# Local Health Network Accreditation Report

SOUTH AUSTRALIAN MEDICAL EDUCATION & TRAINING HEALTH ADVISORY COUNCIL

## Royal Adelaide Hospital Local Health Network

**Central Adelaide Local Health Network**

### Accreditation Report Details

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| **Date of Visit:** | **22 & 23 March 2018** |
| **Team Leader:** | **Dr Christine Burdeniuk**<br>**Dr Ben Teague** |
| **Team Members:** | **Dr Rodney Fawcett**<br>**Dr Dennis Pisk**<br>**Dr Justine Turnbull**<br>**Dr Kate Wheldrake** |
| **SA MET Ex-Officio:** | **Ms Stacey Holst**<br>**Ms Vicki Foote** |
| **Date approved by SA MET Health Advisory Council:** | |
| **Expiry Date:** | |

### Accreditation Decision

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| **31 August 2019** with **15** provisos<br>Accreditation revisit in first week of **June 2019** |

# Executive Summary

The Central Adelaide Local Health Network (CALHN) is accredited for:

- 83 Interns and 87 prevocational (PGY2+s) posts at the Royal Adelaide Hospital (RAH); and
- 52 Interns and 64 prevocational (PGY2+s) posts at the Queen Elizabeth Hospital (TQEH).

Trainee Medical Officers (TMO) currently rotate across the RAH and TQEH, the two major health facilities within CALHN. Significant changes have occurred following the move to the new RAH and some of these have impacted the TMO experience across CALHN.

CALHN is currently developing a network strategy in line with the 2017 SA Health Strategic Plan as major changes have occurred within the network over the last two to three years. The future direction of the TMO education and training program strategy at CALHN is also not apparent as the focus was on training requirements of staff prior to the opening of the new RAH.

CALHN is committed to linking the RAH and the TQEH as part of three overlapping principles these being service delivery, education and research. The strategy will focus on a 'single service, multiple site' model for the hospitals within one network. The operation of CALHN as a network and individual sites is still evolving and clear plans for internship are expected to evolve over time with more collaboration between the medical education units. The Executive Director Medical Services (EDMS) noted that the relationship between the TQEH and the RAH on how to share services is uncertain. This has been evident from units that are struggling to coordinate their leadership, with consultants and heads of units spread across the two sites. This raises concerns around ensuring continuity of supervision for TMOs and for patient care across CALHN at the new RAH, TQEH and the old RAH. The attention of CALHN has understandably been focussed on moving the RAH to its new site, but a strategy for TMO education and training is evidently still to be developed.

CALHN has indicated that its strategy document will include a governance structure advising where clinical units and the TQEH Medical Education Unit (MEU) / the RAH The Postgraduate Medical Education Office (PGEd) will sit within the organisational matrix. For example, currently TQEH and the RAH operate separately and administer their TMO programs with differing processes and methods. This is evidenced by the mid and full year assessment process whereby the TQEH conducts and collates results electronically whilst the process at the RAH is paper-based.

TMOs receive a good CALHN orientation at the start of the year, while the unit based orientations are generally adequate although there is room for improvement on some units. In particular, unit orientation is lacking for TMO working after-hours, especially TMOs from the TQEH covering RAH shifts. In addition to orientation, the handover to the Night term TMO is at times basic and not beneficial given the night patient workload. A detailed handover from nights to day and vice versa is vital support to the unit and continuity of care for patients.

TMOs are provided the opportunity to provide feedback at the end of any tutorial session to the PGEd. All programs are adjusted based on feedback for content and speakers, in one instance intern feedback resulted in a change to the orientation package providing clearer information on Code Black processes resulting in interns being more prepared when this occurred. Code Black instances are generally led by interns and some remain uncertain or nervous of the process. TMOs request assistance from senior nurses as some appeared to be unsure/unaware of a formal protocol outlining when to escalate for additional medical support.

TMOs reported a concerning level of workload in certain units, particularly Cardiothoracics, Cardiology, Haematology, Vascular Surgery, Orthopaedics, Gastroenterology & Hepatology, Neurosurgery, Stroke, Upper GI, Urology and Plastics. This workload affects a number of interns' ability to attend weekly education sessions, their ability to complete discharge summaries as well as TMO welfare. Some PGY2+s are unaware of the hospital education and tutorials available for them to attend outside of their unit arrangements.

CALHN identified that there was a CALHN-wide policy on documenting TMO non-rostered hours and that they are aware that non-rostered overtime is not uncommon on a number of units within the RAH. Most units will pay for reasonable claims but there are many who are not as supportive and only approve non-rostered overtime for MET calls. One intern was instructed by a Head of Unit to adjust the timesheet to reflect 'more

reasonable hours'. Units did note that non-rostered overtime is required mainly for completing discharge summaries, MET calls or patient follow-up. TMOs are encouraged to fill in the non-rostered section on their timesheet for any hours they do outside the prefilled timesheets but some are reticent to do so.

A major area of concern is that some wards have no dedicated space for TMOs to work as it is shared by all staff. Hence, access to and availability of a quiet work space can be difficult. Some departments have made space available to TMOs in their 'blue space' office areas but this is not the case in many departments particularly in the medical directorate which is very restricted in the space it has available for many levels of staff. A new purpose-build TMO lounge was built to ensure a private, safe, secure, comfortable and self-contained space away from any clinical work spaces. Once up and running it will have a small kitchen, study cubicles and recreation facilities. The MEU space is also in the middle of an 'open plan' space shared with Nursing Education and does not provide a private area for TMOs to raise concerns with the Director of Clinical Training (DCT). Concern exists that TMOs will not attend the PGEd because of this 'open plan' space when they are in crisis and need of support, due to lack of privacy.

TMOs enjoy a good balance of autonomy and supervision, however some TMOs expressed the need for more structured support with some units. TMOs provided positive feedback on the efforts some term supervisors show to advocate for TMO welfare and support. In particular, the Emergency Department Term Supervisor for his high level of support, education and supervision, the Term Supervisors within the Thoracic Medicine and Cardiology Units for advocating on TMO welfare and resourcing, the Intensive Care Term Supervisor for the high levels of support, education, mentorship and the Term Supervisor for the newly establishment Medical Emergency Response Service (MER) Unit for his motivation and enthusiasm for TMO supervision and support. CALHN is commended for establishing the MER Unit to support TMOs in managing unstable patients.

It has been identified through this accreditation process that CALHN's governance structure is lacking and unsettling with no unifying structure to bind the Local Health Network together. There has been substantial change with the lead up to the move to the new hospital, with units restructured and workloads increased with many services unclear of the direction of their unit. In the context of TMO training, this is evident in such problems as the lack of communication between the MEUs about TMO performance and the uneven orientation of TMOs across the Network, the latter particularly where a TMO must temporarily provide cover at a hospital other than their home facility. Given these significant changes, CALHN requires more time to establish organisational control and until that has been rectified a four year accreditation is unable to be granted.

The accreditation report outlines the strengths and areas for development in the TMO programs at CALHN.