Waikato District Health Board

Position Description

This position description will be used in conjunction with Section B

| Job Title: | House Officer – Community Based Attachment – Victoria A+M [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: | Nil |
| (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 Ngakauunui

- 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: January 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 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

Prepared / reviewed: January 2017
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: ________________________________________________

Prepared / reviewed: January 2017
SECTION B – RUN DESCRIPTION – HOUSE OFFICER [PGY1 or PGY2], COMMUNITY PLACEMENT (General Practice with A&M Centre)

JOB TITLE: HOUSE OFFICER [PGY1 or PGY2]

DEPARTMENT: Community Placement – General Practice with Accident and Medical Centre

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

KEY RELATIONSHIPS WITH:

- Healthcare consumers
- Community Placement and specialist medical staff
- Community Placement nurse managers
- Community Placement Clinic Director
- Community Placement 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 at Waikato DHB
- Director of Clinical Training (Waikato DHB)
- Designated Community Placement Manager
- RMO Unit staff (Waikato DHB)

PRIMARY OBJECTIVE: A three-month (13-week) clinical attachment in a community setting as defined by the Medical Council of New Zealand (MCNZ)

The attachment offers individual clinical supervision with a clinical supervisor and practical medical experience in a primary care setting.

The house officer manages and treats patients within the community placement commensurate with and appropriate to their skill level and under the clinical supervision on a nominated clinical supervisor and a Prevocational Educational Supervisor of the Waikato DHB.

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

CLINICAL DUTIES:

- House officers (HOs) work under delegated responsibilities to the clinical supervisor.

- The HO has responsibility for the day-to-day care of patients within the community placement. The HO’s clinical responsibilities include the assessment of cases scheduled for the day and 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, where required, in consultation with clinical supervisors.

- The HO will perform required procedures under the supervision of the clinical supervisor or appointed delegate within the community placement.

- The HO should consult with the clinical supervisor or appointed delegate within the community placement on any non-routine matters or regarding procedures that are risky, complicated or beyond their experience or expertise. They will stabilise the patient as much as possible and call for immediate assistance when experiencing any unexpected deterioration in a patient’s condition or if a complication occurs.

ADMINISTRATION:

- The HO must review investigation results each day and acknowledge these according to Community Placement requirements. The HO must be able to report to the Clinical Supervisor and/or appointed delegate the results of investigations and must draw their attention to results of significance (i.e. outside the normal range).

- The HO will liaise and coordinate patient care with other staff, organisations, or hospital departments and community practitioners. The HO will communicate with the patient and, where appropriate, their family in important matters of clinical decision making.

- The patient’s consultation entries must be completed as required by the community placement. A note will be made of any laboratory or other tests ordered. Clinical record content must meet the Community Placement standards. A full history and tailored examination findings must accompany clinical entries. Telephone calls received regarding patient care and other administrative matters must be recorded in the clinical records as required by the practice standards. All entries (clinical or administrative)
must be signed and dated with the designation of the doctor noted.

- The HO must provide appropriate follow up care for community / primary care patients taking into account the urgency from medical perspective and also taking into account patient / family needs.

- The HO will arrange appointments with the administrative staff at the placement and prioritise appointments as per the Community Placement triage arrangements. 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 the Community Placement, organised in the most efficient way. Seek help if the workload becomes unmanageable.

EDUCATION:

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

Unless HOs in Hamilton-based community placements are required for a medical emergency, the HO shall be given the opportunity and time to attend:

- House Officer Teaching: Wednesday 1330-1430hrs (at Waikato Hospital)
- Grand Round: Thursday 1230-1330hrs (at Waikato Hospital)

Community Placement requirements may include but are not limited to the following:

The HO will assess patients and receive individual supervision from an approved clinical supervisor.

The HO will participate in the following:
- Reviewing patients
- Attend a minimum of two hours didactic teaching time per week. (A further two hours per week will comprise bedside/chair-side, self-directed and clinical supervision learning).
- ‘Corridor teaching’
- Direct observation by the clinical supervisor during consultations
- Have opportunities to observe the supervisor consulting with patients
- Reviewing videotaped consultations (where available)
- Reviewing (and discussing) patient notes (i.e. case-based discussions)
- Conducting discussions with clinical supervisors
- Visits to other primary health practitioners
Learning activities in community placement.

The HO will be given an introductory / orientation programme on commencing work at the community placement.

The community placement 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. 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 placement 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. This will be recorded in their Professional Development Plan (PDP) on the e-Port (MCNZ)

Specific, regularly scheduled time for clinical supervision) should be set aside. Supervision includes case or personal development discussions, observation, review, feedback and career planning. HO and supervisor should determine supervision arrangements at the start of the attachment.

