# Orientation, Conduct and Policy Guidelines

## Orientation

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## Conduct Guideline for Medical Staff

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Welcome to the Department of Medicine.

I. Background:

Edendale Hospital is the largest of the three state-sector hospitals in Pietermaritzburg, and provides District and Regional level care. The Department of Medicine has 216 beds, 3 beds in the Intensive Care / High Care Units and a large outpatient service, including the largest antiretroviral rollout program in the Province. The hospital was built in the 1950’s and, before 1994, was situated within the KwaZulu homeland. Subsequently the hospital was integrated into the KwaZulu-Natal Department of Health. The hospital’s relatively poor infrastructure is a legacy of South Africa’s divided past, and deficiencies are gradually being addressed. Edendale is on the Department’s Revitalization Programme.

The public health sector has experienced serious financial constraints over the past decade. The most severe consequence has been the movement of experienced nursing staff to developed countries. Fortunately public sector funding has increased and nurses have had meaningful pay-rises. However it will take several years to train sufficient numbers of nursing staff for the medical wards. The vision of the Department is to re-establish standards of medical excellence in order to attract and retain nursing staff.

II. Medical Staff:

Dr Wilson (Head of Department) is a physician and infectious disease specialist. - responsible for managing the Department and for conducting research in HIV and tuberculosis.
Dr Michowicz is a physician and cardiologist and Deputy Head of the Department. Dr Michowicz is also the Intern Coordinator.
Dr Rasmussen is a general physician and the Registrar Coordinator.
Dr Caldwell is the outreach physician who takes ward rounds and participates in the after-hours call roster.
Dr Collinge is a nephrologist from Grey’s Hospital who takes weekend ward rounds and participates in the after-hours call roster.
Dr Thembela is the Chief Specialist for the Complex, takes ward rounds at Edendale and participates in the call roster.
Dr Shwe, Dr Barreto, Dr Pons, Dr Otero, Dr Khan, Dr Islam, Dr Beharie, Dr Nurrudin and Dr Saleh are the Department’s Principal Medical Officers.
Dr Shwe is the most senior medical officers in the Department, and holds the Higher Diploma in Internal Medicine.
Dr Saleh and Dr Nurrudin are registrars in Family Medicine.
Dr Khan is the Occupational Health medical officer.
Dr Njis is the senior ARV PMO and heads the Imbalenhle Community Health Center rollout and provides medical cover for the Doris Goodwin TB Hospital.
Dr Duma, Dr Haines, Dr Nxuluamo, Dr Naidoo, Dr Madlala, Dr Makhobo Dr Naidoo, Dr Xengxe, Dr Xaba, Dr Ndaba, and Dr Bishop work in the ARV Clinics.
The Department has eight medical Registrars rotating through the Department, who are training to become specialist physicians.
There are usually 13-14 medical interns in the Department who rotate through the department every 2 months.

Dr Dong is an infectious disease specialist from Harvard Medical School. Dr Dong has secured substantial funding to support the Department including the antiretroviral and TB programmes, and is also conducting research (the iTTEACH programme). She is supported by Zinhle Thabethe, Mathanja Coetzee and Gugu Mofokeng. The iTTEACH programme (situated in 5B2) provides the Department with important infrastructure including computers and Internet access.

Mathanja Coetzee works for iTTEACH and administers the Department’s NGO (Umkhuseli). Rhoda Marie is the Department’s administrator - she facilitates the many different functions of the Department, draws up the call roster and keeps copies of all the Department’s forms (e.g. rural allowance, leave, discharge summary, mental health care act). Ms Marie’s telephone number is extension 4146.

The Department is fortunate to have Residents from the Internal Medicine programmes at the Massachusetts General Hospital in Boston and Columbia University in New York who visit the Department on 4-week rotations. The program is facilitated by Dr Dong and Dr Hurtado, who is an infectious disease specialist from Massachusetts General Hospital and Harvard Medical School.

Grey’s Hospital has a strong tertiary level consultant service in Internal Medicine. Dr Moodley (Neurology), Dr Joti (Gastroenterology), Dr Naidoo (Pulmonology), Dr Collinge (Nephrology), Dr Shein (Cardiology), Dr Dawood (Infectious Diseases), Dr F Mahomed (Endocrinology), Dr Y Mohammed (Rheumatology) and Dr Caldwell (Outreach Physician) are based at Grey’s. Dr Lee is a physician and qualified intensivist. Discuss potential referrals by paging via the Grey’s switchboard (speed dial 5035).

Dr Y Mahomed is the Intern Curator for Medicine for the Complex.

III. Nursing staff:

Edendale is fortunate to have highly experienced nurses working in the wards and clinics. However many nursing posts are unfilled. Doctors can assist by asking a member of staff to join the daily ward round and by communicating important management decisions immediately using the communication chart. It is also helpful to stop intravenous medication as soon as possible and to discharge patients promptly.

Orientation and Conduct Policies, Department of Medicine, Edendale Hospital, Updated July 2010.
Mrs Madondo is the Manager responsible for coordinating the Nursing Staff in the Department.

The names of the Sisters in charge of the wards and clinics are:

<table>
<thead>
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<th>Deputy</th>
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<tr>
<td>Ward 5F</td>
<td>Sr Shezi</td>
</tr>
<tr>
<td>Ward 5B1</td>
<td>Mr Dayimani</td>
</tr>
<tr>
<td>B Ward</td>
<td>Sr Gwiji</td>
</tr>
<tr>
<td>C Ward</td>
<td>Sr Mbatha</td>
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<tr>
<td>E Ward</td>
<td>Sr Lazarus</td>
</tr>
<tr>
<td>MOPD</td>
<td>Sr Sibisi</td>
</tr>
<tr>
<td>TB Team</td>
<td>Sr Mthalane</td>
</tr>
<tr>
<td>ARV clinic</td>
<td>Mrs Thembi Shange</td>
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IV Wards:

The Department has two regional wards located on the 5th floor: 5B1 (female ward) and 5F (male ward). The two district wards are H ward (female) and C ward (male) and are located in the complex at the back of the Hospital (most conveniently reached via the covered walk-way at the end of the first floor passage, past the lifts). B Ward is being commissioned as a medical admissions ward. The female step-down ward is E Ward, and male patients are stepped down to D Ward (from 5F) and G Ward (from C Ward). The multi-disciplinary Intensive Care Unit (Ward 2R) and High Care Unit (Ward 2F) is staffed by the Departments of Anaesthetics and Medicine.

V Clinics:

The Antiretroviral Clinic is located between the main building and the Nurses Home and runs from Monday to Friday. The Family Clinic is located in the new HAART building.

Medical Outpatients provides focused assessment and follow up for patients discharged from the wards (on Tuesdays, Thursdays and Fridays), for patients taking warfarin (the INR clinic on Monday) and for diabetics (on Wednesdays). Importantly, the diabetic clinic is especially busy. A booking system is being introduced. Dr Michowicz run his outpatient clinic on Tuesday.

VI Emergency Medicine Rooms:

An important part of the Department of Medicine’s function is to provide 24-hour cover for the Emergencies and Admissions (located at the end of Medical Outpatients). During working hours this service is run by medical registrar and two to three interns, and after hours by the on-call team. Patients are referred from medical outpatients if the doctors think admission is indicated, and medical emergencies are brought directly to the resuscitation room. The South African Triage Scoring System is being implemented.

