Resident and Registrar Orientation Manual

Palliative Care

For the purposes of this manual, the term Resident or Resident Medical Officer (RMO) is considered to encompass medical staff employed at the level of Intern (PGY1), Junior House Officer (JHO or PGY2) or Senior House Officer (SHO or PGY3) and Registrars.

Manual compiled by: Dr Patricia Lee-Apostol (Unit Director & Term Supervisor)
Dr Angharad Davies, Dr Min Min Win

Date reviewed by unit: December 2025
Next review date by unit: December 2026

December 2025

Metro North Health | Queensland Government

Published by the State of Queensland (Metro North Hospital and Health Service), 2025

For more information, contact:

Medical Workforce and Education Unit, Westblock, Redcliffe Hospital, Anzac Avenue, Redcliffe, QLD, 4020 email meded-redcliffe@health.qld.gov.au phone 3883 7336 for Medical Workforce and Education Unit.

An electronic version of this document is available at http://qheps.health.qld.gov.au/redcliffe/medical-education/orientation-resources.htm

Contents

UNIT OVERVIEW

The palliative care team aims to provide a comprehensive service for those diagnosed with a life limiting illness. This encompasses skilled symptom control, physical, spiritual and emotional comfort. Ongoing support is provided to carers and family during the illness and bereavement services are available after the patient's death.

The Redcliffe Hospital Palliative Care Service consists of an in-patient unit (16 beds), a consultation service and close links to the Metro North Community Palliative Care Service.

Outpatient Palliative Care Clinics are held at Redcliffe Hospital on Monday, Wednesday, Thursday, and Friday.

The MN Community Service is based at North Lakes and covers the Redcliffe catchment of MNHHS.

The Palliative Care Unit manages approximately 700 separations per year with an average length of patient stay approximately 6.5 days.

The unit is staffed with a highly skilled multidisciplinary team. The multidisciplinary team is comprised of doctors, nurses, chaplains, social worker, clinical psychologist, physiotherapist, dietician and occupational therapist. The nursing staff are particularly skilled in the delivery of palliative care, and they can be extremely helpful if you need advice.

Patients are admitted to the inpatient unit for:

- Short periods for pain and symptom control and other reasons defined within the Palliative Care Australia and WHO definition of palliative care
- Care during the last days to weeks of life when care at home is not possible.

The Palliative Care Unit however is not a long-term facility and some palliative patients who have stabilised may be discharged to residential aged care facilities if they are not able to return home.

Clinical Personnel

Unit Director & Term Supervisor	Dr Lee-Apostol	Phone: 4913	0.9 FTE	Mon, Tues, Thurs, Fri
Staff Specialist	Dr Angharad Davies	Phone: 7064	0.8 FTE	Mon, Tues, Wed, Thurs
Staff Specialist	Dr Min Min Win	Phone: 7897	0.9 FTE	Mon, Tues, Wed, Fri
Staff Specialist	Dr Ashwin Kaniah	Via Switch	0.9 FTE	Mon, Wed, Thurs, Fri
Nurse Practitioner	TBA	Via Switch	1.0 FTE	

Multidisciplinary Team Members – Redcliffe

Nurse Unit Manager	Phone: 7050
Clinical Nurse Consultant	Phone: 6972
Ward Pharmacist	Phone: 6845
Physiotherapist	Phone: 7483
Occupational Therapist	Phone: 9796
Social Worker	Phone: 2377
Clinical Psychologist	Via Switch
Chaplain	Phone: 2376

Accreditation

The Palliative Care Service is accredited for Royal Australasian College of Physician Palliative Medicine Advance Training for the following core training terms: Inpatient unit, Consultation, and Cancer Care Setting. We are also accredited for the Clinical Foundation in Palliative Medicine Program (previously the Clinical Diploma in Palliative Medicine).

UNIT ORIENTATION

An orientation to the Unit is provided by the Palliative Care Consultant covering the ward, who will give you an overview of the expectations during your rotation, such as proposed learning objectives for the upcoming term. You should also meet the Registrar who will introduce the main unit personnel and outline the daily tasks of the unit as well as the Nurse Unit Manager to identify and discuss ward processes, relevant forms and equipment and to familiarise yourself with the geography of the unit.

Prior to commencement and at the completion of your term, Residents will be provided with term handover sessions scheduled during protected time. Residents are able to discuss handover, exchanging notes and useful tips. Handover notes for the term can be documented and provided to the incoming Resident for their reference (Appendix 4: Term Handover Notes)

LEARNING OBJECTIVES

Clinical Practice – The Prevocational Doctor as Practitioner

- Place the needs, safety, and comfort of patients at the centre of the care process.
- Communicate clearly, sensitively, and effectively with patients, their family/carers, doctors and other health professionals in the multidisciplinary palliative care team.
- Participate in family conferencing and support patients and their families in this process.
- Communicate bad news sensitively and empathetically.
- Perform holistic assessment of the palliative patient including patients with cancer pain, neuropathic pain, and palliative care emergencies.
- Arrange and interpret routine haematological and microbiological results pertaining to palliative medicine.
- Formulate goals of care and care planning in partnership with patients, their families, and others in the healthcare team under the supervision of the registrar.
- Apply knowledge of opioid pharmacology to safely prescribe, administer and titrate analgesia in accordance with goals of care.
- Prevent and manage side effects of opioid medications.
- Identify a dying patient and manage the terminal phase in accordance with care plan.
- Recognise, assess, and manage palliative care emergencies in accordance with goals of care and advance care directive.

Professionalism and Leadership – The Prevocational Doctor as a Professional and Leader

- Provide care to all patients according to *Good Medical Practice: A Code of Conduct for Doctors in Australia*
- Adhere to organisational policy to mitigate health risks of professional practice including infection prevention and control, fatigue, and stress.
- Recognise limits of expertise and seek help from other professionals as needed to contribute to patient care.
- Respect the roles and expertise of other healthcare professionals, learn and work effectively as a member or leader of an inter-professional team, and make appropriate referrals.
- Effectively manage time and workload demands, be punctual, and show ability to prioritise workload to manage patient outcomes and health service functions.

Health and Society – The Prevocational Doctor as a Health Advocate

- Perform duties in accordance with the principles of palliative care and with respect for diversity of cultural, spiritual and community values that influence palliative and end-of-life care.

Science and Scholarship – The Prevocational Doctor as Scientist and Scholar

- Consolidate, expand, and apply knowledge of the aetiology, pathology, clinical features, natural history and prognosis of common and important presentations encountered in palliative care.

