Waikato District Health Board
Position Description

This position description will be used in conjunction with Section B

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

Vision (Te Matakite)
Healthy People. Excellent care.

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

Values
Theme “People at Heart” – Te iwi Ngakaunui
- Give and earn respect - Whakamana
- Listen to me; talk to me – Whakarongo
- Fair play – Mauri Pai
- Growing the good – Whakapakari
- Stronger together – Kotahitanga

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

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

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

**TEAM RESPONSIBILITIES**

**Quality and Patient Safety collective responsibilities**

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

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

QUALIFICATIONS AND EXPERIENCE

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

Desirable
- Previous work within the New Zealand health system.

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

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

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

Developing self and others (national leadership framework engage others)
- Seeks opportunities to continuously improve, and works to learn and grow (54)

Building relationships (national leadership framework develop coalitions)
- Maintains effective relationships patients/clients/consumers/customers, and with peers and the employer, and encourages collaboration and effective group interactions (42)

Achieving results (national leadership framework leading care)
- Is open to learning new things and picks up technical skills in a reasonable timeframe (61)
- Is action oriented and undertakes duties with professionalism and enthusiasm (1)
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
I certify that I have read this position description and reasonably believe that I understand the requirements of the position. I understand that:

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

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

Position holder’s name:  

Position holder’s signature:  

Manager’s name:  

Manager’s signature:  

Date of signing:  

Prepared / Reviewed: January 2017
SECTION B – DESCRIPTION OF CLINICAL ATTACHMENT – HOUSE OFFICER, ENT

JOB TITLE: HOUSE OFFICER

DEPARTMENT: Otolaryngology (ENT)

REPORTS TO: Clinical Director, Otolaryngology (ENT)

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 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]

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.
- House officers work under the delegated clinical responsibilities of the designated ‘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 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 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 specialities or in the Emergency Department covered in our “after hours” roster.

**EDUCATION:**

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

- **Grand Round** and teaching session each Thursday from 1230-1330hrs
- **Wednesday clinical meeting** – 4th Wednesday – Bryant Education Centre
- **Radiology session** – 4th Wednesday
- **House officer teaching programme** - Wednesday: 1330-1430hrs.

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

**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 sighted and acknowledged electronically.

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 3’ for a detailed list of ‘Surgical House Officer roles and responsibilities’

All ACC Elective cases to have a completed discharge report for invoicing. Audiology ACC cases completion of Form 45 for ACC claiming

All ACC acutes to have an ACC45 completed

**DAILY SCHEDULE**

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Prepared / Reviewed: January 2017
PRE - ADMISSION CLINIC:
If anaesthetic review required, Tuesday morning.
Non-anaesthetic review, afternoons as required.

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).

– this requires that the house officers record their learning, have their progress tracked, create and update their ‘Professional Development Plan’ (PDP), record ‘continued professional development’ (CPD) activities plus complete their assessments through an e-portfolio system known as ‘ePort’.

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

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

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

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

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

Year two house officers will meet with their educational supervisor at the beginning of the year and after each clinical attachment and will meet with their clinical supervisor on the clinical attachment at the beginning, mid-way through and at the end of the clinical attachment. It is important that the quarterly assessments are completed within two weeks of finishing a clinical attachment.
It is the individual house officer’s responsibility to meet all ‘ePort’ assessment deadlines and to have completed all documentation to allow both their clinical supervisor(s) and PES sufficient time to fulfill 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.

[NEW 2015 ROSTER – WORKLOAD EXPLANATION: Please refer to ‘Appendix 2’]
ROSTER - HOURS OF WORK

Ordinary hours -
Monday to Friday 0730-1600hrs (excluding Public Holidays).

After Hours -

a) Monday to Friday 1600-2230hrs ‘on duty’.
   (This is a 1:10 roster – including cardiothoracic, vascular, ENT, neurosurgery, plastics and urology house officers. The house officer may be rostered to work ten long days in a 13 week period.)

