



CLINICAL
EXCELLENCE
COMMISSION

PATIENT SAFETY REPORT

FROM REVIEW OF CLINICAL INCIDENT REPORTS

Clinical supervision at the point of care



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This report was prepared by the Clinical Excellence Commission Patient Safety Team and endorsed by the State Root Cause Analysis (RCA) Review Committee, in consultation with the Greater Metropolitan Clinical Taskforce (GMCT), Clinical Education and Training Institute (CETI), Area Health Services (via Directors of Clinical Governance) and the NSW Ambulance Service.

The information contained has been de-identified and analysed in accordance with the Incident Information Management System (IIMS) datasets and where relevant, the classification sets used by the CEC and the RCA Review Sub-committees.

It should be noted that all reviews of incident data, including root cause analysis, are retrospective and can reflect both hindsight and outcome bias. Such reviews are conducted to better understand the impact which patient, system and human factors may have on the provision of clinical care and to facilitate ongoing improvement across the health system.

This report is intended to provide a snapshot of issues identified and to make recommendation about system improvements to improve the safety and quality of clinical care.

Clinical Excellence Commission

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“The current flaw is that many work practices depend on the judgement of junior doctors to recognise when they don’t know or are out of their depth. Trainees are junior, mobile, inexperienced and may be “unconsciously incompetent” in their task and need to be actively supported and supervised rather than passively overseen”.

(Comment received)

Background

Clinical supervision is frequently defined as a formal process of professional support and learning which enables individual clinicians (medical, nursing and allied health professionals) to develop knowledge and competence and assume responsibility for their own practice (Cutcliffe & Butterworth 2001).

The focus of this report, however, is *point of care* supervision, defined as:

Effective leadership, support and guidance on clinical practice from senior to junior members of the clinical team, to ensure patients receive safe and appropriate care at the bedside (ibid).

Other definitions for this report:

- Senior clinician: the clinician who has overall responsibility for the patient.
- Junior clinician: any clinician who is part of the health care team, but does not have the overall responsibility for the patient.

Supervision of junior staff in the clinical setting is complex. The processes involved are not always clearly articulated and those responsible for the supervision may not fully understand what is required.

Supervision of junior staff is a key component of both clinical training and patient safety programs. Variation to models of supervision to suit the clinical environment and professional groups across the State is expected. Ideally such models, many of which work well, should be defined and risk-assessed.

Hore et al (2009) suggest that unsupervised experience may lead to acceptance by registrars and other junior staff of lower standards of care. This can impact significantly on patient outcomes and may have lasting influence on behaviours and clinical practice of junior clinicians. The importance, therefore, of proactive clinical supervision cannot be overestimated.

Commentary received acknowledges that “The apprenticeship model persists as the major model of training, especially in procedural specialities. Inherent in the apprenticeship model is the need for appropriate supervision. The literature on supervision is not completely definitive but is highly suggestive of the need for supervision to improve patient safety. The colleges are at different stages of definition of the approach that needs to be taken in supervision and clearly it’s a difficult task.”

“Nonetheless, the NSW Department of Health (Ministry) and its facilities have an obligation to ensure that supervision is appropriate, defined and supported by a transparent process. It is no longer acceptable for trainees to muddle through procedures and learn by experimentation rather than guided instruction under appropriate supervision.” (Comment received)

Root cause analysis (RCA) reports reviewed by the patient safety team and the RCA Review Committee (a sub committee of the Clinical Risk Review Committee) identified a number of cases where gaps in clinical supervision contributed to an adverse patient outcome. These were primarily reported under the principal incident type (PIT) of clinical management. This prompted further analysis of the issue.

As stated above, this report is confined to point of care supervision which influences clinical reasoning, decision making and subsequently the care provided.

Method

All RCAs where ‘clinical supervision’ was described as a contributing system issue, by either the RCA team or the RCA Review Committee, during the period January 2008-December 2009 were identified through the CEC database. RCAs related to wrong patient/site/procedure were excluded as these RCAs have been reviewed in early 2010. The classifications attributed to the remaining 54 RCA reports by the RCA Review Committee were aggregated and the reports subjected to further content analysis with a view to identifying key factors/themes related to the already identified supervision issues.

Discussion about the identified themes occurs throughout the document. This is supported by case studies based on real incidents. Comments received from clinicians/others have also been included in the discussion points as relevant to the themes/findings. They have not been attributed to individuals, as many of the comments were collated by health services or organisations prior to submission to the CEC.