DUTIES AND RESPONSIBILITIES

Scope of Practice

It is the responsibility of the Resident and their Term Supervisor (or delegate) to discuss the individual's scope of practice relevant to their clinical area and their level of experience. This discussion should include identification of clinical skills which require direct observation prior to independent practice and any limitations in clinical duties.

Resident Responsibilities

The Resident will work closely with the Registrar to:

- Order and make changes to therapy as appropriate.
- Order and review investigations as appropriate (complete forms for blood tests the day before and for the weekend on a Friday, where possible)
- Organise discharges, including medication (including medication for planned leave)
- Communicate with the community team when patients are discharged back into the care of the community team or are newly referred to the community team.
- Communicate with the patient's GP whenever possible particularly when patients are discharged from the Unit/Service
- Complete Patient Discharge Summary prior to discharge
- Provide pathology and radiology forms for additional tests as required after discharge
- Be involved with Family Conferences. These are organised by a team member and attended by a representative from each discipline. Conferences occur at a convenient time for family, patient and staff during the weekdays.

Management of Overtime and Fatigue

There are a number of proactive measures taken to minimise overtime and fatigue for junior doctors. These include regular review of term rosters, term evaluation feedback by junior doctors and overtime data with corrective actions implemented, where relevant.

The department recognises the importance of minimising unnecessary medical overtime, particularly in respect to junior doctors starting early or staying late. Excessive un-rostered overtime impacts on fatigue and, most importantly, patient care and your health and work/life balance. However, medicine is a profession whose primary concern should be the wellbeing and safety of the patients under your care, and the department does not support the exit of medical staff simply on the basis of rostering. There must be plans made to ensure their ongoing care requirements have been appropriately managed and all relevant information is handed over to those who will continue their care.

As a consequence, un-rostered overtime should be managed as follows:

- Wherever appropriate, all junior doctors at the completion of their shift should handover ongoing care requirements to the incoming or continuing Resident Medical Officer, which may be Ward Call.
- Prior to doing "continuous" overtime where you can't leave in time, you should call your clinical supervisor (consultant), or if not available, the relevant registrar, to seek approval or take their advice regarding what work can be left for the following day or handed over to another member of the team.
- All legitimate overtime (i.e. clinical work) will be approved and paid. However, it is essential that you record the UR numbers of patients seen on the Attendance Variation and Allowance Claim (AVAC) form.
- For Remote Call (recall): this is clearly approved (i.e. no further action is required by junior doctors in regard to seeking approval). However, it is essential that you record the UR numbers of the patients seen on the AVAC form. If called in overnight and have less than 10 hours break before the next rostered shift, alert Switch of the need to take fatigue leave (see **Redcliffe Hospital procedures** Junior Doctors: Remote Call **and** Fatigue Leave and Fatigue Reporting**,** Management of for further details).
- Any concerns about work practices, e.g. excessive overtime, should be raised with your term supervisor who will discuss a management plan with you and/or escalate issues.

Fatigue should be managed as per the **Redcliffe Hospital procedure:** Fatigue Leave and Fatigue Reporting, Management of. Importantly, if there are issues that impact your safety or the safety of patients, you should speak with your clinical supervisor (i.e., Consultant or Registrar) to determine appropriate immediate strategies to manage the situation. For general or ongoing concerns about fatigue risk, speak with your Term Supervisor, the Director of Clinical Training, or the Chair of the Fatigue Risk Management Working Group (contactable via the Medical Workforce and Education Unit).

Finally, your suggestions for ongoing quality improvements in term work practices are valued. Feedback can be provided directly to your Term Supervisor or to the Medical Workforce and Education Unit, or anonymously via end of term evaluations.

Supervision

The Term Supervisor and Clinical Supervisors are responsible for ensuring supervision is adequate at all times in order to provide safe patient care and a safe learning environment for the Resident. The Registrar is available at all times to provide supervision to the Residents allocated to the unit.

The following tasks can only be performed by **Interns under direct supervision:**

- Indwelling bladder catheterisation
- Blood transfusions

The following tasks can only be performed by **JHO/SHOs under direct supervision:**

- Abdominal paracentesis.

CLINICAL RESPONSIBILITIES OF REGISTRARS

The clinical responsibilities of registrars encompass assuming medical responsibility for clinical decision-making in relation to the overall management of palliative patients (i.e., while working under the supervision of the relevant Palliative Care Specialist and the palliative care multidisciplinary team in general).

Registrars are directly responsible for day-to-day patient care. This includes negotiating between cure and care options and incorporating downstream care into management. Registrars need to ensure that services, interventions, and referrals appropriate for each particular palliative patient are indicated after consideration of the patient's wishes and disease trajectory, and that these are delivered in a timely, efficient and compassionate manner. Registrars are also required to provide a consultative service to other medical and nurse practitioner staff and to assume the role of an authority person, when indicated, in giving advice and recommendations to patients' carers and relatives.

When treating patients, registrars are given discretion as to when contact should be made with the relevant Palliative Care Specialist - this optimises teaching and training opportunities. However, the Palliative Care Specialist carries the final responsibility for patient care. Registrars **must** seek consultant opinion in situations where they are experiencing uncertainty and where any mismanagement may compromise the patient's and/or family's likelihood of a good clinical outcome.
Specific instances where consultant contact is **mandated** include:

- A patient or patient's relatives are demanding to see a consultant and/or have a consultant review a particular patient.
- Unanticipated and unexplained deterioration in the condition of the patient.
- Situations where there may be medico-legal and/or medico-political ramifications to a patient's care (including if an Acute Resuscitation Plan (ARP) has not been signed).
- Any unexpected death.

Should there be any queries the medical registrar should contact the on-call consultant.

EDUCATIONAL AND RESEARCH RESPONSIBILITES

Registrars are offered many educational opportunities. It is assumed that each registrar will take ongoing responsibility for and actively participate in their education.

Registrars need to attend all weekly rostered clinical meetings for their particular area of the service as per previous timetable.

Other learning opportunities:

Palliative Care Interest Group: This is a meeting of palliative medicine specialists held every second month. These occur after working hours in a restaurant with dinner sponsored by a pharmaceutical company. This is an excellent way to meet other consultants and network with registrars outside of Redcliffe PCU.

In addition, registrars will be informed of upcoming educational events and conferences.

Registrars are encouraged to increase their research skills by becoming involved with research projects in PCU and/or to develop their own research projects.

UNIT POLICIES AND PROCEDURES

Referrals to the Service

Patients must have a medical referral to be admitted to the services. Patients admitted to Redcliffe are frequently referred to the Palliative Care Service. We also get referrals from other Brisbane metropolitan hospitals. In all cases the referrals must be doctor to doctor.

