able to help answer questions, and there is always a consultant supervisor in charge of the rotation too.

Orientation / handover

You should receive an orientation for each term. If you are provided with a document, make time to have a detailed read through it. It should provide you with key contacts and the education and training opportunities for the term. Orientation will give you a good understanding of the unit you have joined; if you don't receive it, then ask for it!

Handover between interns is probably even more useful so you should definitely make sure you contact the previous intern and find out the dos and don'ts of the term. You should do this a couple of weeks before the term so you can find a mutually convenient time to meet / telephone the outgoing intern. Prepare yourself as effectively as possible so you don't start on the back foot.

Supervision

Supervision is integral throughout your intern year, not only to reassure you that you are doing the correct thing but also to learn from. Your supervision will come from a number of staff: consultants, registrars and other TMOs. A good supervisor will test you but also teach you. If you feel you are isolated and not adequately supported then speak to your supervisor / Medical Education Officer as soon as possible. Nursing staff, especially on specialty wards, have deep knowledge and experience and will also provide guidance on relevant matters.

Feedback / assessment

As an intern, you are closely supervised and this has its benefits as you should receive constant feedback on your performance. Take the praise and the ideas for improvement and enjoy the feeling of growing confidence and ability. If you are unsure how you are going or you want additional feedback, then ask. This can be as simple as asking your immediate superior (resident or registrar) if there is anything you can do better at the end of each week. You must also receive formal mid- and end-of-term feedback. In many cases you will need to initiate these assessments but they are mandatory and extremely beneficial to your development as a doctor.

Education and training

The whole point of internship is to learn. Your learning will be in many areas including theoretical knowledge, clinical skills, procedural skills, working in a team, organising a clinical day, and the mechanics of actually getting things done in a hospital. Each unit should provide an education program which is a chance for you to learn and sometimes an opportunity for you to present.

4. Qualities of an effective intern

Safety

Patient safety is priority number one.

The number one rule for interns, especially in the first few weeks of the year, is to ensure you are safe. The old adage is very true in this setting: the only stupid question is the one unasked! If in doubt, we strongly encourage you to ask for help.

Importantly, if your consultant / registrar asks you do to something (e.g. request a consult or scan, or chart a certain medication) and you don't understand why, then it is your professional responsibility to clarify this. Understanding what you are doing is central to safety but also to ensuring you get the best results from the relevant consult / scan.

There is always (literally always) someone you can ask for help. The person you ask for help may be a clinical superior such as the registrar / consultant for your unit and / or the general medical registrar on duty and / or the intensive care unit registrar on duty, but do not forget that there are also many other people available for particular scenarios including: the chemical pathologist on call for assistance in the interpretation of tests, the pharmacist on call for drug doses / monitoring, and the team leader on the usual home ward for such problems (e.g. urology nurse for catheter issues).

If things seem urgent and you are concerned about the patient, then call a MET Call. There is absolutely no shame in calling a MET Call if you feel it is necessary.

Planning

Plan three important things: your daily structure, what you hope to get out of the rotation overall, and how you are going to use your time off.

Daily Structure

There is no 'ideal' way to plan your day and in many cases your workflow will be determined by a clinical superior. However, we think there are a few tips to managing your day as efficiently as possible:

- **Use (and never lose) your patient list:**

  Writing down all your jobs on your patient list is an effective way to ensure that you do not accidentally forget to do anything. Everyone develops their own elaborate system of boxes, ticks and crosses but basically you want to be able to determine at a glance (a) what needs to be done, (b) what you have done and can forget about and (c) what you've done but needs to be chased / remembered. It is a good idea to hold on to your patient list at the end of the day so that you can transcribe any outstanding tasks / things you needed to remember on to your new patient list the next morning before ward round. However, please ensure you ultimately dispose of patient lists confidentially.

- **Think about how your jobs will affect patient care and prioritise them effectively:**

  After your ward round, generally a good approach is to (1) divide the jobs up amongst the people on your team according to seniority / other commitments, (2) request radiology and consults, and then (3) conduct other jobs. Remember that if you are called to see a patient about whom someone is concerned (or one of your inpatients has a MET Call), and then this immediately trumps all other jobs in terms of priority! Leaving consults until later in the day (especially after midday) is also a recipe for disaster.

Requesting consults can be daunting but we have provided some guidance below under the 'communication' section.

- **Complete a checklist before leaving each day:**

  There is nothing more frustrating than getting halfway home and realising you forgot to put in blood forms for your patients the following morning. Some things cover and nights will do, but asking someone to do your blood forms is probably a step too far! Other annoying but avoidable things for interns include being repeatedly paged about expired drug charts / discharge scripts during a consultant ward round.

  Especially in your early days, we suggest having a checklist that you go through before leaving each day including (a) ensuring all tests ordered that day have been chased or have been handed over to cover / nights to chase, (b) blood forms for the following morning, (c) discharge summaries complete for patients that left that day, (d) all medication charts have at least a day or two left, and (e) any patients that are planned for discharge the next day have their discharge medications organised.

  Ensuring that you hand over any outstanding tests or jobs to cover / nights is especially important for medico-legal reasons. Do not order a troponin / CTPA and only check it the next morning! It is **critical** to ensure that when you hand something over to cover / nights, you hand over a task and **a plan** (ideally from your resident / registrar / consultant). Further guidance is provided below under the communication section.

Rotation

It is important to plan what you want to get out of your rotation at the beginning. This may include learning about particular diseases or becoming more proficient in some clinical skills / procedures. We encourage you to flag your learning objectives with your supervising registrar / resident; they will often be eager to help you achieve your learning goals.

We also encourage you to put reminders in your diary / online calendar at least a week or two before your mid-term and end-of-term assessments are due so you can contact your supervising consultant to make a time to go through these with them; it is fair to assume that you will need to initiate the assessments in all cases. Planning ahead will take the stress out of rushing to get these important assessments done late in the rotation.

Time off

Most rotations will allow you to identify your free time well in advance. We encourage you to think about how you are going to use this. Things you might want to schedule some time for include sleep, exercise and socialising with friends / family, but also don't forget doing some preparation for job applications for the following year.