VII Useful telephone numbers:

<table>
<thead>
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<th>Resuscitation Room:</th>
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<td>4527 / 4562</td>
<td>Ward 5F:</td>
<td>4522 / 4561</td>
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<td>Ward B:</td>
<td>4021 / 4287</td>
<td>Ward C:</td>
<td>4288 / 4290</td>
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<td>Ward E:</td>
<td>4294 / 4296</td>
<td>Medicine Office:</td>
<td>4146</td>
</tr>
<tr>
<td>2R ICU:</td>
<td>4212 / 4211</td>
<td>2F HCU:</td>
<td>4061</td>
</tr>
<tr>
<td>Occupational Therapy:</td>
<td>4216/7/8</td>
<td>Regional Clinic:</td>
<td>4393</td>
</tr>
<tr>
<td>Psychiatry Clinic:</td>
<td>4058</td>
<td>Sr BT Mthalane</td>
<td>6299</td>
</tr>
<tr>
<td>ECG:</td>
<td>4618</td>
<td>Special Clinic:</td>
<td>4126</td>
</tr>
<tr>
<td>iTeach</td>
<td>4523</td>
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Tie-lines: Grey’s Hospital: 5035 / Albert Luthuli Hospital 5043 / King George V 5049 / Doris Goodwin TB Hospital 6063
Telephone King Edward Hospital: 031-3603111 / 3000 / Townhill Hospital 5062 033-3415500

Speed-dial numbers: Dr Wilson 6164 / Dr Michowicz 6258 / Dr Thembela 6279 / Dr Rasmussen 6281

Hospital practice number: 5600871

VIII Patient transport:

The District runs two services for patient transport:

- Emergency service vehicle (ESV) - for same-day transfer of very ill stretcher patients who may require advanced life support (e.g. to Grey’s Medical Admission Ward or ICU, to IALH neurosurgery) - see below
- Planned patient transport (PPT) - for booked appointments at other hospitals (e.g. Cardiac Clinic and Thoracic Clinic at IALH) - ask the Unit Manager to book transport via the Control Room and the PPT Coordinator.

If you need to transfer a patient by the EMRS the following details will be required:

1. Patient name
2. Age
3. Diagnosis
4. Glasgow Coma Scale
5. Heart rate
6. Blood pressure
7. Respiratory rate
8. Oxygen saturations and % inspired oxygen
9. Referring doctor's name and EDH ward
10. Receiving institution and receiving doctor's name and cell phone number
11. Equipment needed during transfer (e.g. oxygen, suction, mechanical ventilation, cardiac monitor)

Note that the patient will need a nurse escort.

**Contacting the Metro Ambulance Service or EMRS:**
Dial '9' (Edendale’s switchboard) and request Metro Ambulance Service
**OR**
Dial ‘10177’ or ‘033-3947293’ or 033- 3946666’ or ‘080005133’
**OR**
Dial ‘5035’ (Grey’s switchboard) and request Metro Ambulance Service
**OR**
Dial ‘4007’ (Nursing Control Room)
**OR**
Go to the Control Room – find the numbers on the White Board and call from exchange
**OR**
Call ‘112’

**IX 5B2 (ITEACH) etiquette:**

Dr Dong has made the expertise and equipment in 5B2 available to the Department of Medicine staff. This includes:
- The TB warriors
- The Treatment Programme support staff (Mrs Thabethe AKA ‘Mom T’)
- Computers with internet access
- ‘Up to Date’ on line medical textbook
- Digital cameras

When you go into 5B2 please introduce yourself to Ms Gugu Mofokeng at the reception desk and explain what you need. The 5B2 staff will go out of their way to assist you.

**X American Internal Medicine Residents:**

The Department is fortunate to have Internal Medicine Residents from Massachusetts General Hospital and the University of Columbia rotating through the hospital on a 1-month Global Health elective. The main purpose of the elective is to gain exposure to the practice of internal medicine in a resource-limited high HIV/TB burden setting. The Residents are highly trained physicians, often with an additional PhD or MPH qualification, who are in a position to make substantial contributions in the following areas:

- Medical education - the Residents prepare state-of-the art presentations on relevant topics
- Ward rounds - the Residents’ are often able to improve patient care by suggesting diagnostic and management solutions
- Resuscitation and admissions - the Residents spend time with local staff assisting in the management of medical emergencies

Please go out of your way to make the Residents feel welcome - they have come a long way to be with us! All the members of the Department are encouraged to discuss patient management with the Residents and to compare differing approaches to medical care in well-resourced and under-resourced environments.

**XI Facilities:**

Cafeteria – 1st floor, walk towards the ward (1F), left onto a ramp. The cafeteria is on your right. A cooked meal with a juice and fruit costs less than R20.
Lavatory – Male and Female toilet in 5B2 (ITEACH).
Kettle & Microwave – Available in 5B2 ‘kitchen’ or Department of Medicine Seminar Room.
Printing & Photocopying – Ask Gugu in 5B2 (Doctors from abroad).
Work related and educational needs for E-mail & Internet – Available in 5B2. (Sign in with Gugu)
Camera’s – available in 5B2 on a booking system. Available to all Dr’s to take photo’s of interesting cases and/or for presentations.

**XII On-call room keys:**

Keys for the sleep-in rooms should be signed out (register with Ms Marie) at the beginning of the call and signed back in at the end of the call. Currently the Department uses rooms D24, D29, D9 and D10 in Doctors’ Quarters. If you forget to pick up your key call Dr Wilson on 6164 and he’ll open up the Department to get the key for you.
XIII The Laboratory:

Edendale has a large and busy laboratory that provides all routine investigations. Many specialized investigations are sent to IALH in Durban, and are often assayed in batches, so results can take time to return. These results can be accessed by checking on the intranet computer in the laboratory (more computers will be installed on the 5th Floor and Special Clinic during the course of 2010) or by calling IALH directly. Please visit the laboratory and meet the technicians. You should take the time to take important specimens, such as CSF samples, to the laboratory yourself.

The laboratory system is not fully computerized (the Department has motivated for this major problem to be addressed). Results of specimens sent to Albert Luthuli can be obtained off the computers in the adult antiretroviral clinic, from Ms Marie’s computer or in the Laboratory Manager’s office. In order to prevent laboratory results from getting lost please use the following two centralized filing systems:

- **INPATIENTS AND EMERGENCIES** - Mark form ‘Ward 5B2’: the on-call intern will collect all these result from the lab before the 08:00 meeting and file the results in the seminar room. The ward doctors will need to collect these results at the end of their ward round.
- **OUTPATIENTS**: - Mark the form ‘MOPD’ or ‘Special Clinic’

Please ensure that **all the fields** on your blood requisition are complete (date, time, full names, surname, your name, ward, clinical details).

Please write down in your notes where the results have been directed to, and use the ‘double box’ system: e.g.

FBC, diff, CEU, LFT, blood culture       Ward 5B2  DD/MM/YYYY

Please do not overload the after-hours laboratory service with specimens marked as ‘urgent’:

Only specimens from patients suspected to have of the following conditions should be marked urgent:

1. Diabetic emergency (DKA / NKC)
2. Change in mental status/delirium
3. Respiratory distress
4. Renal/liver failure/cardiac failure
5. Hypotension, hypertensive urgency/emergency
6. Dehydration, fluid overload
7. Arrhythmias
8. Seizures
9. Lactic acidosis
10. Overdose
11. Myocardial infarction

XIV The Radiology Department:

The Radiology Department is on the 1st floor. Edendale Hospital has a sophisticated CT scanner and abnormal scans can be faxed to Durban or sent to Grey’s for further interpretation. There is also an ultrasound service, and a comprehensive radiographic service. Please discuss urgent investigations with the radiologist and hand in the request form personally. The Department of very short staffed so please only request essential investigations. Bedside unit chest radiographs should only be requested if the patient is too ill to be taken to radiology.

The date format on the x-rays is: MM/DD/YY

Echocardiography should be booked at extension 4146.

A radiology meeting is held at the Grey’s Radiology Department on Thursday at 15:15. Please take any interesting films with you to the meeting.

XV Pharmacy:

The Pharmacy is exceptionally busy. The Outpatient Pharmacy is part of Medical Outpatients, and the Inpatient Pharmacy is on the ground floor beyond the lifts. To make our Pharmacists’ lives easier please ensure that your handwriting is readable, and that you have checked doses in an up-to-date copy of the SAMF. Occasionally you may have one of your prescriptions returned with a query from the Pharmacist: these notes are written to protect your patient from potential problems such as medication availability (some drugs require a specialist signature), drug interactions, allergies and incorrect doses. This is a valuable service provided by the Pharmacy, so please respond to the query promptly.

XVI Current Research Projects

The Sutherlandia study is a double-blind placebo controlled study evaluating the efficacy of a traditional medication in patients with early HIV infection. These patients will be recruited as outpatients.

The SNTB 4 study is evaluating the utility of CRP in diagnosing outpatient TB.

XVII Students:
Fourth year medical students from the Nelson Mandela Medical School in Durban will be rotating through Edendale’s medical wards on Mondays, Tuesdays and Wednesdays. Please make the students welcome and help them to find cases to present for their tutorials. Dr Thembela supervises the student teaching program.