The review did not include maternity/obstetric service related RCAs or incidents as this data was not available. However, there is some evidence to suggest that the issues are the same.

Findings

There are many classification sets considered by the RCA Review Committee during its review process. The two which were considered most relevant for this review were:

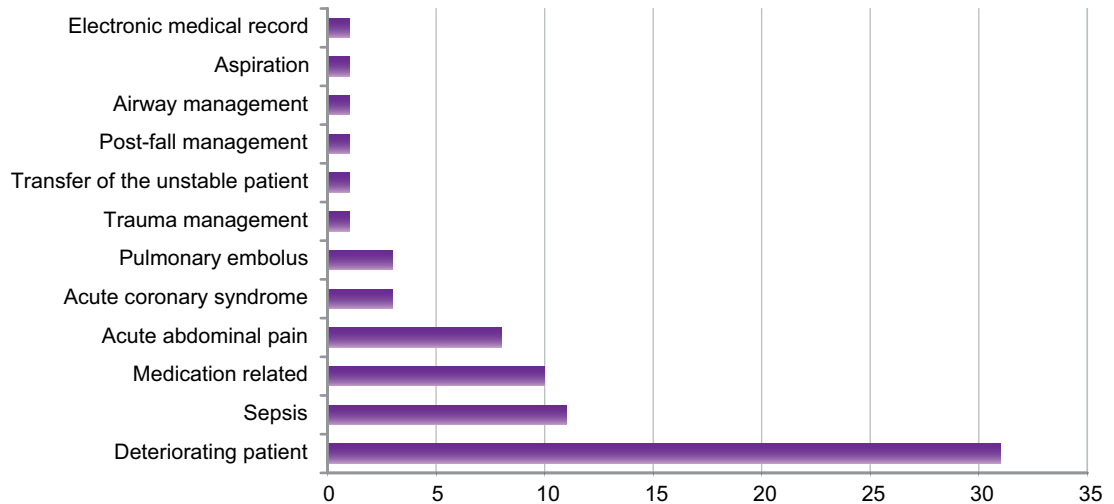
- Highlighted diagnostic/clinical risk groups
- Clinical management sub-classification

Highlighted Diagnostic/Clinical Risk Groups

The classification of diagnostic/clinical risk groups includes recurring themes identified by the committee over a period of time. It remains an evolving classification set.

The 54 RCAs were assigned the following highlighted diagnostic/clinical risk groups.

Figure 1: Highlighted diagnostic/clinical risk group



As noted above, there were a number of the RCAs which reflected a failure to recognise/respond to a deteriorating patient. Highlighted diagnostic/clinical risk groups were not identified in every RCA and some had more than one such classification.

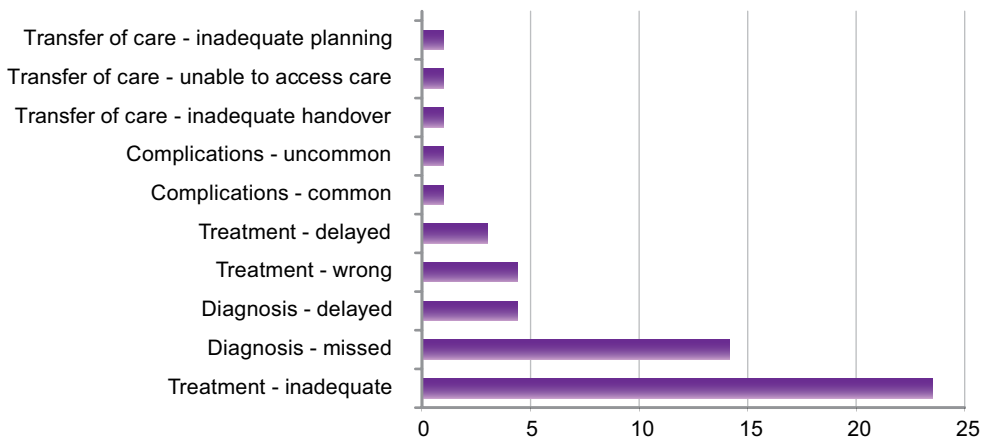


Clinical Management Sub Classifications

The clinical management sub-classifications applied to each of the RCAs is shown below. This classification is based on IIMS datasets and the RCA Review Committee's learnings. It helps to identify common themes and underlying issues from the RCA reports. Classifications determined by group consensus are recorded in a CEC database to facilitate future reviews. Unlike the highlighted diagnostic/clinical risk group, only one classification is attributed to each RCA report.

