**Waikato District Health Board**

**Position Description**

This position description will be used in conjunction with Section B

<table>
<thead>
<tr>
<th>Job Title:</th>
<th>House Officer – Maxillo-Facial and Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reports to:</td>
<td>Clinical Director of Maxillo-Facial and Clinical Director of Dental</td>
</tr>
<tr>
<td>Clinical supervision by:</td>
<td>Clinical Supervisor or Pre-Vocational Education Supervisor (PES) as appropriate</td>
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<tr>
<td>Professional links to:</td>
<td>Director of Clinical Training</td>
</tr>
<tr>
<td>Delegation:</td>
<td>Nil</td>
</tr>
<tr>
<td>Responsible for:</td>
<td>Nil</td>
</tr>
<tr>
<td>(Total number of staff)</td>
<td>Nil</td>
</tr>
<tr>
<td>Budget:</td>
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<tr>
<td>Job Purpose:</td>
<td>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</td>
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<tr>
<td>Direct Reports:</td>
<td>Nil</td>
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<td>Date:</td>
<td>April 2017 v3</td>
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**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

Prepared / Reviewed: April 2017
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 and maintaining safe practice is a condition of registration for all new dentists in New Zealand
  - Professional responsibility
  - Scopes of practice
  - Practice standards
  - Recertification
  - Competence, Conduct & Health

**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 Dental Practitioner with the Dental Council of New Zealand (DCNZ)
- 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 engages 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)

Prepared / Reviewed: April 2017
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

Prepared / Reviewed: April 2017
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: ...........................................................................
SECTION B – DESCRIPTION OF CLINICAL ATTACHMENT – HOUSE OFFICER, DENTAL (2) / MAXILLO FACIAL (1) (rotating positions: two year 1 house officers and one year two house officer)

JOB TITLE: HOUSE OFFICER

DEPARTMENT: Maxillo-Facial and Dental

REPORTS TO: Clinical Director, Maxillo-Facial Surgery and Clinical Director of Dental

KEY RELATIONSHIPS WITH:

- Healthcare consumers
- Specialist medical staff and clinical unit leader for clinical and professional matters
- Unit manager
- Hospital and community health care workers
- Clinical unit administrators - for administrative matters
- Prevocational Education Supervisor
- Clinical Training Director
- RMO Unit staff

PRIMARY OBJECTIVE: The house officer / SHO manages patients within surgery, commensurate with and appropriate to their skill level

CLINICAL ATTACHMENT: Recognised as a Category “B” clinical attachment by the Medical Council of New Zealand (MCNZ)

[PLEASE NOTE: this categorisation refers to the level of supervision provided to the registrar- this is NOT the pay category for this clinical attachment]

RECOGNITION: Two or three positions are designated as a year one clinical attachment with the opportunity to apply to the third and/or fourth position as a second year house officer.

KEY TASK: PERFORMANCE STANDARD

CLINICAL DUTIES: Assess patients who are referred to the speciality for admission including:

- Taking a history, performing an appropriate physical examination and formulating a management plan in consultation with the registrar and/or consultant
- That the patients admissions and discharges, investigatory procedures, changes in treatment and all similar matters are completed with the assistance of the Plastics HO or ‘on call’ HO for sub speciality were required for medical matters.
- House officers 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

Prepared / Reviewed: April 2017
of Responsibilities to RMOs” [see Appendix 1] guides this relationship.

- Assess assigned patients on a daily basis (Monday to Friday).
- Implement treatment plans of assigned patients, including ordering of appropriate investigations and acknowledging results under supervision of registrar, and acting upon abnormal results in a timely fashion.
- Perform required procedures under the supervision of the registrar or consultant.
- Liaise with other staff members, departments and general practitioners in the further management of assigned patients.
- Attend consultations from other medical/surgical specialties in response to referrals after hours (when on duty) under the supervision of the registrar on duty.
- Communicate with patients and their families (when appropriate) about patient’s illness and treatment
- When on duty after hours, respond to requests by nursing staff and other medical staff to assess and treat patients under the care of other surgical specialties or in the Emergency Department covered in our “after hours” roster.
- Review the status and treatment of patients located in Ward 7, ICU, HDU and other wards, at least once a day and provide a verbal report to the surgeon of the day on the post-operative status of the patients.
- Be available for discussion on possible admissions with the referring doctor by telephone and ensure that admission or some other mutually satisfactory arrangement is agreed. Liaise with the registrar or consultant admitting for the day
- Participate in the Maxillofacial unit ‘out of hour’s’ duty roster and provide on-going clinical management of patients within the unit.

EDUCATION:

Unless rostered for acute admitting or required for a medical emergency, the house officer shall be given the opportunity to attend:

- Grand Round and teaching session each Thursday from 1230 - 1330 hours
- Journal Club meetings.
- Weekly Maxillofacial tutorials.
- Audit meetings
- Weekly Head and Neck oncology meeting Thursday 0800 – 0930hrs.
- Other teaching sessions arranged according to accredited Trainee requirements

House officers are required to attend those teaching sessions required by the DCNZ

ADMINISTRATION:

Legible notes must be written in the patient’s clinical records on admission, daily on weekdays and whenever management and treatment changes occur.

