Canberra Health Services

 Evening to Night Handover JMO Guidelines

2021

**WHY**

Why Do Handover?

Clinical handover has a nationally and internationally recognised definition. ‘…*transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis*.’ (Australian Medical Association, 2006)

Handover is essential and must occur at shift change.

**GOOD HANDOVER BENEFITS PATIENTS:**

* Safety is protected – lapses in information handover can, and do, lead to mistakes being made. This increases morbidity and mortality
* Greater continuity of care – poor handover can lead to fragmentation and inconsistency of care
* Decreased repetition – patients dislike having to answer the same questions over and over again. Diﬀerent individuals providing care will be accepted as long as existing team knowledge is retained
* Increased service satisfaction – every doctor attending a patient can begin where the last one left oﬀ. Patient perception of professionalism is reaﬃrmed and improved
* Increased eﬃciency of the healthcare system and improvement to patient care through timely investigation and diagnosis, management and discharge

**GOOD HANDOVER BENEFITS DOCTORS:**

* Professional protection – accountability has become more prominent with the move toward a more litigious culture within healthcare. Clear and accountable communication can protect against wrongful attribution of responsibility for errors that occur
* Reduction of stress – feeling informed and having up to date information enables doctors to feel more conﬁdently in control of a patient’s care. Doctors have found that handover can be a useful experience that gives them the opportunity to involve appropriate specialties early, for example intensive care. There is ability to discuss cases with other specialties in an open environment
* Educational – handover provides development and practice of communication skills and a well-led handover session provides a useful setting for clinical education
* Job satisfaction – providing the best possible quality of care is highly rewarding and is fundamental to a doctor’s sense of job satisfaction
* Good handover has been shown to change culture, increase doctor participation, improve supervision of after-hours work and improve educational value.
* Decreases frequency of repetition of information between clinicians, improving clinical efficiency.

**WHO**

WHO SHOULD BE INVOLVED?

***JMO’s******completing evening shift*** *and handing over to* ***JMO’s commencing night shift****.*

See **APPENDIX 6** for a summary of JMO’s required to attend Pod handover, Paediatrics Handover and Obstetrics and Gynaecology Handover.

**A registrar** is required to lead handover – this will generally be the **Night Registrar/M1 Registrar.**

**The night registrar’s pager number is - 50470**

JMOs are at the beginning of their careers and are developing their clinical experience and knowledge base.

Leadership and supervision by a more senior clinician (e.g. medical registrar) is essential to help JMOs provide effective clinical handover.

A more senior clinician (e.g. medical registrar) will have experience that can help JMOs deliver the most important key messages for effective transfer of patient care in a complete yet concise manner.

The leadership roles required from a more senior clinician (e.g. medical registrar) include:

* Oversee and implement handover processes
* Attend and lead handover at JMO shift changes
* Understand the signs and symptoms of deterioration
* Recognise clinical risks and convey these concepts to JMOS
* Prioritise which patients and what information is handed over
* Involve JMOS in clear prioritisation of patients and allocation of tasks.

Some examples of how senior leadership for JMO handover can be demonstrated include:

* Senior Medical Officers involving and guiding JMOs in clinical decision-making before and during clinical handover.
* Senior Medical Officers attending and leading handover to manage clinical issues early and reduce call outs.
* Using handover as a teaching opportunity.
* Senior nurses facilitating the process of handover.

It is feasible that there may be occasions when a more senior clinician (e.g. medical registrar) are unable to attend and lead clinical handover.

In such instances, JMOs should have access to the evening medical registrar or home team registrar in preparing their patient lists for shift handover.

Prior to handover, senior clinician leadership ***can*** include:

* JMOs consulting with senior medical staff, including Consultants, Staff Specialists and Visiting Medical Officers
* Registrars and JMOs should discuss which patients and what information to handover at shift change
* JMOs undertaking a face to face or telephone paper round with registrars prior to handover.

**Those attending handover must sign in via the provided electronic sheet on Q: Drive.**

If you are unable to attend handover in person, please email CHSTCHMosu@act.gov.au to indicate why you could not attend and how and to whom you handed patient details over.

Follow – up will be undertaken by MOSCETU for those JMO’s who do not sign in to handover and do not provide an email as per the above.

