FRAMEWORK

Consultant Led Clinical Care: A Framework for Consultant presence and senior decision making for safe and high-quality care

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Document governance	
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1. BACKGROUND

Lack of senior medical staff (SMS) oversight in clinical decision making and lack of timely escalation of care have been the key contributors to serious adverse events including sentinel events.

Consultant led clinical care implies clinical decisions about a patient's care are overseen by a specialist and a specialist is accessible, available, approachable and accountable to review or attend to a patient in person or remotely as per clinical need.

Benefits of consultant led clinical care include:

- Higher level of clinical experience and competence to enable prompt appropriate decision making about clinical management including early recognition and response to clinical deterioration.
- Improved outcomes for patients which follow from appropriate timely diagnosis and management.
- Experienced clinical judgement and skill leading to more effective working and more efficient use of resources through, for example, length of stay reduction or fewer investigations.
- Patient expectation of access to appropriate and skilled clinicians and information in a timely fashion.
- Improved supervision, training, mentoring and support of junior doctors.
- Enhanced communication and teamwork between consultant and junior doctors, leading to increased likelihood of escalation of clinical concern.
- Consultant led escalation to address barriers to progression of care.
- Support for multidisciplinary team in communication with other teams involved in the care of the patient.
- Increased consultant to consultant conversations to resolve barriers to care.

2. PURPOSE/AIM

This framework outlines the principles of consultant led care, medical leadership accountability for consultant led care and the systems and processes expected at a unit level to enable consultant oversight and decision making for safe and high-quality care.

It also highlights key responsibilities of junior and senior medical staff in two areas:

- Consultant ward rounds: frequency/ mode.
- Escalation by junior medical staff (JMS) to consultant.

3. SCOPE

The document addresses the minimum expectations for consultant presence and senior decision making for safe and high-quality care. This framework will support the principles and deliverables of the Excellence in Timely Care initiative.

4. EXCLUSIONS

While traditional models of consultant led ward rounds are a well-known system to ensure that patients are reviewed by a consultant regularly, these are resource intensive and may not be feasible in all settings on a daily basis. Units may develop alternative innovative systems that will enable consultant decision making, accountability and oversight of patient care. Such units are required to develop an alternative plan in agreement from their Program Director, and to be approved by the Monash Doctors Leadership Committee (MDLC), detailing the rationale for variance, alternate systems and processes for ensuring Consultant oversight. This plan must be endorsed by the Program Director before approval by MDLC. A template for the alternative plan is found in Appendix 1.

5. TARGET AUDIENCE

All medical staff employed at Monash Health.

6. IMPLEMENTATION

Unit Directors are responsible for implementation of this framework in their units.

Program Directors and Chief Operating Officer will review the need for additional resources required for implementation of the framework. Units should discuss the need for additional resources with their Program director who will discuss this with the Chief Operating Officer/relevant DCOO must occur.

Chief Medical Officer is accountable for communication and monitoring of implementation of this framework.

7. PRINCIPLES

The consultant on ward service/on call is responsible for all decisions about the care of the patient during the service period.

The operating proceduralist (Surgeon, Physician, and Radiologist) is responsible for the pre and post-operative care of the patients operated on their lists.

JMS are supervised by a consultant and work within the scope of practise appropriate for their level of experience and competence.

JMS have access to a consultant at all hours of the day to discuss clinical concerns.

JMS are aware of criteria for escalation to a consultant and encouraged, supported and rewarded for escalating concerns.

7.1 Frequency and timing of consultant review

Admission

All patients are physically reviewed by a consultant of the admitting unit within 24 hours of admission or earlier as per clinical need. Frequency of Consultant reviews thereafter may vary.

- Acute admissions must be reviewed daily as a minimum till their condition is physiologically stable, a provisional diagnosis has been made, a management plan is in place and clear criteria for escalation to a consultant have been determined and documented.
  Following that they may be reviewed every 48 hours or earlier as per clinical need.
- For subacute patients the above criteria apply if the patient is physiologically unstable.
  In other circumstances subacute patients must be seen physically 1-2 times a week depending on clinical need.
- Patients in ICU/HDU must be reviewed daily as a minimum.
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In some units, subject to approval by the Program Director, on some instances ward rounds may be conducted by senior, experienced advance trainees or fellows ensuring that the consultant is available to physically attend where required and are in regular contact with the trainee to discuss new admissions, complex cases, clinical deterioration, and lack of progression of care. It is expected that the consultant will review patients at least once every 48 hours. The accountability for clinical outcomes still remains with the consultant.

