DWK 58

Review of

Resident Medical Officer

Rostering

Bundaberg Base Hospital

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Background

Dr John Wakefield, Director of Medical Services, Bundaberg Base Hospital requested a review of aspects of the Resident Medical Officer Rostering to ensure efficient and effective service provision. The scope of the review included the following

- Emergency Department fixed roster arrangements including the number and level of resident medical staff
- After-hours and weekend resident medical officer cover for the Bundaberg Base Hospital
- Appropriateness of numbers and level of resident medical officers attached to the clinical units of surgery, orthopaedics, medicine, O&G, paediatrics, anaesthetics/ICU and mental health.
- Arrangements for relief at Gin Gin and Childers hospitals.

Methodology

A site visit was conducted from the evening of the 6th June to the afternoon of the 7th June 2001. All Unit Medical Directors and Resident Medical Officer staff were offered the opportunity to meet with the writer though, only one Unit Director and a significant proportion of the Resident Medical Officer workforce availed themselves of that opportunity. Meetings were subsequently arranged with the following staff to obtain relevant information:

- District Manager
- Director Medical Services
- ESO to the Director Medical Services
- Acting Director Emergency Department
- Director of Surgery
- Director of Anaesthetics/ICU
- Director of Mental Health
- Resident Medical Officers (a majority of staff attended a Lunch Time Forum)

Copies of rosters, financial and activity reports were perused to gain a detailed understanding of the issues surrounding Resident Medical Officer allocation and rostering at Bundaberg Hospital.

Current Situation

An analysis of the current Senior and Resident Medical Officer allocation was undertaken. These findings are summarised and presented in Table 1 below. The Resident Medical Officer on call and relieving arrangements were also reviewed. The after-hours cover at Bundaberg Hospital is provided by the Emergency Department staff and three ward Principal House or Junior House Officers. The Emergency Department staff, including the sole Junior House Officer on night shift, only cover the ward calls if they are not busy so the ward calls are regularly covered by the on call ward staff.

Table 1: Medical Officer Allocation

Department	Senior MO	VMO	PHO/Reg	SHO/JHO/Int
Emergency	1.5		3	5 (÷ 2 relievers)
Medicine	1.6 (2)	0.4 (0)	3	2
Ortho	1 (2)	0.3	1 (0)	1
Surgery	2 (1.5)	0.2	2	2
O&G	1 (3)	~~(provide call only)~~	1	2 (1)
Paediatrics	1	0.2	1	1
Anaes/ICU	4 (1)	0.5	1	1
Mental Health (acute unit)	0		1	1

The ward cover and new admissions reviews are provided by three ward based Resident Medical Officers who cover the facility in the following combination of disciplines:

- Medicine, Mental Health, ICU
- Surgery, Orthopaedics
- O&G, Paediatrics

The Anaesthetic Department first on call is covered by a combination of the Senior Medical Officers, Visiting Medical Officer and Principal House Officer who all work on a rotating roster.

Country relieving for Gin Gin and Childers Hospitals is provided by the Bundaberg Hospital Resident Medical Officer staff who are usually drawn from ward based terms. The relief for these Medical Superintendents is provided on the basis of a weekend off per fortnight. Bundaberg Hospital provides a medical officer each and every weekend to either Gin Gin or Childers and the required days off for these Resident Medical Officers are absorbed into the ward roster from which they are drawn. The relief for Gin Gin Hospital is provided from 6pm Friday until 6pm Sunday whilst Childers Hospital relief is from 8am Saturday until 7am Monday morning. The resident medical officers are paid as Principal House Officers for a rostered shift for the period 8am to 12 midday on each day of the weekend and held on remote call for the rest of the period. Recalls are paid as per the Senior Medical officers and Resident Medical Officers Award at Principal House Officer rates.

Possible Strategies

In order to discuss the possible strategies each area is dealt with separately though it is realised that many of these are interdependent. The first area for discussion is the Emergency Department.

Emergency Department

The Bundaberg Hospital Emergency Department averages approximately 2,500 attendances per month. The vast majority of patients being categorised as National Triage Scale Category 4 or 5 (approximately 80%). Waiting times for these patients are within Queensland Health benchmarks for Emergency Departments and the percentages of patients who are admitted/transferred are within acceptable benchmark limits supporting appropriate triage categorisation. Reviewing the staffing of the Emergency Department against this activity indicates that the level of Resident

Medical Officers is reasonable though consideration towards more senior on site cover on the night shift is recommended. The addition of a Principal House Officer on the night shift roster (and therefore an increase in establishment of one Principal House Officer) will provide increased supervision for the night Junior House Officer and improved capacity for ward call cover from the Emergency Department. The cost of this improved Emergency Department cover could be off set by changes to current ward cover arrangement and this aspect is discussed further in the individual department sections below. Further, the additional medical officer on night duty will facilitate meal relief and will support roster changes to allow a 10-hour night shift commencing at 2130 hrs and finishing at 0830 hrs, with a one hour meal break, or 0800 hrs allowing for a half hour meal break. Hand over to the oncoming admitting teams and the morning shift can be commenced at 0800 or 0830 hrs allowing improved day and afternoon coverage. It is also recommended that consideration be given to an evening shift being rostered on the day before commencement of the night shifts as this is in line with safe-hours rostering. It is recognised that this would entail further changes to the Emergency Department roster to accommodate teaching that would possibly need to be undertaken on Thursday rather than Wednesday, as is currently the case.