**WHAT**

WHAT SHOULD BE HANDED OVER?

***Sufficient clinical information must be handed over to ensure transfer of responsibility and accountability for patient care.***

The information and level of detail that is included in a clinical handover session depends on several factors including the severity of the patient’s illness and whether they are pending results of investigations and require prompt follow-up.

**Which patients should be handed over?**

* Sick or deteriorating patients (eg, MET calls or patients with unstable or deteriorating observations or escalating MEWs)
* Patients with significant changes in condition or management plan during the previous shift
* Important outstanding actions, including: –
	1. tests or procedures that need to be done
	2. test results that need review
	3. transfer of care planning (this includes inter-ward or inter-hospital care and also discharge to GP care)
* New patients
* Any patients you are worried about – do not discount your clinical acumen.

Deciding who should be handed over cannot be limited to a strict categorisation.

**Example of information to handover:**

1. Clearly identify the patient, you and your role
2. State the immediate clinical situation of the patient
3. List the most important and recent observations
4. Provide relevant background/history to the patient’s clinical situation
5. Identify assessments and actions that need to occur
6. Identify timeframes and requirements for transition of care
7. Promote the use of the patient record to crosscheck information
8. Ensure documentation of all-important findings or changes of condition
9. Ensure comprehension, acknowledgement and acceptance of responsibility for the patient by the clinician receiving handover
10. Who to call if there is a change in patient condition (e.g. speciality registrar or consultant on-call?)

**At the end of handover the JMO receiving handover should have a clear understanding of**:

* Sick, deteriorating and unstable patients
* Outstanding actions, procedures, tests or results to be reviewed
* Other important factors that will impact work on the following shift
* Who needs to be informed of these issues

The type and level of handover conducted is also inﬂuenced by the doctor to patient ratio and workﬂow.

Priorities need to be set to ensure that the essential information is communicated and understood.

Patients who are less stable or have changing management plans may require a detailed handover, while others who are relatively stable and with fewer outstanding tests or actions can be summarised more quickly.

**Where the condition of a patient is deteriorating: Escalate the management of these patients as soon as a deterioration in condition is detected.**

If for any reason you are concerned by any part of a patient’s clinical situation or their management plan, this concern should be handed over to the oncoming shift.

***Escalation of concerns for any part of a patient’s clinical situation or management plan must not be held back until shift handover***

Handover of other information about environmental features may benefit the oncoming shift and should be led by registrars, including:

* Critical care bed availability
* Ward patient flow or bed pressure points
* Staff levels or availability
* Relevant contact persons if required
* Any specific patient or equipment risks that are likely to affect JMO or staff safety.

**APPENDIX 5** has a summary to provide guidance on the clinical information that should be considered when handing over specific patient types:

* Medical
* Surgical
* Paediatric
* Psychiatry
* Obstetrics and Gynaecology
* Emergency Department

**HOW**

HOW DO YOU HAND OVER?

Handover between JMO’s and to the supervising clinician (e.g. M1/Night registrar) should be undertaken **verbally** and ideally **face to face**.

The **ISBAR** Format is the recommended format for verbal handover processes (see **APPENDIX 2**)

The **ISOAP** Format is the recommended format for written handover processes (see **APPENDIX 3**).

Electronic tools are supplementary and cannot replace processes of human interaction at handover.

**Verbal handover is vital to highlight:**

* Patients with anticipated problems, to clarify management plans and ensure appropriate review
* Outstanding tasks and their required time for completion

**Written (or IT based) handover** should include at minimum:

1. Current inpatients
2. Accepted and referred patients due to be assessed
3. Accurate location of all patients
4. Operational matters directly relevant to clinical care such as ICU bed availability
5. Information to convey to the following shift
6. Patients brought to the attention of the critical care outreach team (where appropriate)
7. Patients who are unstable or whose clinical status is deteriorating

The above, as well as being included in the written handover, should be discussed within the handover meeting.