The initial assessment for ambulatory patients will be at an Outpatient Clinic.

Admission Procedures

Patients may be admitted directly to the unit provided they are registered and known to the Service or are clearly palliative (e.g., EOL patients). Admissions during office hours are completed by the ward or consultation registrar.

Internal referrals requiring a bed in PCU are placed on a waiting list by the CNC. An in-patient consult to palliative care order via iEMR should be completed by the referring treating team. Information regarding major problems, reason for seeking admission and relevant details are gathered on referral to assist in decision-making. Priority for admission is given to community patients over patients already in a health care facility. Transport to hospital is the responsibility of the family or referring agency.

Ideally, planned admissions will occur during business hours and preferably before 1500 hours weekdays. Admissions that do not arrive by 1500 hours are assessed for need of admission on that day. Those who have not left their hospital are delayed until the next working day.

Admissions after hours can only be arranged if consultation with the consultant on call has occurred and the admitting registrar is aware. The PCU day team will endeavour to complete admission paperwork where and when able for planned admissions that arrive out of hours. On call rosters and contact details are located on the noticeboard at the staff station and via switch.

After hours

Admissions after hours and on weekends must be through the Emergency Department. Palliative care admissions are done by medicine and have equal priority to other medical admissions. A patient who is admitted to the palliative care unit out of hours must have approval by the on-call Palliative Care Consultant. The patient can be seen by the medical registrar in ED or following transfer to the palliative care unit (if deemed safe for transfer by ED). The patient must have a full admission done, all medications charted and expectant PRN medications. If admitted medically, patients should be referred to the Palliative Care Service as soon as practical after medical admission.

Documentation

The first entry in any admission should document the reason for the patient's admission to hospital. This should be followed closely by relevant medical conditions and past history. Where relevant, medications and allergies should also be noted in the first paragraph.

A daily entry must be written on most patients and occasionally more than once daily if the patient has deteriorated, if there is new information that should be shared or an incident such as a fall has occurred. In the case of stable patients such as those awaiting nursing home placements, an entry three times per week is acceptable.

The Resident is responsible for the appropriate medication of the patient and must watch for interactions between their usual medications and any pain-relieving medications or antibiotics that they might be administered during their admission. Blood tests should be done where indicated by the registrar or by clinical situation. Details of abnormal blood tests, microbiology and radiology should be documented as well as the treatment course.

Admission - Investigations

A conservative policy is usually appropriate. It is often helpful to have a haematology and biochemistry examination at the time of admission, but if recent reports are available there is no need to repeat the tests. Investigations may be necessary to assess delirium for good symptom management and also to assist with a prognosis. Always discuss with your consultant before ordering expensive investigations such as organ imaging. If urinary tract infection is suspected, first order a ward Dip-Stick urine test to check for nitrites and leucocytes. A urinary tract infection is unlikely in the absence of nitrites and leucocytes.

Pathology Tests and Imaging

On admission to the ward some basic investigations should be organised to complete the patient's assessment. These include FBC, UECs, LFTs and calcium and should be requested for the following day. It is the RMOs responsibility to have the results on hand for the medical ward round.

Confirmation of Life Extinct

The Resident will be responsible to certify death. Once this has been confirmed, documentation must occur in both the iEMR **AND** completion of a Life Extinct Form.

For example:

13/12/11 – 1030 hours – Dr R Smith, Registrar
No palpable carotid pulse
No heart sounds heard for 30 seconds
No breath sounds heard for 30 seconds
No response to central stimuli
Fixed dilated pupils
I declare life to be extinct at 1025
Signature of doctor

Death Certificates

Death certificates are needed to arrange a funeral and are required by Births Deaths and Marriages Australian legislation to be completed within 2 business days. You can write the death certificate even if you have not seen the patient provided the patient has been seen and attended to by another member of the medical team.

Death certificates (Form 9's) are completed via the Births Deaths and Marriages online portal – paper based will no longer be accepted. Please sign up as soon as practicable as authorisation can take up to 48hrs.

- https://www.bdm.qld.gov.au/services/registrations/serviceprovider Please list the cause of death, not the way the patient died (e.g. pneumonia, not respiratory failure).
- Put diagnoses, not symptoms on the death certificate (e.g. oesophageal stricture, not dysphagia).
- Detail required on certificates:
    - Type of infective organism (bacterial, viral) – if known.
    - Cause of cardiac or renal failure, e.g. ischaemic heart disease, idiopathic.
    - Primary site and morphology of a neoplasm (state 'unknown primary site' if necessary).
    - Part of an organ or system diseased or injured.
    - A description of the severity, nature, stage or degree of a morbid condition, for example: acute or chronic, congenital or acquired, benign or malignant, primary or secondary.
    - Nature of physical conditions associated with mental disorders.
    - Complications which were associated with pregnancy, childbirth, or the puerperium.
    - Cremation risk
- No entry is necessary in lines (b) and (c) of part 1 if line (a) completely describes the train of events.
- Other conditions which were present but did not directly contribute to the death are listed in the "other" section.
- Discuss what to write on the death certificate with your Consultant or Advance Trainee.
- Contact with the Coroner must be made by the Registrar or RMO under the direction of the Consultant.
- Submission of a Form 1A to the Coroner is completed in the portal at the time of drafting the Form 9.
- The Form 1A may be used where:

a. The Medical Officer seeks advice from the coroner about whether a death is/is not reportable or
b. The death is reportable, and the Medical Officer seeks the coroner's authority to issue a death certificate because the cause of death is known and no autopsy or investigation appears necessary. For example, an elderly person who has died proximate to a fall resulting in a fractured neck of femur,
c. **DO NOT** issue the Cause of Death Certificate until the Office of the State Coroner has advised of their decision for 'no further investigation' and given authority for the Cause of Death Certificate to be issued,
d. Using the Form 1A process in appropriate cases means there is no need to call the police and the body can be released directly to the family from the hospital mortuary, upon Coronial Authorisation, reducing stress on the deceased patient's relatives.
e. The next of kin must be informed by the Medical Officer in a timely fashion of potential Coronial involvement as this may impact on or delay funeral arrangements.

- Note: some deaths are reportable to the Coroner, including violent or unnatural deaths (e.g. deaths caused by accident or suicide) or where the death was related to health care. The commonest reason to report or discuss a death with the Coroner is a patient who had a fall within the month before death. You must seek guidance from your Consultant as to whether a death is reportable to the Coroner. Please contact the Mortality Clinical Nurse Consultant if in need of advice or guidance on Ext 7207

- A standard death summary is sent out to the GP and other relevant treating specialists. All agencies involved in the care of the patient must be informed of the patient's death as soon as possible. Nursing staff will inform the domiciliary nursing service (if involved).

