AUCKLAND
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[redacted]

Re Official Information Request for information about hours worked by senior doctors in maternity wards

I refer to your official information request of 6 May 2019 for the following information:

1. ***How many consultants/senior doctors are rostered on and physically present on your hospital maternity wards on Saturdays and Sundays and between 10pm and 8am during the week?***

2. ***If consultants/senior doctors are rostered on to work in the ward on the weekend, what times do their shifts start and end? (ie, is there someone there at all times?)***

3. ***What times are consultants/senior doctors rostered on until during the week? (ie, is there someone there at all times?)***

4, ***Why are/why aren't consultants/senior doctors present/not present on the ward at all times?***

5. ***Are senior doctors/consultants on call for help on the maternity ward during the weekend and between 10pm and 8am on weekdays?***

6. ***How quickly are any on call-doctors expected to be able to be at the hospital?***

7. ***If senior doctors/consultants are not on the ward at all times, who is available to provide care to women when they are not present? (midwives, junior doctors etc)***

The information you have requested is enclosed below

1. **How many consultants/senior doctors are rostered on and physically present on your hospital maternity wards on Saturdays and Sundays and between 10pm and 8am during the week?**

On Saturdays and Sundays there are two senior medical officers (SMO) rostered to be available for each 24 hour period, across the Women's Health service.

As far as maternity is concerned, one of these SMOs is responsible for acute maternity assessments, and the other for labour care and maternity inpatients.

They are responsible between them for all inpatients of Women's Health, which includes the Women's Health wards, acute assessment unit, Labour and Birthing Unit, and operating rooms; and

also for patients who are under Women's Health but in other parts of the hospital such as the Emergency Department or other wards.

Each SMO in the weekend will be available for 24 hours from 8 am to 8 am the following day. During that time they are required to be in the hospital for the following activities:

- Morning handover meeting 0800 – 0830h
- Ward rounds (generally these last the whole morning and depending on interruptions by emergency or procedural work may extend into the afternoon)
- For defined clinical activity as per our Registrar Support guidelines (attached)
- For any other circumstance where additional support is required to the acute resident team.
- Evening handover meeting 2200 – 2230h

Between 10pm and 8am during the week?

As above, there are two senior medical officers (SMOs) rostered to be available for each 24 hour period, across the Women's Health service.

As far as maternity is concerned, one of these SMOs is responsible for acute maternity assessments, and the other for labour care and maternity inpatients.

They are responsible between them for all inpatients of Women's Health, which includes the Women's Health wards, acute assessment unit, Labour and Birthing Unit, and operating rooms; and also for patients who are under Women's Health but in other parts of the hospital such as the Emergency Department or other wards.

During the week, SMOs have daytime work and then, if they are rostered to be available after hours, they will start at 5 pm and be available until 8 am.

From 10pm to 8 am during the week they are required to be in the hospital for the following activities:

- evening handover meeting 2200 – 2230h
- defined clinical activity as per our Registrar Support guidelines (attached)
- any other circumstance where additional support is required.

2. **If consultants/senior doctors are rostered on to work in the ward on the weekend, what times do their shifts start and end? (ie, is there someone there at all times?)**

SMOs are rostered to be available from 8 am to 8 am in the weekend, as above.

They are responsible between them for all inpatients of Women's Health, which includes the Women's Health wards, acute assessment unit, Labour and Birthing Unit, and operating rooms and patients who are under Women's Health but in other parts of the hospital such as the Emergency Department or other wards.

In the weekend, in addition to the SMOs being in the hospital as described above, there is a team of three Women's Health resident medical officers (RMOs) on site at all times, a fourth from 8 am to 4 pm for postnatal wards, and a fifth from 8 am to 10 pm for acute assessments.

The above is known as the acute team and is always available to attend to emergencies in any clinical area.

3. **What times are consultants/senior doctors rostered on until during the week? (ie, is there someone there at all times?)**

During the week, when full services are running, usual hours of work for SMOs is 8 am to 5 pm. They are also required to be in the hospital or at Green Lane Clinical Centre at all times.

The acute service, which includes acute assessments, labour care, emergency operating theatres, and responding to emergency calls, will always have two SMOs and four RMOs in the hospital from 8 am to 5 pm during the week.

During the week, ward care is provided by multiple teams of doctors, led by SMOs, and there is always an RMO on the ward.

4. **Why are/why aren't consultants/senior doctors present/not present on the ward at all times?**

During the week, SMOs are rostered to other duties such as elective operating lists and clinics both in the hospital and at Green Lane Clinical Centre.