The clinical management classifications attributed to the 54 RCAs follows:

Figure 2: Clinical management classifications



Inadequate treatment and missed/delayed diagnosis were the most common clinical management classifications in the RCAs reviewed.

Although it is acknowledged that issues related to clinical supervision are multifaceted, the review found that the adequacy of supervision was often linked to issues around:

- the recognition and response to a deteriorating patient
- missed or delayed diagnosis
- inadequate treatment
- recovery strategies/failure to rescue when a complication occurs.

Many of the RCAs reflect a busy environment. This is conducive to less than optimal patient care in the absence of adequate point of care supervision. These reports also reflect issues related to culture, work practices and scheduling.

Timeframes were not examined during the review process, as this information was not well documented. Where this information was available, however it was clear that incidents occurred both during office hours and after hours. This, therefore, raises questions around the adequacy of point of care supervision across the board.

It was not always possible to understand all the underlying reasons for the problem, however, the following factors were clearly evident:

- unavailability of senior clinician
- lack of senior clinician review of the patient or input to their care planning

These broad categories may have more than one factor and these factors may be common in both categories.

Availability of Senior Clinician

Twenty-seven of the 54 RCAs reviewed reflected issues around the non-availability of senior staff.

The availability of senior staff related primarily to medical staff, although availability of senior nursing staff was also cited. The following are examples of how unavailability of senior staff impacted on the patient's care.

CASE 1: AVAILABILITY OF SENIOR CLINICIAN

A patient was admitted to a mental health inpatient unit with a provisional diagnosis of psychosis. The patient had a complex medical history. On admission she had a comprehensive mental health assessment but a physical assessment was not completed until several days later. The patient had a number of both mental and physical health problems. Her treating psychiatrist was on leave and therefore the patient was mainly managed by an intern, with only indirect input from another clinician.

The focus of care was the patient's mental health. Consultation about the patient's physical symptoms was sought informally from a physician. This consultation was provided by a medical registrar over the phone and there was no follow-up face to face consultation. The patient's family were concerned that the medical problems were not being addressed.

The mental health review tribunal requested that the patient undergo further investigation of his physical problems before having ECT. ECT was not contra-indicated. There is no evidence that the patient had any further investigation of her physical problems.

The intern who was mainly managing the patient completed her term and a new intern commenced two days later (Monday). There was no verbal handover.

The patient died. A provisional cause of death was bilateral pulmonary embolism with a deep venous thrombosis of his right leg.

Case 1 reflects lack of appropriate medical consultation and lack of clarity about who had the responsibility for various aspects of the patient's care. It also raises issues around the status of telephone consultation processes and how advice given over the phone may be applied.

CASE 2: AVAILABILITY OF SENIOR CLINICIAN

An elderly patient with significant comorbidities, including congestive cardiac failure, chronic obstructive pulmonary disease and renal impairment was admitted with right-sided lateral neck pain. He had a previous admission following a MVA. He was eventually transferred to a ward, having had morphine and midazolam in ED to control his pain and agitation. He had also been administered naloxone due to his decreased GCS and respirations.

Shortly after transfer, he was reviewed and was noted to have a potassium level of 5.6 mmol and creatinine of 381mmol. He was reviewed at least twice more because of agitation and was given sedation. After a further review by the night RMO, assistance was sought from the medical registrar, who was unable to review the patient immediately. Fifty minutes later the patient was found in cardiac arrest.

The medical officer who initially reviewed the patient on the ward was due to finish work two hours earlier, but had remained on duty due to a medical staff shortage. The emergency department had no staff specialist on duty and the HDU had to be closed because of medical staff shortages. During this period the emergency department had significant access block and was also required to cover MET and other calls from the wards

While case 2 demonstrates issues of rostering and workload it also reflects a situation where the most senior medical officer on duty was not in a position to provide immediate advice and support.

As demonstrated above and in the following cases the non availability of senior staff may be linked to competing clinical demands, rostering/skill mix and conflicting priorities - for example VMO consulting room commitments and operating schedules.

Workload

It is clear from the RCAs that competing clinical demands of the senior medical and nursing staff can often impact on their capacity to provide supervision to junior staff. This is particularly so where senior medical officers may be busy managing critically ill patients or operating. Consequently, they are not readily available to oversee the management of inpatients or provide advice on clinical matters. This may reduce awareness that junior medical officers are making decisions about a patient's condition or care, which are beyond their level of experience and expertise.