***Please remember to dispose of paperwork containing patient information in a secure disposal.***

**HOW**

PROCESS OF HANDOVER

1. Handover **commences** at **2100**.
2. **Night Medical Registrar**, **Evening Medical Registrar** and **JMO’s** attend **The Main Hospital Auditorium (2030 on weekends).**
3. One JMO will be nominated as **scribe** by Night Medical Registrar.
4. JMO’s **record attendance via the** handover **attendance template** in– **Q:\TCH\Division of Medicine\Medical Handover\Night Handover\2021**
5. Scribe will also put in patient details and plan in handover **patient spreadsheet** on laptop/projector.
6. This spreadsheet will be administered by the Medical Registrar(s) but able to be reviewed/altered by any JMO.
7. The handover Patient Template File is located in – **Q:\TCH\Division of Medicine\Medical Handover\Night Handover\2022**
8. When **updating** this document please end any additions/notes with your **initials** in brackets e.g. ‘Mrs Jones now taking oral fluids as of 0100 hours (JD)’.
9. The **Mental Health JMO** may handover to the **Medical Pod 3 JMO** by **phone**, but must email CHSTCHMosu@act.gov.au with the details of this handover (time, patient, to whom handed over).
10. Night Medical Registrar to introduce themselves initially and determine if any JMO’s are present who are commencing their first night shift (‘ever’ or for this ‘block’).
11. Night Medical Registrar to clarify how to contact them and for what issues.
12. Each JMO in attendance listens to the handover from each pod as the patient is presented to the registrar.
13. The order this occurs is at the Night Medical Registrar’s discretion and may be dictated by time of attendance of JMO’s, or alphabetical/ward numerical.
14. RN Handover is also at 2100 – RN’s will be informed to avoid paging from 2045 until 2130 unless critical/urgent.
15. Commence handing over the **sickest/most unstable/MEWS increasing, MET calls, and critical results** to the Night Medical Registrar using ISBAR format.
16. JMO’s may handover small tasks or f/up issues amongst themselves following the completion of formal handover of unwell/sick/unstable/post MET patients.
17. If a JMO does not attend handover, the Night Medical Registrar is to contact the JMO following handover to identify why they could not attend and obtain handover or plan how handover is to occur.
18. If you are unable to attend due to urgent clinical necessity and could not communicate to the Night Medical Registrar, please alert MOSCETU via email at CHSTCHMosu@act.gov.au to indicate:
19. why you could not attend handover,
20. who, when and how you handed over (e.g. ‘I was at a MET call on 9A, I handed over patient X at 2230 to Dr Joe Blogs via face to face meeting’).
21. Follow up will be undertaken the next day for those who do not attend handover and do not alert MOSCETU/Night Registrar as above.

**WHERE**

WHERE SHOULD HANDOVER TAKE PLACE?

**Medical and Surgical Pod JMOs:**

* Main Hospital Auditorium

**Paediatric JMOs:**

* Building 10, Medical Student Lounge, Paediatric Ward

**Obstetrics and Gynaecology JMOs:**

* Education Room, Birthing Suite, Building 10, Level 3.

**WHEN**

WHEN DOES HANDOVER OCCUR?

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| **Medical and Surgical Pod JMOs** |
| **Day** | **Time** | **Place** |
| Monday to Friday | 2100 | Main Hospital Auditorium |
| Saturday | 2030 | Main Hospital Auditorium |
| Sunday | 2030 | Main Hospital Auditorium |
| Public Holidays | 2030 | Main Hospital Auditorium |

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| **Paediatric JMOs** |
| **Day** | **Time** | **Place** |
| Monday to Friday | 2130 | Building 10, Medical Student Room, Paediatric Ward |
| Weekend/Public Holiday | 2030 | Building 10, Medical Student Room, Paediatric Ward |

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| **Obstetrics and Gynaecology JMOs** |
| **Day** | **Time** | **Place** |
| Monday to Friday | 2130 | Building 10, Education Room, Birthing Suite |
| Weekend/Public Holiday | 2030 | Building 10, Education Room, Birthing Suite |

**APPENDIX**

**(1 – 6)**

**APPENDIX 1:**

**Common Pitfalls During Handover:**

The Human Factors and Arterial Switch Operation study collected data on operations performed by 21 UK cardiac surgeons in 16 centres over eighteen months. During the study, researchers were present at operating theatre to ICU handovers.