XVIII Necessary equipment:

In order to work effectively you’ll need the following:

− Cellular phone
− Stethoscope
− Halogen bulb torch
− South African Medicines Formulary
− Small paper punch and staple (to keep your notes tidy)
− Small pair of scissors
− Shoulder carry bag (some interns also carry an A4 sized folder for forms - this is an excellent idea)

On call remember to bring:

− Food and drink (chocolate is good for a quick mood lift)
− Mosquito repellent (e.g. Tabard, Peaceful Sleep)
− Toothbrush and toothpaste
− Soap, shampoo, towel
− Electric fan (in summer)

XIX Personal safety:

Be aware that there will be situations when your personal safety may be at risk:

− Do not attempt to sedate violent psychotic patients without adequate back-up - see ‘Management of the acute confusional state’
− Do not go to the District Wards at night without a security guard
− Report any strangers in Doctors Quarters to security - Extension 4092
− Consider carrying an anti-assault spray (e.g. pepper spray) in your shoulder bag

Do not expose yourself unnecessarily to needlestick injuries. Consider the option of subcutaneous fluids (hypodermoclysis) and an intramuscular antibiotic if you are finding it difficult to obtain intravenous access. Be generous with local anaesthetic and premedication (e.g. IM morphine) before doing painful procedures - this will help the patient to remain still while you work.

When you are in contact with patients with MDR TB make sure you wear a N95 mask (available in the Department). Do not wear a surgical mask.

XX Needlestick injuries:

Take needle stick injuries seriously: wash the puncture site immediately with soap and water followed by alcohol handwash (note if the alcohol stings at the puncture site) and go immediately to contact the Occupational Health Clinic (working hours) or the Matron on Call on the 4th Floor (after hours) for antiretroviral prophylaxis, which should be taken as soon as possible. You will need to have an HIV test and have an IOD form filled out within 72 hours at the Occupational Health Clinic. Please let Dr Wilson know as soon as you have had an injury so you can get the necessary support.

XXI Theft:

Theft of equipment and personal belongings is common. Please do not leave anything of value in the wards or in the on-call rooms. The Department office behind the security gate and the boot of your car are safe options!

XXII Looking after yourself:

Working at Edendale Hospital is exceptionally rewarding but can be stressful. In order to look after your patients it is important that you look after yourself too. Visit the Human Resource Department on the first floor of the Nursing Home as soon as you join the Department and ensure that all your details are correct, including your Persal number, salary level and bank account number. Make sure that you have paid your HPCSA and MPS fees and consider joining a medical aid, insuring your car and household contents, and paying into a retirement annuity.

It is easier to prevent burnout than to treat it!

− Leave your stress behind when you leave the hospital
− Use your free-time to relax and socialize
− Take leave regularly
− Explore the ’Burg and the Beaches
− Exercise at least three times a week
− Don’t take up smoking (and avoid other recreational drugs)
− If you feel you aren’t coping: tell someone (preferably a senior colleague)

Make careful career plans and discuss them with your colleagues. Don’t leave important decisions to the last minute. If you are planning on working overseas allow plenty of time for the necessary paperwork, and sign your contract before you leave. Enjoy yourself, learn as much as you can, but come back to South Africa: you can do the most good here!
Conduct Guideline for Medical Staff

I. Introduction

Department of Medicine works on trust and collegial respect, and is guided by principles of respect, beneficence and fairness.

Management understands that Edendale Hospital is a difficult environment to work in and staff are paid an additional rural allowance. Please collect your claim form from Ms Marie. The purpose of the Conduct Guideline is to make it as easy as possible for doctors to work effectively. The aim is to ensure a fair distribution of work load, appropriate patient care and ongoing medical education. The Conduct Guideline covers aspects of doctors’ work that have medico-legal and disciplinary implications. The Orientation gives details of the day-to-day running of the Department.

Edendale Hospital is funded by the provincial government, which obtains its funding from national tax revenue. All the doctors employed by the hospital are therefore civil servants and need to be guided by the Batho Pele principles and the Patients Rights Charter. The Department of Medicine is responsible to the HPCSA to supervise the training of interns and registrars, and to the Department of Health to provide ongoing performance evaluation and professional development for all permanent staff.

II. Weekly programme

Daily 08:00 - 08:30 meeting (5th Floor Seminar Room):

The purpose of the meeting is for the post-call team to hand over from the previous day’s intake, and to improve patient care and intern training. The meeting should be attended by all the medical interns and the post-call registrars and PMOs. The admission statistics should be presented by the post-take interns, followed by a post-call case admitted over the past 24 hours for teaching purposes. The following details need to be presented:

- Name, outpatient number, age
- Presenting symptoms and relevant medical history
- Examination findings
- Urgent laboratory results and chest x-ray (if available)

This is followed by feedback on the previous day’s case and a 5-minute talk by a medical registrar. The meeting ends at 08:30.

Academic meetings:

Wednesday morning Grand Round 07:30 - 08:30 (4th Floor Boardroom telelink or Grey’s Auditorium)

- For senior medical staff (register will be taken)
- Note that the post call Medical Registrar must cover Resuscitation Room and cannot go to the meeting

Thursday registrar teaching 14:00 - 17:00 (Grey’s Hospital Radiology Seminar Room)

- For medical registrars

Rule for Med Reg cover on Wednesday am and Thursday pm

- Wednesday - Cover by post-call Reg OR Resus Reg*;
- Thursday - On-call Reg OR Ress Reg*

*If PMOs doing call

Friday medical meeting 09:30 - 10:30 (Orthopedics 1st Floor Seminar Room)

- All Edendale medical staff - refer to presentation roster; administrative updates will be discussed at the end of the meeting

MGH Resident Seminars 13:00 - 14:00 (5th Floor Seminar Room):

- Open to all Edendale staff, as arranged by Residents

III. Sign in / out

It is a requirement of the Public Service that employees sign in and out of work. The register is kept on the table in the Medical Seminar Room on the 5th floor. Please sign the times that you arrive and leave for work. Note that this is not meant to police individuals, but to provide a transparent account of the Department’s time to Management.

IV. Allocations

Medical staff are allocated to various work stations in the Department by the coordinator, who needs to ensure that the workload is spread equally (see Medical Staff Orientation). Allocations are shown on the white board in the seminar room. Intern allocations should be arranged for the full 2 months according to the following guidelines:

- All interns should rotate for two weeks through Emergency and Admissions
- Interns assigned to Grey's Hospital for the next rotation should be assigned to the District Wards (B, C, E, H)
- Interns assigned to Northdale Hospital should be assigned to the Regional Wards (5B1, 5F)
Interns are allocated to: Registrars are allocated to:

- Resuscitation room: 1 intern
- Medical admission: 2 interns
- 5B1 and 5F: 4 interns
- B and C: 4 interns
- E and H: 2 interns
- Resuscitation room: 1 registrar
- Regional clinic: 2 registrars
- 5B1 and 5F: 4 registrars
- ICU: 1 registrar

V. Job roles and principles

Interns
- Training under supervision to become registered Medical Practitioners
- Admitting, investigating and treating medical patients under the supervision of a senior doctor
- Ensuring that admissions have been reviewed by a senior doctor
- Reviewing the progress of inpatients with a senior doctor each day
- Discharging patients with a suitable discharge plan
- Presenting the post-call case at the morning meeting

Triage duties:
1. To sort patients according to urgency
2. Prioritize those with score >4, e.g. TB suspects, meningitis suspects.
3. To direct patients to appropriate departments if incorrectly sent to MOPD.
4. To redirect patients to appropriate Health Care Institutions if stable and out of area.
5. To manage minor problems and request urgent investigations (e.g. CXR)
6. To maintain filing of CSF / pleural fluid / bacteriological results.