Any lack of progression of care, serious adverse event, family or interdisciplinary conflict must trigger a consultant review within 12-24 hours or earlier as per clinical lead.

All consultant reviews and decisions must be documented in the medical record.

Transfers

All patients transferred out to other units, sites or external health services have a consultant review 24- 48 hours prior to patient transfer, and aligned with Patient Transfer (Operational) procedure.

Discharge

All patients have a consultant review 24- 48 hours prior to patient discharge, and aligned with Discharge Planning procedure.

7.2 Medical Leadership accountability for consultant led care

Unit Director is accountable for delivery of safe and high-quality care for patients under the care of their unit.

- For inpatients this is the Unit Director of the bed card holding unit, including after hours.
  When the patient is in ICU it is the joint accountability of the ICU Director and the Bed card holding Unit Director.
- For outpatients it is the Unit Director of the unit the clinic comes under.
- For patients in the Emergency Department (ED), it is the Unit Director of the relevant ED until the patient is admitted to an inpatient unit when it becomes the accountability of the inpatient Unit Director.
- Unit Directors are expected to implement and oversee systems and processes for quality and safety within their units.

Program Director and Chief Operating Officer are responsible for ensuring all units are supported adequately to provide safe and high-quality care.

8. SYSTEMS AND PROCESSES FOR CONSULTANT LED CARE

8.1 Ward Rounds

Consultant led ward rounds must occur at the frequency outlined above in line with the principles of consultant led care.

- In general, it is expected that the SMS on ward service will attend the hospital to do a ward round at the frequency outlined above. Timing of the ward round should be at a consistent time and must be communicated to the Unit Manager of the ward, so they are able to facilitate attendance of the bedside nurse. Each patient will have a management plan approved by a consultant each day of their admission and a daily review of their estimated discharge date (EDD). Alternatives to this as approved by the Unit Director, may include:
  - The use of virtual consultant led ward rounds in conjunction with JMS attendance in-person by the patient's bedside if safe to do so.
  - When the patient does not meet the criteria for a daily consultant ward round a registrar led ward round must occur, and a management plan discussed and approved by the consultant on service each day with a review of the patient's estimated discharge date (EDD) and documentation of the plan and EDD in the patient's EMR.
  - On weekends and public holidays, as a minimum, a registrar led ward round should occur, and new admissions, complex cases, clinical deterioration, and lack of progression of care must be discussed with the consultant on ward service/on call. It is expected that consultants will attend in or out of hours, weekdays or weekends if required, in addition to routine ward rounds.
  - To assist limited staffing on weekends home teams must ensure a management plan, discussed and approved by the consultant, is documented in the Electronic Medical Record (EMR) prior to the upcoming weekend and/or public holiday.

8.2 After hours consultant availability

- All units must have an afterhours on-call consultant roster that is made available to contact centre and to the clinical teams.
- Unit heads must outline clear expectations of their consultant medical staff, SMS, and JMS about escalation of care and clinical concerns.

All overnight and after hours MET calls and Code blues must be communicated to the consultant on call and treating team.
The timing of escalation to a consultant will depend on the clinical urgency and experience of the treating JMS team.
Any significant concern must be escalated to a consultant and if unsure, notification should occur immediately.
All SMS are responsible for handover of care to another SMS when they are on leave or not working at Monash Health.
SMS must be easily contactable when on call by their preferred method as nominated to switchboard.
When on call, an SMS is expected to respond to calls from a JMS within 30 minutes, unless earlier contact is clinically required. If the SMS is not contactable for any reason, the Unit Director must be contacted followed by the Program Director if required. Each unit must have a clear escalation policy that is communicated frequently to JMS and SMS with appropriate processes of escalation if concerns are not appropriately addressed within a reasonable timeframe.

8.3 Supervision of junior medical staff

- All JMS must be oriented to their units at the start of their rotation, must work under supervision and within their scope of practice.
- For resident medical staff all units must appoint a SMS as a dedicated prevocational supervisor to oversee the orientation, performance, and training of prevocational staff in the unit. Clinical support time must be allocated for this portfolio and clear performance measures agreed between the unit director and supervisor.
- Scope of practice of registrars and fellows must be documented and supervision in accordance with level of experience must be in place.

8.4 Response to referrals for consultant opinion

- Consultant opinions must be obtained within 24 hours for all inpatient referrals. Referrals must be requested on EMR using ISBAR format and have a question for the consulting team. The consulting team will provide advice and the bed card team will determine actions with respect to that advice including referrals to other services.

