



RANZCOG Training Registrar Supervision Guideline

1. Objective

To ensure safe and timely Consultant supervision of RANZCOG trainees.

2. Outcome

To ensure that appropriate mechanisms are in place for Consultants to attend to supervise and support trainees in a variety of clinical scenarios.

3. Target Audience

RANZCOG Trainees, Consultants, Training Supervisors and ITP Co-ordinators.

4. Purpose

The purpose of this guideline is to outline circumstances when a RANZCOG trainee Registrar is expected to consult with the O&G Consultant on call, and situations when the Consultant may be expected to attend, irrespective of the credentialing and experience of the Registrar, because of the clinical circumstances.

5. Preamble

RANZCOG trainees are expected to work in a variety of hospitals with varying levels of acuity and clinical capability. It is important from a patient safety perspective that trainees are adequately supported and supervised at all levels of their training by their Consultant staff, and that Consultants are supportive of a trainee's need to train, and the differing rates at which trainees gain requisite skills.

Consultant staff are rostered on call to undertake and support the provision of safe quality care to women and their families across the spectrum of Obstetric and Gynaecological problems. It is also the responsibility of the Consultant staff to provide appropriate and timely support, teaching and supervision to doctors in training and to nursing and midwifery staff. It is essential that appropriate Consultant support and supervision is available through the 24 hours, and that all staff have the ability to escalate care to the on call Consultant in the face of emerging difficulties, that may be beyond the capability of the rostered junior doctors to safely manage, or other clinical concerns.

Trainees on entrance to a RANZCOG Training Program will have differing levels of skills and experience, and it is expected that each training site should have a credentialing process such that trainees can be credentialed for the performance of various procedures unsupervised. It is expected that credentialing is reviewed at least every 6 months, usually at the time of the Registrar's summative assessment.

Trainees can be credentialed in a variety of ways. One way that has been suggested by RANZCOG is as follows:

RANZCOG Trainees should be credentialed in three bands

1. Level 1: The Consultant is in the room actively supervising/assisting the trainee
2. Level 2 : The Consultant is in the hospital while the trainee is performing a procedure
3. Level 3: The Consultant is remote from the hospital while the trainee is performing a procedure, but is available within 20 minutes

Another way to credential trainees could be in 2 bands only. These are:

Band 1: The trainee is able to perform the procedure unsupervised.

Band 2: The trainee must be supervised in the performance of the procedure.

Clearly, there are subtle differences in each of the two systems and individual hospitals should utilise the system that best works for them, and it is important that trainee credentialing is reviewed and updated regularly, at least 6 monthly at the time of the Summative assessments, and that acute care areas e.g. Birth Suite and Operating Theatre have a copy of current credentialing privileges for each trainee.

Given the complexity of training, and the reduced numbers of hours that trainees are working, it is sometimes difficult to ensure that each trainee is exposed to sufficient cases across the breadth of Obstetrics and Gynaecology to ensure that all their training needs are met. Because of this, even more experienced trainees may not have been exposed to a particular clinical scenario before and may require the attendance of a Consultant to assist in the patient's management.

6. Consultant Attendance

For this reason, there may be circumstances when particular hospitals deem that Consultant attendance is essential, because of either

- (a) The complexity of the clinical problem
- (b) The likelihood that the Registrar will have insufficient experience to deal adequately with the problem

There is abundant evidence in maternity care for poor outcomes related to delays in escalating care to senior staff, and various clinical practice guidelines have recommended early involvement of Consultant staff in e.g. management of cases of severe pre-eclampsia and eclampsia, caesarean section (CS) at full dilatation and so on. Patient expectations in maternity care have never been higher, and it is reasonable that women should expect to receive 'the right care by the right person at the right time'.

Maternity care is delivered in teams and it is important that each team member is supportive of others. Thus it is important that a midwife or scrub nurse in Operating Theatre has confidence in the ability of a trainee to carry out a particular procedure safely, and that they have the ability to escalate care to the Consultant if they feel that a trainee is getting into difficulties.