Registrars
- Training under supervision to become registered specialists in Internal Medicine
- Admitting, investigating and treating medical patients under the supervision of a physician
- Managing a regional medical ward, including supervising interns and reviewing inpatients daily
- Running an afternoon investigations and results round with the interns
- Reviewing step-down patients
- Managing medical patients in the regional medical clinic
- Managing the medical emergency unit, assessing and treating medical emergencies, supervising intern admissions
- Presenting viva-style topics at the morning meetings and academic slide presentations at the Friday meeting
- Attending the Wednesday morning Grand Round at Grey’s and the Thursday afternoon registrar teaching
- Participating in audit and quality control activities

Principal Medical Officers
- Admitting, investigating and treating medical patients under the supervision of a physician
- Managing a district medical ward, including supervising interns and reviewing inpatients daily
- Running an afternoon investigations and results round with the interns
- Managing the medical emergency unit, assessing and treating medical emergencies, supervising intern admissions (after-hours)
- Running the triage station and the outpatient assessment clinic
- Managing medical patients in the regional medical clinic
- Presenting academic slide presentation at the Friday meeting
- Participating in audit and quality control activities

Triage duties:
- To sort patients according to urgency:
  1. Prioritize those with score >4, e.g. TB suspects, meningitis suspects.
  2. To direct patients to appropriate departments if incorrectly sent to MOPD.
  3. To redirect patients to appropriate Health Care Institutions if stable and out of area.
  4. To manage minor problems
  5. To maintain filing of CSF / pleural fluid / bacteriological results.

Chief Medical Officers and Consultants
- Oversight of the management of medical emergencies, admissions, inpatients, outpatients
- Regular review of acutely ill patients including intensive / high care patients
- Intern and registrar training, continuing medical education
- Management of human resource issues
- Development and maintenance of the Department’s policies and systems
- Audit and research

VI. Organograms

Orientation and Conduct Policies, Department of Medicine, Edendale Hospital, Updated July 2010.
VII. Department of Medicine Rules for Equitable Resource Allocation

Outpatient
- Triage takes priority over all outpatient services
- Outpatients should be followed for the minimum number of visits needed to establish an accurate diagnosis and treatment plan
- Outpatients should be referred to their primary care clinic as expeditiously as possible with a diagnosis list and long-term management plan detailed in the referral letter

Inpatient
- Inpatients take priority over patients seeking admission
- Patients can only be admitted to 5B1, 5F, B and C Ward
- Treatment should be given in the least resource-intense manner possible
- Disposition planning should begin at the time of admission (e.g. transfer to a tertiary hospital, or step-down ward or TB Hospital, or follow up as an outpatient or at the primary care clinic)

VIII. Working in Medical Emergencies, Admissions and Outpatients

Procedures:

Work stations
- B Ward MAW - Two interns, one PMO and one registrar
- Assessment and emergencies - One registrar
- Triage - One intern
- Ambulatory procedures and emergencies - one intern
- H Ward - Two interns
- C / G Ward - Two interns
- E Ward step down - one PMO
- 5B1 - Two registrars, two interns
- 5F / D - Two registrars, two interns
- Intensive care - One registrar
- Assessment clinic - Three PMOs
Regional clinic - Two PMOs, two registrars

Leave:

PMO on leave - Registrar covers MAW or assessment clinic runs on two doctors
Registrar on leave - PMO covers MAW or 5F runs with one Registrar
Two interns usually on leave

Total number of doctors needed:

- Interns: 14
- Registrars: 9
- Medical officers: 7

Triage

Triage will be staffed by 1 intern who will:
1. Supervise and train 2 Professional Nurses in the implementation of the South African Triage Score
2. Ensure that all patients EXCEPT for booked patients are triaged

Triaged patients will be redirected to one of the following locations:
1. Resuscitation / Emergency Room (Red and Orange Triage Score)
2. Assessment Clinic (Yellow Triage Score and appropriately referred Green Triage Score [Note 1])
3. Other Departments in the Hospital (e.g. Gynaecology or Surgery)
4. Local Primary Health Care (PHC) Clinic (inappropriately referred Green Triage Score [Note 1])

Patients arriving by the EMRS who have a Green Triage Score should be redirected to the PHC Clinic.

If all the patients have been triaged the Triage Doctor should assist in the Assessment Clinic.

Assessment Clinic

Patients will be seen at the Assessment Clinic for:
1. Initial evaluation by a PMO
2. One booked review of results (if needed)

Unbooked patients should be sent to Triage.

The booking diaries for review (Booking Book 1 and Booking Book 2) will be maintained by the two PMOs and patients will be given an appointment card. No more than 15 review cases should be booked each day, including follow-up patients requiring sputum AFB results. The review date and Booking Book (BB) used should be documented in the patients notes and appointment card [Note 2].

After evaluation at the Assessment Clinic patients can be:
1. Referred back to the PHC Clinic with a revised diagnosis and treatment plan [Note 3]
2. Observed and treated in the Drip Room for not more than 12 hours [Note 4]
3. Referred to Admissions and Procedures
4. Referred to the Regional Clinic for a booked evaluation

If there is a lull in the Assessment Clinic work the Doctors should assist with Triage.

Admissions and Procedures

This clinic is staffed by Interns who work under the supervision of the Registrar in the Resuscitation Room. Patients should not be referred to the Admissions and Procedures Room unless an evaluation has been made by the PMO or Registrar and documented in the patients notes. The indication for admission or the procedure required should be clear [Note 5].

After clerking, the ward the patient is being admitted to should be clearly written on the blue prescription chart and the pink orders chart. Medical patients cannot be admitted into non-medical wards.

Resuscitation Room

The Resuscitation Room is for the emergency assessment and stabilization of acutely ill medical patients.

After stabilization patients can be:
- Admitted directly to the ward
- Referred to Admissions and Procedures (if the Resuscitation Room is very busy)
- Referred to the ICU Team
- Referred to another Hospital
- Discharged home [Note 6]

Regional Clinic
The purpose of the Regional Clinic is to evaluate and manage patients referred with conditions that require more detailed and prolonged care than can be provided by the Assessment Clinic. This clinic also has a training function for Registrars.

Once all medical conditions have been satisfactorily diagnosed and treated the patients should be:
- Referred to the PHC Clinic for ongoing treatment [Note 7]
- Given a 6 month prescription and pink card and rebooked for review in 6 months.

**Booking system at Regional Clinic**

- Each doctor is responsible for maintaining one Booking Book (3 / 4 / 5 / 6)
- Each doctor should book at least 5 - 7 new patients and 15 follow-up patients
- All follow-up cases from the Wards should be booked from the Ward by the Ward Clerk
- A pink patient attendance and diagnosis register must be maintained by each doctor for auditing purposes

**Special circumstances:**

- Registrars run Booking Books 3 and 5
- Monday: Booking Book 3 is responsible for INR clinic on a Monday and should book 3 new patients and 8 follow-up patients and 20 INR patients [Note 8]. The Booking Book 5 Registrar should assist in INR clinic before leaving
- Wednesday: reserved for diabetic patients (Booking Books 3, 5)
- Thursday: Booking Book 4 is responsible for Dermatology Clinic and should book 5 new dermatology cases, 15 follow-up dermatology cases, 3 new medical and 8 follow-up cases
- Thursday: Registrars book 3 new patients and 8 follow-up patients and attend teaching in the afternoon - leaving at 13:30 to arrive at 14:00. Patients should be told to arrive by 09:00. Late patients must be rebooked.

**Consultant’s Office**

A consultant should be available in MOPD throughout the day and a roster will be maintained. The consultant should not book patients in a clinic but will be readily accessible to all MOPD doctors. The consultant will give advice on diagnosis and management and teach around interesting cases. The onus is on MOPD doctors to contact the consultant for advice.

**Notes:**

**Note 1:** As defined by the Primary Care and Hospital Level National Treatment Guidelines and Essential Drug Lists. Examples - newly diagnosed hypertension, type 2 diabetes and tuberculosis suspects are initially managed at the Primary Care Clinic; uncontrolled hypertension on appropriate treatment, uncontrolled diabetes on appropriate treatment, suspected smear-negative tuberculosis need evaluation at the Walk-in Clinic.

**Note 2:** Example: ‘TCA Assessment Clinic 15 October 2008 BB1’

**Note 3:** Use the standardized referral form, and include full details of the diagnosis, treatment, indication for re-referral and essential investigations. Example: ‘Essential hypertension - BP 140 / 85 after adherence counselling and addition of Amlodipine 5 mg daily. Creat 105. Meds: HCTZ 25 mg daily; Enalapril 10 mg bd; Amlodipine 5 mg daily. Please refer back if BP >160/100 >2 occasions.’