Punctuality

Be on time! Figure out how long it takes to get to work and into the unit, where you need to be at what time, and what you need to do beforehand (e.g. print patient lists, check results from any early bloods, and get handover from night staff). Senior staff will forgive an intern for not knowing something, but the tolerance for tardiness is much shallower.

Time management

This is vital for your job satisfaction and your sanity. Learn to prioritise your tasks for the day, delegate appropriately within the team, use available resources for support (including nurses and allied health), and handover suitable tasks to the next shift.

Communication

Good communication is inherent in good patient care. You cannot rely on anyone to read your notes (no matter how detailed or neat they are) so you must verbally communicate plans to all involved, including the patient! Even if other staff do read your notes, they may not get around to it until much later in the day, delaying the implementation of important tasks that you have requested. The patient will get better care, and your day will run more smoothly, if you verbally communicate your plan to the nurse responsible at the time of actually seeing the patient.

Two key areas of difficulty with communication are handover of cover / nights jobs and requesting consults. We have provided some tips below to help with these.

We encourage you to learn the 'ISBAR' format. It is widely used throughout SA Health in many types of interactions including ward round presentations, requests for consults, and clinical handovers.

Identify
Yourself and role
Patient with three identifiers

Situation
What is going on with the patient?

Background
What is the clinical background/context?

Assessment
What do I think the problem is?

Recommendation
What do I recommend?
Check back for shared understanding
Assign and accept responsibility/ accountability

Handover to cover / nights

It is appropriate and essential to hand over your jobs to cover and nights so that you can get out of the hospital and recharge for the next day. However, it is equally critical that you provide effective handovers that allow cover / nights to triage their work appropriately and make safe decisions about your patients. Cover and night shifts are sometimes simply too busy to get all the jobs done, so if you're asking for a gentamicin level or fasting bloods that could potentially be done during the day, it is fair for cover / nights to insist that you provide a reason why they should have to do it.

Bad handover: 'please chase this troponin on Mrs Smith, Kthxbye.'

Good handover: 'I am XXXX from team XXXX. I would like to ask you to please chase this troponin from Mrs Smith, which should be back within the next hour. The background is that Mrs Smith is an 80 year old lady in with an infective exacerbation of COPD and she has just had new chest pain with coughing tonight. The initial ECG is normal and she is pain-free now. I think it's musculoskeletal. However, if the troponin is above 100 could you please treat her as an NSTEMI with aspirin, ticagrelor and therapeutic enoxaparin? In any event she'll need a repeat ECG and troponin in six hours which the nurses know about, but I would like you to please also hand this over to nights in case the second ECG or troponin is abnormal. If she becomes tachypnoeic / hypoxic then my registrar suggested a CTPA.

She is handing the patient over to the night medical registrar so if you have any concerns please give them a call, such as if the initial troponin is frustratingly slightly abnormal. Does that all sound alright? Thanks!'

Requesting consults

Requesting consults can be daunting. The registrars / residents on consult services are often extremely busy and potentially finding their own feet in a new role. This can mean that they can seem abrupt / condescending / frankly angry on the telephone. We have suggested a few tips below to ensure you get the most valuable information from your consults in the smoothest possible way:

- **Ensure you have a question about what you want and lead with the question**

  If you are unclear about this, consider clarifying the matter with your registrar or consultant before requesting the consult. Otherwise you may end-up being a middle man as you speak to the consults person, go back to your registrar, than have to go back to the consults person. If it is a very straightforward question, you may want to consider whether telephone advice might be sufficient and ask your registrar about the appropriateness of this; however, telephone advice needs to be handled carefully and, when in doubt, it is safest to request that the consults person clinically reviews the patient (e.g. provides a formal consult).

  The most important tip about requesting a consult is to **lead with the question**. Starting with 'can you please see this person because we are not sure what to do' or 'we need help' is not strong. You should lead your introduction with the key question:

  Bad consult request opening: 'Hello, my team would like to ask you to please see one of our patients because they have low platelets and we don't know what to do about it.'

  Good consult request opening: 'Hello friendly haematology registrar, I am XXXX, the intern from the Orthopaedic Team. I was wondering would you to please see one of our patients regarding investigation and management of their suspected HITS...' (and you can then go on to deliver your brilliant explanation as to why you think the patient has HITS, but really the Haematology Registrar is already putting away their microscope to come and help you because you had him / her at 'HITS').

- **Think back to Medical School...**

  Put yourself in the shoes of the person on the other end of the telephone and actively think about what they might want to know about the patient. They will not expect you to have performed the joint aspirate or dilated the pupils and examined the eyes with a slit-lamp yourself, but they will expect you to have done the basics. Needless to say, if you request a neurology consult without having done a neurology examination, you are cruising for a bruising.

- **Clarify the story in your own mind and have the information available**

  Ensure you are familiar with the patient, the current admission and, particularly, the problem underlying why you are currently calling for a consult. When you page / call to make the consult, ensure that you have in front of you (a) the patient notes, (b) the medication chart, (c) any other relevant charts and (d) the laboratory / radiology findings available on OACIS. You may need these to answer any direct questions. Do not let anyone take any of these things away from you before the telephone discussion has finished.

- **Before you go! Ask if you can help, and check when they expect to see the patient**

  There may be some investigations you can order or other things you can do to help the person providing the consult. Some consult services require you to put through an OACIS referral and some require an 'M60' or other form to be faxed. It is best to ensure you ask about this before you hang up, and make sure you don't forget to do what they have asked! It is ideal to clarify when the person providing the consult expects to be able to see the patient and you can then document this in the case notes. If they are not able to come within a timeframe that is acceptable to your team, you may need to call them back to kindly remind them about your consult +/- highlight your perceived urgency.

- **Say 'hello'**

  If you see some new doctor pouring over the notes of your patient after your consult, it is most likely the person who has come to do the consult. So make sure you say 'hello'! They may have other questions that they forgot to ask over the telephone. Additionally, they may have a detailed plan that they need to communicate to you; it is much easier for them to do this in person and they'll appreciate your presence greatly. It will also make requesting the next consult from this person easier, because they'll be able to put a face to your telephone voice and they'll remember how helpful you were.