Also, an individual SMO may be rostered to the acute service during the day, or have been rostered overnight.

SMOs who are rostered to ward cover will aim to do ward rounds in the morning and then be available to consult to provide specialist opinion and advice by phone at other times.

The acute team is always available during the day to attend to emergencies in any clinical area.

After hours, due to the responsibility for all clinical areas in Women's Health, and 24 hours availability the SMO may be either be working in another part of the hospital, or taking some rest time.

5. **Are senior doctors/consultants on call for help on the maternity ward during the weekend and between 10pm and 8am on weekdays?**

Yes, as described above

6. **How quickly are any on call-doctors expected to be able to be at the hospital?**

Within 20 minutes.

Some SMOs prefer to stay on site even though they are not paid to do so. Accommodation is provided.

7. **If senior doctors/consultants are not on the ward at all times, who is available to provide care to women when they are not present? (midwives, junior doctors etc)**

RMOs provide care at all times whether an SMO is present or not.
Midwives and nurses provide care within their scope of practice, and work with the doctors as part of the team providing care.

The information provided above applies to Senior Medical Officers trained in Obstetrics and Gynaecology. In addition, there are SMOs from the following specialties rostered to work in the Women's Health service: Obstetric Medicine, Anaesthesia, Maternal Fetal Medicine. These have separate rosters. Ward cover is provided by an SMO for Obstetric Medicine with similar arrangements. Maternal Fetal Medicine does not provide after hours cover but does provide ward care during working hours.

I trust this information answers your questions.

You are entitled to seek a review of the response by the Ombudsman under section 28(3) of the Official Information Act. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the Auckland DHB website.

Yours faithfully

Ailsa Claire, OBE
Chief Executive

Encl. *Registrars Guidelines for support in Obstetrics and Gynaecology.pdf*

Registrars' guidelines for support in Obstetric and Gynaecology (O&G)

Document Type	Guideline
Function	Clinical Practice, Patient Care
Directorate(s)	National Women's Health
Department(s) affected	Obstetric and Gynaecology
Applicable for which patients, clients or residents?	n/a
Applicable for which staff members?	Registrars in Obstetric and Gynaecology
Key words (not part of title)	Credentialing, operating, birth, labour, delivery, supervision
Author - role only	Obstetrician & Gynaecologist
Owner (see ownership structure)	Service Clinical Director - Secondary Maternity Services
Edited by	Clinical Policy Advisor
Date first published	1 March 1998
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Contents

1. Purpose of guideline

The purpose of this guideline is to provide all Obstetric and Gynaecology (O&G) Registrars working in National Women's Health (NWH) with guidelines for support.

2. Principles

Safe patient care is our first priority.

Senior medical officers (SMOs, specialists) and registrars must develop a working relationship that enables a registrar to ask for assistance. Senior medical officers must be physically available when on duty, responding in a timely manner to requests.

SMOs should be aware of the credentialing status and approximate level of experience of the Registrar/s with whom they are working with, particularly when on-call.

Where other medical, nursing or midwifery staff become aware of specific concerns regarding procedural complexity or supervision, they should assist with seeking appropriate levels of assistance.

These guidelines are flexible according to the clinical experience of the individual registrar and the complexity of the procedure.

Information regarding registrar in-hospital credentialing is available on the N-drive, in the registrar folder.

3. Registrars: RANZCOG trainees

Prior to arrival at NWH, RANZCOG Trainees will complete a credentialing spreadsheet of procedures, which is based on the RANZCOG assessment of procedural and surgical skills 'sign-offs'. Each trainee indicates which procedures they have satisfactorily completed a SUMMATIVE assessment (Yes/No/Not applicable). In an adjacent column, they self-assess their required level of supervision (1=SMO in room 2=SMO on-site 3=SMO offsite). For clarity, SMO presence onsite must be provided for certain procedures and situations (see Section 4) regardless of a trainee's self-assessment.

The credentialing spreadsheet documents are merged and placed on the N drive at the beginning of the attachment. It is expected that each registrar will discuss their credentialing document with their training supervisor at their first meeting together, which should occur in the first two weeks of the attachment and the registrar will arrange alterations of the N-drive document as necessary.

Ultrasound:

- Trainees who have commenced training in or after December 2016 are credentialed for ultrasound as per their APSS sign-offs. https://www.ranzcog.edu.au/Training/Specialist-Training/Training-Requirements/Ultrasound-Training
- Trainees who commenced training before 2016 are credentialed for USS as per their in-hospital clinical assessment (IHCA) ultrasound module.