* Healthcare professionals sometimes try to give verbal handovers at the same time as the team taking over the patient’s care are setting up vital life support and monitoring equipment. Unless both teams are able to concentrate on the handover of a sick patient, valuable information will be lost. The importance of written handover information must be stressed
* Roles and responsibilities are not always clear during handover and this can lead to omissions, for example, if one staﬀ member assumes that another will verbally update the team taking over the care of a patient
* Checklists and written updates are important and often under-utilised. They provide important sources of information for the team who have taken over care of the patient during the following shift. When such information is incomplete or omitted it has a knock on eﬀect of increasing the workload of the staﬀ who have taken over the patient’s care because they have to spend a signiﬁcant proportion of time chasing information
* It is important that nursing staﬀ are made aware of critical features in the medical management of a patient that will aﬀect care during the next shift. Similarly, medical staﬀ must be aware of speciﬁc nursing issues that may aﬀect care. Multidisciplinary team handover helps minimise these omissions
* Fragmentation of information at the point of handover is a major problem. It is important to avoid multiple concurrent conversations between individuals and let one person (a nominated lead) speak at a time to everyone. This reduces the opportunities for conﬂicting information to be given
* Handover is a two-way process. Good handover practice is characterised by the team who are taking over the patient’s care asking questions and having the opportunity to clarify points they are uncertain of. They should not be passive recipients of information

**APPENDIX 2:**

**ISBAR FORMAT**

FOR VERBAL HANDOVER

**I = Introduction:**

Use three unique identifiers (Name, DOB, URN or address) to identify the consumer, introduce yourself and the clinician taking over the consumer’s care

**S = Situation:**

State the immediate clinical situation of the consumer and list the most important and recent observations including interpretation of observations

**B = Background:**

Provide relevant background/history to the consumer's clinical situation; i.e. reason for admission and other health and risk factors including allergies and infection status

**A = Assessment:**

Identify assessments, including risks and actions that need to occur; i.e. anticipated consults, test results, risk of falls, risk of deterioration, medications etc.

**R = Recommendations/ Read back:**

Identify timeframes and requirements for handover of care. Read back is an opportunity for staff/consumer/carers to ask questions or comment. Ask receiver to repeat key information to ensure a shared understanding.

**APPENDIX 3:**

**ISOAP FORMAT**

FOR WRITTEN HANDOVER

**I = INTERVENTION/INTRODUCTION**

Identify yourself and give your reason for the clinical handover or interventions planned. Identify consumer using unique identifiers and others present such as carer, advocate or interpreter.

**S = SUBJECTIVE INFORMATION**

Presentation of the patient’s viewpoint – their story, how they may feel.

**O = OBJECTIVE INFORMATION**

Objective observations of the patient – factual, unbiased and measurable.

**A = ANALYSIS/ACTIONS/ADVICE**

Analysis and interpretation of subjective and objective information followed by action implemented and any related advice or education provided.

**P = PLAN**

Plan of care to incorporate any required changes to interventions and time frames – includes changes to care plans.

**APPENDIX 4: - examples**

The right clinical information needs to be handed over to ensure transfer of responsibility and accountability for patient care.

Patients who are less stable or have changing management plans may require a detailed handover, while others who are relatively stable and with fewer outstanding tests or actions can be summarised more quickly.

Senior clinician supervision of JMOs at clinical handover is important to help decide which patients, how much and which clinical information needs to be handed over.

In total, the detailed handover example shown below would take no more than 2 minutes to deliver.

Example Case 1:

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| **ISOBAR** | **Example** |
| **Introduction** | My name is John Smith. I am an RMO2, in Westmead, Emergency Department |
| **Situation** |  The situation is that I am requesting admission for Mrs Jane Jones, who is an 80 year old woman with an acute exacerbation of chronic left ventricular failure |
| **Background** | By way of background, she presented with gradually progressive SOB over 3 days, with exertional chest heaviness, and is now SOB at rest and experiencing PND. She was admitted under Dr X 2 months ago with a non-STEMI AMI, Type 2 Diabetes Mellitus and hypertension. She is currently on aspirin, perindopril, diltiazem and gliclazide. She has had allergies to penicillin, and is an ex-smoker and does not drink or use sleeping tablets. She lives alone. |
| **Assessment** | On assessment, she has signs of left and right heart failure with CO2 retention: central cyanosis, asterixis, respiration 16, saturations 88% on room air. Her vital signs include BP 145/88, regular pulse 70 bpm and JVP slightly elevated. She has moderate peripheral oedema and medium-coarse bisbasal crackles. The CXR shows interstitial and alveolar oedema, ECG sinus rhythm with new lateral t-wave flattening, TNT elevated at 0.4, EUCs showing mild hyponatraemia (Na 130) and renal impairment (Cr 142) but normal K (4.0). LFTs, Glc, CMP, FBC and coags normal. She has left ventricular failure associated with a non-STEMI and has been commenced on Oxygen (6L/min), aspirin, frusemide, fluid restriction and therapeutic enoxaparin and will be monitored and have serial ECGs and TNTs. The diltiazem has been withheld by the team. |
| **Recommendation** | My recommendation is that this patient needs admission by the Cardiology team in a monitored CCU bed and will need an Echo within 24 hours. |

Example **Case #2:**

It’s the evening shift, you’ve seen a surgical patient with chest pain, you need to handover to the night team

The night registrar asks - “Dr X, do you have anything to handover?”

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| **ISOBAR** | **Example** |
| **Introduction** | My name is Dr X, I am the intern covering Ward A, asked to see Mr Joe Smith |
| **Situation** | The situation is that I Mr Smith , a 76 year old man developed central chest pain at 1700 which resolved spontaneously at 1730. |
| **Background** | Patient is Day 2 post R NOF surgery, uncomplicated, but developed some anaemia. No history of AMI/Ischaemic Heart Disease. Type 2 diabetic, dietary control only. Pain commenced at 1700 while at rest – central chest, 5/10 severity. No associated SOB, diaphoresis or hyper/hypotension. No radiation. No LOC. 40 pack year smoking history. No known allergies. |
| **Assessment** | ECG showed non specific ST-T changes, medical registrar reviewed at 1730 and thought weren’t significant and were on his old ECG, however, a troponin was ordered. Physical examination was unremarkable. Observations stable and within normal limits. No additional medications given. On prophylactic aspirin by GP, ARB and No other change to management at this time. |
| **Recommendation** | My recommendation is to review the troponin result. If normal, repeat in 3 hours. If raised, please ring the medical registrar, and the patient will need a monitored bed, consider anticoagulation, and call the cardiology registrar for further advice. |

Example Case #3:

A patient needs repeat APTT after a heparin infusion dose adjustment

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| **ISOBAR** | **Example** |
| **Introduction** | My name is Dr X, I was the intern covering Ward H, asked to review a heparin infusion for Ms Jones,  |
| **Situation** | The situation is that Ms Jones, a 60 year old female has required a bolus of 5000 units heparin and increased infusion rate 150 units/hr (1.5ml/hr) due to an APTT of <50 and an APTT ratio of <1.5 at 1700. |
| **Background** | Patient is Day 2 post myocardial infarction, first event. Long smoking history, hypertension, type 2 diabetes mellitus (oral medication only). Commenced infusion at 1100 today (14/01/2020). |
| **Assessment** | APTT <50, APTT ratio <1.5 at 1700. No active bleeding. Infusion was commenced today. Observations within normal limits. Patient otherwise stable and not in distress. On aspirin, metformin, metoprolol (new since diagnosis) and rampiril. |
| **Recommendation** | My recommendation is to repeat the APTT and ratio in approximately 6 hours (~1100pm) and alter the infusion rate as per the APTT nomogram. If no change in APTT or ratio or excessively elevated, contact medical registrar. Otherwise repeat APTT six hours after any further change in infusion rate. |

