Waikato District Health Board

Position Description

This position description will be used in conjunction with Section B

| Job Title: | House Officer – Community Based Attachment – Northcare [PGY2 + SHO] |
| Reports to: | Clinical Director |
| Clinical supervision by: | Clinical Supervisor or Pre-Vocational Education Supervisor (PES) as appropriate |
| Professional links to: | Director of Clinical Training |
| Delegation: | Nil |
| Responsible for: (Total number of staff) | Nil |
| Budget: | Nil |
| Job Purpose: | To manage patients within the designated departments commensurate with and appropriate to the skill level of the position. To maintain and extend the knowledge and skill base required for effective performance learning through attending ward rounds, journal clubs, and other informal and formal teaching sessions |
| Direct Reports: | Nil |
| Date: | December 2016 v2 |

Vision (Te Matakite)
Healthy People. Excellent care.

Mission (Te Whakatakanga)
Enable us all to manage our health and wellbeing.
Provide excellent care through smarter, innovative delivery

Values
Theme “People at Heart” – Te iwi Ngakaunui

- Give and earn respect - Whakamana
- Listen to me; talk to me – Whakarongo
- Fair play – Mauri Pai
- Growing the good – Whakapakari
- Stronger together – Kotahitanga

Code of Conduct
The Waikato DHB’s code of conduct incorporates the State Services standards of integrity and conduct and sets expectations relating to behaviour in the workplace.
INDIVIDUAL ACCOUNTABILITIES

- To deliver the accountabilities required of the House Officer including meeting the key performance indicators (KPIs) established annually with the line Manager.
- To adhere to professional requirements for development, and assume responsibility for personal development
- Awareness of personal limitations and consults with others and seeks advice when appropriate
- Take responsibility for the accuracy and completeness of reports, patient notes and other official documentation as required.
- Identify any learning needs and discuss appropriate education and training with the Clinical Supervisor or Pre-Vocational/Education Supervisor.
- Participate in own performance review quarterly
- Ethical standards and codes of conduct are complied with.
- Orientate, coach and provide feedback to year one House Officers
- Complete rotation performance reviews biannually
- Regularly attend House Officer and departmental training and education sessions
- Meet training obligations in a timely fashion.
- Ensure that all other additional duties are performed in an efficient manner, within a negotiated timeframe

Supervision is a condition of registration for all new doctors in New Zealand
- Domains of competence
- Clinical expertise
- Communication
- Collaboration
- Management
- Scholarship
- Professionalism

TEAM RESPONSIBILITIES

Quality and Patient Safety collective responsibilities
- Be responsible for treating patients / service users with respect, dignity and compassion
- Be responsible to the line manager for the provision of quality services; quality improvement is part of this and a fundamental duty of all staff, whatever their grade, role, service or base
- Comply with DHB policies and procedures to ensure delivery of good quality care reporting risks to quality and safety to their line manager
- Identify areas for improvement in their day to day work and to act upon these when appropriate and/or bring these to the attention of their line manager, in order that appropriate action may be taken.
- Participate in on-going quality improvement activities throughout the year within their team, service, site or department.
- Raise concerns with their line manager, if there are quality or patient / service safety issues in their area
ORGANISATIONAL RESPONSIBILITIES

- Aligns with the Waikato DHB strategy.
- Being accountable for own work and provide a high quality service, and contributes to quality improvement and risk minimisation activities.
- Read and understand the organisations policies and procedures that have an impact on the role and maintaining understanding is based on the most current version. This includes but is not limited to Corporate Records Management policy, privacy, and information security policies.
- Follows established Health and Safety and other policies and procedures to ensure the safety of oneself and others.
- Work in partnership with Māori patients and whānau to provide culturally responsive and appropriate care and support to improve health experience, outcomes and reduce health inequities.
- Knows department emergency response plan and participates in response as applicable to the role.