- **Do not start World War Three**

  At the end of the day, sometimes requesting a consult can go badly and you might be told that the person is not going to see your patient for whatever reason. This is frustrating but there's not much point starting World War III with someone significantly more senior than you. At this point, it is appropriate to explain the situation to your resident / registrar and they can take it from there.

5. Physician heal thyself

'Pheeew.... I have survived Medical School, and now I get to put all I've learnt into action and have a long and successful career.' Easy as that, right?

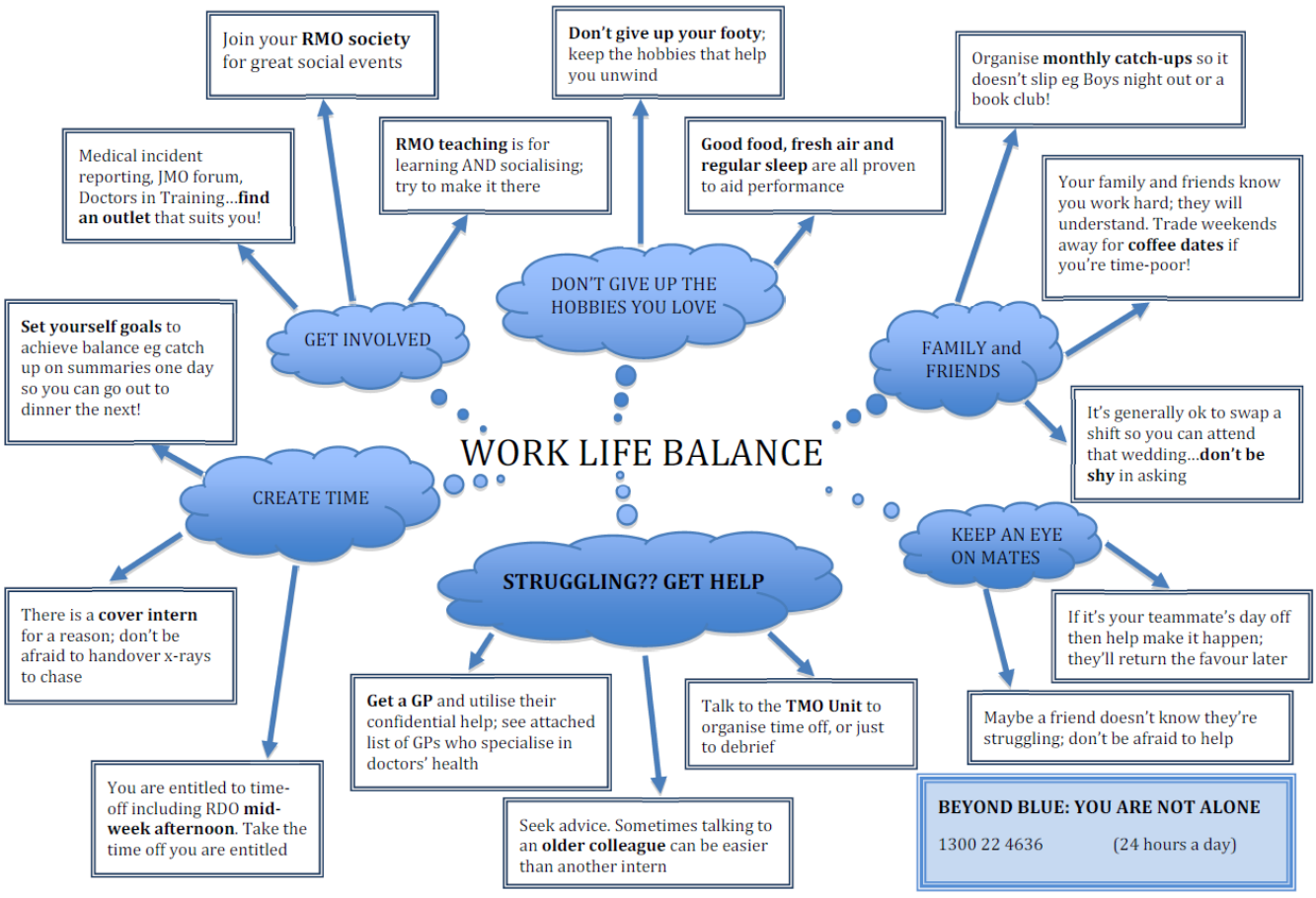
Internship is not all smooth sailing; it is certainly satisfying and rewarding, but adapting from being a medical student to now being responsible for patient care can be tough. You will be challenged mentally, physically and emotionally on a daily basis so it's important to look after yourself and your colleagues too.

Work-life balance is a two-way street. On one hand, we reasonably expect to be provided with safe working environments and to be rostered on for reasonable hours with adequate time / days off. On the other hand, transitioning from being a medical student to a being doctor means taking greater responsibility for your ability to perform, upon which patient care now depends ever more directly.

Medical students might be able to get away with falling asleep at the back of a lecture theatre after staying up all night to watch the cricket, but when your patient is deteriorating on the ward, you will not have that luxury. Looking after yourself is a positive feedback loop: if you sleep well, eat well and exercise regularly, your performance at work will improve and everything will get better and better. Importantly, the reverse is also true.

However, even the most diligent efforts at self-care can be overwhelmed by unexpected illness, family members / friends requiring support, and all kinds of other unavoidable trouble. It is important that you seek help early if you think you require it. Despite our years of study, we are not always great at identifying when we are struggling or being receptive to suggestions that we need to take a break or potentially seek help. Consider these suggestions carefully rather than perceiving them as criticism.

Tips for ensuring work-life balance



Where to go for support

It is widely accepted by all levels of medical professionals that the welfare of junior doctors is vital. There are a number of internal and external supports available to you as a junior doctor. Internally you have the Director of Clinical Training (DCT) and Medical Education Officers (MEOs) whose role is not only to ensure you receive a comprehensive education program but also provide welfare / emotional / professional support. The contact you have with them can remain confidential or they can help you to plan a solution to your problem and liaise with your supervisors.

There are also external bodies that can help in all kinds of scenarios. Some include:

- **South Australian Medical Education and Training (http://www.samet.org.au/)**

  SA MET has a wealth of useful information. It also has two bodies which exist to represent junior doctors. First is the Junior Medical Officer Forum, which interns from all hospitals are elected to each year. Second is the Doctors-in-Training Committee which focuses on training / education matters. Please contact SA MET to find out who your local representative is and who you can contact for more information or help.

