Waikato District Health Board
Position Description

This position description will be used in conjunction with Section B

| Job Title: | House Officer – O+G [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.

Prepared / Reviewed: January 2017
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)
Health leadership capabilities and competencies – staff, no delegation. Waikato DHB values are included as a drop down with competency (22)

Leading change (national leadership framework mobilise system improvements)

- 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: ...............................................................
SECTION B – DESCRIPTION OF CLINICAL ATTACHMENT – HOUSE OFFICER, OBSTETRICS & GYNAECOLOGY

JOB TITLE: HOUSE OFFICER

DEPARTMENT: Obstetrics and Gynaecology

REPORTS TO: Clinical Director, Obstetrics and Gynaecology

KEY RELATIONSHIPS WITH:

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

PRIMARY OBJECTIVE: To manage patients within the obstetrics and gynaecology service, commensurate with and appropriate to their skill level.

CLINICAL ATTACHMENT: Recognised as a Category “C” run 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: * Approved for the Diploma of Obstetrics (Auckland and Otago)

KEY TASK PERFORMANCE STANDARD

CLINICAL DUTIES

- Be responsible to the admitting consultant (where appropriate) for the supervision of admissions and discharges, investigatory procedures, changes in treatment and all similar matters.
- House officers work under delegated clinical 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.
- Assess assigned patients on a daily basis (Monday-Friday).
- Attend scheduled ward rounds and review the status and treatment of patients.
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 registrars or consultant.

Communicate with patients and their families (when appropriate) about patient’s illness and treatment.

Ensure clear communication with nursing staff for changes or updates in medical orders.

Foster a team environment with other medical and nursing staff.

Attend outpatient clinics, theatre, clinics where scheduled and rostered as directed.

Appropriate laboratory tests will be requested and results sighted and signed.

Participate in the obstetrics and gynaecology after hour’s roster and provide ongoing clinical management of patients within the unit.

(For a more detailed description of clinical duties, run expectations and learning outcomes please refer to ‘Appendix 2’)

**EDUCATION:**

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

- Participate in multi-disciplinary teaching sessions as appropriate eg: nurses, technicians.
  - **Grand Round** and teaching session each Thursday from 1230 - 1330hrs.
  - MDM (Pathology), Tuesday 1330 – 1400hrs
  - Registrar led SHO / house officer teaching, Wednesday 1230 – 1300hrs
  - House Officer teaching programme: Wednesday 1330-1430hrs
  - O+G unit meeting, Thursday 0830 - 0930hrs
  - Registrar teaching, Thursday 0930 - 1030hrs
  - Perinatal mortality meeting, last Thursday of month 0830 – 0930hrs

**ADMINISTRATION:**

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).

Assist with the quality improvement programme and make known concerns about any areas of practise.

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

Appropriate laboratory tests will be requested and results sighted and acknowledged electronically.

**WEEKLY SCHEDULES:**

To be finalised
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 substantially 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

FOR INTERNATIONAL MEDICAL GRADUATES AND ALL SENIOR HOUSE OFFICERS
The house officer is to meet with their clinical supervisor at start of the clinical attachment to identify goals and discuss responsibilities.

Performance is assessed by the designated clinical supervisor the house officer is working for and in accordance with the MCNZ’s supervision and reporting requirements

All house officers who are registered under the general scope of practice and who are not on a vocational training programme will be required to join the “bpacNZ” Recertification Programme at recertification time [when their Practising Certificate is due for renewal]; through this programme they will be required to complete:
- a Professional Development Plan (it is understood that a ‘Career Development Plan’ would fulfill the same function)
- 20 hours of medical education
- 10 hours of peer review
- Participate in clinical audit
- The required number of meetings with the nominated collegial relationship provider (six in the first year and four in subsequent years)

Please note that if any deficiencies are identified during the clinical attachment, the clinical supervisor, and where appropriate, along with the house officer’s assigned PES, will discuss these with the house officer at the time (preferably no later than two thirds of the way through the clinical attachment), and make a plan to correct or improve performance.

The Health Workforce New Zealand (HWNZ) and the Resident Doctor’s’ Association (RDA) have worked together to produce career planning forms (CDPF) 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.

ROSTER - HOURS OF WORK:

Ordinary hours are:

Monday to Friday 0800 to 1600hrs excluding public holidays.

After Hours Roster:
a) Monday to Friday: 1600 to 2230hrs ‘on duty’.