QUALIFICATIONS AND EXPERIENCE

Qualifications

- Registered Medical Practitioner (recognised by the New Zealand Medical Council – MCNZ), preferably from a New Zealand medical school
- A current practising certificate with one of the following Scopes of Practice: Current Advanced Cardiac Life Support certificate

Desirable

- Previous work within the New Zealand health system.

Other requirements

- To work on call and after hours rosters.
- New Zealand full driver’s license and the ability to drive to rural hospitals and clinics and, if required to stay overnight outside of Hamilton.

Health leadership capabilities and competencies – staff, no delegation. Waikato DHB values are included as a drop down with competency (22)

Maximising contribution (national leadership framework be a values leader)

- Models and adheres to the DHBs values, vision, and code of conduct (22) DHB Values
- Provides safe and quality service delivery for patients/ clients/ customers (15)
- Completes work within required timeframes (62)

Developing self and others (national leadership framework engage others).

- Seeks opportunities to continuously improve, and works to learn and grow (54)

Building relationships (national leadership framework develop coalitions)

- Maintains effective relationships patients/ clients/ consumers/customers, and with peers and the employer, and encourages collaboration and effective group interactions (42)

Achieving results (national leadership framework leading care)

- Is open to learning new things and picks up technical skills in a reasonable timeframe (61)
- Is action oriented and undertakes duties with professionalism and enthusiasm (1)

Leading change (national leadership framework mobilise system improvements)
Health leadership capabilities and competencies – staff, no delegation. Waikato DHB values are included as a drop down with competency (22)

- Looks for opportunities to improve processes and uses logic and analysis to review information in order to make sound decisions (14)

The numbers in brackets are only applicable to current staff who have a career and development plan.

**SCOPE OF POSITION**

**Relationships**

Internal
- Service/ department team
- Specialist Medical Staff,
- Managers of Units
- Hospital and community based healthcare workers
- Appropriate / designated HR Practitioners
- RMO Unit
- Director of Clinical Training
- Healthcare consumers

External
- General Practitioners
- New Zealand Medical Council
- Primary Health Providers

**WORK ENVIRONMENT AND WORK FUNCTION / ACTIVITY**

Work environment:
- Works indoors in hospital wards, operating theatres, clinics and offices within hospitals, and specialist clinics
- Works in adequately lit, heated, ventilated and clean, well maintained and sterile workspaces with special lighting and equipment in operating theatres relevant to the surgical speciality.
- Works with blood and possibly contaminated items.

Work function/activity:
- **Sedentary to light** physical demand.
- **Sits** during consultations and when writing patient notes.
- Frequently **stands** for long periods of time to conduct surgical procedures.
- **Walks** frequently to check and prepare equipment, examine patients, case notes and medical images.
- **Lifting, stretching and reaching** is not a significant component of the job but may be required for some surgical procedures and when undertaking physical examinations.
- **Repetitive hand and finger movements** will be required for some surgical procedures and when using a computer or writing.
- There will be frequent use of **surgical and medical equipment** and materials including medicines, operating tables, computers, monitoring screens, medical dressings, surgical equipment, instruments, surgical clothing, sterilising materials and other medical equipment.

**Mental skills** necessary include a high level of cognitive functioning with medical, surgical, assessment, diagnostic, communication, interpersonal, organisational, problem solving and decision-making capabilities. . Source: www.acc.co.nz
DECLARATION

I certify that I have read this position description and reasonably believe that I understand the requirements of the position. I understand that:

a) this position description may be amended by the employer following reasonable notice to me

b) I may be asked to perform other duties as reasonably required by the employer in accordance with the conditions of the position.

Position holder’s name: ........................................................................................................

Position holder’s signature: .................................................................................................

Manager’s name: ..............................................................................................................

Manager’s signature: ........................................................................................................

Date of signing: .................................................................................................................