Removal of Implanted Pacemakers/Defibrillators

Patients with active defibrillators are not usually accepted for admission in the inpatient unit. These devices need to be de-activated first, please discuss with the Consultation team if you are unsure. Pacemakers are not an issue.

Pacemakers and defibrillators are removed at the funeral parlours. In case you are ever asked to remove one of these devices it is important to remember that implanted defibrillators must not be removed by us as there is a risk of an electric shock. These devices must be disabled prior to removal.

Wills and Legal Documents

Hospital staff are not allowed to witness the signing of wills or any other legal document.

Follow up Arrangements

Planning for care and discharge commences at admission. Each team member may contribute to the overall plan of care at the weekly team meetings. Ongoing discussion, interventions and documentation ensure the plan of care is current and relevant to the patient's needs.

Day leave or overnight leave can be arranged for patients for a maximum of 72 hours. The bed occupied by the patient is held for the leave period. Trial discharge may be offered to see if the patient will manage at home. Maximum leave allowed is 72 hours before discharge. The discharge planner will arrange referral to the home care nursing agency.

If the patient is returning to community-based care, then the planning for discharge will review resources available, carer skills and environmental issues. This involves the multidisciplinary team. If the patient is referred to a community nurse practitioner, then the discharge summary and medication summary should be sent to the nurse practitioner. Family conference may be arranged at times during an admission to discuss care and discharge issues. The social worker or medical team may coordinate family conferences. Consideration should be given to inviting relevant community staff to attend the conference as required.

Families/carers are encouraged to participate in the care of the patient, and this is especially important if care is to occur at home. Families/carers are taught aspects of day-to-day care on the ward prior to discharge as required.

Patients who do not require specialist palliative care but require ongoing 24-hour care may need to be transferred to residential care facilities. This will be outlined to the patient and their family/carer prior to admission to the unit and during the admission process. The social worker is usually involved in planning and preparations for transfer to residential care. Families and carers are encouraged to be actively involved in care transfer. Once a bed is confirmed Aged Care Consultant liaises with staff at the relevant facility. Discharge summaries are sent to the GP and the facility, so continuity of care is maintained. Referral to SPACE (Specialist Palliative Care in Aged Care Service) must be considered for patients returning to RACF.

Discharge Summaries

These are an important means of communication for the medical practitioners who will be caring for the patient in the community. As discharges are usually planned well in advance it should be possible to have the discharge summary prepared prior to the day of discharge. You are expected to remember to have discharge summaries and scripts ready well in advance.

The Electronic Discharge Summary icon is on the ward computer. A medical discharge summary is to be completed by the resident and copies sent to the Local Medical Officer and any treating specialist currently involved in the patient care. The ward clerk will file copies in the medical record and community medical record. **Highly recommend a phone call to the GP if there are complex discharge instructions that GP will need to follow up**.

When a patient is discharged from hospital, it is important that they be given clear instructions as to both the normal and abnormal course following discharge. Outpatients' appointments may be arranged as appropriate.

On discharge, enough medication for one month is supplied to the patients. The pharmacist requires medication scripts for all drugs. Telephone approval should be sought either from the PBS (1800 888 333) or from the RPBS (Department of Veterans' Affairs 1800 55 2580).

The Resident is responsible to write the medication request forms to be sent to Pharmacy. This is best done before the day of discharge. The pharmacist will organise one month's supply of medications and will complete a Medication Booklet for the patient with dosages and times of administration.

Outpatient Clinics

Palliative clinics are held Mondays, Wednesdays, Thursdays and Fridays at Redcliffe Hospital. The Redcliffe Clinics are held in MBICC level 3. Please discuss with a member of the palliative care team if you wish to refer your patient to a Palliative Care out-patient appointment.

Bereavement Services

A bereavement booklet is provided to the carers of deceased patients. Our Social Worker is also our Bereavement Service Coordinator. All deaths are reviewed in the twice weekly separation meeting.

When a palliative care patient dies, the family, including significant others, are followed up by a Social Worker. While their immediate bereavement needs are assessed from the first meeting with patient and family, their follow up needs are discussed in the separation meetings following the death of the patient. Contact is made by letter and/or phone and ongoing support is arranged as is appropriate.

Supportive measures such as one-on-one counselling, grief literature and the opportunity to attend a memorial service is made available to each family. The coordinator will also re-refer the bereaved to other health professionals or self-help groups if appropriate.

Community Service

The community service is run from the North Lakes Health hub. The Palliative Care service also works closely with Karuna, another community palliative care service.

UNIT EDUCATION OPPORTUNITIES

Palliative Care is a small, multidisciplinary unit which offers a range of structured and informal teaching opportunities for Residents. There is the capacity and flexibility to accommodate any particular areas of interests identified by junior doctors related to palliative medicine. Personal learning objectives are discussed with residents at the commencement of term which helps to formulate a personal learning action plan (Refer to appendix 1, 2 and 3). The teaching talents and strengths of the training Registrars also add to the quality of learning experiences of residents.

Journal Clubs

- Oncology Journal Club: Monday at 12:00 with lunch provided
- Palliative Care Journal Club: Wednesday 13.00. The Resident will be required to present at least once to this meeting during the course of the term.
- The Journal Club runs from February to the early December.

Multidisciplinary Team Meetings

Held twice weekly on Monday and Thursdays to formally discuss deaths, discharges and current admissions. Plans of care are updated, discharge plans confirmed, and referrals generated for current admissions. The Resident is expected to present the patients that they have admitted, with the Consultant and Registrar presenting the rest.

Separation Meeting

Held twice weekly, just before the multidisciplinary team meetings, and are attended by the multidisciplinary team. They provide a forum for discussion about the deaths from the unit the previous week.