- **JMO Health (http://jmohealth.org.au/)**

  This website has a range of useful tools for promoting junior doctor health.

- **Doctors Health SA (http://www.doctorshealthsa.com.au/)**

  This is a fully independent and profession-controlled organisation dedicated to improving the health of South Australian doctors and medical students.

- **Australian Medical Association (South Australia) (https://ama.com.au/sa)**

  The AMA(SA) is the primary independent association for doctors in South Australia. It focuses on medico-political advocacy with an overall aim to improve the care we can offer patients. Members also receive a range of benefits and support. It has a Doctors-in-Training Committee which focuses exclusively on matters related to medical training.

- **South Australian Salaried Medical Officers Association (http://www.sasmoa.com/)**

  SASMOA is the registered industrial association representing salaried doctors (which include interns) on issues relating to their salaries and conditions of employment. It has junior doctors on its Council to ensure it considered medical training issues.

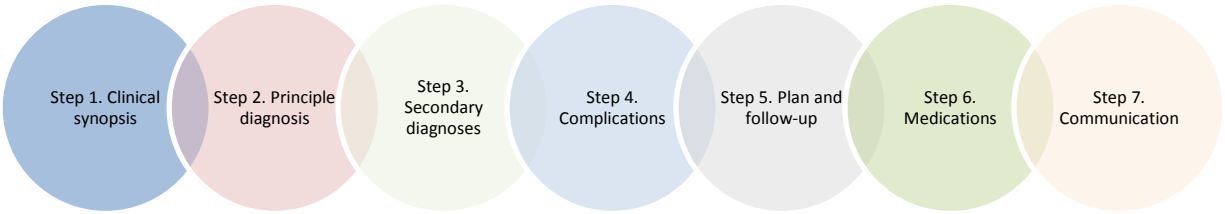
6. Goodbye, Mrs Smith: getting discharge summaries right

Discharge summaries

Discharge summaries are incredibly important. They are a key tool in communication with a patient's General Practitioner and other specialists and, as such, are an important medico-legal document. Previous discharge summaries will often be the first documents reviewed when a patient presents to the Emergency Department. If you were not already convinced, most units will keep track of how many discharge summaries are outstanding and use this as a marker of your efficiency and performance. Many will also review random discharge summaries at unit meetings as a quality control measure.

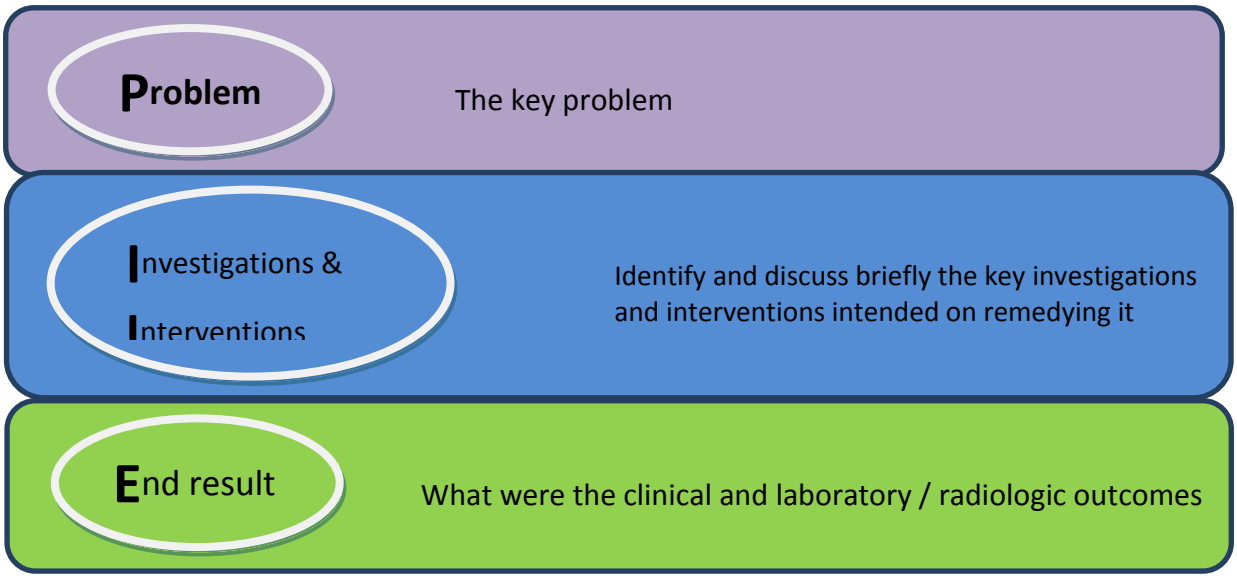
Below is a general guide for writing effective discharge summaries. However, some units have particular preferences and it is important to comply with these. If in doubt, ask your resident / registrar. It is critical to note that discharge summaries will vary immensely from unit to unit and patient to patient. Someone who has a one or two night admission for an uncomplicated elective procedure may require literally one or two sentences in the discharge summary. Conversely, a complex patient with a long stay or a detailed plan on discharge may need far more detail.

It is also critical to highlight that discharge summaries are only one method of communicating with other care providers, and they may not always get through to the essential person. Therefore, if a matter is critically important or if you are unable to complete the discharge summary on the day of diagnosis, then it is important to actually call the General Practitioner / specialist in question and explain the plan to them directly.



Step 1: Clinical synopsis

Ideally the discharge summary should begin with a succinct clinical synopsis that summarises the key features of the patient's presenting problem(s). This may include the key (and only the key) findings on history, examination and investigations. However, a clinical synopsis is not a past medical history or admission history. The synopsis can also summarise the conclusion and ongoing plan, which can be elaborated in further detail later. The 'PIE' approach can be helpful:



Step 2: Principle diagnosis

The principle diagnosis is placed in the corresponding field in the OACIS discharge summary module. It is the primary reason the patient came to / required hospital admission. Diagnoses should be characterised based on the underlying pathological aetiology. For example, 'falls' is not a pathological diagnosis, but rather Parkinson's disease is. Similarly, 'CCF' is not a specific diagnosis *per se* but rather ischaemic cardiomyopathy (or alcoholic cardiomyopathy) is.