Another area of potential benefit in the Emergency Department, though technically outside of the scope of this review, is the methodology of care provision to some of the Triage Category 4 & 5 patients. A recent Policy and Procedure Paper undertaken by the Health Funding and Systems Development Unit, Queensland Health described a mechanism whereby National Triage Scale Category 4 and 5 patients could treated as private patients. If these patients voluntarily elected to be seen as private patients in a Primary Care Clinic that is operating within the private clinic guidelines they could be billed under Medicare. As 80% of attendances to the Emergency Department are Triage Category 4 & 5, this has the potential to provide a revenue stream for Bundaberg Hospital. There is the possibility that the Emergency Department consulting rooms adjacent to the current waiting room could be utilised for this purpose though it is recognised that workforce issues and direct competition with the private sector might make this impracticable.

Medical Unit

The medical officer allocation of this unit seems reasonable. The Medical Unit Principal House Officers currently provide cover to the medical, intensive care and mental health units after hours. Discussions with the Resident Medical Officer staff indicates that in their opinion this cover could be rationalised as they feel they are not necessarily adding value after hours, particularly as a number of the recalls to duty are for ward call type issues. It is recommended that the current after-hours medical cover duties be reviewed with a view to incorporating these into the function of the proposed night Principal House Officer located in the Emergency Department. Operationally this would entail the Emergency Department Principal House Officer covering the wards as first senior call for all medical issues and accepting responsibility for most overnight admissions. The Medical Unit Principal House Officers will provide cover to the wards during normal business hours Monday to Friday and up until the Emergency Department night shift Principal House Officer commences duty Saturday and Sunday. This will eliminate any fatigue pay/leave concerns for the Medical Unit. Depending upon the level of medical cover in the Emergency Department and the amount of work generated from the wards the evenings could also be covered by the Emergency Department staff. Accurate costing for the reduction in recall and fatigue will need to be undertaken though it is the impression of the writer that the savings achieved from the reduction in these will be sufficient to offset any additional cost incurred in providing the additional Emergency Department cover.

Surgical and Orthopaedic Unit

The allocation of medical officers to these units seems reasonable. Concerns were raised regarding the skill level of the Principal House Officer staff but it is recognised that Bundaberg Hospital is constrained by the availability of skilled staff. The surgical and orthopaedic Principal House Officers provide the after-hours cover for surgery and orthopaedics by a rotating one in three proximate on call roster. It is recommended that this be reviewed in conjunction with improved senior cover in the Emergency Department as it is envisaged that the requirement for a proximate call

surgical Principal House Officer will be vastly reduced if not rendered obsolete. It is recommended that the Principal House Officers be placed on remote call and only recalled for patients deemed to require surgical intervention. The surgical and orthopaedic Principal House Officers will need to provide some daytime and possibly weekend ward cover for patient ward rounds, new admissions and discharges. It is recommended that the Emergency Department staff, in the first instance, conduct all other after-hours ward call and initial patient reviews.

Obstetric and Gynaecology Unit

The allocation of medical officers to these units appears to be primarily based on the requirement for after-hours cover being one Principal House Officer and two Junior House Officers. Each of these staff provides cover for Obstetrics and Gynaecology and Paediatrics on a one in three after-hours proximate call rotation. This oncall arrangement seems reasonable, though during the daytime it is questionable whether the workload requires the attendance of three staff. It is recommended that, with due consideration to skill level, the roster be adjusted towards an evening shift which then provides midnight till dawn oncall cover for these areas. Further, depending on the workload of the Emergency Department staff they, and in particular the Principal House Officer, could provide first call for the Paediatric Unit reducing the requirement to recall to Obstetrics and Gynaecology staff further offsetting the cost of the additional Emergency Department Principal House Officer.

Paediatric Unit

The allocation of medical officers to this unit seems reasonable though the provision of the Junior House Officer to this unit in the summer months may be more for teaching than service provision. Caution should be exercised in removing this position during the summer months though, as this is likely the only position that can provide sick leave and other relief at very short notice should the need arise. The after-hours paediatric cover options have already been discussed in detail in the sections above.