Issues related to the availability of senior nurses were mostly associated with the nursing model of care, particularly where the senior nurse has allocated patients. This reduces the level of supervision/support available to more junior staff.

The following is an example of a procedure being done without supervision, as the nominated supervisor was busy elsewhere.

CASE 3: WORKLOAD

A patient was admitted for the management of a decreased level of consciousness and seizures, after an unwitnessed fall. A lumbar puncture was performed by a junior medical officer without supervision. The procedure was abandoned as a "traumatic tap" as no cerebrospinal fluid was obtained. Documentation of the lumbar puncture by the proceduralist did not include any detail about the procedure or the difficulties encountered. The patient sustained injury to the conus.

The RCA team found that the junior medical officer's clinical supervisor was unavailable to supervise the procedure due to other work commitments, and that the junior medical resident had not been credentialed to undertake the procedure without supervision.

Case 3 reflects issues related to level of skill, credentialing processes but also reflects a situation whereby the supervising clinician was unavailable due to competing clinical demands/commitments.

Rostering/Skill Mix

Replacement of staff at short notice, e.g., due to illness, may result in staff who do not have the same level of skill as those initially rostered being allocated to the clinical unit/team. In addition there were a number of RCA reports which suggest that rostering patterns particularly related to medical staffing may not have the flexibility required to reduce the risks associated with predictable periods of vulnerability. Such practices cited by commentators include staggered rostering practices which allow greater cover by medical registrars, more flexible casual pool opportunities to ensure rosters do not go unfilled or filled with inappropriate staff and ensuring that there is at least one available clinician who has critical care skills on each shift. The following examples from RCA reports demonstrate risks associated with inadequate rostering.

CASE 4: ROSTERING AND SKILL MIX

A patient, who was deteriorating, was allocated to a new graduate registered nurse with only a few months experience. A patient allocation nursing model was in place. This model assigns patients to individual nurses, who are responsible for all their care during the shift. A team leader was rostered, but also had allocated patients. The overall staffing numbers were adequate, but the skill level of the nurses was mostly very junior because of staff shortage.

The patient was deemed the sickest on the ward, but due to the level of activity, the support/supervision of the junior nurse was less than ideal. There was a failure to recognise that the patient was deteriorating. This resulted in delayed treatment and a poor outcome.

Conflicting Priorities

Managing conflicting clinical priorities may be challenging as often there are expectations related to, for example, operating lists, consulting room commitments and other tasks. This may result in a patient not being seen by the senior clinician for some time after admission or as part of the normal review process/multidisciplinary ward round. This in turn can reduce the effectiveness of team interaction and point of care supervision.

The following is an example of an incident where the senior clinician was not available to review a patient due to conflicting priorities and work practices.

CASE 5: CONFLICTING PRIORITIES

A patient deteriorated unexpectedly. On review, there had been a failure to appreciate the significance of the patient's urinary output and a delay in review by a senior medical officer. This was due in part to communication issues, but also to competing priorities.

The ward round was done early in the day, but priority was given to ICU/HDU patients. The three rostered senior medical staff were required elsewhere: - one in the operating theatre, one at another hospital and the other in the emergency department. This left the junior medical officer to review the general ward patients, with a plan for review by a senior medical officer later in the day.

Lack of senior clinician review of the patient or input to their care planning

The RCA reports reflect that there was no senior-level input to the care/management of twenty-four patients. There were also a number of incidents in which the senior level input/review may have been delayed. It was noted that in many instances, even when a senior medical officer was available, they were not consulted or were consulted later than may be expected.

A recently published UK National Confidential Enquiry Report into Patient Outcomes and Death (2009) *Caring to the End?* indicates that "half the patients dying within four days of admission in the UK lacked input from senior doctors". Expert reviewers assessed patient records, together with further information provided by hospital staff. They found that consultants were not involved in making a diagnosis in just over half (53 per cent) of cases. There was evidence of poor decision-making and lack of senior input, particularly in the evenings and at night. Other findings indicated that a clinically important delay in the first review by a consultant in 25 per cent of cases, poor communication between/within teams in 13.5 per cent of cases and nearly 22 per cent of 'Do Not Attempt Resuscitation' (DNAR) orders were signed by very junior staff."

