Quality and Safety at Night.

Whilst noting the MCNZ limit on provisional registrants performing night duties in the first 6 weeks of employment, the parties agree to adopt a quality and safety approach to first year participation on night shift rosters.

Night duties are a risk for the following reasons:

1. *They usually represent isolated practice for the doctors on duty with little time to provide or receive supervision or collegial dialogue over individual patient care.*
2. *The most experienced doctors (senior registrars and SMOs) are rarely immediately available, and the need to wake them for assistance is a natural barrier.*
3. *Fatigue is always a human factor when night shifts are being worked.*
4. *Patients being attended to have presented as or are inherently "very sick" and in need of immediate attention (that cannot / should not wait until the morning).*
5. *Minimum staffing levels of both doctors and other health practitioners are on duty; many staff are only available on call and not on site and not all functions of the hospital are active (e.g. limited radiology available).*

This environment should be actively considered prior to seeking to place the least experienced of our doctors, our first year house officers on night duty. In doing so the following parameters must be assessed, and able to be audited against. Written documentation surrounding each parameter and the DHBs facilities and support should be readily available to review, and undergo reassessment in November when first years start work, and June ahead of the particularly busy and often pressured winter months, of each year.

What contributes to quality and safety at night?

- *Experience*
- *The right skills*
- *Physical alertness*
- *Support and supervision*
- *Not working in isolation*
- *Only doing what needs to be done and not being loaded up with catch up work from the day*
- *Effective, documented and approachable escalation processes*
    - *From the doctor on duty's perspective;*
    - *Not activated by the doctor;*
    - *Clear protocols.*

Experience.

- *The doctor should have sufficient experience to be able to perform the expected duties of someone working a night duty. They must be able to readily and accurately recognise and assess the sickest of patients in an environment where limited support and diagnostic assistance is available.*
- *A significant risk for the inexperienced is "not knowing what we don't know". DHBs need evidence to assure themselves that the doctor's level of experience is sufficient*

to manage this.

- *How long the doctor has worked in the hospital should be considered to ensure the doctor is familiar with protocols, procedures and systems.*

The right skills.

- *The doctor must be proficient at undertaking procedural skills that are reasonable required whilst on night shifts e.g. IV lines, catheters. In being proficient, the doctor must be able to do the "hard procedures" given they are the people who ultimately will be called to undertake such.*

Physical alertness.

- *Both the supervisors as well as house officers should be rostered in a manner to support physical alertness whilst on nights. A fatigued doctor is a compounding risk to inexperience and business when working night shifts.*

Supervision and support.

- *Both sufficient support and supervision must be identified, documented, and readily available.*
- *Support – may come in the form of non-medical staff as well as medical staffffrom other teams such as ICU regs, senior or specialist nurses. To be effective these people must be aware that a first year is on duty and available to provide support to them. It must be accepted that this support is likely to be more than that normally provided (when the doctor on duty is not a first year).*
- *Supervision comes from members of the medical team directly responsible for the first year house officer on night shift. This includes SMOs in small provincial centers through to registrars in bigger hospitals and through them, SMOs. There must be sufficient nominated supervision available to actively and directly provide supervision to the first year house officer. This would normally take the form of individual patient review during the night shift. The workload of the nominated supervisor must formally include time for these activities.*
- *SMO is responsible for knowing the capability and capacity of RMOs they are ultimately supervising.*
- *There can be no absence from the normal compliment overnight.*

Not working in isolation.

- *The entire team including senior nurses and registrars must be available (and workload allow) to actively check on and support the house officer.*

Only doing what needs to be done.

- *Night duties are to be kept to only doing what needs to be done; essentially acute work. It is not a time for discharge summaries, organising CT scans, re-charting drug charts etc.*
- *Active management of evening work should be undertaken to ensure as much as possible is done before night shift takes over. Handover must be effective and supported.*

Effective documented and approachable escalation processes.

- *There should be an identified competency set for the resident doctors on nights, both first years and those supervising.*
- *Intern supervisors should "sign off" both the first year and the night shift as suitable.*
- *Protocols should be clearly documented, readily available to the doctors and monitored for effectiveness.*
- *Escalation processes must also be clearly documented. They must be both effective and approachable from the resident doctor's perspective and able to be activated by practitioners other than the doctor. We must recognise that there is still a strong cultural barrier in NZ against calling an SMO for assistance, and sometimes reluctance on the part of SMOs to be called or respond appropriately.*
- *Timely orientation (3 nights recommended) in a supernumerary position should be provided to acclimatise and familiarise the first year to their first night shiftwork.*