Prepared / reviewed: January 2017
SECTION B – DESCRIPTION OF CLINICAL ATTACHMENT – HOUSE OFFICER [PGY1 or PGY2], COMMUNITY PRACTICE [Northcare]

JOB TITLE: HOUSE OFFICER [PGY1 or PGY2]

DEPARTMENT: Community Practice

REPORTS TO: Clinic Director / Medical Director of the accredited Community Practice

Clinical Director, General Medicine (at Waikato DHB – when the PGY1 or PGY2 is working after hours duties in the DHB)

KEY RELATIONSHIPS WITH:

- Healthcare consumers
- Community Practice and specialist medical staff
- Community Practice nurse managers
- Waikato DHB clinical nurse managers - A3 and A4
- Community Practice Clinic Director
- Community Practice allied health care workers – clinical pharmacist, district nurses, social workers, school nurses, physiotherapists, Maori health care workers, etc
- Clinical administrators - for administrative matters
- Pre-vocational Education Supervisors of Training (formerly known as Intern supervisors)
- Clinical training Director (Waikato DHB)
- Business managers – Waikato DHB and PHCL

PRIMARY OBJECTIVE:

A three month clinical attachment in a community setting (as defined by the Medical Council of New Zealand (MCNZ))

The attachment offers one-to-one teaching from a clinical supervisor, regular facilitated tele-conferences with other trainees on the programme and hands on medical experience

The house officer manages patients within the community-based practice and (DHB) general medicine department commensurate with and appropriate to their skill level

CLINICAL ATTACHMENT: This clinical attachment is accredited by MCNZ
KEY TASK

PERFORMANCE STANDARD

CLINICAL DUTIES:

- House officers (HOs) work under delegated responsibilities to the supervising ‘on call’ consultant – The policy: “Senior Medical Officer (SMO) and Resident Medical Officers (RMOs) Responsibilities and the Limits of Delegation of Responsibilities to RMOs” [see Appendix 1] guides this relationship; and when working in the ‘community practice’, they work under the delegated responsibilities of the supervising clinician.

- The HO has responsibility for the day-to-day care of patients within the practice. The HO’s clinical responsibilities include the assessment of appointments scheduled for the day and participating in in-patient assessments when on duty after-hours at the main hospital. For both settings this includes: taking an appropriate history, performing a tailored physical examination, formulating a management plan, ordering appropriate investigations and initiating treatment or referral for specialist opinion / tertiary care in consultation with Community Practice clinicians and/or the registrar and consultant (when working duties in the DHB).

- When on duty after hours and covering the wards, the HO will respond to requests by nursing staff and other medical staff to assess and treat patients under the care of other Medical teams and specialties covered in the ‘after hours’ roster. If the workload means that a timely response is not possible, inform the Registrar and call for help. See the Escalation Plan in the orientation handbook.

- The HO will perform required procedures as directed by the Community Practice clinicians and/or registrar or consultant (when working duties at the DHB), including procedures in the Medical Day Care Unit.

- The HO should consult with the Community Practice clinicians and /or registrar or consultant on any non-routine matters or regarding procedures that are dangerous, complicated or beyond their experience or expertise. They will report any unexpected deterioration in a patient's condition or if a complication occurs.

ADMINISTRATION:

- The HO must review results each day and record these in the clinical record as required according to Community Practice / hospital requirements. The HO must be able to report to the Community Practice clinician and/or registrar and consultant.
the results of investigations and draw their attention to results of significance. When working duties at Waikato DHB, all results are acknowledged electronically - see the Electronic Acknowledgment section in the orientation handbook.

- The HO will liaise with other staff, departments and community practitioners in the management of their patients and co-ordinate patient care with the clinical nurse manager or the patient’s nurse. The HO will communicate with the patient and their family. It is essential that the patient and, if appropriate, their family are involved in decision making.

- Legible notes will be written in patient records as required by the community practice or, when at the DHB, in charts on admission, daily on weekdays and whenever management changes are made. A note will be made of all tests ordered. Documentation must meet the Community Practice and/or Health Waikato standards for clinical record content. A full history and detailed examination findings must be recorded. All entries must be signed and dated with the designation of the doctor noted. For the Waikato DHB standards, refer to the Clinical Records Management Policy.