In simple admissions, the clinical synopsis may be all that is required in the actual body of text of the discharge summary (e.g. 'Mrs Smith presented for an elective laparoscopic cholecystectomy which was entirely uncomplicated. She will be reviewed in surgical outpatients in six weeks at which time the pathology will be reviewed,' or 'Mr Jones presented with low risk chest pain for investigation which was deemed likely musculoskeletal. He had normal ECGs and troponins at six, twelve and twenty-four hours. He had a normal exercise stress test. He was discharged with simple analgesia and a recommendation for follow-up with his GP in a week.'). However, in more complicated admissions, it is often helpful to follow the clinical synopsis with more detail about the principle diagnosis, secondary diagnoses and complications. There is no 'ideal' way to do this but often a heading and dot-point approach can be effective.

Common acronyms are acceptable; however, remember that the audience of discharge summaries may not be familiar with acronyms that may seem commonplace in your specialty units. Therefore anything more complex than the most common acronyms should be spelled out when first used and the relevant acronym placed in brackets afterwards.

An example of a heading and dot-point approach to summarising the principle diagnosis may be:

Infective exacerbation of COPD:

- Diagnosed based on cough, dyspnoea, raised WCC and CRP with no radiologic opacity
- Initially PaO2 was XX and PaCO2 was XX requiring XXXX days of NIV on respiratory ward
- Treated with XXXX antibiotic(s) for XXXX plus bronchodilators and respiratory-dose steroids
- Improved, weaned off NIV by XXXX, PaCO2 back to baseline of XX on day before discharge
- Discharged with completion oral antibiotics and weaning steroids
- Requires follow-up with Respiratory OPD which is booked for XXXX

Step 3: Secondary diagnoses

A secondary diagnosis could be defined **as any problem in hospital that required monitoring, treatment or investigation**. These secondary diagnoses should be entered into the corresponding field in the OACIS discharge summary module. This field exists below the 'complications' section for the relevant admission. Some examples are:

- Well-controlled hypertension on the patient's pre-admission drug regimen
- Diet-controlled diabetes mellitus may require blood glucose monitoring, but not treatment
- Consider deleting from list of secondary diagnoses any diagnosis carried over from previous discharge summaries that is clearly no longer relevant (e.g. influenza… in 1998)
- Refrain from including laboratory data (e.g. chronic kidney disease, baseline creatinine 140) or dates (e.g. 'cholecystectomy in 1999') as these will readily become out-of-date

If a secondary diagnosis was genuinely significant in the admission that the discharge summary relates to (e.g. Type 2 Diabetes Mellitus that became very difficult to control with hypoglycaemic episodes, endocrine input and a new insulin regimen on discharge) then this can be expanded upon the actual body of text of the discharge summary. This can be done in exactly the same heading / dot-point fashion as the primary diagnosis. If there are multiple such secondary diagnoses, it can be appropriate to order these either from most to least important or chronologically depending on the nature of the admission.

Step 4: Complications

Complications can be entered into the relevant field in the OACIS discharge summary module. Importantly, locations (e.g. ICU) are not complications; instead, the complication might be Type 2 Respiratory Failure requiring NIV support in ICU, or hypotension requiring vasopressors in ICU. In terms of describing relevant complications in the actual body of text of the discharge summary, they can be handled in exactly the same way as secondary diagnoses. An example might be:

MSSA Bacteraemia:

- Diagnosed on XXXX
- Treated with XXXX for XXXX
- Negative blood cultures since XXXX
- Negative TTE and WBBS
- PICC inserted XXXX
- Plan for XXXX antibiotic until XXXX via Hospital@Home
- Requires follow-up in Infectious Diseases OPD on XXXX (booked)

Step 5: Plan and follow-up

At the end of the body of text of the discharge summary, you should summarise the discharge plan and any follow-up requirements under an appropriate heading (e.g. 'plan') followed by clear dot points. Responsibility for tasks should be made clear (e.g. 'GP to kindly consider repeat electrolytes in one week to monitor potassium', 'we will chase surgical pathology and contact patient if any issues' or 'OPD with Infectious Diseases at TQEH is required in four weeks and will be arranged by them'). This plan can be copied and pasted into the 'management' section on the discharge medications page of the OACIS discharge summary module, however that field has text limitations which may be problematic for long plans. In this setting, or if repetition is unwanted, then some practitioners simply write 'please refer to body of text' in this 'management' text field.

Step 6: Medications

Even if you use a hand-written script for discharge medications (or if you have printed an electronic script but subsequently made changes to it / used an additional hand-written script), please ensure that you fill in the medications section of the OACIS discharge summary module as accurately as possible. This is very important for future admissions and as a record for the General Practitioner (probably the most common section of the discharge summary queried by General Practitioners).

Step 7: Communication

As you finalise a discharge summary, you should always ask yourself whether you need to call anyone to convey important / time-critical aspects of your plan. You should also ask yourself whether the discharge summary needs to be faxed or posted to anyone else (e.g. some patients have more than one General Practitioner, some discharge summaries need to go to specialists, and so on). The Ward Clerk can often be helpful in faxing / sending your discharge summaries to the relevant people but, at the end of the day, you need to ensure you communicate the essential information to the relevant parties.

If a patient has had surgery or a biopsy and the pathology results are not back or only interim results are available (e.g. specialised immunohistochemistry is awaited), please ensure you specify this in the Discharge Summary. It is very important to flag with General Practitioners and other recipients of the Discharge Summary that results are interim and will be updated in due course, as otherwise there can be communication issues that lead to confusion and miscommunication with patients.