Given that it was not always possible to identify within the RCAs why senior input was sought late or not at all, the following factors do need to be considered: There may be:

- a failure to recognise the need for senior input, which may be directly related to knowledge, skills and experience. Junior clinicians may be "unconsciously incompetent" (Crandall et al 2003) and believe they have the skills to manage the situation. This in turn may result in a failure or delay in seeking assistance with a clinical problem
- a reluctance to seek assistance from a senior clinician, for fear that this may be perceived as incompetence
- work practices within the team which influence whether or not assistance is sought. There appears to be an understanding within some teams that the senior clinician is not usually contacted
- or that the senior clinician is not available to the junior medical officer as he/she does not visit the hospital on a regular basis.

The following are examples of incidents where senior level input/review was delayed or not sought.

CASE 6: LACK OF SENIOR STAFF INPUT AND ESCALATION OF CARE

A young patient, who was developmentally delayed, presented to ED following a reported first-ever seizure. She had been unwell with fever, headache and ear pain for two to three days before presentation. Her GP had seen her that morning and prescribed antibiotics for otitis media. The ED junior medical officer confirmed the diagnosis of otitis media, discharged the patient with analgesia, antibiotics and recommended follow-up with her GP. The patient was returned by ambulance in cardiac arrest six hours later. Preliminary autopsy findings were suggestive of “florid purulent streptococcus pneumoniae meningitis”.

The RCA team found that there were no formal policies/guidelines for the supervision of junior medical or nursing staff in ED, which resulted in inconsistent supervision of junior staff. This led to the patient not being reviewed by a senior nurse or doctor. In addition, there were no formal policies or processes to escalate the concerns of nursing staff or family regarding the patient discharge.

The case above suggests a need for formal mechanisms to ensure that patients are reviewed by a senior clinician, when there are concerns about the patient’s care and discharge.

Some RCAs reflected that a senior clinician reviewed the patient initially, but the ongoing management was left to a more junior medical officer.

The following example describes a situation where a patient was critically injured. Review by the relevant speciality occurred but ongoing management was left to the emergency department registrar.

CASE 7: LACK OF SENIOR INPUT/ESCALATION

A patient had been involved in a high speed MVA and had been trapped for 30 minutes.

A trauma call was initiated at 1600 hours, to assist the ED registrar with the management of this critically injured, unstable patient. Two registrars (surgical and anaesthetic) responded. After providing an initial assessment, the surgical registrar left the department. The ED registrar was then responsible for the ongoing management of the patient.

The RCA team noted that the consultant surgeon was involved in review of the patient approximately 90 minutes after the patient arrived. The consultant surgeon discussed the management options with the registrars, before leaving the department, but this was not documented. There appears to have been no further senior clinical input until the on-site ICU consultant become involved in the patient’s management four hours after the patient presented.

The case above suggests that the on-call surgeon role and responsibility to remain on site to oversee the management of the critically ill patient was not clearly understood. It also suggests escalation processes were not utilised.

Coincidentally a draft document provided by a commentator “Supervision of Trainees in NSW” cites: “the need for consultant led services is a world wide trend (see New York State Department of Health ruling NYCRR title 10 Section 405.4 – medical staff) and a source of many local developments e.g., acute surgical units, orthopaedic models of care in Liverpool & RPAH. There are significant medico-legal implications of inadequate supervision of trainees for hospitals and area health services as well as individual practitioners”.

The New York State Department of Health ruling referred to above - Section 4.5.4 - Medical Staff states that:

Effective July 1, 1989 for postgraduate trainees in the acute care specialties of anesthesiology, family practice, medicine, obstetrics, pediatrics, psychiatry, and surgery, supervision shall be provided by physicians who are board certified or admissible in those respective specialties or who have completed a minimum of four postgraduate years of training in such specialty. There shall be a sufficient number of these physicians present in person in the hospital 24 hours per day

seven days per week to supervise the postgraduate trainees in their specific specialties to meet reasonable and expected demand. In hospitals that can document that the patients' attending physicians are immediately available by telephone and readily available in person when needed, the on-site supervision of routine hospital care and procedures may be carried out in accordance with paragraph (2) of this subdivision by postgraduate trainees who are in their final year of postgraduate training, or who have completed at least three years of postgraduate training;

(iv) supervision by attending physicians of the care provided to surgery patients by postgraduates in training must include as a minimum:

(a) personal supervision of all surgical procedures requiring general anesthesia or an operating room procedure;

(b) preoperative examination and assessment by the attending physician; and

(c) postoperative examination and assessment no less frequently than daily by the attending physician”.