**APPENDIX 5:**

**Example of Team Specific Information to Handover:**

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| **ISBAR** | **Medical** | **Surgical** | **Emergency** | **Obstetrics** | **Mental Health** | **Paediatrics** |
| **I = Information** | What is your name?What is your surname? What is your position in the Hospital? Which Hospital are you calling from?Which part of the Hospital are you calling from? | No Change | No Change | No Change | No Change | No Change |
| **S = Situation** | Why are you calling me?What is the patient’s name (first name followed by surname)?How old is the patient?What gender is the patient?What is/are the problem/s or diagnosis/es? | No Change | Add: – Has the patient been admitted or accepted by a specialty team. – Is the patient scheduled under the Mental Health Act, do they need a nurse special | No Change | Add: – Is the patient in the ED, Ward, Community? – Is the patient in seclusion? – Is the patient under the Mental Health Act? | No Change |
| **B = Background** | What is/are the presenting symptom/s?How bad are these symptoms?What relevant problems has the patient had previously?What medications is the patient on?What allergies does the patient have?Does the patient smoke, drink or use benzodiazepines? Why does the patient need to be treated in hospital rather than at home or in the clinic? | Remove: “How bad are these symptoms”Add:Has the patient had a recent surgery? If so, what surgery and when?When did the patient last eat or drink? | Add: – What is their pre-morbid status and social situation? – Any important linkages with out of hospital care / General Practice | Add: – Is the patient pregnant? – How many weeks gestation? – If in labour, what is the Cervix dilation? – Information relating to the CTG trac | Remove: – “How bad are these symptoms” – Why does the patient need to be treated in hospital rather than at home or in the clinic?Add: – How long has this patient been in care? – Do they have a primary carer? – Accommodation? – How/why did this person get brought to hospital? – Substance abuse? | Add: – Birth history (antenatal, perinatal etc) – Developmental & growth assessments (growth charts) – Social/family issues – Vaccination statu |
| **A = Assessment** | What are the patient’s vital signs (appearance, comfort, Bp, pulse rate and rhythm, JVP, respiratory rate, temperature and urine output)?What are the salient clinical signs that support the diagnosis and indicate the severity?What are the key investigations/ procedures – planned or results?What are the problems and treatments you have begun in order of importance?Is the patient/carer up to date with the diagnosis and treatment plan? | Add: – Is the patient having DVT prophylaxis? – What intravenous fluids are being administered and at what rate? – What antibiotics are being administered? – What analgesia is being utilised? | Add: – Are they fasting, or limited oral intake? – Can they take oral medications? – Any outstanding consultations or reviews – Where should the patient go when they finish in ED? – Is the transfer paperwork complete? | No Change | Add: – What is the patient’s current mental state? – Are they distressed, suicidal or wanting to harm others? – If in the ED what was the result of the examination by the medical officers? – Key MSE findings? – What risks (to self/others) have been identified? | No Change |
| **R = Recommendation** | Your recommendations for ongoing care with clear timeframes that facilitate the transfer of responsibility and accountability for patient care. Read back to prevent misconceptions and clarify what you have understood | No Change | No Change | No Change | Add: Specific recommendation relating to: – Location for treatment – Medications – What other teams should be involved? | No Change |

**APPENDIX 6:**

The following tables on pages 20 - 27 are a visual representation of JMO Handover and those required to attend Evening to Night Handover.

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| **Night Medical Registrar** |
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*Unwell patients, critical results, significant issues, METs, MEWS increasing*

*Outstanding tasks, results follow-up, patient reviews, unwell patients, critical information, MET’s*

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| **Evening** | **Night** |
| **Medical Pod 1 Evening JMO** | **Medical Pod 1 Night JMO** |
| **Medical Pod 2.1 Evening JMO** | **Medical Pod 2 Night JMO** |
| **Medical Pod 2.2 Evening JMO** |
| **Gastroenterology Evening JMO** | **Medical Pod 3 Night JMO** |
| **Medical Pod 3 Evening JMO** |
| **Mental Health Evening JMO** |
| **Orthopaedics Evening JMO** | **Orthopaedics Night JMO** |
| **ASU Evening JMO** | **Surgical Pod 1 Night JMO** |
| **Surgical Pod 1 Evening JMO** |
| **Surgical Pod 2 Evening JMO** | **Surgical Pod 2 Night JMO** |
| **Neurosurgery Evening JMO** |