Supervision sessions must include the mid-attachment completion of the PDP and arrangements for the HO to meet with their nominated Prevocational Educational Supervisor. End-of-attachment assessment and PDP should be scheduled in the final week of the placement. Supervision arrangements must 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 clinical 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 (i.e. clinical reasoning skills).
- 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 clinical 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 would not commonly encounter.
- Direct observation with the staff or allied health staff at a community placement.
- Direct observation of a procedure performed in the clinic setting.
- 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. Valid consent is required from the patient if this method is used. Use of the recordings outside the practice without the patient and practice manager / clinical director’s consent is not permitted.
- Academic topic discussion (e.g. a current literature review) with the clinical supervisor or within a journal club setting with reference to patients’ conditions / situations can occur.
- Review and discussion of a Trainee log (procedural skills).

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

### DAILY SCHEDULE:

<table>
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<th>TUES</th>
<th>WED</th>
<th>THURS</th>
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<tbody>
<tr>
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<td>A+M</td>
<td>A+M</td>
<td>A+M</td>
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</tr>
<tr>
<td>0800-1700hrs</td>
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<td>0800-1700hrs</td>
<td>0800-1700hrs</td>
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</tbody>
</table>

|                      | CLINIC: Injury / Rehabilitation | 1330-1430hrs House Officer teaching (Waikato Hospital) if linked | 1230-1330hrs Grand Round (Waikato Hospital) if linked | CLINIC: Allergy (2 x during rotation) |
|                      |                                  |                                                                 |                                                           |                                 |

### ASSESSMENT:

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. Please note that if any deficiencies are identified during the community placement, the clinical supervisor, along with the HO’s assigned Prevocational Education Supervisor of
Training, will discuss these with the HO at the time (preferably no later than two thirds of the way through the community placement), and make a plan to correct or improve performance. 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*

ROSTER - HOURS OF WORK:

**Ordinary hours are:-**
Monday to Thursday – 0800-1700hrs and GP Clinic hours [Fridays] 0930-1630hrs (excluding public holidays – working at the Community Placement

**After Hours Roster (in Accident and Medical):-**

a) Monday to Friday: 1700 – 2000hrs
   *(The house officer may be rostered to work nine long days over a 13 week period)*

b) Weekends (Saturday & Sunday): 0800-2000hrs
   *(The house officer may be rostered to work three weekends over a 13 week period)*

c) Nights: N/A

THE ROSTER TEMPLATE FOR GENERAL PRACTICE WITH ACCIDENT AND MEDICAL CLINICS ATTACHED

[M (day roster)=9hrs, L (‘long day’)=12hrs, X (Weekend)=12hrs, O=Off]:

<table>
<thead>
<tr>
<th>Week</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
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<th>Saturday</th>
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<td>M</td>
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<td>L</td>
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<td>GP</td>
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</table>

**SALARY:**

a) **Average Weekly Hours:**
   
   Weekly Hours = 45.00 hours over 13 weeks
   
   Long Days = 2.07 hours over 13 weeks
   
   Weekend Hours = 5.53 hours over 13 weeks
   
   Nights = N/A
   
   **Total: = 52.60 hours over 13 week**

**PAY CATEGORY D**

(52.60hrs)  (UNROSTERED HOURS = 2.30hrs)

**LEAVE:**

The HO must complete 10 weeks of employment in the community placement, 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. No cover is provided in the community placement.
# 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>
</tr>
<tr>
<td>Committee Approved</td>
<td>Policy Committee</td>
</tr>
<tr>
<td>Date Approved</td>
<td></td>
</tr>
<tr>
<td>Committee Endorsed</td>
<td>Board of Clinical Governance</td>
</tr>
<tr>
<td>Date Endorsed</td>
<td></td>
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<tr>
<td>Authorised</td>
<td>Chief Executive</td>
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### Policy Review History

<table>
<thead>
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<th>Version</th>
<th>Updated by</th>
<th>Date Updated</th>
<th>Summary of Changes</th>
</tr>
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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>
</tr>
</tbody>
</table>

**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 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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<thead>
<tr>
<th>Doc ID:</th>
<th>2561</th>
<th>Version:</th>
<th>02</th>
<th>Issue Date:</th>
<th>27 July 2016</th>
<th>Review</th>
<th>26 July 2019</th>
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<td>Dr Paul Reeve</td>
<td>Department:</td>
<td>Clinical Services</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 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 the House Officer and counter-signed by Waikato DHB)

This Check-list 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