8.5 Escalation of Care

- Each unit must have a clear escalation policy that is communicated frequently to Junior and Senior Medical Staff.
- JMS must escalate to the consultant on service when patients meet escalation criteria or if they have any clinical or operational concerns.
- Usually, residents will escalate to registrars and registrars will escalate to consultants. However, if concerns are not appropriately addressed, then anyone, including nursing and allied health staff, can escalate directly to a consultant (or unit director).
- Lack of escalation must be discussed at unit meetings and with JMS at orientation and education meetings to understand and address barriers to escalation.
- Unit specific resources on escalation of care can be found via Prompt and include:
    - All Departments
        - Deteriorating Patient Recognition and Management (Operational)

        - Escalation: Minimum criteria for notification to a Consultant
        - Adult MET and Code Blue
        - Adult Clinical Observations and Response
    - Maternity
        - Escalation: When to notify an obstetric Consultant
    - Children's
        - Escalation for Neonatal review 52 Maternity
        - Neonatal MET call / Code Blue
        - Escalation - when to notify a Consultant Monash Newborn
        - Criteria for Mandatory Escalation to the Paediatric Intensive Care Unit (PICU) Consultant
        - Paediatric MET and Code Blue
        - Paediatric Patient 'Call Now' Criteria
    - Emergency
        - Emergency Department MET - Identification and Response to Patient Deterioration
        - Prioritising patient care Emergency Department Admissions
    - Surgery
        - Escalation and Care of the Surgical Patient
    - Other
        - Monash Imaging request escalation of critical demand
        - Escalation of Abnormal Pathology Results - Chemotherapy Day Unit Moorabbin/Dandenong
        - Deteriorating patient Hospital in the Home

9. FOLLOW UP AND ACCOUNTABILITY

All future adverse events due to failure to escalate or lack of sufficient consultant oversight as a contributing factor will be monitored by the Quality and Safety Unit, Program Director and Chief Medical Officer to understand and address reasons for lack of adequate quality and safety control measures.

10. RESOURCES

The document is aligned to the current Monash Health policies and procedures on Escalation of Care / Consultant Supervision:

- Deteriorating Patient Recognition and Management (Operational)
- Escalation: Minimum criteria for notification to a Consultant
- Adult MET and Code Blue
- Adult Clinical Observations and Response
- Escalation and Care of the Surgical Patient

11. REVIEW

This document will be reviewed every year or as required by MDLC.

APPENDIX 1

Implementation tool: Consultant led clinical care checklist for Units

Context: The minimum expectations for consultant presence and senior decision making for safe and high-quality care are outlined in the consultant led clinical care: A Framework for consultant presence and senior decision making for safe and high-quality care.

Aim: As it is acknowledged that units may vary in systems and processes whilst continuing to deliver safe and high-quality care with senior oversight and input. This template will define the agreed unit plan for consultant led care. It should be completed by the Unit Director, signed off by the Program Director, and approved by Monash Doctors Leadership Committee (MDLC).

Note: Review by a consultant can occur either in person or virtually.

Date:	**Unit:**		**Program:**		
	Consultant Led Clinical Care Expectations	**Framework Model of Care**	**Alignment**	**Rationale and details of suggested alternate model of care and risk mitigation:**	
				Weekday	**Weekend**
Admission	All patients are reviewed by a Consultant, with a documented management plan and estimated discharge date in the patient notes.	Within 24 hours or earlier as clinically needed on admission	Yes ☐ No ☐		
Ward Rounds	All patients are reviewed each day by a Consultant, with a documented management plan and estimated discharge date in the patient notes.	**Acute/ ICU/ HDU** Daily (minimum)	Yes ☐ No ☐		
		Subacute patients Daily if physiologically unstable.	Yes ☐ No ☐		

		Otherwise, patient must be seen physically twice per week.			
Escalation of Care	All patients who experience any lack of progression of care, clinical deterioration, serious adverse events (including MET Calls and Codes), family or interdisciplinary conflict are discussed and/or reviewed with a consultant.	Within 12- 24 hours, dependent on clinical urgency. HOWEVER, all events must be communicated.	Yes ☐ No ☐		
Referrals & Transfers	All patients transferred out to other units, sites or external health services have a consultant input/ review prior to patient transfer.	24 – 48 hours prior to transfer	Yes ☐ No ☐		
Discharge	All patients have a consultant input / review prior to discharge with a documented discharge plan	24 or 48 hours prior	Yes ☐ No ☐		
Date: Completed by Name and Signature:				Date: Program Director Name and Signature:	
Date endorsed by MDLC:				Suggested date of next review:	