**Note 4:** Examples: dehydration due to HIV-associated diarrhoea; mild exacerbation of asthma after nebulization. Patients who do not respond to treatment within 12 hours should be re-triaged and sent to either the Resuscitation Room (Red or Orange Triage Score) or Admissions and Procedures (Yellow Triage Score).

**Note 5:** If the Intern disagrees with the indication the case should be discussed with Consultant, CMO, or the most senior PMO or Registrar. Feedback to the referring doctor is very helpful.

**Note 6:** Examples: hyperventilation after exclusion of organic causes; seizure followed by full recovery; benign cause of chest pain.

**Note 7:** Use the standardized referral form, and include full details of the diagnosis, treatment, indication for re-referral and essential investigations. Example 1: ‘Mixed mitral valve disease with LV failure well controlled on current meds. LVEF 45%. Atrial fibrillation on warfarin. Meds: Furosemide 40 mg daily; Enalapril 10 mg bd; Digoxin 0.125 mg daily; Warfarin per INR monitored at INR Clinic. Please refer back to Regional Clinic if patient develops Grade 3 SOB or ankle swelling on treatment. Example 2: Type 2 DM HBA1c 7.5% on meds. Hypertensive BP 130 / 80 on meds. Renal impairment creat 345, 1+ proteinuria. Fundoscopy normal. Meds: Metformin 1,0g bd; Protophane 35 u at night; Enalapril 10 mg bd; Furosemide 40 mg daily. Booked for repeat HBA1c in 12 months (15 October 2009 BB4)

**Note 8:** INR results should be reviewed and managed according to the INR policy. Patients should not be routinely clinically reviewed. INR Clinic patients who are symptomatic should be reviewed briefly for problems related to the reason for anticoagulation (e.g. for decompensated heart failure) and rebooked at the Regional Clinic if necessary. Patients with symptoms unrelated to the indication for anticoagulation should be redirected to the PHC Clinic or Triage.

It is the responsibility of the Registrar in charge of the Resuscitation Room to use his/her time and the interns’ time effectively. This means that by 15:30 all patients should have been assessed and a note made by the Registrar in time for the consultant round.

Orientation and Conduct Policies, Department of Medicine, Edendale Hospital, Updated July 2010.
IX. The medical clerk:

Accurate, concise and legible clerking notes made when admitting a patient are one of the hallmarks of a good doctor. The elements of a good clerk are:

1. Diagnosis (may be several different conditions)
2. Management plan - including special investigations, medications, fluids and consultations
3. Implementation of the management plan and subsequent responses - e.g. results of urgent investigations, opinion from consultation with other doctors, modified diagnoses
4. Important positive and negative findings from the history and examination to support the diagnosis and management plan

These elements should be written in the usual format of history / examination / assessment / management plan / investigation results / re-assessment

X. Equitable use of resources:

There are often not enough available beds in the Department to admit everyone who should be admitted. Discuss patients who you think can be managed as an outpatient with your senior colleague. If there is a bed shortage it is the responsibility of the senior doctor to liaise with Nursing Management to ensure that all stable patients are transferred out of the wards to the step-down wards (E and H).

Note that:

- Only patients who are signed off as fit for transfer can be moved out of the medical wards.
- Medical patients CANNOT be admitted into non-medical wards.
- If patients are waiting for admission it is the responsibility of the ward doctors to transfer or discharge patients to make space for the new admissions - ask your consultant for help.

If all medical beds are full and patients are waiting for admission please:

- Ensure that the patient is receiving all prescribed medications and fluids in the Drip Room or Resuscitation Room
- Inform Nursing Management
- Ask the patient’s family to meet with the Public Relations Officer

XI. Working in the Medical Wards

Different doctors run their ward rounds in differently ways. Team work is essential. Please ensure that you make effective use of the attending nurse’s time and that a doctor sees every patient every weekday.

1. Check for patient in extremis:
   Briefly walk around the ward and check for patients with respiratory distress, unresponsiveness or chest pain. You do not need a nurse to accompany you at this time. One member of the team should deal with any emergencies while the rest of the team start rounding.

2. Check on new patients:
   Make sure that you get the investigation results you'll need to manage the patient effectively.

3. The ward round:
   Remember that many of your patients are very ill and you need to keep moving in order to see all your patients. Ensure that you engage with the nursing representative throughout your round. Assess each patient in a focused, structured manner and document your assessment and management plan in your notes using the SOAP format:
   
   **Subjective:** ask each patient how s/he is feeling, LISTEN CAREFULLY, and document what the patient says
   **Objective:** record relevant vital signs followed by a focused physical examination (e.g. for a patient with pneumonia record pulse rate, blood pressure, temperature, respiratory rate, respiratory examination, whether the patient can talk in complete sentences, is wearing an oxygen mask, or is cyanosed)
   **Assessment:** one well-formed sentence describing who your patient is, relevant medical history, current problems and prognosis (e.g. 29 year old woman, CD4 count 24, taking ARVs for the past 2 months, presented 5 days ago with cough, night sweats, weight loss and found to have miliary TB, now doing well on TB therapy). It is also helpful to write down a problem list every couple of days: e.g. #Post-TB bronchiectasis; #COPD; #Cor pulmonale - O₂ dependent, beginning to diurese; #Community acquired pneumonia - improving on IV Co-amoxiclav; #Type 2 diabetes - glucose control range 8 - 12 (OK); #Hyponatraemia - improving Na 125 yesterday; #Renal impairment creatinine 220 stable.
   **Plan:** create a plan that is clear, and can be read by any doctor or nurse. The plan should address each of the points in the assessment. Always remember to include:
   - Medication review - stop unnecessary drugs - number the medication charts and re-prescribe full charts
   - Fluids / Electrolytes / Nutrition: Is the patient eating (ask the nurse). The patient may need intravenous or subcutaneous fluids or tube feeds.
   - Prophylaxis: For DVT, GIT bleeds (feeding or antacid), aspiration (elevate the head of the bed by 30 degrees), opportunistic infections (encourage the patient to consider VCT), pressure care.
   - Disposition: Where will the patient go when the condition is improving? Will the patient need step down care, need to return to MOPD for follow-up or can the patient be discharged to the Primary Care Clinic?
4. **Discuss cases with Nursing**
   Check each patient from 09:00 onwards according to bed number: this will allow the nursing staff to plan their participation and ensure the patients are bathed first. Chat briefly with the nursing representative about each case, do some bedside teaching for nursing students, make sure everybody knows the treatment plan. Discharge medication must be prescribed by 12:00 and discharge summaries completed by 14:00. Please note that our nurses are fluent in Zulu and English but are not Afrikaans-speaking.

5. **12:00 deadline**
   By 12:00 all patients should have been seen and a plan made. The handover list should begin to be made out with the names of patient for discharge and review, and the discharge medications should be prescribed. The afternoon is spent arranging investigations and writing discharge summaries.

6. **Prescribing fluids, feeds and medications to medical patients:**
   Many medical patients are very ill and unable to eat or take oral medications. Therefore you will need to make use of:
   - **Intravenous fluids and medications:** ensure that the patient has a running intravenous line and that the fluids have been ordered on the communication chart. It is preferable (and cost effective) to prescribe once daily or twice daily intravenous medication (e.g. ceftriaxone 2.0g IV daily, furosemide 80mg IV 12 hourly).
   - **Nasogastric feeds and medications:** especially important for comatose patients (e.g. stroke or TB meningitis). Remember that TB therapy cannot be given IV and therefore must be given by NG tube if the patient cannot swallow. Nasogastric feeds should be prescribed.
   - **Subcutaneous fluids (hypodermoclysis):** this technique is especially appropriate for frail patients (e.g. advanced HIV or geriatric) who are dehydrated but not shocked. An IV cannula is inserted under the skin parallel to the anterior abdominal wall and connected to an IV line. Up to 4 liters can be given daily: the fluid is rapidly absorbed into the lymphatic system and enters the circulation. Morphine and haloperidol can be added to the fluid for patients receiving palliative care. Other medications can be given IM or by NG tube.