   If the house officer is rostered to three weekends and nights a maximum of seven long days in a 13 week period may be rostered

   The house officer may also be rostered to work the ‘duty surgery’ house officer ‘long day’ - this provides additional support to the three surgical house officers ‘on duty’ and includes ALL surgical house officers. This duty starts at 1600hrs

b) Saturdays and Sundays –(long): 0800-2130hrs ‘on duty’
   and (‘short’): 0800-1600hrs ‘on duty’
   The HO/SHO may be rostered to work three weekends in a 13 week period and each weekend duty will consist of one ‘long’ (0800-2230hrs) and one ‘short’ (0800-1600hrs) day

c) Nights: Monday – Friday: 2200 – 0800hrs
   Saturday + Sunday: 2100 – 0800hrs.
   (The house officers may be rostered to work one set of nights in a 13 week period, with the roster template splitting the nights into a 4/3 pattern)

   In some circumstances, two sets of nights may be rostered:
   (During the first six months of each new ‘doctor year’ [November-May], year one house officers are not allowed to work nights – clause 6.5 RDA MECA – this may result in other house officers working up to two sets of nights in any 13 week period. In such circumstances, these house officers will be paid up one pay category for the duration of that run)

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 = 42.50 hrs over 13 weeks
   Long Days = 3.50 hours over 13 weeks
   Weekend Hours = 4.96 hours over 13 weeks
   Nights = 5.53 hours over 13 weeks
   Total: 56.49 hours over 13 weeks

CATEGORY C

(56.49hrs)  (UNROSTERED HOURS = 3.41hrs)

LEAVE:

Is the responsibility of the employer and is provided by a reliever. 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>
</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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Policy Review History

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<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

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:
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

Document Owner: Dr Paul Reeve  Department: Clinical Services

Prepared / Reviewed: January 2017
APPENDIX 2

NEW 2015 ROSTER:

WORKLOAD / ROSTERING EXPLANATION

Points to note:

- Plastics will drop from three to two house officers.
- Two house officers will be rostered to work each sub-specialty weekend. They will be rostered to one ‘short’ (0800-1600hrs) and one ‘long’ (0800-2130hrs) day. These will alternate on the Saturday and Sunday.
- One house officer will primarily look after plastics / urology / ENT / ophthalmology / maxillo-facial. It is expected they will ‘round’ with the busiest of these specialties.
- One house officer will primarily look after cardiothoracic / vascular / neurosurgery. It is expected they will ‘round’ with the busiest of these specialties.
- When working the ‘long day’ either on Saturday or Sunday from 1600-2130hrs the house officer is expected to cover ALL the sub-specialties.
- It is expected that these two sub-specialty house officers will communicate and work together to complete jobs especially when one is not busy.
- Plastic surgery house officers can get rostered to the ‘Duty Surgery’ duties for long days
  - When rostered to work this ‘Duty Surgery’ duty, it will state on ‘Amion’:
    “Medical/elective admissions. ED. To call: <<RMO’s name>> + <<RMO’s pager number>>”
    This description will appear on ‘Amion’ under EVERY surgical specialty
  - The ‘Duty Surgery’ duties will mostly / ideally be rostered to a PGY2+ house officers
  - This role entails medical / elective admissions for ALL surgical specialties from 1600hr-2230hours. It is also inclusive of ED if required.
- When rostered to work the long day for a specialty eg general surgery, orthopaedics, or any of the sub-specialties, it will state on ‘Amion’:
  “Wards/HDU to call: <<RMO’s name>> + <<RMO’s pager number>>”
- On ‘Amion’, two names will appear on every surgical specialty.
APPENDIX 3
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 ready to START the ward round at 07:30 – NOT arrive at 07:30
- Be available and contactable during rostered hours
- Respond promptly and politely to all pager requests
- If calling in sick, notify the RMO Unit / Duty Manager AND your team Registrar 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, mandatory 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

Prepared / Reviewed: January 2017
• 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

**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
APPENDIX 4

'End of Clinical Attachment' assessment form

House Officer
Supervisor Report - C