- When working duties at Waikato DHB, patients will receive an electronic discharge summary on discharge, a prescription for any new drugs and a follow up appointment if needed. A letter can also be dictated for complicated cases. See the Discharge Documentation section in the orientation handbook. This is a team effort and the registrar may assist.

- Provide appropriate follow up care for community/primary care patients.

- The HO will arrange appointments with the administrative staff at the practice and prioritise appointments as per the practice’s triage arrangements. When working after hours at the DHB, one of the most important skills to develop is appropriate prioritisation of the workload. It is essential that the sickest patients have their management attended to first. The remaining workload needs to be arranged so that it best fits in with other hospital deadlines, organised in the most efficient way. Call for help if the workload becomes unmanageable.

**EDUCATION:**

HOs are required to attend those teaching sessions required by the MCNZ.

Unless rostered for acute admitting or required for a medical emergency, the HO shall be given the opportunity to attend:
House officer teaching programme:
Wednesday: 1330-1430hrs (at Waikato DHB)

Community Practice requirements may include but are not limited to the following:
The HO will see patients and receive one-to-one teaching and oversight from an approved GP supervisor.

The HO will participate in the following:
• Reviewing patients
• Attend a minimum of two hours teaching time per week
• ‘Corridor teaching’
• Direct observation by the clinical supervisor during consultations
• Have opportunities to observe the teacher consulting with patients
• Reviewing videotaped consultations (where available)
• Reviewing patient notes
• Conducting discussions with clinical supervisors
• Visits to other primary health practitioners

Learning activities in community practice attachments.
The HO will be given an introductory / orientation programme on commencing work at the community practice.

The community practice attachment will allow the HO to learn about continuing care of patients through patient consultations.

Patient numbers will be kept at a rate appropriate to the HO’s level of experience and to enable them sufficient time for reflection and alternative activities. This should depend on HO’s stage of experience and be negotiated with the clinical supervisor. Generally, as a rough guide, patient loads will normally be a minimum of five and maximum of eight patients in each consulting session (half day). The HO will be given 30 minutes per patient initially, with the time reducing as the HO gains more experience.

Practice-based teaching.

Teaching in the community practice will be centred on HO needs, as identified by the HO and clinical supervisor during the initial (and subsequent) supervision sessions and will include previous experience and readiness

Specific time (clinical supervision) should be set aside for discussion, observation, review and feedback. HO and supervisor should determine supervision arrangements at the start of the attachment. Supervision arrangements should also include HO access to the clinical supervisor in emergency / acute situations.
Teaching sessions can be held in a number of different ways:

- Review sessions in which the HO and clinical supervisor review the HO’s diary and patient records. The aim is to get both an overview and a brief appraisal of each consultation.
- Random record review in which patient records are chosen randomly from those seen on a particular day and discussed in some depth. This approach focuses on what can be learned from individual patient consultations.
- Problem-case analysis looks at the patients the HO has found to be a challenge or those cases recognised as having particular points of interest. Difficult consultations can be role-played.
- Direct observation with the HO sitting in with their clinical supervisor often happens in the early weeks of an attachment but is also valuable at regular intervals throughout the attachment.
- Sometimes a community supervisor and other practice staff members may call the HO to sit in on a particularly interesting case or with patients with conditions that they have not often seen.
- Direct observation with the community staff or allied health staff.
- Videotape review of consultations offers a less intrusive method of observation, with the added benefit of the HO being able to reflect on their performance in conjunction with their clinical supervisor.
- Topic discussion can be facilitated with reference to patients who present with the condition and through the usual journals and reference books on the subject.
- Trainee log (procedural skills).

The HO’s community supervisor will also be available for informal discussions or corridor teaching and be available to respond to on-the-spot queries and concerns.

Audit of a community practice topic.