General Education Programs (at Redcliffe Hospital)

• Intern Only Education (IOE)	Tuesday	12.00 -13:00 (Protected Time)
• Hospital X-Ray Meeting	Wednesday	08:00-09:00
• Grand Rounds:	Thursday	12.00 -13:00
• Junior Doctor Professional Development Program	Friday	12.00 -13:00 (Protected Time)

UNIT TIMETABLE

RMO	TIME	ACTIVITY	LOCATION
Monday			
RMO 1 & 2	08:15	MDT Meeting	Pall Care Unit
RMO 1	09:00	Consultant Ward Round	Pall Care Unit
RMO 2	09:00	Ward Work	Redcliffe Hospital Wards
RMO 1 & 2	12:00	Oncology Journal Club (lunch provided)	Education Centre
RMO 1	13:30 – 14:30	Consultant Ward Round	Pall Care Unit
RMO 2	13:00 – 16:00	Admissions from wards	Redcliffe Hospital Wards
Tuesday			
RMO 1	09:00 – 11:45	Registrar Ward Round	Pall Care Unit
RMO 2	09:00 – 11:45	Ward work	Redcliffe Hospital Wards
RMO 1 & 2	12:00 – 13:00	Intern Only Education (Other RMOs do not attend)	Education Centre
RMO 1	13:00	Ward Work	Pall Care Unit
RMO 2	13:00	Admissions from wards	**Caboolture** Hospital Wards
Wednesday			
RMO 1 & 2	08:00	Hospital X-Ray Meeting	Rm 4 Education Centre
RMO 1	0900	Consultant Ward Round (Dr Win)/ Registrar Ward Rounds	Pall Care Unit
RMO 2	0900	Ward work	Redcliffe Hospital Wards
RMO 1 & 2	13.00	Palliative Care Journal Club / Education	
RMO 1	14:00	Consultant Ward Round (Dr Win)/ Registrar Ward Rounds	Pall Care Unit
RMO 2	14:00 – 16:00	Admissions from wards	Redcliffe Hospital Wards
Thursday			
RMO 1	08:00	MDT meeting	Pall Care Unit
RMO 1	09:00	Consultant Ward Round (Dr Davies, Dr Kaniah, Dr Lee-Apostol)/ Registrar Ward Rounds	Pall Care Unit
RMO 2	09:00 – 11:30	Ward work	Redcliffe Hospital Wards
RMO 1 & 2	12:00 – 13:00	Grand Rounds	Rm 1 Education Centre
RMO 1& 2	1330 to 1400	Palliative Care Journal Club	Palliative Care Unit
RMO 1	1400 – 14:30	Ward Work	Pall Care Unit
RMO 2	13:00 – 15:00	Admissions from wards	Redcliffe Hospital Wards
Friday			
RMO 1	09:00	Registrar Ward Round	Pall Care Unit
RMO 2	09:00	Ward work	Redcliffe Hospital Wards
RMO 1 & 2	12:00-13:00	Junior Doctor Professional Development Program	Education Centre
RMO 1	13:00	Ward work	Pall Care Unit
RMO 2	13:00 – 15:30	Admissions from wards	Redcliffe Hospital Wards

If RMOs are allocated to Palliative Care for a full term, they will swap roles from RMO 1 to RMO 2 and vice versa at the mid-term point to allow for time primarily working in both the Palliative Care ward and the consultative service provided in the rest of the hospital.

ASSESSMENT AND EVALUATION

Assessment and evaluation are a routine and essential component of junior doctor education and training.

Residents must ensure that:

- Feedback and formal assessment are conducted throughout the term taking into account your progress towards achieving the nominated learning objectives. You will also be asked to assess your own performance as part of the appraisal process. A self-assessment can be completed on the CLA™, e-portfolio for PGY1 and PGY2 trainees.
- Progress is discussed at mid-term with feedback provided by the Term Supervisor and team.
- Feedback will also be obtained from the Nurse Unit Manager at the end of term for junior doctors assigned to the unit. This provides an indication of communication and teamwork skills. 360° feedback is becoming a common expectation of medical training for many specialist colleges.
- For Interns (PGY1) and Junior House Officers (PGY2), a mid-term **and** end of term assessment MUST be completed by your term or clinical supervisor on the Clinical Learning Australia (CLA™) e-portfolio.
- For PGY3, Senior House Officers an end of term assessment must be completed.
- Evaluation of the term is completed via the SurveyMonkey® application sent to you during the last week of your term.

Any junior doctor identified as requiring additional measures to meet the standard of performance appropriate to their level of training will be referred to the Director of Clinical Training and Medical Education Officer for support and commencement of an Improving Performance Action Plan (IPAP) to support remediation and achievement of the expected level of performance. Further information regarding the assessment and evaluation process can be found in the relevant Redcliffe Hospital Junior Doctor Procedures.

Appendix 1. Skills List Palliative Care

A list of assessment, management and procedural skills that may be achieved during your rotation in Palliative Care has been listed below. These have been grouped according to complexity and degree of supervision required if being undertaken for the first time. Opportunities to achieve these during the term will vary depending on exposure and case mix.

This list can be used to identify learning objectives for your term. It may also be used as a personal record or log of skills achieved over the course of your training.

Level 1 Skills: Require minimal or no supervision to perform competently
Level 2 Skills: Require closer supervision
Level 3 skills: Require full and close supervision

Skills: Palliative Care	Performed Independently	Required MINIMAL Supervision	Required CLOSER Supervision	Required FULL Supervision	Not Applicable or No Opportunity
LEVEL 1 SKILLS: Require MINIMAL to NO Supervision to perform competently					
• **Diagnosis, initial management and appropriate referral of:** o Spinal cord compression					
• **Basic management of common symptom control problems:**					
o Pain					
o Hypercalcaemia					
o Nausea / vomiting / anorexia					
o Diarrhoea					
o Constipation					
o Bowel obstruction					
• **Understanding of:** o Principles of palliative care and their application in advanced disease					
o Pharmacological and non-pharmacological pain control mechanisms					
o Regulations governing prescriptions of controlled drugs					
o Quality of life issues and their relevance in late-stage disease					
o The grief process and psychosocial responses of patients and relatives in illness and bereavement					
o Religious and cultural aspects on patient and family attitudes to death and dying					
• **Perform:** o Venepuncture, Intravenous Cannulation and Administration of IV Fluids					
o Wound swab					
• **Insert:** o Nasogastric Tube					
o Indwelling Catheter in males and females					
LEVEL 2 SKILLS: Require CLOSER Supervision					
• **Diagnosis, initial management and appropriate referral of:** o Acute confusional states					
o Acute severe pain					

Skills: Palliative Care	Performed Independently	Required MINIMAL Supervision	Required CLOSER Supervision	Required FULL Supervision	Not Applicable or No Opportunity
○ Fits					
○ Superior venal cava obstruction					
• **Basic management of common symptom control problems:**					
○ Malignant effusions and ascites					
• **Ethical issues relating to:** ○ Appropriate interventions					
○ Truth telling					
○ Treatment choice					
○ Euthanasia					
○ Advance health directives					
• **Practical skills:** ○ Counselling of patients and their families on palliative or conservative management					
○ Aspiration of pleural / ascitic fluid					
LEVEL 3 SKILLS: Require FULL & CLOSE Supervision					
• **Practical skills:** ○ Manage more challenging patient interactions such as:					
○ Angry patient					
○ Difficult family					
○ Patient in denial					
○ Lead family conference and achieve some degree of competency where difficult issues are to be solved					
○ Increased involvement in the psychosocial and emotional aspects of palliative care to develop greater understanding of the holistic approach to managing patients with a life limiting illness					

Appendix 2. Personal - Professional Knowledge - Behaviours

Below is a list of generic capabilities related to the fundamental personal and professional attributes of medical practice. These are provided simply as a guide in identifying additional learning opportunities during the term and will be dependent upon previous experience as well as the availability of opportunities during the term.