Mental Health Unit

The allocation of medical officers to this unit also seems reasonable though like paediatrics, the provision of the Junior House Officer to this unit may be more for teaching than service provision. Caution should be exercised in removing this Resident Medical Officer allocation as the move towards a more community based model providing an extended care arrangement may require conversion of this position to a Principal House Officer to provide greater flexibility. It is recommended that the Emergency Department provide the immediate after-hours cover for the inpatient unit though this should be revisited if the above-mentioned changes occur.

Anaesthetic and Intensive Care

Primarily staff specialist and senior medical officer anaesthetists currently provide the Bundaberg Hospital anaesthetic service. Based on this model the allocation of one Principal House Officer for anaesthetics and one Junior House Officer for the Intensive Care Unit is reasonable. The after-hours arrangement for anaesthetics to be covered by a rotating roster including the Staff Specialists/Senior Medical and Principal House Officers though not ideal is the most reasonable considering the model and available staff. The Medical Unit Principal House Officer on proximate call currently provides the first call for the Intensive Care Unit though it is recommended that the proposed night shift Emergency Department Principal House Officer cover this.

Another item warranting consideration, though not specifically within the scope of this review, is the number of staff specialists, senior medical officer and visiting anaesthetists required to cover the allocated operating sessions. The ratio of morning to afternoon sessions where anaesthetic cover is required is significantly biased towards the morning. This is seen particularly within the operating theatre with most mornings requiring four sessions whilst in the afternoon there are one or two and rarely three sessions requiring an anaesthetist. It is acknowledged that the preadmission clinic is also provided in the afternoons and there is also routinely allocated an emergency operating theatre which, based on the information provided, is

severely underutilised. It is recommended that the operating theatre schedule be reviewed to provide a more appropriate balance of morning and afternoon session allocation, which will reduce the requirement on anaesthetic services, by an equivalent of approximately one full-time position.

Relief for Gin Gin and Childers Hospitals

The current arrangement for the provision of relief to these two hospitals is significantly negatively impacting the flexibility of rostering within the Bundaberg Hospital. The provision of one Resident Medical Officer to Gin Gin or Childers Hospital each weekend limits the frequency of weekends off able to be provided to the Resident Medical Officers. In addition, the methodology of payment and perceived inequity by the Resident Medical Officers provides significant impetus for gaming to improve the income generated from these weekends. Though the current relief arrangement is in accord with IRM 2.7-10, providing two full days off per fortnight, it is recommended that the relief provision to these hospitals be reviewed toward providing one of the following options. Relief provided for 5 days every 5 weeks or 1 week every 6 weeks is possible within in the guidelines described within section 11 of the Award for Medical Superintendents With Right of Private Practice and Medical Officers With Right of Private Practice – Public Hospitals, Queensland as reproduced below.

> *"Leave – relief of Employees*
>
> *An employee shall be entitled to the equivalent of one (1) day free from duty in each week upon which duties under the Award are performed:*
>
> *Provided that such time, free from duty, may accumulate up tro five (5) days without the approval of the employee or up to nine (9) days by mutual agreement between the employer and the employee"*

This will allow for income to be generated from the Medical Superintendent relief arrangement in the hospital as well as the private practice. Alternatively, arrangements could be considered toward involving Gin Gin and Childers Hospitals in a relieving circuit for which the Bundaberg Hospital provides a reliever on a regular

basis. This will require an increase in the Resident Medical Officer establishment though for the time spent out of the district appropriate reimbursement of salary and on cost will be provided. During the site visit the Resident Medical Officers expressed their dissatisfaction regarding the current relief arrangements and felt either of the options outlined above would be preferable.

Recommendations

Following the review of Resident Medical Officer numbers, allocations and rostering the following recommendations are made. These are:

- Increase the establishment in the Emergency Department to provide a night shift Principal House Officer
- Alter the Emergency Department roster to include a ten hour night shift commencing at 9.30pm and the day staff to commence duties at 8.00am.
- Review the business practices within the Emergency Department with a view to capitalising on the ability to treat Triage Category 4&5 patients in a private environment
- Alter the oncall arrangements for the Medical Principal House Officer reducing these as cover will be provided by the Emergency Department night shift Principal House Officer
- Considering appropriate skills modify the rostering of the Obstetrics and Gynaecology Principal and Junior House Officers to include a rostered evening shift
- Consider removing the Paediatric Junior House Officer position over the summer months
- Review the junior medical officer allocation for the Mental Health Unit in conjunction with anticipated service delivery models
- Modify the operating theatre schedule improving the balance between the anaesthetic resources required in the morning and afternoon sessions thereby reducing the demand on anaesthetic services by approximately one full-time position

- Alter the relief arrangements provided to Gin Gin and Childers Hospitals toward providing relief for an entire week rather than the weekends as is currently the practice.