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2 Feburary 2009

Don Hunn (Chair)
c/- Brenda Wraight
Director-General's RMO Commission
Ministry of Health
PO Box 5013
Wellington

Dear Don Hunn,

Thank you for the opportunity to make a submission to the RMO Commission. Members of the College of Nurses Aotearoa work alongside RMO on a shift by shift basis, and this is the perspective from which this submission is prepared. Given this is a brief submission, highlighting areas of interest from our perspective, we would be happy to meet with the Commission at any time to explore any areas of interest to you.

It would seem currently the prime reason for having RMOs is to deliver service, yet RMOs are trying to develop to be our future specialist workforce, be that in general practice or acute and speciality services. Similar resources are required across the sector to meet learning needs. Managers of the environments across the health sector need to understand the requirements and meet the specifications required from a learning environment. Such an investment has huge benefits for the culture of services, teamwork, collaboration, and patient safety/outcomes and service outcomes.

The Environment
Issues we see facing RMOs are high acuity patients, high occupancy, often outliers from home wards, fast turnover of caseloads with short rotations in complex environments with multiple specialty and sub-specialty multi professional teams. Also many nurses are no longer New Zealand educated (23%) and may no longer provide the same level of support.

Often in inpatient service wards the nursing teams are experiencing shortage and skills mix issues along with decreased participation levels (part time) and casualisation of the nursing workforce. The workforce can be quite junior in parts, and this challenges our traditional ability to teach, collaborate, and be the safety net.

Teaching and supervision by registrars who are training and sitting exams while trying to deliver service in the above environment is problematic *(Resident Duty Hours: Enhancing Sleep, Supervision, and Safety http://www.iom.edu/CMS/3809/48553/60449.aspx).*
Relief for time away, locums etc all then impact on the broader team. Consultants have similar burdens, with multiple settings of practice, thus multiple teams, generally with heavy workloads (high contact time), and competing priorities.

From a systems perspective, the current construction and timing of PGY1 and PGY2 rotations are not conducive to quality patient care, team service improvement or development of inter professional ways of working. The novice level of practice of the PGY1 and advanced beginner level of practice of PGY 2 is not sufficient to meet the needs of patients and nurses. RMOs get exposure to case types but one could ask "Is it enough to develop competence and competence in what, the specialty or sub-speciality or the general underpinning foundational skills?" Is this clear to all?

Change-over of the years occurs just before the summer holiday period, which can be problematic, given the learning required to operate in the environment, the team/s, and the specialty. The pace of work means that shared teaching on rounds can be compromised not just for RMOs but nurses as well.
Any learning programme needs to be able to operate in the current realities of practice and the service environment.

The Education

The Medical Training Board has asked whether there should be one national integrated medical training body. The argument for one and the aims of such a body are laudable. We would recommend, given the nature of the health system, other professions have a role in such a body.

Competency frameworks and levels of practice are not new to nursing. The use in Medicine would seem to assist all parties to support RMOs.

The Teachers

Many people and situations contribute to RMO learning. The opportunities seem limited to service delivery and don't seem to have the RMOs involved in the broader team and service development. Longer runs and less rotations would increase teamwork and a sense of sharing the burden and would reduce the recurrent systems issues that plague high turnover environments. Issues are very similar for students of nursing.

Currently much time is perceived to be spent in clerking in patients, yet this generally creates a major learning opportunity; comprehensive assessment. Perhaps this process needs to be reconsidered and reframed.

At the same time the sector is being driven to reduce duplication across services and professions. Nursing and Medicine need to get together on this topic to thrash out how these goals can be achieved while preserving learning opportunities required for the knowledge and skills development of both professions. A combined approach here would reduce much of the "clerking", yet keep RMOs engaged in the management of patients and reduce the work of nurses as well. To achieve this, there would need to be some joint education to build trust and confidence of the professional groups across the country, not just locally.

Senior Medical Officer contact time needs to be managed to enable adequate supervision and energy for training and service improvement.

Combining the education with the environment for an RMO's learning seems to need a national approach to placements, regional at a minimum, for an integrated education system to optimise success for the individual while maintaining service, and reducing risk.

The current environment and the history of international new policy has created a strong market driven environment in health. This has had a major impact on the professions, introducing a level of industrial behaviour in response to the market. The "unseen hand" has not been able to prevail to reinforce professional values and behaviours. This is well documented in many texts. Our challenge, which we share with you, is to reform for the current and future health and safety of all New Zealanders.

Yours sincerely

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Executive Director

Ms Sue Wood RN MA FCNA(NZ)
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