Personal & Professional Knowledge and Behaviours	Little Experience	Much Experience	Need Opportunity	Need Support	Not Applicable or No Opportunity
Communicated effectively verbally and non-verbally with patients, relatives and a multidisciplinary team in the following ways:					
○ Concerning conditions, tests and treatments					
○ Listened effectively and responded in an appropriate manner					
○ With uncooperative, hostile, anxious or resistant patients/relatives/other staff					
○ Regarding preventive measures e.g., dietary, health risk behaviour, hygiene etc.					
○ Regarding prognosis					
○ Regarding the risks, discomforts and inconvenience of therapies proposed					
○ Concerning the issues of death and dying: ▪ Palliative Care ▪ Breaking bad news ▪ The grief processes ▪ Not for resuscitation orders ▪ Organ donation					
Organised and provided appropriate handover of care for patients					
Demonstrated knowledge of:					
○ An ability to use information technology tools					
○ Principles of basic and clinical research and statistics					
○ Employment issues e.g., EEO, WH&S					
○ Prevention of cross infection (hand washing, sharps disposal etc)					
Demonstrated knowledge and understanding of medico-legal/administrative issues:					
○ Informed consent					
○ Patient identification					
○ Death certification					
○ Power of attorney					
○ Advanced health directive					
○ Notification of coroner					
Demonstrated effective standards of behaviour and professional development:					
○ The ability to read around cases and pursue independent inquiry including use of technology and other data access methods					
○ Evaluate own strengths, recognised limitations, planned to increase effectiveness and worked within the bounds of technical competence					
○ Recognised the need to continually take advantage of learning opportunities					

Personal & Professional Knowledge and Behaviours	Little Experience	Much Experience	Need Opportunity	Need Support	Not Applicable or No Opportunity
○ Taken appropriate health precautions					
○ Assess the need to seek advice and consult appropriately					
○ Applied basic ethical principles in various case scenarios					
○ Maintained appropriate standards of personal appearance and hygiene					
Demonstrated:					
○ Respect for patients and staff					
○ A caring and supportive attitude to patients					
○ An appreciation of family, social and cultural influences on health					
○ An ability to interact effectively in a multidisciplinary team					
○ Enthusiasm and initiative					
○ Reliability, dependability and efficiency					
○ Versatility					
○ Honesty and integrity					

Appendix 3. Orientation/ Beginning of Term Discussion Checklist

Resident Medical Officers (RMOs) (Interns, Junior and Senior House Officers) participate in **Unit Orientation / Beginning of Term Discussion with Supervisor* the first week of each term**, that includes (not limited to):

Discussion points: (Most unit material that is unchanging should be in the unit orientation manual, your start of term supervisory interview provides an opportunity for questions to be clarified).

[ ] *Orientation manual* (has it been read, any questions arising, how to find it (on QHEPS or by QR Code to

Redcliffe Medical Orientation – Staff Extranet (health.qld.gov.au) accessible remotely),

[ ] *Weekly timetable* (Outpatients, Clinics, Theatres, Ward rounds, MDT, Teaching etc.),

[ ] *Supervision* (who and how to contact),

[ ] Overtime expectations (when and how to claim),

[ ] *Working out of hours* (evenings/night shifts/on call),

[ ] *Wellbeing resources* including *Fatigue Management*,

[ ] *Assessment* (who to approach, e-portfolio): □ Mid-term and □ End of term - Clinical Learning Australia (CLA™),

[ ] *Medication Safety* Orientation with Unit/Department Pharmacist

[ ] *Education and teaching including:*
- Unit learning opportunities
- Cultural Safety and
- Resources for asynchronous access @ Medical Education Program Resources

[ ] *Self-directed learning* (recommended reading and resources),

[ ] *Individual learning objectives and career goals* should be discussed with your clinical supervisor within the first week of term. (Objectives should be SMART: Specific, Measurable, Achievable, Relevant and Time-limited).

Additional Learning Goals and Strategies to achieve these:

_____

_____

_____

_____

_____

_____

*A plan to orient those missing the orientation/supervisory interview should be established.

Appendix 4. Term Handover Notes

To ensure that term handover occurs, sessions have been scheduled during protected time. Residents are able to discuss handover, exchanging notes and useful tips at the end of RMO presentations just prior to the commencement of the new term.

Handover notes for the term can be documented and provided to the incoming resident for their reference
Please use the space provided below to record term handover details. You may wish to consider providing details on the following:

- Ward Routine/Rounds
- Clinics
- Meetings
- Training
- Consultant/Registrar Expectations
- Patient Casemix
- Discharge Summaries

CLINICAL UNIT: PALLIATIVE CARE_____ **TERM 1 2 3 4 5** (Please Circle)

RESIDENT'S NAME: _____ **CONTACT DETAILS:** _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

CHECKLIST OF REMINDERS:

- ☐ Identify and read through the Unit Orientation Manual for your new term
- ☐ Complete Unit Evaluation Form and return to Medical Education Unit
- ☐ Seek out Term Supervisor to facilitate the completion and discussion of End of Term Assessment
- ☐ Visit the unit/ward for an informal orientation with the current RMO

Useful information for Training Registrars / Diploma candidates

Appendix 5. Royal Australasian College of Physicians Information

The home page for the Royal Australasian College of Physicians (RACP) is: www.racp.edu.au [Note: This is the main portal to other important information sites].

Palliative medicine training within the RACP is administered by the Australasian Chapter of Palliative Medicine (AChPM):

- The Chapter provides training and assessment to advanced trainees undertaking their specialist training in palliative medicine. At the completion of three years of advanced training the successful trainee is made a Fellow of the Australasian Chapter of Palliative Medicine (FAChPM) and may pursue a career as a palliative medicine specialist.

- The Chapter also offers a Clinical Foundation in Palliative Medicine. This is a 6-month qualification designed to encourage medical practitioners to spend time in palliative care as part of their vocational training and continuing professional development.

Entry to personal Advanced Trainee Information is via the **Advanced Training Portal** on the home page of the RACP website (requires username and password). This launches the **Physician Readiness for Expert Practice (PREP) Advanced Training Program** site. It is the most important site that you will use so read the information therein carefully.