7. **Use of analgesics and local anesthetic:**
   Many medical patients experience severe pain. Please take note of the following points:
   - Lignocaine should be injected appropriately before arterial puncture, lumbor puncture, central line insertion, intercostal drain insertion, or percutaneous biopsy
   - Premedication with morphine should be given before elective procedures
   - Appropriate initial analgesia for meningitis is morphine injections and ibuprofen with paracetamol - all given regularly
   - Pleuritic or pericardial pain responds to ibuprofen or diclofenac with paracetamol/codeine
   - Analgesia for an intercostals drain should include morphine for the first 48 hours
   - Chronic pain should be treated according to WHO guidelines with paracetamol, ibuprofen, codeine or morphine (refer to the front pages of the SAMF)
   - Oral morphine can be given as a solution (10 mg in 5 mL), or as 10 mg or 30 mg morphine sulphate tablets. Titrate up the morphine dose until pain is controlled. Note that morphine prescribed appropriately for pain is not addictive.
   - Use adjuvant agents as appropriate (e.g. amitriptyline or gabapentin for neuropathy)
   - Diclofenac and naproxen are available for patients not responding to ibuprofen, but requires a specialist signature.

8. **Maintaining prescription charts**
   It is the doctors’ responsibility to maintain and update prescription charts. Numbering charts is very useful. Blue prescription pages should be used to prescribe all medications. Pink prescription charts should be used to prescribe fluids, feeds, observations and nursing care.

9. **Who should the doctor speak to if medications aren’t given?**
   **Step 1:** Review all medications - are they necessary?
   **Step 2:** Speak to nurse in charge of cubicle
   **Step 3:** Inform Operational Manager (Unit Manager)
   Be courteous and constructive
   Request feedback and follow-up

10. **Using the step-down wards (E, H, D and G)**
    Patients transferred to the step-down wards remain the responsibility of the ward team (5B1, 5F, B, C) and should be reviewed one of the ward intern daily, who reports problems to the PMO or registrar. Patients can be moved if:
    - The diagnosis and treatment has been reviewed by a consultant
    - Intravenous medication is no longer needed
    - Ongoing inpatient care is needed (e.g. rehabilitation for stroke patients; waiting for placement at a TB hospital; treatment for PCP; improved glucose or blood pressure control; adjustment of warfarin dose; initiation of antiretroviral therapy [Treatment Project patients])

11. **The discharge summary:**
This is an important document that provides invaluable information and assists with the long term care of our patients. The summary should be concise, and should include the diagnosis/diagnoses, results of relevant investigations, relevant treatment, discharge medications (including doses!) and follow-up plan. The form should be completed in triplicate (use carbon paper): one copy for the patient to take home; one copy for the patient’s outpatient file (stapled in as soon as the summary is finished); and one copy for the ward file. Please note that most patients can be discharged to their local clinic: there is a list of the primary care clinics in all our wards and clinics. Patients with important outstanding results or serious medical conditions can be referred to the Special Clinic.

When completing the summary avoid abbreviations that may not be familiar to the primary care nurse at the patient’s local clinic.

When you have finished the summary put the patient’s copy into an envelope, tell your patient that the discharge summary is important and should be kept in a safe place, and explain the discharge plan. Ask one of the nursing staff to help you with translation if necessary. If you don’t do this all your hard work is wasted!

**Interns should have their discharge summaries and TTO prescriptions counter-signed by a PMO or Registrar.**

Patients cannot be transferred to E/H Ward until the discharge summary diagnosis and plan section has been completed. The medication section will be completed at the time of discharge. Example: Diagnosis 1/ Hypertension (controlled) 2 / Stroke with right hemiplegia (able to eat and talk). Plan: Transfer to E Ward for physiotherapy and mobilization with input from family. Example: Diagnosis 1/ Cryptococcal meningitis 2/ HIV infection CD4 28. Plan: Transfer to E ward to complete 2 week course of intravenous amphotericin and to start ARVs with research team as outpatient.

It is preferable to refer patients at discharge to their Primary Care Clinic. Please ensure that the medications you prescribe are available at the clinic (see Annexure 1). If the medications are not available at the clinic complete a pink prescription card for six months and book the patient to return to MOPD or Special Clinic for a repeat pink card prescription. The pharmacy will arrange for the pink card medications to be sent to the patient’s local clinic.

12. **Follow-up appointments:**

Most patients should be discharged from the ward directly to their nearest clinic with medications that are available at primary care level (see Addendum 1). If patients need follow-up for clinical review or review of outstanding results make a booking for a follow-up appointment at MOPD Patients who are returning for TB culture result should go first to the TB Team to collect the result before seeing the doctor.

13. **Afternoon cover:**

It is the responsibility of the Registrar or PMO in charge of each ward to draw up an afternoon cover roster for the week. This doctor will be responsible for outstanding results, procedures and discharges from 14:00 – 16:00. The name of the doctor should be written daily by the doctor in charge on the ward white board. Nursing staff will be asked to contact Dr Wilson or the acting HOD if medical staff are not available on the ward in the afternoon.

14. **Hand Over:**

It is the responsibility of the senior doctor in the ward to prepare the handover list for the Intern on call. Use the handover form to list the names and diagnosis and action needed for:

- Unstable patients or patients with outstanding laboratory results (e.g. CSF analysis, hyperkalaemia)
- Patients who have been discharged or who are stable enough to be transferred to a non-medical ward if there is a bed shortage overnight. This is of great assistance to Nursing Management.
- All patients fit for transfer or discharge should have a completed Discharge Summary except for the discharge medications.
- The forms will then be returned to the ward doctors the following morning, with relevant feedback.

The Intern may ask the senior doctor on call for assistance with the handover tasks.

Handover forms are available in the labeled Handover Box in each ward. The forms should be completed in duplicate (one copy for the ICU doctor and one copy for the Ward Sister).

15. **The Good Doctor - making medical notes and prescriptions**

The hospital is regularly audited by the national accreditation body. A key part of the audit is whether doctors’ notes and prescriptions meet the minimum legal standard. Making good notes reflects well on you as a medical practitioner and on the Department.

This is the minimum standard for a medical note:
1. Write with black pen
2. Complete the case sheet thoroughly. (Date, time, diagnosis, notes, your name (print), your signature)
3. Use the SOAP format
4. Write the date and time for all your patient notes, and print your name under your signature.
5. To save time you can buy a self-inking stamp with your name, degree and MP number at PostNet for about R100.00
6. Complete the diagnosis section of the discharge summary for patient who have died (do not write R.I.P!)
These are the minimum public health assessments that need to be in your notes:
1. Smoking status [pack years and brand] / Alcohol use [number of units and brand]
2. Nutritional status [underweight / cachexic / overweight / morbidly obese] - give BMI if possible
3. TB exposure / TB symptoms [cough] / HIV status
4. Psychosocial [mood status / employment or income / living conditions - running water, toilet, electricity]

This is the minimum requirement for a prescription:
1. Name and address (or Hospital Number) of the patient
2. Legible handwriting – printed if necessary
3. Your name and qualification
4. Date of prescription
5. Approved name of the medication
6. Dosage form
7. Strength of the dosage form and the quantity of the medication
8. Instructions on the administration of the dosage and frequency of administration.
9. Number of times the prescription may be repeated

[E.g. Amoxycillin 500 mg capsules – take two capsules three times daily by mouth with food for 5 days. No repeats. Refer to the front pages of the SAMF for further examples.]

Prescription points for specific drugs:
- **Ceftriaxone** needs to counter-signed by a PMO or medical registrar. A consultant needs to sign if the ceftriaxone is being given for more than 3 days.
- **Phenytoin** IV formulation can cause gangrene of the hand if it is given into a small vein. If a patient needs to be loaded with IV phenytoin please insert a large cannula and ensure that the drip is running rapidly. Refer to the policy on control of status epilepticus. If this cannot be achieved control the seizures with IM / IV lorazepam and load with phenytoin orally or by NG tube. Valproate is often a better choice for intravenous infusion (see status epilepticus policy).

16. **Resuscitation trolley:**

Please check the resuscitation trolley on a Friday morning before the morning meeting and sign in the book if everything is in order. If items are missing please document this in the book and notify the Unit Manager.

**XII. Requesting a consultation from another Department**

Effective consultation between departments greatly enhances patient care but requires a careful and thoughtful ’request for consultation’ note.