- An audit topic will be developed in discussion with the clinical supervisor. Clinical Audit is a way to understand whether an area of work is following defined standards of best practice. An audit will answer “What standard does this service achieve?” Audits most often involve note review.
- Clinical audit is not research. “Research is concerned with discovering the right thing to do;
- Audit with ensuring that it is done right “(Smith R, 1992)
- Clinical Audit answers the question, “Are we following agreed best practice?”

Examples of clinical audit in community practice include:
- How many people with stable severe COPD who receive an antibiotic prescription to prevent or treat an acute exacerbation of COPD have been admitted to the hospital?
- How many people who are given IV antibiotics for cellulitis have completed a course of oral antibiotics?

**DAILY SCHEDULE:**

<table>
<thead>
<tr>
<th>MON</th>
<th>TUES</th>
<th>WED</th>
<th>THURS</th>
<th>FRI</th>
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</thead>
<tbody>
<tr>
<td>0830hrs Accompanying MDT nurses for home based assessments</td>
<td></td>
<td>1230-1330hrs Grand Round</td>
<td>1230-1330hrs Community Practice Supervision Meeting</td>
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<td>1330-1430hrs House Officer teaching (DHB)</td>
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**ASSESSMENT:**

FOR INTERNS WHO HAVE GRADUATED FROM A NEW ZEALAND MEDICAL SCHOOL OR NZREX DOCTORS

Interns must work in accredited clinical attachments under the supervision of a prevocational educational supervisor (PES). Prevocational medical training requires the Waikato DHB to deliver a 2-year intern training programme with specific requirements for postgraduate year 1 (PGY1 house officers) and postgraduate year 2 (PGY2 house officers).

The MCNZ introduced the ‘New Zealand Curriculum Framework’ (NZCF) in 2015 (https://www.mcnz.org.nz/news-and-publications/media-releases/new-zealand-curriculum-framework-for-prevocational-training-nzcf/) – this requires that the house officers record their learning, have their progress tracked, create and update their ‘Professional Development Plan’ (PDP), record ‘continued professional development’ (CPD) activities plus complete their assessments through an e-portfolio system known as ‘ePort’.

The NZCF outlines the learning outcomes – underpinned by the concepts of patient safety and personal development - to be substantively completed in PGY1 and by the end of PGY2. These learning outcomes are to be achieved through clinical attachments, educational programmes and individual learning.

Additionally, every intern is required to complete one clinical attachment in a community based setting over the course of their PGY1 and PGY2 intern years; therefore as a year one house officer you may be rotated into a community placement and this may require daily travel or a relocation for the duration of the clinical attachment; in such situations,
reimbursements can be claimed as per the relevant clauses in the RDA MECA.

Year two interns are required to establish an acceptable PDP for PGY2, to be completed during PGY2. The PDP will be reviewed and endorsed as appropriate by the advisory panel at the time they consider recommending registration in a general scope of practice.

When an intern is approved registration in a general scope of practice an endorsement related to completing a PDP will be included on their practising certificate for the PGY2 year, under the competence provision of the HPCAA.

At the end of PGY2, interns must demonstrate through the information in their ePort that they have met the prevocational training requirements and achieved their PDP goals. The prevocational educational supervisor will then recommend the intern’s endorsement be removed from their practising certificate as part of the practising certificate renewal process.

Year two house officers will meet with their educational supervisor at the beginning of the year and after each clinical attachment and will meet with their clinical supervisor on the clinical attachment at the beginning, mid-way through and at the end of the clinical attachment. It is important that the quarterly assessments are completed within two weeks of finishing a clinical attachment.

It is the individual house officer’s responsibility to meet all ‘ePort’ assessment deadlines and to have completed all documentation to allow both their clinical supervisor(s) and PES sufficient time to fulfil their assessment and reporting duties in the e-portfolio system.

**ROSTER - HOURS OF WORK:**

**Ordinary hours are:**

Monday to Friday 0800 to 1600hrs excluding public holidays – working at the Community Practice

**After Hours Roster (working duties at Waikato DHB):**

a) Monday to Friday 1600-2230hrs, covering AMU, acute medicine duties and medicine wards.