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| **Night Medical Registrar** |
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| **Evening** | **Night** |
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| **Medical Pod 1 Weekend Evening JMO** |

 | **Medical Pod 1 Weekend Night JMO** |
| **Medical Pod 2.1 Weekend Day JMO** | **Medical Pod 2 Weekend Night JMO** |
| **Medical Pod 2.2 Weekend Day JMO** |
| **Medical Pod 3 Weekend Evening JMO** | **Medical Pod 3 Weekend Night JMO** |
| **Orthopaedics Weekend Evening JMO** | **Orthopaedics Weekend Night JMO** |
| **Surgical Pod 1 Weekend Day JMO** | **Surgical Pod 1 Night JMO** |
| **ASU Weekend Day JMO** |
| **Surgical Pod 2.1 Weekend Day JMO** | **Surgical Pod 2 Night JMO** |

*Unwell patients, critical results, significant issues, METs, MEWS increasing*

*Outstanding tasks, results follow-up, patient reviews, unwell patients, critical information, MET’s*

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| **Night Medical Registrar** |
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| **Evening** | **Night** |
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| **Medical Pod 1 Weekend Evening JMO** |

 | **Medical Pod 1 Weekend Night JMO** |
| **Medical Pod 2.1 Weekend Day JMO** | **Medical Pod 2 Weekend Night JMO** |
| **Medical Pod 2.2 Weekend Day JMO** |
| **Medical Pod 3 Weekend Evening JMO** | **Medical Pod 3 Weekend Night JMO** |
| **Orthopaedics Weekend Evening JMO** | **Orthopaedics Weekend Night JMO** |
| **Surgical Pod 1 Weekend Day JMO** | **Surgical Pod 1 Night JMO** |
| **ASU Weekend Day JMO** |
| **Surgical Pod 2.1 Weekend Day JMO** | **Surgical Pod 2 Night JMO** |

*Unwell patients, critical results, significant issues, METs, MEWS increasing*

*Outstanding tasks, results follow-up, patient reviews, unwell patients, critical information, MET’s*

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| **Night Medical Registrar** |
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| **Evening** | **Night** |
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| **Medical Pod 1 Weekend Evening JMO** |

 | **Medical Pod 1 Weekend Night JMO** |
| **Medical Pod 2.1 Weekend Day JMO** | **Medical Pod 2 Weekend Night JMO** |
| **Medical Pod 2.2 Weekend Day JMO** |
| **Medical Pod 3 Weekend Evening JMO** | **Medical Pod 3 Weekend Night JMO** |
| **Orthopaedics Weekend Evening JMO** | **Orthopaedics Weekend Night JMO** |
| **Surgical Pod 1 Weekend Day JMO** | **Surgical Pod 1 Night JMO** |
| **ASU Weekend Day JMO** |
| **Surgical Pod 2.1 Weekend Day JMO** | **Surgical Pod 2 Night JMO** |

*Unwell patients, critical results, significant issues, METs, MEWS increasing*

*Outstanding tasks, results follow-up, patient reviews, unwell patients, critical information, MET’s*

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| **Evening** | **Night** |
| **Paediatrics Evening JMO** | **Paediatrics Night JMO** |

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| **Paediatric Evening Registrar** |
| **Paediatric Night Registrar** |

*All patients are discussed*

*All patients are discussed*

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| **Evening** | **Night** |
| **Paediatrics Evening JMO** | **Paediatrics Night JMO** |

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| **Paediatric Long Day Registrar** |
| **Paediatric Night Registrar** |

*All patients are discussed*

*All patients are discussed*

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| **Evening** | **Night** |
| **Obstetrics and Gynaecology Evening JMO** | **Obstetrics and Gynaecology Night JMO** |

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| **Obstetrics and Gynaecology Evening Registrar** |
| **Obstetrics and Gynaecology Night Registrar** |

*Unwell patients, critical results, significant issues, METs*

*Outstanding tasks, results follow-up, patient reviews, unwell patients, critical information, MET’s*

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| **Evening** | **Night** |
| **Obstetrics and Gynaecology Weekend JMO 2** | **Obstetrics and Gynaecology Weekend Night JMO** |

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| **Obstetrics and Gynaecology Evening Registrar** |
| **Obstetrics and Gynaecology Night Registrar** |

*Unwell patients, critical results, significant issues, METs*

*Outstanding tasks, results follow-up, patient reviews, unwell patients, critical information, MET’s*