Irrespective of the approach that individual colleges may take, there is a need for guidelines on supervision of trainees with special emphasis on the procedural specialties.

CASE 8: SENIOR LEVEL INPUT/CULTURE

An elderly patient died twenty-four hours after an open cholecystectomy. This 81 year-old man presented to the emergency department with abdominal pain and was diagnosed with obstructive jaundice. He was transferred to another hospital for an ERCP which was unsuccessful. He underwent a laparoscopic cholecystectomy three days later. He was noted to have episodes of hypotension during surgery and recovery, but responded to fluid boluses.

He was transferred to the surgical intensive nursing unit (SINU) for close monitoring. The anaesthetist also notified the evening medical officer of the patient's condition and requested a review of the patient's fluid status. Seventy-five minutes after transfer, the intern on call was notified of a further fall in the patient's blood pressure. A further fluid bolus was ordered, but the patient was not reviewed. The ICU registrar was asked to review the patient 45 minutes later when the patient's blood pressure decreased further. Fluids, blood pathology and blood transfusion were ordered by the ICU registrar. The patient's blood pressure improved for a short time, however, two hours later a rapid response call was made. This was escalated to an arrest call. The patient was transferred to ICU, where he later died.

While the RCA team identified issues around the initial management of the patient, including the delayed transfer for ERCP and subsequent laparoscopic cholecystectomy, they had concerns about the skill level of after-hours medical officers and the supervision arrangements.

While the ICU registrar recognised the need to review the patient, workload delayed this review. Further, there was no call to senior medical officer, including the surgical registrar for assistance.

The RCA review team identified that there was a second on-call medical officer off-site who can be called if workload of the primary medical officer is overwhelming. However, it was reported that “there is a culture of reluctance surrounding the calling this additional on-call medical officer for assistance”.

To further compound the problem, the SINU had a staffing ratio of only one nurse to eight patients. The SINU RN was also in charge of the surgical ward and was overseeing/providing support to a junior RN. During the shift, two other critically ill patients required transfer to ICU.

Some incidents had more than one classification. For example, availability of senior staff and workload were seen together in some reports.

Also of note are incidents which suggest that when supervision is provided, it may be less than ideal. The following is an example of where the level of communication between the junior and senior doctor, delayed the management of a deteriorating patient.

CASE 9: EFFECTIVENESS OF SUPERVISION/ESCALATION

An elderly patient underwent an open reduction of a para-oesophageal hernia with gastropexy to the anterior wall. Two days after transfer to the ward, the patient was noted to be vomiting bilious fluid and having chest and abdominal pain. The patient was reviewed at least twice by the intern because of ongoing nausea and vomiting. The amount of vomiting was underestimated in verbal handover. The fluid balance chart, which showed significant amount of vomitus, was not reviewed. A diagnosis of gastric stasis was made by the registrar on the Saturday morning round, following discussion with the consultant. The verbal plan was to release the gastrostomy tube by placing it on free drainage. The nursing staff and intern were unable to place the gastroscopy tube on free drainage and determined that it was blocked. Despite several attempts and consultation with more senior staff, the tube remained blocked. This was not reported to the nurse in charge or the admitting medical officer. Discussions focussed on how to unblock the tube and lacked details about the patient's condition, which may have alerted more senior staff about the significance of the problem.

The patient was allocated to new-graduate nurses, who may have been falsely reassured by the continued involvement of the medical staff. The patient was again reviewed by the registrar the following morning. A nasogastric tube was inserted and two litres of fluid removed. The patient had oxygen saturation of 75 per cent on 4 litres of oxygen, laboured breathing and pulse rate 140bpm. The patient was transferred to ICU with a diagnosis of massive gastric aspiration with severe lung injury. A CT scan demonstrated detachment of the stomach from the abdominal wall with retraction into the chest. The patient died of sepsis and multi-organ failure.

The RCA team identified that there was a lack of recognition of the signs of deterioration and therefore no escalation to senior staff.

The problem was compounded by the NUM having a clinical load as well as responsibility for running the ward thus reducing his/her ability to adequately supervise junior staff and the status of their patients.

Conclusion

The incident reports described above show us that patients are at risk when clinical supervision is not working well. Point of care supervision is at least as important as the formal professional and clinical development processes. The latter are generally well-structured and important learning opportunities.