Additional tips about discharge summaries

- Keep to the point
- Refrain from any detail irrelevant to current admission
- Only include key laboratory / imaging results
- Remember it is a legal document and the authorship can be determined: take great care when writing about behavioural issues associated with the patient and / or family members, and never criticise other teams which had input into the patient's care
- If unsure about how to manage a certain aspect of a discharge summary, as always, ask for help

7. Effective ward-round notes

Heading:

Team name and name of people on the ward round

e.g. 'Orthopaedics 1 Ward Round (consultant name, registrar name, intern name and team)'

If writing notes when on **cover**, heading should include:

Your role, name, reason you are reviewing the patient

e.g. 'Surgical Nights (J. Smith)

Asked to see patient (or 'ATSP') for systolic blood pressure 90 mmHg'

HINT: always order team from the most senior to junior

Acknowledgements:

Acknowledgement of other teams who have seen your patient. This is mainly to show that you are aware of the most current events / plans and it is a nice thing to do to demonstrate your thanks.

e.g. 'Thanks Endocrine for review' or 'Events overnight noted, thanks Surgical Nights'

Issues:

All the active issues that need management and your note will deal with:

e.g.

Day 3 (or 'D3') post left hemiarthroplasty for #NOF

Urinary tract infection

HINT: on surgical teams, always good to include the day post-operation

Subjective (**S**OAPE):

Similar to the 'history' section of an admission note but obviously briefer, in dot-points

Should include all the relevant positive / negative things the patient / family / staff report

Should address the issues listed above and address any new issues

Objective (S**O**APE):

Similar to the 'examination / investigations' section

Should address the issues listed above and address any new issues

Should include the things you observe / find on the examination and bloods/investigations

If any relatives or friends are present during your review, it is important to document this (normally in this 'objective' section)

Should include relevant information from relevant charts, e.g. fluid balance chart, blood glucose charts, bowel / vomit charts, visual observation charts

HINT: When first seeing a patient / unstable patient, should always write down all the vital signs not just 'obs stable and afebrile'

Assessment (SOAPE):

Always write an assessment. This is not the same as the issues, but an assessment of the issues.

e.g.

- Day 3 post left hemiarthroplasty: pain controlled with increased mobility

- Resolving UTI, day 2 oral antibiotics

Plan (SOAPE):

The plan needs to address all the assessment and issues, including plans for discharge if the patient is improving towards that point. This should be communicated to the nurse responsible for the patient during (or immediately after) the ward round.

HINT: This is the most important thing to pay attention to and write down on ward round

Education (SOAPE):

Any education that's provided to patient / family. Sometimes this might be a relatively detailed note addressing concerns the patient / family have.

e.g. Asthma management plan, wound care

SIGN NOTE & LEAVE CONTACT NUMBER

Final Hints:

Leave lots of space

Especially when you are trying to scribble down the plan on ward round, always leave space for the 'S, O and A' sections and rather than trying to cram it all into two lines.

Leave plans for cover

If you are asking cover to chase something up for you, write a plan for what to do with the result (of course, any plan for cover **must** also be communicated to them by telephone).

e.g.

BAD INTERN: *'cover to please chase CXR'*

GOOD INTERN: *'Cover to please chase CXR to be done tonight: if suggestive of infective changes, please start antibiotics for HAP; if no changes, we will review in morning; if unexpected changes, please contact Med. Reg. on duty'*

8. Money…. a whole lot of spending money

One beautiful thing about 'working for the man' is that you get paid. But in order to get paid, you need to ensure that you submit time sheets on a timely basis. Each hospital and unit has a slightly different approach to time sheets and it is important that you find out about this during handover / orientation. Some key tips about time sheets include:

Pre-formatted time sheets

Some units have pre-formatted time sheets. These clearly outlined your rostered hours and also save you having to write out a new time sheet each fortnight. However, if you do conduct overtime or miss breaks or so on, pre-formatted time sheets can make it difficult to claim the associated penalties; in these instances, you may need to hand-write your time sheet anyway.

Signing of time sheets

Different units have different processes for signing time sheets and you need to ensure you know what this is so you can get paid! It is sometimes useful (particularly on surgical rotations or other rotations on large units when the supervising consultant may be less visible) to make a copy of your completed (but as yet unsigned) time sheet at the end of each pay cycle and put that in a safe place while you have the original in your pocket; that way if you happen to bump into the consultant responsible, you can whip out your time sheet and get it signed then and there. On relieving and nights terms, often a designated person in Medical Administration will sign your time sheets.

Submitting time sheets

Time sheets can be submitted by fax or email. The relevant email for submitting time sheets is (Payroll21Documentation@sharedservices.sa.gov.au). Ensure that the file size is not too large if using email. Based on our experiences, we recommend email as a more reliable method. During periods where public holidays, time sheets may need to be submitted earlier to allow Shared Services to process them in time. In these settings, you will be notified of this beforehand by email (SA Health email).

Record keeping

It is advisable to keep a copy of every time sheet and every pay slip, either electronically or in hard copy or both, for the reasons outlined below.

- ***Incorrect pay (over and under):***

  You should check your pay slips against your time sheets as well as expected HECS, salary sacrificing, RMO Society and car park deductions. You should also check correct payment of superannuation entitlements and leave accrual. If you are unsure whether your pay slip is correct based on your time sheet then you can check it against the Enterprise Bargaining Agreement yourself (and address queries to Shared Services via telephone or email) or, if you are a SASMOA member, then you can ask SASMOA to do this for you. There is also a private company called OpayQ (https://opayq.com.au/) which offers an automated pay-for-service mechanism to check your pay slips.

  Note that you will be paid back if you are under paid (this is not uncommon), but if you are overpaid (this is rare) then this must be paid back to the Government; it is better to find this out sooner rather than later if the over payments are significant, although there are measures in place if repayments would put you into financial hardship.

- ***To claim or not to claim...***

  Unpaid overtime is a sad reality for many junior doctors. It varies extensively from unit to unit. If you are concerned you are unfairly being expected to do unpaid overtime, you should address this matter with your supervisor / Medical Education Officer(s) or alternatively SASMOA.

9. Cover and nights

The thought of cover / nights can fill one's heart with dread: there are the innumerable jelcos and difficult bloods, endless pages about unclear issues or things that should have been addressed during the day, and moments of terror when called to review a sick complex patient. However, cover and nights also represent a fantastic opportunity to learn and expand your skills. Many interns will say, at the end of the year, that it was their experiences on cover / nights from which they learnt the most. Plus it can also be great fun!

Tips for being an effective intern on cover:

- **Get a plan**

  If someone hands over a task to you, it is entirely reasonable to insist on a plan with what to do with the result of whatever they have requested.