*(This is a 1:8 roster. The house officer may be rostered to work nine long days on the combined medical rosters over a 13 week period)*

b) Weekends (Saturday & Sunday):

‘Long’ weekend: 0800-2230hrs ‘on duty’ or

‘Short’ weekend: 0800-1600hrs, covering AMU, acute medicine duties and medicine ward

*(This is a 1:8 roster. The house officer may be rostered to*
work three weekends on the combined medical rosters over a 13 week period, two of which may be 'long' weekends and one a 'short' weekend)

c) Nights: N/A

**SALARY:**

a) Average Weekly Hours:

- Weekly Hours = 40.00 hours over 13 weeks
- Long Days = 4.50 hours over 13 weeks
- Weekend Hours = 5.69 hours over 13 weeks
- Nights = N/A

Total: = 50.19 hours over 13 week

**PAY CATEGORY D**

(50.19hrs) (UNROSTERED HOURS = 4.71hrs)

**LEAVE:**

Is the responsibility of the employer and cover will be provided internally in discussion with the clinical supervisor / practice manager by the staff working in the Community Practice. The HO must complete 10 weeks of employment in this clinical attachment, with a maximum annual leave allocation being initially set at two weeks. Any statutory holidays worked should be claimed for on a leave form so time may be credited to your leave entitlement.
APPENDIX 1

POLICY

Senior Medical Officer (SMO) and Resident Medical Officers (RMOs) Responsibilities and the Limits of Delegation of Responsibilities to RMOs

Policy Responsibilities and Authorisation

<table>
<thead>
<tr>
<th>Department Responsible for Policy</th>
<th>Clinical Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position Responsible for Policy</td>
<td>Chief Medical Officer</td>
</tr>
<tr>
<td>Document Owner Name</td>
<td>Dr Paul Reeve</td>
</tr>
<tr>
<td>Sponsor Title</td>
<td>Chief Medical Officer</td>
</tr>
<tr>
<td>Sponsor Name</td>
<td>Dr Tom Watson</td>
</tr>
<tr>
<td>Target Audience</td>
<td>SMOs and RMOs</td>
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<td>Authorised</td>
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Policy Review History

<table>
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<th>Version</th>
<th>Updated by</th>
<th>Date Updated</th>
<th>Summary of Changes</th>
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<tr>
<td>02</td>
<td>Dr Paul Reeve</td>
<td>27 July 2016</td>
<td>Combining SMO and RMO responsibilities and the limits of delegation of responsible to RMOs in one document (this now replaces 2172)</td>
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Doc ID: 2561 Version: 02 Issue Date: 27 July 2016 Review 26 July 2019

Document Owner: Dr Paul Reeve Department: Clinical Services

Prepared / reviewed: January 2017
Senior Medical Officer (SMO) and Resident Medical Officers (RMOs)
Responsibilities and the Limits of Delegation of Responsibilities to RMOs

Contents
1. Purpose and Scope
2. Principles of delegated responsibility
3. When RMOs must contact the responsible SMO regarding patients they see or admit
4. Involvement of SMOs in ward referrals
5. Complex cases requiring input from multiple specialties
6. Patients in the Emergency Department and Emergency Department referrals
7. Audit
8. Associated Documents

1. Purpose and Scope
This policy outlines the responsibilities that a Senior Medical Officer (SMO) has for their patients and for referrals and what responsibility can be delegated to Resident Medical Officers (RMOs).
This policy also outlines when and how the SMO is to be contacted regarding a patient for whom they are the responsible SMO and for patients referred to them or their service.
This policy is deemed to apply to all RMOs unless there are specific instructions to the contrary in the department they are working.