“Point of care supervision is equally important but takes time, and is best accompanied by a teaching intervention. This benefits long term patient safety not just the immediate outcome for the patient involved”. (Comment received)

Report summary of findings and feedback

Based on the findings of the review and comments received directly from clinical groups and Area Health Services in response to the draft document the following issues are evident:

Issues identified

1. Point of care supervision of junior medical, nursing and allied health staff is critical to the provision of safe care to all patients. "The apprenticeship model persists as the major model of training especially in procedural specialities. Inherent in the apprenticeship model is the need for appropriate supervision". (Comment received)
2. "The NSW Department of Health (Ministry) and its facilities and all clinicians have an obligation to ensure that supervision is appropriate, defined and supported by a transparent process. It is no longer acceptable for trainees to muddle through procedures and learn by experimentation rather than guided instruction under appropriate supervision." (Comment received) This reflects the Garling Report.
3. "The current flaw is that many work practices depend on the judgement of junior doctors to recognise when they don't know or are out of their depth. Trainees are junior, mobile, inexperienced and may be "unconsciously incompetent" (Crandall et al 2003) in their task and need to be actively supported and supervised rather than passively overseen". (Comment received)
4. There is a need for a shift from the passive to active surveillance/supervision of junior staff. Crampton et al 2010 suggests that the concept of active supervision needs to be promoted in all clinical units. Active supervision occurs when the supervisor is sufficiently engaged and vigilant in their support of junior medical officers. This includes providing assistance, whether they ask for assistance or not. Active supervision acknowledges that some junior medical officers are unconsciously incompetent. Active supervision is described below:
 - Routine oversight, which must be sufficiently vigilant to pick up clues that the supervisors direct intervention in patient care is needed.
 - Responsive oversight when the supervisor actively seeks evidence of the junior medical officer's performance and responds with more a "hands on" or "hands off" approach to supervision.
 - Direct oversight, when the supervisor directly intervenes in patient care as when the senior clinician is clearly responsible for taking the immediate action required.
 - Backstage oversight, when the supervisor ensures that care is progressing appropriately by checking the junior medical officer's record keeping, reviewing tests and imaging and talking with other members of the clinical team. Backstage oversight also includes the management of systems to safeguard care such as handover routines and protocols for escalating care".
5. Workforce including workload, rostering practices and skill mix are common risks elements which impact on to patient care. These risk elements were identified in the RCAs reviewed. Many of the RCAs reflect a busy environment. This environment is conducive to less than optimal patient care in the absence of adequate point of care supervision.
6. Roster patterns particularly related to medical staffing may not have the flexibility required to reduce the risks associated with predictable periods of increased activity. This may leave patients vulnerable and at risk.
7. Senior clinicians, who have overall patient responsibilities, are required to prioritise their work. This may be challenging as often there are expectations related to for example operating lists, consulting rooms commitments, and other tasks. This may result in patients not being seen by a senior clinician with his/or her team for some time after admission/or as part of the normal review process/multidisciplinary ward round. This passive supervision in turn can reduce the effectiveness of team interaction and point of care supervision.

8. Point of care supervision responsibilities may not be clearly articulated and therefore not be fully understood. This relates to both in hours supervision as well as after hours.
9. Within the data there is evidence of no or delayed escalation/input by senior clinician to care planning. The reasons why this occurred is unclear, but some elements are evident and need to be considered. This includes:
 - A reluctance to seek assistance from a senior clinician, for fear that this may be perceived as incompetent or reprisal.
 - Work practices within the team may influence whether or not assistance is sought. There appears to be an understanding within some teams that the senior clinician is not usually contacted.
 - The senior clinician is not available to the junior medical officer as he/she does not visit the hospital on a regular basis.
 - Also as indicated earlier, there may be a failure to recognise the need for senior input, which may be directly related to knowledge, skills and experience. The junior clinician may be “unconsciously incompetent” (Crandall et al 2003) and believe they have the skills to manage the situation. This in turn may result in a failure or delay in seeking assistance with a clinical problem.
10. There is no standardised code of conduct or performance appraisal for registrars who have completed their training, which ensure ongoing commitment to supervision of junior staff.



Recommendations

Those with responsibility for ongoing care of a patient must provide the necessary supervision to ensure that all medical and nursing staff involved have a mutual understanding of who does what and who is responsible. Any delegation of responsibility must be reflected in the patient's medical record.