**DO:**
- Observe professional etiquette - Open with ‘Dear Colleague’ and close with ‘Best regards’ followed by your signature, printed name and cell phone number
- Briefly summarise the patient’s background problems
- Describe the problem for which you need advice
- Ask for advice in the form of a focused question
- Submit your request before 12:00 pm
- Make sure that all relevant urgent investigations are available
- Show your consultation request to a senior doctor before submitting
- Telephone the doctor on call if an urgent consultation is needed

**DON’T:**
- Tell another department to take over the patient’s management
- Ask another department to do a procedure that you can do yourself (e.g. insertion of intercostal drain, pelvic examination, lumbar puncture)
- Write ‘FBC and CXR requested’ - but the results cannot be found
- Leave urgent consultations under the HOD’s door
- Get into turf wars with your opposite number - ask for your consultant’s help to get disputes resolved in a civilised manner

**EXAMPLE:** Dear Colleague, Thank you for seeing Mr Ndlovu, who is a 56 year-old type 2 diabetic with a gangrenous left foot. He was admitted to High Care two days ago with hyperosmolar coma and is now fluid resuscitated and normoglycaemic on an insulin infusion. However he remains febrile and delirious, with deteriorating renal function (creat 258 01/03, 421 03/03) and has not responded to intravenous co-amoxyclov. We don’t think his condition can improve further until the septic focus is removed. Is an amputation indicated? Thank you for your advice. Best regards, Doug Wilson #6164.

**XIII. Consulting the Department of Medicine**

During working hours the one of the medical registrars will see medical consults.* Written consults handed in to the consults box in ICU by 12:00 will be seen within 24 hours, usually by 16:00. Urgent consults should be directed telephonically to the consultation registrar between 08:00 and 16:00, and to the registrar / PMO covering the Resuscitation Room. The call roster is
pinned to the ICU notice board, and the telephone exchange is given an updated list of doctors’ cell phone numbers each month. Dr Wilson can be contacted directly during working hours (speed dial 6164), as can the consultant on call.

The medical registrar’s note should include an assessment, differential diagnosis and concise management plan, including the indications for a second consultation. If a second consultation is needed within 14 days the registrar who first saw the patients should see the patient again. Patients with a condition that is an expected complication of surgery (e.g. deep vein thrombosis, nosocomial / hypostatic pneumonia) are normally managed by consultation, as are common medical conditions such as diabetes, hypertension, epilepsy and asthma. Severe metabolic derangements (e.g. ketoacidosis, hyperosmolar coma or renal failure requiring dialysis) and detailed medical diagnostic evaluations should be accepted into the medical service. Long lists of non-urgent investigations should NOT be requested by the consult registrar!

XIV. The after-hours call roster

Calculation of working hours:

Midway through each month the Medical Officers, Registrars and Interns need to hand in call requests. Please note that not all call requests can be met. Each doctor should work 64 to 80 hours of overtime per month according to the commuted overtime agreement, and 160 hours of normal duty (total 224-240 hours per month). Dr Wilson has examples of how to calculate number of hours worked. An Excel spreadsheet is very useful to rapidly calculate the number of hours worked each month.

*Over a three month period each doctor must have worked an average of 230 - 240 hours per month.*

Structure of the call roster:

The call roster is a legal document and doctors on call are obliged to be available on the hospital premises for the full 24 hours. On call doctors will be contacted on their cell phones.

The after-hours call roster is arranged so that:
- Two PMOs or registrars are allocated to Medical Emergencies and Admissions
- The third medical officer works in Triage
- Two interns work in the Medical Admissions Room and Resuscitation Room under the supervision of the PMOs and registrars.
- Over weekends one Intern works day shift (08:00 - 20:00), the second Intern night shift (20:00 - 08:00), and the third Intern covers the ward work from 08:00 - 14:00.

Doctors working in the wards during the day and all Interns are allocated to the Medical Emergencies and Admissions Roster. Doctors working in MOPD are allocated to the Triage Roster.

The ward nursing staff with management problems will initially contact the intern on call. Interns should not hesitate to contact the more senior doctors on call for advice.

XV. Management of the after-hours service

**Triage:**

The medical officer in charge of triage needs to review the Medical Early Warning Score (MEWS) of all patients presenting to the medical service. Red coded patients should be sent immediately to the Resuscitation Room. Orange coded patients should have a CXR and IV line and be redirected to the Medical Emergency Room. Ambulant yellow coded patients can be managed by the Triage Doctor. Non-ambulant yellow coded patients should be assessed and either managed by the triage doctor (e.g. non-severe community acquired pneumonia, TB pleural effusion, advanced HIV with dehydration) or sent through to the admitting team. The triage doctors should write ‘Refer to Admissions for Review’ in the notes, not ‘For Admission’. Green coded patients should be redirected to their local Primary Health Care Clinic.

**Medical Emergencies and Admissions:**

The PMOs and Registrars are in charge of this service and should ‘work smart’ so that cases are being assessed and managed as quickly as possible. Very ill patients (e.g. DKA, acute coronary syndrome, septic shock, respiratory failure) will need immediate attention from a senior doctor who may decide to clerk the patient too, or delegate clerking to an Intern. Less ill patients can be assessed and clerked by the Interns. Each case clerked by an Intern should be briefly presented a senior doctor who should make a note.

Note that admission may not be indicated - discuss the admission with senior PMO or Registrar. Review the patient’s management with a senior if you are unsure of the management plan. The decision not to admit should be conveyed to family by the senior doctor.

Two senior doctors are usually assigned to Resuscitation and Admissions.

The role of the senior doctor working as **Intake 1** is to:
1. Review all patients clerked by the Interns and to make a brief covering note
2. Clerk admissions if there is a long queue
3. Assist the MOPD PMO with triaging patients

The role of the doctor working as **Intake 2** is to:
1. Assess, stabilise and clerk seriously ill patients, assisted by the Interns (triage code orange or red)
2. Co-ordinate the admission of seriously ill patients

Note that these are guidelines. If there are several seriously ill patients in Resuscitation the entire intake team may need to work in Resuscitation. If Resuscitation is quiet and there are many admissions the entire team should be clerking patients.

*No one should go to bed until all Medical emergencies and Admissions have been assessed and a management plan formulated and acted on. Once all the patients have been seen it is the responsibility of the doctor in charge (Intake 1) to divide up the night fairly so that everyone has the opportunity to sleep. Cell-phones should be kept on for the duration of the call, and should be immediately available.*

*Patients with an Orange or Red triage score should be assessed by the Intern who then presents the case to the PMO or Registrar. Every admission should have a note made by the PMO or Registrar. Patients with a Yellow or Green triage score should be seen by the MOPD doctor on call. These cases should be discussed with the PMO or Registrar.*

Death notices:

Nurses are required to move patients who die from the Ward to the Mortuary as quickly as possible. Death notices should be completed promptly by the on-call Interns except between 02:00 am and 06:00 am when doctors should sleep if there are no clinical emergencies. All death notices should be completed by 07:00 am.

Post call:

Doctors who are post call from Medical Emergencies and Admissions can leave for home at 12:00. Doctors who are post call from Triage can go home at 10:00. *It is your responsibility to ensure that your area is covered before you leave the hospital.*

XVI. Weekend Ward Rounds

Over weekends the post-call consultant round starts at 08:00 in Medical Admissions and the Resus Room and then moves to the Regional Wards. All the members of the post-call and on-call team should be present for the round in the Regional Wards to evaluate ill patients. Thereafter the entire team evaluates unstable patients admitted to the District Wards (please make a list of these patients before the round to prevent delays). Once all unstable patients have been seen the post-call team can go home and the Consultant will finish seeing the district admissions with the Intern on call. Finally the consultant goes to ICU to review medical cases with the ICU team. Some consultants may start the round earlier.

XVII. Leave

It is very important that you book your leave with Dr Wilson at least 4 weeks in advance. In order to book your leave your name must be entered by Dr Wilson into the Excel spreadsheet, and you must hand in a signed leave form. Do not go on leave until you are sure Dr Wilson has counter-signed your leave form and that you have a copy for your personal records.