2. Principles of delegated responsibility
The SMO is ultimately responsible for all patients seen or admitted by their RMOs and the SMO remains accountable for the decisions and actions of their RMOs.
RMOs work under delegated responsibility and have a professional responsibility to remain within their area of competence and to seek assistance from their SMO when required.
The SMO must ensure they are kept reasonably informed regarding the condition of their patients and must ensure they, or another SMO, are always available to give assistance to their RMOs.
Some SMO responsibilities cannot be delegated to RMOs. These include:
- Reviewing all new patients within 24 hours of admission.
- Reviewing all inpatients at least twice a week.
- Reviewing all High Dependency Unit (HDU) patients on a daily basis (or more frequently if clinically required).
- Reviewing patients on day 1 post major or emergency surgery.
- Reviewing and acknowledging histology results.
- Obtaining consent if the RMO is not competent to obtain it.
- Discussing complex cases with the coroner.
- Writing coroner’s reports unless the coroner has specifically requested a report from a RMO.
- Open disclosure of serious adverse events.
- Review of patients when a SMO opinion has been requested by another SMO.
- Responsibility for complex cases requiring multi-speciality input (see Section 5).
- Clinical handover of patient care when the responsible SMO is on leave or at conference.
Senior Medical Officer (SMO) and Resident Medical Officers (RMOs) Responsibilities and the Limits of Delegation of Responsibilities to RMOs

3. RMOs must contact the responsible SMO regarding patients they see or admit in the following circumstances and SMOs must ensure that they are available to respond

- Any patient who is seriously ill or sufficiently ill to require admission to the Intensive Care Unit (ICU), or HDU, or the Low Stimulus Area (LSA) in Mental Health.
- Any patient who requires acute transfer to another service or hospital.
- Any acutely ill patient transferred to Waikato Hospital.
- Any patient for whom the diagnosis or management is unclear; and for whom a delay of management until the next ward round would be inappropriate.
- Any patient who deteriorates unexpectedly.
- Any acutely unwell or unstable patient who requires more than a brief stay in the Resuscitation area in the Emergency Department (ED).
- Before making the decision to take a patient to theatre or for an invasive procedure.
- If requested by the nurse in charge of the ward at the time, or a clinical resource nurse.
- If a patient has a complication following a procedure with which the RMO is unfamiliar.
- To discuss all new admissions, referrals or patients discharged from ED at the end of their duty.
- Any unexpected death.
- Any death that may need to be reported to the coroner, before it is reported.

It is expected that all inpatients are seen each weekday by a RMO, and that the responsible SMO informed of any significant change in the patient’s condition.

On the weekend and out of hours, the on-call SMO is responsible for all inpatients admitted under their speciality or seen by their on-call RMOs. Every patient should have a weekend plan documented in the notes, and the on-call SMO should be informed of any deviation from that plan.

4. Involvement of SMOs in ward referrals

A ward referral is defined in this policy as one clinical team asking another clinical team to assess a patient on a ward and contribute to their inpatient management.

While many phone calls between RMOs regarding inpatients under another team are simply asking for general advice and are not actually referrals, even when providing advice, the RMO is still acting under delegated authority and the SMO should be informed if appropriate.

A RMO of the team receiving the referral should see the patient in a timeframe consistent with the clinical urgency, and then discuss the matter with their supervising SMO.

The SMO should be informed of any opinion their RMO has given, and decide if that is appropriate. The SMO will decide if they need to see the patient themselves.

The SMO initiating the referral should always be informed of the outcomes of the referral. Any urgent action that is required must be communicated verbally to the referring SMO/team.

Only a SMO can make a decision that a ward referral requested by a SMO is inappropriate. In this situation, the SMO of the team receiving the referral request should provide advice to the referring team; this could include an offer of an outpatient clinic appointment or other recommendation.

A direct SMO to SMO discussion is the best way to address any issues or in difficult cases.

The following must always be documented in the clinical notes by the referring team:
Senior Medical Officer (SMO) and Resident Medical Officers (RMOs)
Responsibilities and the Limits of Delegation of Responsibilities to RMOs

- the name of the SMO making the referral
- the expectations that the referring SMO/team have of the SMO/team referred to,
- a summary of the clinical details, and
- the contact details of the referring doctor.