Re-charting of drug charts for weekends.

Appropriate laboratory tests will be requested and results
A discharge summary must be completed on iSOFT, with a copy given to the patient at discharge and copies sent to their general practitioner and other medical practitioners (as requested by the admitting team).

See ‘Appendix 2’ for a detailed list of ‘Surgical House Officer roles and responsibilities’

Enter data onto the ‘Audit.Database’ daily and present printout to consultants as scheduled at the Wednesday morning teaching sessions.

HEALTH & PROMOTION FUNCTIONS:

Maintain good personal physical and mental health and promote oral health and the activities of the department throughout the hospital.

RESEARCH & REVIEW ACTIVITIES:

Attend and present a paper at the NZ Hospital Dental Surgeon's Association annual meeting. Undertake research and review activities as requested by the Consultant(s).

It is a requirement by the DCNZ for Registered Dentists to maintain their competence by participating in a recognised CPD program. This is provided for in the regular scheduled teaching sessions as well as other activities.

It is also recommended that new graduate Dentists participate in their local Graduate Professional Development Program (GPDP).

The Health Workforce New Zealand (HWNZ) and the Resident Doctor’s Association (RDA) have worked together to produce career planning forms (CPDF) and Vocational Career Design guidelines. A supervision report form is required to be completed at the end of each clinical attachment:


Waikato DHB has developed a document to help the registrar determine their career plans and options:


It is the individual house officer’s responsibility to maintain and complete these assessment and reporting requirements in a timely manner.
DAILY WORK SCHEDULE (variable depending on whether on Dental or Maxillofacial runs)

<table>
<thead>
<tr>
<th>RUN</th>
<th>TIME</th>
<th>MON</th>
<th>TUES</th>
<th>WED</th>
<th>THURS</th>
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</tr>
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ROSTER - HOURS OF WORK.

Ordinary hours are:
Monday to Friday 0730 – 1630hrs excluding public holidays.

After hours:

a] 1630 – 0800hrs ‘on call’
b] This is a 1:4 roster

SALARY:

a) A ‘call-back’ / ‘additional duties’ sheet is to be completed for all times worked outside rostered hours.

b) **Average Weekly Hours:**
   - Weekly Hours = 45.00 hours over 13 weeks
   - Long Days = ‘on call’ roster
   - Weekend Hours = ‘on call’ roster
   - Nights = ‘on call’ roster
   - **Total:** = 45.00 hours over 13 weeks

c) $4.00 per hour paid when rostered ‘on call’

**PAY CATEGORY E**

(45hrs) (UNROSTERED HOURS = 4.9hrs)

LEAVE:

Is the responsibility of the employer to cover leave. Any statutory holidays worked should be claimed for on a leave form so time may be credited to your leave entitlement.

**COVER FOR LEAVE:**

a] Sick leave by other Dental / Maxillofacial House Officers.
b] Annual leave by other Dental /Maxillofacial House Officers.

INFORMATION ABOUT THE SPECIALTY / SUB-SPECIALTY REQUIREMENTS OF THIS RUN AVAILABLE FROM:
MAXILLO-FACIAL AND DENTAL UNIT - (07) 839 8805.

Prepared / Reviewed: April 2017
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>
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<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>
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<tr>
<td>Sponsor Name</td>
<td>Dr Tom Watson</td>
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<td>Target Audience</td>
<td>SMOs and RMOs</td>
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<td>Policy Committee</td>
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<tr>
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<td>Board of Clinical Governance</td>
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<tr>
<td>Authorised</td>
<td>Chief Executive</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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</table>


Prepared / Reviewed: April 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 specialities
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:

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<th>Doc ID:</th>
<th>Version:</th>
<th>Issue Date:</th>
<th>Review Date:</th>
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<tr>
<td>2561</td>
<td>02</td>
<td>27 July 2016</td>
<td>26 July 2019</td>
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Document Owner: Dr Paul Reeve
Department: Clinical Services
Prepared / Reviewed: April 2017
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

Doc ID: 2561  Version: 02  Issue Date: 27 July 2016  Review 26 July 2019
Document Owner: Dr Paul Reeve  Department: Clinical Services

Prepared / Reviewed: April 2017
APPENDIX 2

SURGICAL HOUSE OFFICER – ROLES AND RESPONSIBILITIES

Administration

- Escalate any roster / MECA compliance issues to RMO Unit a.s.a.p.
- Submit claims for additional duties/call-backs/cross-cover by the end of the next pay cycle – claim forms submitted beyond this timeframe will still be processed, but will require patient labels for verification and they will take longer to process
- Give at least 6 weeks notice of leave requests wherever possible