Importantly:
- Only one medical officer can take leave at any time
- Only one registrar can take leave at any time
- Only one consultant can take leave at any time

XVIII. Sick leave:

If you are sick you must telephone both your consultant AND your representative (PMO / Registrar / Intern) so that arrangements can be made to cover your duties. After returning to work, even if you have been sick for only 1 day, you need to sign and hand in a sick leave form. If you are away for more than 2 days Public Service rules require you to hand in a doctor’s letter explaining your absence. If you are frequently off sick you will be asked to submit a doctor’s letter even if you have been away for only one day.

XIX. Indisposition list:

If a colleague is seriously ill and cannot take call Dr Wilson or the acting HOD will draw up a list of all doctors from that group (interns, registrars, PMOs) who are not pre-call or post-call by 1 or 2 days (determined by the number of doctors in that list). The names will be written on separate pieces of paper, and folded closed. All the doctors on the list will meet in the seminar room and one piece of paper will be randomly selected by a disinterested person (usually Ms Marie!). The doctor whose name is selected will cover the call. When the ill doctor recovers the covering doctor will be paid back an equivalent call AND an extra 4 hours (16:00 to 20:00), i.e. the call will be repaid 1.25 times over. If the call that needs to be covered is on a weekend, a weekend call will need to be repaid plus an extra 6 hours (1.3 times). The additional pay-back time is to prevent the indisposition list system from being abused.

If you are ill for more than two weeks, and have submitted the appropriate medical certificates, you will not need to pay back your calls. If you are rotating to another hospital before you can pay back your call the information will be passed on to your next Head of Department and your Programme Manager so that the call can still be repaid.

*If you arrange to exchange calls without having to use the indisposition list you won’t need to work the extra on-call time.*
XX. Meal times:

It is important for staff to rest and eat. However in order to cover emergencies all staff can’t take meals at the same time. It is the responsibility of the senior doctor to ensure that everyone has time to eat.

XXI. Discipline:

Many disciplinary problems can be prevented by asking yourself: 1/ ‘Is the care I’m giving my patients good enough for my family?’, 2/ ‘Will my actions give my colleagues extra work that I should be doing?’ If the answer to 1/ is ‘No’ or 2/ is ‘Yes’ please talk it over with a senior colleague. Unprofessional behaviour will be managed jointly with the Chief Specialist in accordance with the rules of the HPCSA and the GUIDE ON DISCIPLINARY AND INCAPACITY MATTERS for the Public Service.

It is important to give examples of unprofessional behaviour:

Compromised patient care e.g.:
- Neglecting to care for your patients
- Not asking for help with patient management
- Not making careful accurate notes
- Not dating, signing and printing your name
- Not following up on special investigations (e.g. CSF analysis, CT scan results)

Breach of professional responsibility e.g.:
- Missing a scheduled call on the call roster
- Turning off your cell phone during working hours or on call
- Not arriving for work
- Arriving late
- Leaving early

Disciplinary problems should be reported to the consultant on call in ‘real time’ so that appropriate action can be taken. Examples include:
- A colleague persistently arriving late for work
- Unhelpful behaviour from nursing staff

XXII. Policies:

The Department regularly draws up and updates policies that are designed to assist in effective patient management and make your life easier. You are expected to be familiar patient management policies. The policies and guidelines are available on the internet (Google ‘Edendale Hospital Department of Medicine’) and additional copies are available from Ms Marie.

XXIII. Adverse incidents and complaints:

Edendale Hospital is busy and understaffed, and circumstances can be difficult. You may encounter situations that compromise patient care. If you do, please complete an Adverse Incident Form and hand it in to Dr Wilson. You will need to include the details of your patient’s name and folder number, and the form should be signed and dated. Without adequate documentation appropriate corrective action can’t be taken: by completing the form you may be saving another patient’s life. You can mention the problem at the 08:00 meeting for constructive discussion, but sensitive information can be kept confidential. Adverse events related to patient transport should be reported in the transport problems diary in the Seminar room.

XXIV. Consent for procedures and patients’ rights

Doctors often have to perform painful or invasive procedures on patients. This includes insertion of intravenous cannulas and central venous lines, lumbar punctures, pericardiocentesis, aspiration of pleural and peritoneal fluid, and biopsies of lymph nodes, bone marrow and liver. It is important to explain to the patient what you need to do and why you want to do it, and to obtain written consent for any but the most minor procedures. The patient has the right to refuse treatment or to withdraw consent at any time. If you think that this decision may have negative consequences for the patient - explain why and ask for advice from a senior. If you think that the patient is unable to reason clearly consider involving the patient’s family.

XXV. The ‘three strikes and you are out’ rule

All doctors will find a given procedure technically challenging at some point. Experience helps a lot. However if you are attempting a procedure and find that your first two attempts do not succeed stop, take a breath, make sure the conditions are optimal (e.g. position, analgesia) and try for the last time. If you have not succeeded stop and ask a colleague to take over. There is no disgrace in stopping after three attempts; but repeated unsuccessful attempts can be physically and mentally traumatic. If the patient, the family or the nurse are uncomfortable with what you are doing - stop!
XXVI: Admission and discharge criteria

Rationale:
The purpose of these admission and discharge criteria is to standardize care within the Department of Medicine, in the context of the HIV epidemic. This is necessary in order to make the optimal use the limited resources available within the Complex.

Protocol:

The decision to admit, refer or discharge a patient should be compatible with this protocol. Difficult decisions should be discussed with a senior colleague, and patients and their families should be informed of the reasons why the decision was made whether or not to admit or refer. Communication and compassion are paramount.

Procedure:

Admission to District Level Facilities

Admission Criteria

- Acute deterioration in medical status due to a potentially reversible cause [Note 1]
- Diagnostic and therapeutic evaluation required and which cannot be undertaken on an outpatient basis [Note 2]

Exclusion criteria

- Confined to bed for more than 50% of the time for the past month, due to an irreversible medical condition [Note 3]

Discharge criteria

- A medical officer has evaluated the patient, and a diagnosis and management plan has been made
- The patient has recovered to the point where treatment can be continued at home

Admission to Regional Level Facilities

Admission criteria

- Acute deterioration in medical status due to a potentially reversible cause, which requires frequent nursing care delivered by a Registered Nurse, and the 24 hour presence of a senior medical practitioner or medical registrar [Note 4]
- Diagnostic evaluation required that cannot be undertaken on an outpatient basis, and which needs to be supervised by a physician or medical registrar [Note 5]

Exclusion criteria

- Confined to bed for more than 50% of the time for the past month, due to an irreversible medical condition [Note 3]

Discharge criteria

- A consultant has evaluated the patient, and a diagnosis and management plan has been made
- The patient has recovered sufficiently to the point where treatment can be continued at home

Indications for transfer to Tertiary Level Facilities

Admission criteria

- Acute deterioration in medical status due to a condition that requires evaluation and treatment by a sub-specialist physician [Note 6]
- Diagnostic evaluation required that cannot be undertaken on an outpatient basis, and which needs to be supervised by a sub-specialist physician [Note 7]

Exclusion criteria

- Anticipated prognosis and quality of life after diagnosis and treatment is poor [Note 8]

Discharge criteria

- The patient has been reviewed by a sub-specialist physician, and a diagnosis and treatment plan has been made.
- The patient has recovered sufficiently to the point where treatment can be continued at the referral hospital or at home.
Notes:

1/ For example: acute community acquired pneumonia with no features of severe infection; decompensated congestive cardiac failure; deep vein thrombosis

2/ For example: abdominal ultrasound scan indicated; patient requires inpatient control of diabetes or hypertension

3/ For example: advanced HIV infection; end stage chronic obstructive airways disease; end stage cirrhosis with portal hypertension; disseminated malignancy; end stage chronic renal failure

4/ For example: severe community acquired pneumonia; diabetic ketoacidosis or hyperosmolar coma; myocardial infarction; overdose with features of toxicity; stroke

5/ For example: CT scan; bone marrow biopsy; liver biopsy; work-up for renal failure

6/ For example: complete heart block requiring insertion of a pacemaker; renal failure requiring haemodialysis

7/ For example: MRI scan; nerve conduction studies; coronary artery angiogram; pulmonary function tests

8/ For example: after treatment it is anticipated that the patient will be confined to bed for more than 50% of the time; or will not be able to resume an independent existence; or will not meet the social criteria required by the chronic dialysis programme

XXVII Lastly:

‘Do the kind thing, and do it first’ (William Osler).

Good luck!