Individual level

1. Review work practices to ensure that all critically/seriously ill patients are reviewed at least daily by a senior clinician who will confirm with junior staff on going care requirements.
2. If a senior clinician identifies concerns about a patient eg sepsis, the follow-up instructions given at point of care must include adequate instruction to junior medical staff on what to do if the condition persists or the patient deteriorates.

Facility/unit level

3. Before discharge, patients seen in the emergency department by an intern should have their care reviewed by a supervisor.
4. Every patient should be seen by the admitting medical officer or senior clinician within 24 hours of admission. The admitting medical officer must ensure that the patient's care plan is documented in the clinical record. As part of active supervision, it is the expected norm that the admitting medical officer discusses the care plan with the junior medical officer to actively confirm their ability to carry out the plan.
5. Every clinical speciality must have guidelines for point of care supervision by on call clinicians. The guidelines should be clear to both the on call clinician and to the junior staff on duty. Unit managers must ensure that both senior and junior staff share a common understanding of the guidelines.
6. Escalation pathways for deteriorating patient should include notification of the admitting medical officer or the consultant who is providing out of hours cover for that admitting medical officer.

Local area district

7. Position descriptions of clinical directors and senior managers must emphasise responsibilities for promoting a culture which:
 - is patient-focussed
 - is supportive of trainees and junior staff
 - encourages all staff to seek help early when confronted with a clinical problem

This needs to be reinforced with people currently in these positions and must be part of senior clinician and senior management performance review process.

8. Position descriptions and visiting medical officer contracts must explicitly outline active clinical supervision requirements. As part of accepting and signing off contractual condition every clinician involved in point of care supervision must acknowledge that they are required to provide active clinical supervision.
9. Rostering practices should allow for adequate supervision at the same time as meeting the demands of clinical care and reporting. This should include the adoption of staggered roosting practices to allow greater cover by registrars. There also needs to be more flexible casual pool opportunities to ensure rosters do not go unfilled or filled with inappropriate staff.

10. Ideally as part of providing greater levels of point of care supervision after hours, there should be senior clinicians on duty in selected specialties (e.g., general medicine, ICU and emergency department). At a minimum at least one clinician should have critical care skills. Examine options including the concept of hospitalists.

Consider broader implementation of patient at risk concepts to improve patient safety after hours. (Campbelltown model). This includes:

- Establishment of CNC–clinical support after hours positions, which provides clinical leadership and clinical advice after hours to both medical and nursing teams.
 - Introduction of Patient at risk Boards which focuses on finding the “signal” in the noise – identifying and tracking those patients deemed at risk of clinical deterioration.
 - Multidisciplinary evening to night handovers with both medical and nursing staff including all incoming /outgoing junior medical officers and registrars, after hours nurse managers and after hour CNC-clinical support.
11. Failures in clinical supervision and other failures in safe patient care may be the effects of staff shortages. These incidents should be reported and monitored within the local networks reporting systems to enable organisational action in response to occur.
12. All orientation programs must contain information about escalation processes, pathways and numbers for contacting senior staff during and after-hours. Contact details must be clear and current.
13. Procedures that entail a potential risk to patient safety and which require previous experience should only be performed:
- by staff members who have been tested and credentialed to perform the procedure
 - for training purposes, by trainees who are under the direct and immediate supervision of a credentialed supervisor.

A system for recording the testing and credentialing of clinicians should exist in each clinical unit and should be readily accessible to staff who are involved in assigning tasks.

State level

14. The Clinical Education & Training Institute’s (formally the Institute of Medical Education and Training) accreditation standards for prevocational training and supervision policy should be revised to make clear that active supervision is the required standard for point of care supervision of junior doctors in training.
15. Implementation of the “Garling Report” recommendation continue. Section 45 (a-g) states that “A best practice model for supervision of junior clinicians will be developed with state wide policy disseminated. Roles and responsibilities in relation to supervision will be clarified in standard position descriptions for all clinical staff. Active supervision is part of the function of any senior staff that have responsibility for juniors and while dedicated time may be required for teaching it is inappropriate to allocate time on this basis for supervision”. The expectations must be clearly articulated and should include the roles and responsibilities of supervisors in the position descriptions of employees and independent contractors. The model should place emphasis on point of care supervision by all senior and on-call clinicians. (This is currently in train)
16. A Statewide approach to ensuring locum agencies include and support the supervision of junior clinicians in job descriptions of senior clinicians.
17. Consultants must have clear guidelines for junior staff about referrals, which includes protocols related to refused admissions.

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