Prepared / Reviewed: January 2017
(This is a 1:7 roster for ‘long days’ Each house officer may be rostered to work 5 long days in a 7 week period.

b) Saturday/Sunday/Public Holidays: 0800 to 2130hrs ‘on duty’.
   (This is a 1:7 roster for weekends – Each house officer may be rostered to work one weekend in a 7 week period)

c) Nights: Monday to Friday: 2200 – 0830hrs.
   Saturday + Sunday: 2100 – 0830hrs
   (This is a 1:7 roster for nights. The house officers will be rostered to work one sets of nights in a 7 week period, with the roster template splitting the nights into a 4/3 pattern)

d) This run has an allocated reliever position. The reliever is required to report for duty every day and is required to cover sick leave and other planned leave (annual, study and exam leave) when requested.

**SALARY:**

a) If ‘additional duties’ are worked, then these must be claimed using the appropriate DHB claim form. Please note, this clinical attachment has no ‘on call’ / ‘call back’ duties

b) **Average Weekly Hours:**

   - Weekly Hours = 40.00 hours over 7 weeks
   - Long Days = 4.64 hours over 7 weeks
   - Weekend Hours = 3.85 hours over 7 weeks
   - Nights = 10.78 hours over 7 weeks
   - Total: = 59.27 hours over 7 weeks

   (The O+G roster requires a house officer to work in a reliever role – this position may be filled by one house officer for the entire run or may be shared amongst a number of house officers. The registrar working in the reliever role is to be paid two categories above the run category, in accordance with the NZRDA DHB MECA. In this instance the reliever would be paid at:

   **Category A**

   The reliever is required to report for duty each day and is required to cover sick leave and planned annual leave. The reliever may be rostered to work long days, nights and weekends)

**PAY CATEGORY C**

(59.27hrs)  (UNROSTERED HOURS = 0.63hrs)

**LEAVE:**

Cover for leave is the responsibility of the employer and is provided by relievers and locums. 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>
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<tbody>
<tr>
<td>Position Responsible for Policy</td>
<td>Chief Medical Officer</td>
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<tr>
<td>Document Owner Name</td>
<td>Dr Paul Reeve</td>
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<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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<tr>
<td>Target Audience</td>
<td>SMOs and RMOs</td>
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<td>Board of Clinical Governance</td>
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<td>Authorised</td>
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Policy Review History

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<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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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

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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 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: 2561</th>
<th>Version: 02</th>
<th>Issue Date: 27 July 2016</th>
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<td>Document Owner: Dr Paul Reeve</td>
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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 responsibly 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

RUN EXPECTATIONS and LEARNING OUTCOMES

Team responsibilities (House Officer will be assigned to a “colour” team for the run)

- Handover in WAU at 0800hr
- Attend ward-round of team’s patients on wards 51, 54 and 55 (+/- outliers) with registrar after handover
- Provide medical cover for team inpatients
  - Organise relevant investigations and ensure results are followed up and acted upon as required in a timely manner
  - Waikato hospital and women’s health’s clinical protocols and guidelines are to be followed where these are available, unless the named consultant indicates that it is appropriate to deviate from the protocol
    - Where protocols seem inappropriate for an individual patient then the opinion of the named or ‘on call’ consultant should be sought
  - The House Officers are required to work collaboratively with nursing and midwifery teams
  - A daily medical review of all team post-natal patients (including all caesarean section cases) is required until the day of discharge or transfer to the lead maternity carer (LMC)
  - All patients are to have a daily documented clinical assessment and plan including:
    - History / update
    - Examination / observations summary
    - Investigations / results
    - ‘Action Plan’ (documentation should include an indication of which registrar has confirmed the plan)
  - Unexpected and important changes in patient status are to be reported to the registrar promptly
    - The registrar will notify the named or on call consultant in a timely fashion
- All patients are to have a documented discharge plan and prescription as required, and this is to be completed prior to the time of their discharge
- LMCs must be communicated with directly when an ante-natal or post-natal patient is being discharged - this is the shared responsibility of medical officers and midwives
- In the anticipated event of a patient being discharged after hours, all paperwork will be completed prior to the end of the House Officer duty
- Complete electronic discharge summaries for all gynaecology admissions
- Check, action and sign team laboratory results in wards 51, 54 and 55
- House officers should not plan / change treatment or discharge an ante-natal patient without prior consultation with an O&G registrar or consultant

Documentation and correspondence

- Each House Officer is responsible to fully document patient care according to the Health Waikato policy for ‘Clinical Records Management’
- Prior to the end of every shift:
  - Complete all documentation
  - Have all drug and IV fluid charts up-to-date
  - Handover to ‘on-duty’ registrar and House Officer all patients whose condition requires monitoring or review
  - Update handover list in WAU
In addition to these responsibilities, each House Officer is rostered to daily duties which rotate each week. It is anticipated that the ward-round and essential jobs will be completed by 0930hrs before attending to the daily duties.
(NB: Please note that the workload for each daily duty will vary and it is expected that all House Officer will help each other at busy times)