- **Record and manage your tasks**

  Time management is absolutely critical on cover / nights. No matter where you are working, some shifts will simply be too busy to get to every job. Ultimately you need to accept that sometimes you cannot get to every single patient; if things are this busy, your priority must be to perform the most important tasks first, to ask for help if multiple important time-sensitive tasks arise at once, and to handover the unimportant or non-urgent matters to nights or the day teams the next morning.

  First and foremost, have a well-organised list of jobs. This need be no more complex than a piece of paper with rows divided into three columns. The first column can be for the patient identifying details and location, the middle column for the case details and the job and the final column for any handover / test chasing requirements.

  Against your tasks you need to assign a clear priority. One helpful manner to do this is to categorise tasks against whether they are very important or less important in the safety and overall care of the particular patient, and then again whether the particular task is urgent or non-urgent. For example, reviewing a patient with ischaemic-sounding chest pain is both very important for safety and urgent. Performing a trough gentamicin level on a patient is important but flexible within the four hour window. Charting temazepam for a patient who is well but having trouble sleeping is, in the overall scheme of things, neither important nor urgent in the context of your other tasks.

- **Enlist the nursing staff**

  Nursing staff know you are busy when you are on cover / nights and they are generally willing to assist you in being as efficient as possible, especially if you are polite and explain your thinking / concerns / priorities. Insist on being provided sufficient information to triage your tasks, even if it means asking for vital signs to be performed / further information to be gathered from the notes before you are paged back. Ensure that you think ahead to what is likely to be required when you get to the bedside; if the patient is going to need an indwelling urinary catheter then ask for the equipment to be set-up, or if an ECG is going to be necessary then ask for it to be performed before you arrive.

- **Escalate if concerned or unsure**

  There is always someone more senior than you in the hospital and there will usually be clear lines of escalation if you are concerned about a patient or unsure regarding a clinical question. If the

patient is sick and deteriorating, call a MET Call. If you are unsure, then you can call the registrar responsible (surgical or medical depending on the patient and the issue).

- **Issues with under-investigation / under-treatment and the reverse**

  Sometimes there may be the temptation not to order investigations because you are concerned about over investigating a patient or even because you are not fully confident in the interpretation of the test. It is reasonable to err on the side of caution and tend towards over-investigation when or cover / nights. It would be unreasonable to criticise a night / cover intern for being cautious, whereas being overly confident is usually where people run into trouble. In the setting of queries about cross-sectional imaging in a younger patient, liaison with your registrar and the radiology registrar can be helpful.

  Never fail to order an investigation because you are not entirely confident about its interpretation! This is completely inexcusable. There is always someone who can help you interpret an usual ECG or radiograph; when in doubt, call the medical registrar or speak to the radiology registrar. They are there to help. The radiology registrars in particular can provide extremely useful information about the value of various imaging modalities in the context of your clinical question; the important thing is to know what you are trying to determine or exclude from your investigations.

  Similarly, if you are unsure whether or not to treat a patient (e.g. someone with new fever), then do not simply defer the matter until the morning if treatment may be warranted. Sometimes interns leave such patients without antibiotics because of uncertainty about which agent to use. If in doubt, liaise with your medical registrar. You will soon develop an appreciation for when treatment is warranted. As you will see on MET Calls, it is not unreasonable to treat empirically based on suggestive but inconclusive clinical evidence until further information can be gathered.

Review and handover

Take responsibility for your patients and your decisions. If you decide a tachypnoeic patient is overloaded and give frusemide, for example, ensure you review them later in the shift (irrespective of whether you are asked to by the nursing staff) to assess how your intervention has worked. If they are still tachypnoeic, perhaps it is time to review your original diagnosis or ask for help.

Effective handover is critical. Tips for this have already been outlined above and the same rules apply. Informing day teams about events overnight is also important and provides an opportunity to circumvent similar issues arising the following night, which is surprisingly common and unsurprisingly frustrating.

MET Calls

MET Calls can be scary but, in reality, the roles of an intern are fairly straightforward: (a) handover what you know about the patient in a clear and loud fashion to the medical registrar and MET Nurse when they arrive, (b) get bloods, intravenous access and an arterial blood gas as required (an ABG is of immense value in a large proportion MET Calls), (c) print bloods, and (d) arrange portable radiography as required. It is advisable to liaise with other intern(s) on MET Calls to determine who will do what in advance of the first call for the shift. If you cannot complete your assigned task promptly, notify the person leading the MET Call so they can make alternative provisions. Finally, if you think something is being missed, then speak up in a contributory manner. As you leave the MET Call, ensure you know who is supposed to be chasing any investigations that were ordered and who you should contact with any queries about the results.

10. Staying alive on nights

Nights can be tough! There are lots of different approaches that people use and you need to find out what works best for you. Below are a few ideas that we have heard of:

- Adjust your rhythm: sleep in as late as possible on the morning you begin nights, or have a nap in the afternoon to ensure you can make it through to the next morning
- Minimise your commitments: when on nights, try to focus on working and sleeping because overloading yourself with other commitments is a recipe for pain, and trying to get study done when on nights is often futile
- Eat and sleep well: maintain a balanced diet, keep hydrated and pay attention to sleep hygiene
- Alcohol is for the last morning: avoid the temptation of breakfast champagne until you have finished your block of nights, but then make sure you go out to breakfast with your entire team and celebrate
- Stay up: after the last shift, try your best to get into a normal rhythm again quickly, otherwise your time off will be wasted in the mysterious grey twilight between sleep and wakefulness...
- Enjoy your time off: make sure you enjoy your time off from nights, because this is the best defence against pre-work blues when the next lot of shifts roll around.

11. Patient restraint and Code Blacks

Patient restraint and Code Blacks are highly stressful scenarios that can also be challenging clinically, especially because some hospitals have interns as the most senior doctor attending Code Blacks. Dealing with agitated patients is often not addressed in significant detail during Medical School. Furthermore, because the response to Code Blacks is limited to particular services and because they often occur overnight, it is difficult to build-up sufficient experience of them as a student.