Advanced Trainee Curriculum
Curriculum standards: About this resource | RACP Online Learning

New curricula: Learning, teaching, and assessment programs
Palliative-Medicine-AM_LTA-programs_v1.2.pdf

Clinical Foundation: ***Consideration should be given to complete a Clinical Foundation of Palliative Medicine for registrars undertaking a 6 month term in Palliative Care***
clinical-foundation-in-palliative-medicine-curriculum.pdf

Training requirements

At the end of your Advanced Training in Palliative Medicine, you'll have completed 36 months full-time equivalent (FTE) of certified training time consisting of work-based learning and assessment tools.

The PREP teaching and learning activities are designed to support you in your reflective practice and self-directed learning. A variety of teaching and learning activities and assessments are used, catering to a range of learning needs, styles and situations that may arise in your workplace training.

See forms and resources for the training program curricula.

Requirements overview

Adult Medicine | trainees who commenced in 2017 onwards

Core training

(24 months minimum)

Supervision

Training terms 1, 2 and 3

2 x supervisors per 6-month rotation, who are Fellows of the RACP or AChPM and are practising in palliative medicine

Training term 4

1 x supervisor who is a Fellow of the RACP (medical oncology), RACP/RCPA (clinical haematology) or ANZCR (radiation oncology) and actively practising in their specialty

1 x supervisor who is a Fellow of the RACP or AChPM and actively practising in palliative medicine*

* Supervision can be conducted remotely.

Teaching and learning

1 x Learning Needs Analysis per 6-month rotation

1 x Professional Qualities Reflection per 6-month rotation (recommended)

Assessments

3 x Case-based Discussions per 6-month rotation

3 x Mini-Clinical Evaluation Exercises per 6-month rotation

1 x Supervisor's Reports per 6-month rotation (full-time and part-time trainees)

Non-core training

(12 months maximum)

Supervision

Training term 5

1 x supervisor per 6-month rotation, who is a Fellow of the RACP or AChPM* and practising in palliative medicine

1 x supervisor per 6-month rotation, who has a relevant Fellowship and is actively practising in a related specialty

Training term 6

1 x supervisor per 6-month rotation, who is a Fellow of the RACP or AChPM* and practising in palliative medicine

1 x supervisor per 6-month rotation, who can be a Fellow of the RACP or AChPM that works on-site closely with the trainee

* Supervision can be conducted remotely.

Teaching and learning

1 x Learning Needs Analysis per 6-month rotation

1 x Professional Qualities Reflection per 6-month rotation (recommended)

Assessments

3 x Case-based Discussions per 6-month rotation

3 x Mini-Clinical Evaluation Exercises per 6-month rotation

1 x Supervisor's Reports per 6-month rotation (full-time and part-time trainees)

Advanced Training summary

After 36 months of certified training time, you will have completed:

- 24 months of core training
  - 6 months of inpatient unit/hospice
  - 6 months of community setting
  - 6 months of teaching hospital/consultation
  - 6 months of cancer care setting
- 12 months of non-core training
  - 6 months of palliative medicine variable or related specialty
  - 6 months of elective training
- 1 x Advanced Training Research Project
- 1 x Case Study
- RACP Online Learning Resource: Pain Management module
- Communication Skills Workshop (recommended)

Appendix 6. Useful Websites

Useful Queensland Health Electronic Publishing Services (QHEPS) Site

- Resident Medical Officer and Registrar Campaign Home Page www.health.qld.gov.au/rmo

Useful Palliative Care Sites

- CareSearch www.caresearch.com.au
- CareSearch: Caring Safely at Home Resources www.caresearch.com.au/caresearch/tabid/2145/Default.aspx
- Clinical Knowledge Network
  https://idp.ckn.dotsec.com/idp/Authn/RemoteUser
  [Note: password required and can also be accessed via QHEPS]
- Australian and New Zealand Society of Palliative Medicine (ANZSPM) www.anzspm.org.au
- Palliative Care Australia (PCA) www.palliativecare.org.au
- Palliative Care Queensland (PCQ) www.palliativecareqld.org.au
- Palliative Care Outcomes Collaborative (PCOC) http://ahsri.uow.edu.au/pcoc/index.html
- Centre for Palliative Care Research and Education (CPCRE) www.health.qld.gov.au/cpcre/
- Niki Pump Self-Directed Learning Package
  http://paweb.sth.health.qld.gov.au/elearning/train_trainer/niki_t34_pump_ed.pps

Appendix 7: Brief Overview of Prevocational Medical Training National Framework

The AMC has conducted a comprehensive review of all the elements of the National Framework for Prevocational (PGY1 and PGY2) Medical Training (formerly, National Framework for Medical Internship) in 2019 – 2021. Following this comprehensive review, key changes have been made to the Prevocational Medical Training framework- most notably training and assessments have been expanded to include the PGY2 year with General Registration with AHPRA still being obtained at completion of PGY1. Changes to the Prevocational Medical Training framework were implemented in 2024.

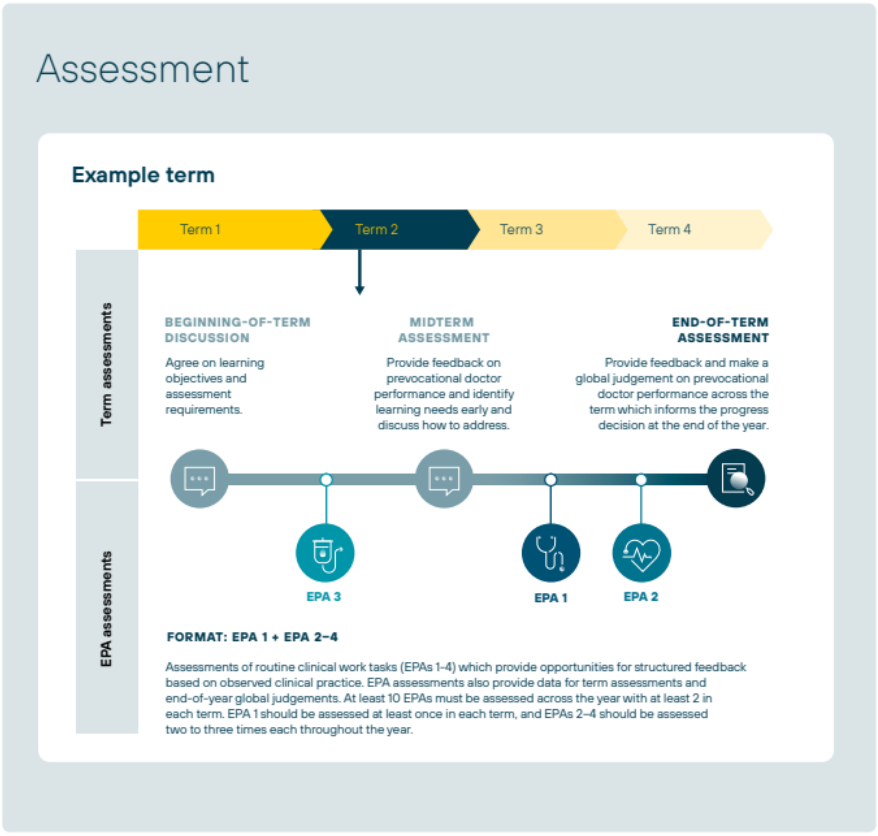
Prevocational doctors must ensure they understand the two-year prevocational training and assessment requirements, monitor their progress against those requirements, and proactively work with their supervisors and training providers to address any areas needing improvement to meet the requirements.