Run Expectations:

Delivery Suite House Officer
- Attend Delivery Suite ward-round with registrar and consultant
- Work with registrar and midwifery staff to provide care for labouring women and high acuity obstetric inpatients
- Provide assistance at obstetric procedures (e.g. Caesarean section, instrumental delivery, vaginal repair)
- Assist WAU staff when WAU is busy

Clinic House Officer
- Attend ante-natal, gynaecology and colposcopy clinics with registrars and consultants as rostered
- May be requested to provide assistance to gynaecology pre-admission nurse when needed

Acute Gynae House Officer
- Under supervision of the acute gynaecology registrar: assess, admit and provide treatment for acute gynaecology patients via the emergency department
- Assist the acute gynaecology registrar in EPAC (early pregnancy assessment clinic)
- Assist the acute gynaecology registrar in theatre

Theatre House Officer
- Attend and assist elective theatre lists
- Ensure investigations are completed for the following day’s theatre list and liaise with the anaesthetist regarding the next day’s patients by 1600hrs

WAU (Women’s assessment unit) House Officer
- Under supervision of the WAU registrar: assess, admit and provide treatment for acute obstetric and booked clinic patients
- Pre-admit patients for elective caesarean section
- Check, action and sign laboratory results in WAU

Reliever House Officer
- Provide cover for House Officer on leave as per roster during day and after hours
- When not rostered to cover leave, cover team whose House Officer is rostered on nights and assist other House Officers as needed and as directed by registrars, the clinical director or unit manager

Out Of Hours Duties
- Provide medical cover for ward 51,54 and 55 inpatients (+/- outliers)
- Under supervision of the ‘on-duty’ registrar assess, admit and provide treatment for acute obstetric and gynaecologic patients via women’s assessment unit, delivery suite and the emergency department
- Assist in theatre and delivery suite as required
TERMINATION OF PREGNANCY

- It is part of the work of the O&G unit to provide a service for termination of pregnancy
- Junior doctors are not involved in the legal certification, or the surgical procedures of termination unless they choose to do so
  - However, there are medical tasks required for junior doctors such as clerking patients in, arranging pre-medication, contraceptive advice and Anti D protection
  - This is regarded as part of a doctor’s duty, regardless of their feelings and/or views about abortion
  - On occasions there have been doctors who for conscience reasons feel they cannot clerk these patients and, in that situation, the doctor concerned must arrange for one of their colleagues to swap duties with them
- We respect the rights of doctors who object to termination of pregnancy on grounds of conscience, morality or religion
- A doctor regardless of their moral or religious feelings must attend, during or following a termination, a medical emergency such as bleeding
  - This is a basic requirement and part of the duty and functions of a doctor.
- Doctors who have difficulties with this policy must discuss the issues with the clinical unit leader and manager, Child & Women’s Health.

LEARNING OUTCOMES

At the end of this rotation it is expected that the House Officer will gain a high level of knowledge / competence in:

- Eliciting a full gynaecological and sexual history
- Performing a full gynaecological examination
- Management of the following:
  - early pregnancy complications
  - hyperemesis gravidarum
  - acute / chronic pelvic pain
  - pelvic inflammatory disease
  - heavy menstrual bleeding
  - pre-eclampsia
  - threatened preterm labour
  - premature rupture of membranes
  - ante-partum haemorrhage
  - post-partum haemorrhage
- Communication skills in the following:
  - breaking bad news (e.g. miscarriage)
  - managing patient anxiety (e.g. fetal welfare assessment)
  - providing information on treatment options (e.g. early pregnancy failure)
  - the informed consent process
  - providing good discharge information
- Working well in a multi-professional environment
- Basic interpretation of a CTG
- Performing ultrasound assessment of presentation and amniotic fluid volume

In addition to the above it is recognised that each House Officer will have their own personal goals – run expectations and learning outcomes); these may include (but are not limited to):

- Manage normal labour and delivery
- Manage induction of labour
- Perform Elective Caesarean Section
- Perform instrumental delivery
- Perform repair of episiotomy/vaginal tear
- Basic surgical skills
- Perform Evacuation of retained productions of conception
- Insert intrauterine contraceptive devices
- Perform Pipelle endometrial sampling
- First trimester ultrasound
APPENDIX 3

‘End of Clinical Attachment’ assessment form

House Officer
Supervisor Report - C

Prepared / Reviewed: January 2017