It is essential to follow local protocols with respect to patient restraint and Code Blacks. Perhaps more than anything else in this guide, this is an area where we can offer only the most general advice.

- ***First try de-escalation***

  It is surprising how often the (outwardly) calm presence of 'the doctor' can soothe tensions. De-escalation can be effective, so first try this, but ensure you do it safely. Sometimes patients will be agitated over very minor practical / administrative issues which you can easily address (e.g. they want their antibiotics at 2200 not 2100).

- ***Memorise the Code Black / agitated patient / restraint protocols***

  Your hospital will have one or more protocols dealing with Code Blacks, agitated patients and restraint. It is advisable to memorise the key details of these protocols, especially the doses and contra-indications to sedatives, as rapid decision-making can be important and it is not ideal to have to look these kinds of things up while a patient is being physically restrained by numerous security guards. But if you are in any doubt, then obviously you must check the protocol! Normally the 'Code Black kits' will have a copy of the protocol stuck to the front / inside cover.

- ***Organic causes for new agitation must be excluded***

  It is said over and over again during Medical School, but it is essential to exclude organic causes for agitation, especially if this is new for the patient. If you are unsure how to investigate an agitated patient, speak with a senior about arranging this. For example, it may be necessary to sedate the patient to allow neuroimaging; this is a call that the responsible registrar should / must be involved in.

- ***Legal obligations***

  You cannot physically or chemically restrain a patient without the legal authority to do so, otherwise this may constitute assault. The legal issues around restraining an incompetent patient needing care are complex and often unclear. If you are unsure, your registrar or consultant should be able to clarify.

  If a patient is detained with an Inpatient Treatment Order, then psychiatry will review the patient within 24 hours (which may also be helpful for ongoing management) and lift the order if they feel it is not appropriate; it is not a negative reflection on you or your decision if an order is lifted. In the case where a patient has already been deemed to be incompetent (e.g. in the context of a dementing illness) and has a guardianship order and appointed guardian via the Guardianship and Administration Act 1993, then it is important to discuss the matter with the appointed guardian if this has not already been done.

  If a patient is neither detained under an Inpatient Treatment Order nor is under a guardianship order but appears incompetent to make decisions around their care / treatment location, and you believe restraint is required, then the question needs to be asked as to which legislative approach is most appropriate to restrain the patient (e.g. Mental Health Act 2009, Guardianship and Administration Act 1993 or Consent to Medical Treatment and Palliative Care Act 1995); in such

settings, it would be advisable to liaise with your superior / the on-call Medical Registrar / treating consultant if the Code Black is occurring overnight. If in doubt and the situation is both urgent and unsafe and a senior person cannot be contacted with sufficient rapidity, then it is reasonable to detain the patient under the Mental Health Act 2009 until further clarification can be sought.

The SAMET Doctors-in-Training Committee is actively working to attempt to clarify the legal issues around patient restraint.

- ***The naughty corner...***

  Sometimes agitated / noisy / annoying patients can find themselves in side rooms as far as possible from the nearest nursing station. This may not necessarily be ideal, particularly if the patient needs close monitoring. In such cases, it is appropriate to discuss this with the team leader (or nurse manager at night) to see if beds can be re-arranged to ensure the patient is in a location where they can be monitored closely, even if this is frustrating for other patients and staff. Another option which is often preferable (but not always feasible depending on staffing) is to arrange a 1:1 nurse special for the patient.

12. What is a young doctor to do?

There can sometimes be confusion around what tasks must be done by a medical officer (and by an intern specifically) and which tasks should be done by nursing staff or more senior trainees. This can be both anxiety-provoking and challenging for interns.

Although task distribution between medical and nursing staff will differ somewhat between different SA Health sites, we would suggest the following delineation to be generally accepted (clearly this is not a list of all tasks which staff conduct but rather a list of jobs which sometimes generate confusion / misunderstanding):

Intern:

- Re-write medication charts
- Complete pathology and radiology request forms
- Complete request forms for other services as appropriate (e.g. outpatient requests)
- Insert male indwelling catheters
- Obtain pathology specimens for blood (on some wards there may be nursing staff trained in venepuncture who may be willing to assist interns by performing this task)
- Insert intravenous cannulae (on some wards there may be nursing staff trained in intravenous cannula insertion who may be willing to assist interns by performing this task and, similarly, some SA Health sites will have dedicated nursing staff employed to insert cannulae overnight)
- Clarify instructions or plans documented in the case notes by their own medical team
- Obtain medications for patients from pharmacy after-hours, if required
- Consent patients for some low-risk procedures (such as blood transfusion)

Nurse:

- Insert female indwelling catheter (urinary), escalating this to an intern if multiple attempts fail
- Obtain pathology specimens for urine, sputum, wound swabs, nasopharyngeal swabs
- Dress / re-dress and attend to wounds
- Assist patients in re-positioning, showering, toileting and other personal activities
- Clarify instructions or plans documented in the case notes by other contributing medical teams
- Request input from allied health providers (e.g. physiotherapy, occupational therapy, social work and rehabilitation review), however please note certain SA Health sites require medical officers to request some allied health and other input such as psychology
- Obtain medications for patients during working hours
- Perform electrocardiograms

Resident / registrar:

- Make (or authorise in their name) modifications to the RDR Observation Charts
- Discuss and complete Resuscitation Plan documentation
- Complete or change chemotherapy drug charts
- Consent patients for operations / procedures / chemotherapy

13. Useful resources

We have listed some key resources below which you might find useful during internship:

- **Local guidelines**: not only are local guidelines often amazingly useful and deal with the precise question you have, but you will also be expected to follow them. They are your first port of call!
- **UpToDate**: available via SA Health computers and at home / on smart phones! Amazing! If you are unsure how to access this, speak with your friendly local library staff.
- **Marhsall and Ruedy's On Call**: the bible for cover / nights!
- **AMH**: pharmaceutical gold.
- **Electronic Therapeutic Guidelines (eTGs)**: not necessarily exhaustive, but the areas that are covered are like a super magical (and succinct) combination of UpToDate and AMH all in one! Notably they cover palliative care especially well, which can be very new and confronting for many interns.
- **Oxford Handbook of Clinical Medicine and Oxford Handbook of Clinical Specialties**: they still got it!