General Expectations

- Regular hours are 07:30 – 16:00 Monday to Friday (07:30 – 17:00 for Vascular & Cardiothoracic Surgery). Out-of-hours on-duty and on-call commitments are as per your position description & roster
- Be available and contactable during rostered hours
- Respond promptly and politely to all pager requests
- If calling in sick, notify the Duty Manager within an appropriate timeframe as defined by the RMO MECA
- Recognise personal limitations and escalate issues to your Registrar or Consultant as required (see WDHB Policy 2172 – When to call your SMO) – i.e. work within your scope of practice/experience
- If you have a light workload, it is expected that you will offer assistance to other House Surgeons who may have a heavy workload
- Attend regular, formal teaching sessions organised by the Clinical Education & Training Unit (PGY-1s – Tuesdays 13:30-14:30; PGY-2s & SHOs – Wednesdays 13:30-14:30)
- Attend out-patient clinics as directed by supervising consultant & as set out in your position description
- Review the history of patients on elective operating lists the day before surgery (or on Friday if the list is on Monday) and discuss patients with the anaesthetist for the list – if patients are coming through DOSA, notes can be reviewed in DOSA from 14:00 on the day before surgery (or on Friday for Monday lists). Where possible, regular meds + post-operative analgesia / anti-emetics should be charted at the same time

Ward Rounds

- Have all patient notes collected and ready to go on ward round by 07:30
- Have an up-to-date and accurate list of all patients under your care by 07:30 (providing patient name, NHI, locations, date of admission and provisional / confirmed diagnosis)
• Have an up-to-date list of blood test results and imaging / investigation reports ready for the ward round by 07:30
• Have investigation request / referral / consent forms ready on all notes trolleys ready for the ward round by 07:30
• Daily ward rounds must be documented in the clinical notes – minimum information includes the date, time (as per 24-hour clock), name and role of most senior clinician on the ward round, plan of action and legible name/contact details of the author
• Routine observations should also be documented (i.e. temperature, heart rate, blood pressure, respiratory rate and oxygen saturation + others as appropriate) in the record of the daily ward round
• Confirm an estimated date of discharge for **ALL** patients (both acute and elective) within 24 hours of admission and communicate this to the CNM
• Raise the question to revise the estimated date of discharge daily on the ward round and communicate changes to the CNM or nursing staff concerned
• Communicate treatment plans to CNM or nursing staff – don’t rely on nursing staff having time to read the notes to know what is going on
• Catch-up with your Registrar / Consultant in the afternoon for a paper ward round / phone conversation to review patients & any outstanding results / investigations / interventions

**Investigations and Results**

• Once a treatment plan / decision has been made, request / refer for investigations / interventions / consultations within an appropriate timeframe
• Review, action, escalate and acknowledge all blood test results and investigation reports daily
• Put out blood test request forms for collection by phlebotomists the night before wherever possible

**Discharges**

• Maintain draft discharge summaries on all patients which may be updated daily wherever possible (+: they can be finalised quickly when a patient is cleared for discharge – they can also be printed off as Weekend Plans)
• Complete discharge summaries (and prescriptions +/- medical certificates) prior to the patient leaving hospital wherever possible (they need to be sent to primary care within 24 hours of discharge at the latest)
• Aim for all patients to be discharged or transferred to the Transit Lounge by 11:00 am once medically cleared for discharge.
• Provide follow-up advice for every patient being discharged (even if it is only “See your GP if you have any problems”)
• Communicate any issues to be followed up after discharge to primary care (e.g. GP, Practice Nurse, District Nurse) or other relevant services

Prepared / Reviewed: April 2017
Handover & Weekends

- At the end of any shift, handover to the incoming House Surgeon – this should include any patients in HDU/ICU, any unstable patients, any expected patients or those needing admission from ED or Theatre / DOSA.
- Re-chart any drug charts due to expire over a weekend by **16:00 on Friday**
- Document a weekend plan in the clinical notes by **16:00 on Friday** for each patient who will be in hospital for any part of the weekend
- Provide an up-to-date list of patients and handover sheet for the weekend House Surgeon detailing any action that needs to be taken – further information may be included in the Weekend Plan in the clinical notes
- Prepare a discharge summary and prescription for any patient who may be discharged over a weekend and hand this over to weekend House Surgeon
- The primary role of the Extra Weekend House Surgeon is to see patients in ED for General Surgery, Urology or any of the Sub-Specialties (not including Orthopaedic Surgery). If you are not busy in ED (which is often the case before midday at weekends) you are expected to liaise with the ward-based House Surgeons and offer assistance as required. For example, this may take the form of completing tasks at the request of the ward-based House Surgeon or holding and responding to their pager while they are on a ward round and performing tasks as they occur, until you hand the pager back – make sure you also handover any unstable patients or outstanding tasks

Prepared / Reviewed: April 2017
APPENDIX 3

‘End of Clinical Attachment’ assessment form

House Officer
Supervisor Report - C