It is important that trainees are able to readily access Consultant support in clinical situations where they may feel uncomfortable, out of their depth etc. Equally, it is reasonable for a Consultant to have the expectation that a trainee will attempt to manage a case appropriately, and not to seek Consultant input until they have managed the case to the best of their ability. Patient safety is paramount and workforce disputes between Consultant and trainee must NOT be an obstacle to a patient receiving appropriate care.

In view of the above, RANZCOG deems it necessary that each hospital have a list of clinical scenarios where Consultant attendance is expected regardless of the experience of the trainee. This list should be widely circulated to all appropriate staff and be available in the relevant clinical areas of the hospital (e.g. Birth Unit, Operating Suite). Listed below are suggested events which may be included on the list:

- (a) Maternal death in pregnancy
- (b) Amniotic fluid embolus
- (c) Eclampsia
- (d) Severe pre-eclampsia when the patient is not responding to standard anti-hypertensive therapy
- (e) Severe sepsis when the patient is showing signs of septic shock
- (f) Caesarean section - at full dilatation
 - anterior placenta praevia

- CS with suspected abnormal placentation
- Circumstances where it is likely a classical CS may be necessary
- (g) Postpartum haemorrhage of >1.5 L when blood loss is ongoing
- (h) Vaginal breech birth of a live baby at a viable gestation
- (i) Patient refusing life-saving treatment (mother or baby)
- (j) Placental abruption with evidence of coagulopathy
- (k) Peripartum hysterectomy
- (l) Any return to Operating Theatre
- (m) Any patient requiring admission to Intensive Care
- (n) 4th degree perineal tears
- (o) Assisted vaginal delivery in theatre (mid-cavity or rotational births)
- (p) Multiple pregnancies in labour

Further, it seems reasonable that the trainee notify the Consultant in the following circumstances. Whether the Consultant attends in these circumstances will be discretionary, based on the discussion with the trainee.

- (a) Transverse lie with ruptured membranes
- (b) Women in active pre-term labour
- (c) Fetal death in labour or unexpected stillbirth
- (d) Any case requiring transfer to theatre

Consultant attendance may be requested by the trainee in a variety of other clinical situations in both Obstetrics and Gynaecology. Whether the Consultant attends or not should be determined by

- (i) The request of the trainee
- (ii) The trainee's level of credentialing for the procedure
- (iii) The Consultant's assessment of the complexity of the case
- (iv) The Consultant's knowledge of the capability of the trainee
- (v) Other acuity in E.g. Birth Suite or other acute care area where patient safety may be compromised if the trainee is unavailable to attend

Should the Consultant decide not to attend, and the trainee feels unable to perform a particular procedure without supervision, they must seek help from an alternative Consultant, who may not be on call.

7. Clinical Handover

Trainees rostered for evening or night shifts should liaise with day team to effectively triage ongoing problems, and then discuss any problems with the on call Consultant at a reasonable hour to provide them with an up to date list of problem cases and potential difficulties that may arise in patient care over the course of a shift. Appropriate management plans should be in place and documented in the patient's record.

It is important that trainees are aware of how long it may take a Consultant who is on call and off site to travel to the hospital, and that Consultant referrals are made in a timely fashion.

It is also important that Consultants inform trainees of what they wish to be informed about overnight, if patients require admission, as Consultant behaviours in this area will vary.

8. Workplace Difficulties

Should trainees face difficulties in getting Consultants to attend in a timely way, and may have to seek alternative Consultant assistance in an emergency situation, it is essential that they notify their supervisors the next day of such behaviours.

If Consultants have significant concerns about the capability of a trainee working in night shifts unsupervised, it is equally important that those concerns are notified to the Head of Department, and that those concerns, if unrectified, are reflected in the trainee's Formative Appraisals and Summative Assessments, as necessary.