- It is recognised that trainees yet to complete their IHCA *may* already be competent to perform basic fetal viability, presentation, number, placental position and liquor volume assessments, in line with the new APSS mentioned above. They should discuss their required level of supervision with their training supervisor and duty SMO on a case by case basis.
- In most cases, and unless agreed otherwise by the patient's responsible SMO, a formal ultrasound should be requested for the next working day.

4. House officers (including senior house officers) and registrars who are not RANZCOG trainees

Registrars who are not RANZCOG Trainees will undergo credentialing on an individual basis, in discussion with a nominated training supervisor. The credentialing process for procedures should be similar to that for trainees, for example, utilising the RANZCOG APSS form as a means for feedback and objective assessment of competency. Their credentialing information will also be on the N-drive. Information such as prior competency assessments (eg RCOG or ACOG) may be included as appropriate.

House officers and senior house officers will be directly supervised by a consultant or a delegated senior registrar for procedures in theatre or delivery suite, with the exception of facilitating a normal birth, which may be supervised by an appropriately experienced midwife.

5. Notify the duty specialist

A registrar is to notify the duty specialist of all cases of:

- Prematurity < 34 weeks
- Instrumental deliveries of parous women
- Syntocinon augmentation of established labour in parous women or women with previous caesarean section
- Repair of vaginal or perineal trauma that is done in the operating room
- Third degree tear or any cervical tear
- Emergency caesarean section
- Stillbirth
- Suspected neonatal encephalopathy, or other unexpected serious neonatal morbidity or mortality
- Maternal death or perimortem caesarean
- Major gynaecological procedure
- Admissions to High Dependency Unit (HDU) or Department of Critical Care Medicine (DCCM)

AND

- At any time the registrar believes his or her limits of expertise are reached.

6. Specific procedures where the specialist is to be in the hospital

A specialist should be in the operating room or labour and birthing unit for the following:

- ALL procedures for which the registrar is not credentialed
- Repeat evacuations of uterus, including ERPOC post STOP
- Evacuations within one month of delivery
- Evacuation of uterus in setting of infected RPOC
- Evacuation of suspected molar pregnancy
- Ruptured ectopic pregnancy
- Vaginal breech birth
- Vaginal twin birth
- Rotational instrumental deliveries
- Trial of forceps or ventouse in theatre
- Assessment prior to and during second stage LSCS
- Placenta praevia and major placental abruption
- Eclampsia
- Caesarean sections under 34 weeks gestation
- Caesarean with transverse lie and ruptured membranes
- Suspected amniotic fluid embolism
- Postpartum haemorrhage greater than 1 litre
- Cases when requested by the registrar
- Occasions where the workload exceeds safe limits without them, at the discretion of the clinical charge midwife or other senior colleague
- Registrar-only lists must have a named SMO present on site, agreed by and with sufficient notice to the SMO, with each of the cases discussed between the registrar and SMO and assessed for suitability and degree of supervision required. It is expected that such discussion will occur at least one week before the planned list. The SMO must be realistically available to attend - preferably with no concurrent clinical commitments. The registrar must confirm with the SMO that they are present on site before the first patient is anaesthetised. The registrar should inform the anaesthetist and theatre nursing staff of the name and cell-phone number of the supervising SMO at the start of the list.

In an emergency, and under extraordinary circumstances, a registrar may commence a procedure for which they are not credentialed. They must immediately notify the Duty Specialist of this intention, and the decision should be supported by a senior midwifery or nursing staff member.

7. Supporting evidence

- The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). *RANZCOG Training Registrar Supervision Guideline.* Retrieved from, https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-

MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20Training/RANZCOG-Training-Registrar-Supervision-Guideline-(C-Trg-5).pdf?ext=.pdf

- The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). *Registrar in-Hospital Credentialing*. Retrieved from, https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Training%20and%20Assessment/Specialist%20Training/Hospitals/Registrar-In-House-Credentialing.pdf
- The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). *Ultrasound training - revised*. Retrieved from, https://www.ranzcog.edu.au/Training/Specialist-Training/Training-Requirements/Ultrasound-Training

8. Disclaimer

No guideline can cover all the variations required for specific circumstances. It is the responsibility of the health care practitioners using this Auckland DHB guideline to adapt it for safe use within their own institution, recognise the need for specialist help, and call for it without delay, when an individual patient falls outside of the boundaries of this guideline.

9. Corrections and amendments

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed ***before*** the scheduled date, they should contact the owner or the Clinical Policy Advisor without delay.