The team who respond must clearly document their opinion and answer any specific questions.

Any urgent action that is required must be communicated verbally to the referring SMO or team.

Disagreements between SMOs must be escalated immediately to their Clinical Directors (CD) and, if necessary, the Clinical Unit Leader (CUL), Service Head or Chief Medical Advisor (CMA).

5. Complex cases requiring input from multiple specialities

- Early SMO to SMO communication should be established to delineate the responsibilities and expectations of the different services involved in patient care. This cannot be delegated to RMOs.
- For ICU cases, the responsible ICU SMO will coordinate care.
- While a patient is in the ED Resuscitation, the ED SMO will coordinate care until there is an agreed designated team who will take primary responsibility. This should be agreed in a timely way.
- For trauma cases, the Trauma Director will coordinate care (see the Trauma Protocol).
- In non-trauma cases, it must be agreed which SMO and team will take primary responsibility and for what. The responsibilities of the other services should be agreed and understood.
- The SMO with the primary responsibility may change over time but must always be clear.
- If there is any disagreement over the most appropriate service and SMO to take primary responsibility, there should be a SMO to SMO discussion, if necessary escalated as noted above.
- For patients in the HDU, the SMO identified as the primary SMO responsible for the patient’s care is responsible for coordinating all care provided to that patient.
- The SMO primarily responsible for patient care should be documented in the patient’s clinical notes. This SMO is also responsible for coordinating all care provided to that patient.

6. Patients in the Emergency Department and Emergency Department referrals

Refer to the Speciality Referral Guidelines which outlines the responsibilities of RMOs referred patients by the ED and the need to immediately escalate issues to their SMO to deal with at the SMO to SMO level and if needed at a CD to CD, or CUL to CUL level or to the CMA.

7. Audit Indicators

Compliance with this Policy will be monitored by incident reporting and mortality reviews.

8. Associated Documents

Waikato DHB Specialty Referral Guidelines (5295)
Waikato DHB Trauma Protocol (1538)
Waikato DHB Electronic Results Acknowledgement: The responsibility of the Senior Medical Officer and the delegation of the responsibility to Resident Medical Officer (1452)
Waikato DHB Clinical Records Management (0182)
Waikato DHB Deceased (Care of) policy (0133)
Waikato DHB Admission, Discharge and Transfer (1848)

Resuscitation Policy

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APPENDIX 2

COMMUNITY PLACEMENT CHECKLIST

(Pre-attachment Checklist to be Completed by House Officer and counter-signed by Waikato DHB)

This checklist needs to be received by your community based attachment host one month prior to attachment commencing.

Please remember evidence may need to be produced for Contractor to view on request

You need to answer yes to all of the statements prior to commencing your community based attachment (please circle):

1. I hold a current annual practicing certificate issued by MCNZ Yes/No
2. Date of Expiry of Current APC…………………………
3. I hold appropriate indemnity insurance Yes/No
4. Date of expiry of current indemnity insurance…………………………
5. I have undergone an official police check since commencing my employment at Waikato DHB Yes/No
6. I have been allocated this attachment via the RMO unit Yes/No
7. I comply with Waikato DHB and community site vaccination / Immunisation standards (Health + Safety) Yes/No
8. I have completed Waikato DHB provided privacy training Yes/No
9. I have completed Waikato DHB provided cultural training Yes/No
10. I have completed the ‘Conflict of Interest’ declaration and sent a copy to the RMO Unit and to the Contractor Yes/No
11. I have provided my community based attachment with a copy of position description Yes/No

Signed: (House Officer) .................................................................

Full name: (House Officer).................................................................

Signed:  
Waikato DHB (Clinical Director, Primary and Integrated Care)  

.................................................................

Date:  .................................

Prepared / reviewed: January 2017
APPENDIX 3

Documents relating to supervision reports and career planning

House Officer
Supervisor Report - C