Assessment in prevocational training is done through two main methods:

1. Term assessments (mid and end)
2. Assessments of Entrustable Professional Activities (EPAs).

Each term, prevocational doctors will participate in a **beginning-of-term discussion**, a **midterm assessment**, at least two **EPA assessments**, and an **end-of-term assessment**. The assessment review panel will consider the outcomes of the EPA assessments and the end-of-term assessment at the end of the year. Note that there is no minimum number of successful EPAs or end-of-term assessments. The assessment review panel bases its decision on a judgement of whether the prevocational doctor has achieved the prevocational outcomes at the end of the year. An example of assessment activities within one term during a prevocational year (taken from "AMC NATIONAL FRAMEWORK FOR PREVOCATIONAL (PGY1 AND PGY2) MEDICAL TRAINING - Training and Assessment" guideline) is shown below:

Figure 6 – An example of assessment activities within one term during a prevocational year



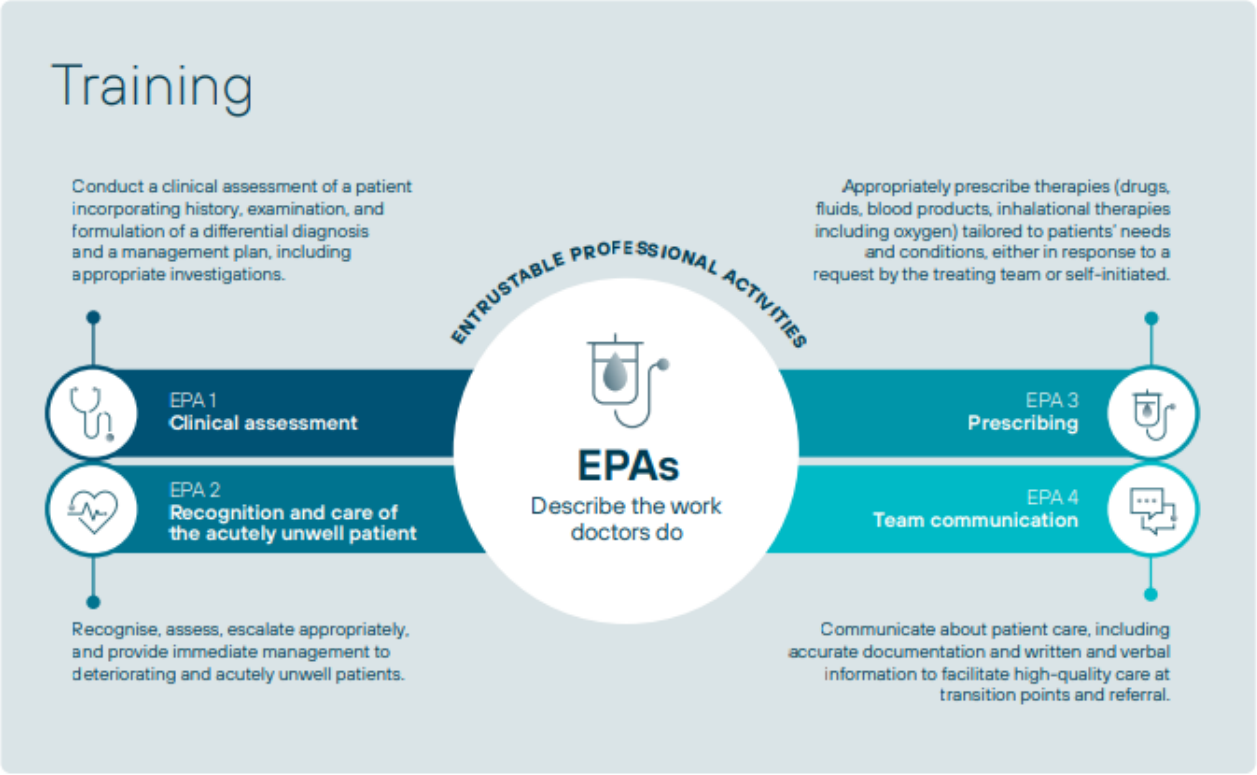
The four EPAs (Entrustable Professional Activities) describe essential work undertaken by PGY1 and PGY2 doctors. They are anchored to the prevocational outcome statements in the same domains and thus help align PGY1 and PGY2 doctors' roles with both training activities, and assessment and achievement of prevocational outcomes (see Figure below for an overview of EPAs). Assessment of EPAs provides structured opportunities for observation, feedback and learning, and informs global judgements at the end of terms and the end of each prevocational year.
The following are important points about EPAs in the prevocational context:

- An EPA is a description of essential work. This contrasts with outcomes or capabilities, which describe characteristics of a prevocational doctor.

- An EPA is not an assessment tool, but performance of an EPA can be assessed. Assessment of EPAs will include judgements about entrustability, that is, the level of supervision required for the doctor to perform this work safely.
- While PGY1 and PGY2 doctors will be assessed using the same EPAs, PGY2 doctors will be assessed to a higher level based on the complexity, responsibility, level of supervision and entrustability, as well as the context, of PGY2 doctors' work.
- Information about assessing EPAs is detailed in 'Prevocational assessment' (Section 3 of Training and assessment requirements for prevocational (PGY1 and PGY2) training programs)

An overview of the EPAs (taken from "AMC NATIONAL FRAMEWORK FOR PREVOCATIONAL (PGY1 AND PGY2) MEDICAL TRAINING - Training and Assessment" guideline) is shown below:

Figure 4 – Overview of the entrustable professional activities (EPAs)



For a comprehensive guide for the new National Framework for Prevocational Medical Training please refer to: National Framework for Prevocational (PGY1 and PGY2) Medical Training (amc.org.au).