Accreditation Committee Guideline

Appropriate Acute Adult Inpatient Workloads for RANZCP Trainees March 2018

The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

Introduction

The current RANZCP *Training Program Accreditation Standards* provide:

3.5.1 The workload for trainees within each post is such that time spent in clinical service delivery does not compromise training and trainee welfare.

3.5.2 The working conditions for trainees within each post are such that the working conditions are conducive to training and trainee welfare.

3.5.3 Fatigue management programs are in place to diminish the impact of fatigue on the training experience, incorporating automatic mechanisms for sending trainees home or considering shift or night duty options.

The current *Rotation Accreditation Standards* also provide:

Services must have:

1.2.1 Processes to monitor and manage trainees' workload in place and a policy on how concerns about excessive workloads are raised and addressed.

1.2.2 Processes and policies to address the trainee's and/or supervisor concerns about workload and to help trainees manage clinical workloads.

This Standard requires a statement from the Health Service that indicates the expected case load during the rotation (per 1.0 FTE), and a copy of written processes to monitor, review and manage trainee workloads. In addition, evidence is required to confirm that fatigue management programs are in place, and their effectiveness is regularly monitored by the Director of Training and the Branch Training Committee/New Zealand National Training Committee (Training Committees).

All RANZCP trainees are required to obtain experience in a variety of clinical settings during their training. The 2012 Fellowship Program requires considerable amounts of time during normal working hours from both trainees and their supervisors. The Accreditation Committee (the Committee) is aware of the impact of service provision arrangements in the workplace on trainees' welfare and wellbeing, and on their ability to complete the specific requirements of the 2012 Fellowship Program.

The Committee also notes that data in both Australia and overseas suggest doctors in training are vulnerable to psychological distress and burnout (Beyondblue, 2013; Dyrbe et al, 2014; Kealy et al, 2016; Amoafa et al, 2015). The literature underlines the importance not just of individual resilience measures for doctors in training, but of the importance of system and organisational interventions to promote wellbeing and a quality learning environment (Slavin and Chibnall, 2016; Ripp et al, 2017; Lee et al, 2013).

From accreditation site visit feedback regarding acute adult psychiatry rotations, there will be a maximum volume of clinical work beyond which a trainee's training is compromised by excessive workload demands. The acute adult inpatient unit is commonly a trainee's first clinical placement within their RANZCP training. Work intensity may be particularly high in this initial period given junior trainees may experience greater cognitive load than more senior trainees given their limited experience (Ripp et al, 2017; Schumacher et al, 2012).

Workload has been one of many factors associated with burnout in doctors (Lee et al, 2013; Schmacher et al, 2012; Eckleberry et al, 2017). Workload may also impact quality patient care (Thanarajasingam et al, 2012; Vidyarthi et al, 2007).

Accreditation site visitors have also noted that in some services non-psychiatry trainee junior doctors working in the same setting are subject to formal workload caps, and that, at times, this has led services to increase patient numbers for RANZCP trainees who have no formula. Accreditation site visitors have found it difficult to take a consistent position in such cases because no formal RANZCP guidelines have been in place. Service managers have also observed that they cannot be expected to adhere to standards which have never been explicitly set out.

Guidelines for Acute Adult Inpatient Workloads

These guidelines are intended to provide guidance for Training Committees when accrediting or re-accrediting posts, for service managers when designing posts, for supervisors and Directors of Training when monitoring posts, and for accreditation site visitors.

The parameters of workloads such that clinical service delivery does not compromise training and trainee welfare are variable. The parameters will change with individual circumstance, and will differ according to how much of the trainee's time is designated as being spent in the inpatient unit or elsewhere (community clinic, emergency department cover etc), and other factors such as patient illness profiles.

The Committee recognises that the large differences in the way in which services work give rise to widely varying factors that influence an individual trainee's workload. These might include:

- **stage of the trainee and seniority of other trainees in the ward**
- **complexity of the patient load**
- **acuity of the patients under care**
- **voluntary versus involuntary settings**
- **length of stay**
- **level of available supporting staff**
- **amount of consultant cover**
- **presence of junior resident medical officers/house officers on the team**
- **staffing profiles of nursing and allied health personnel**
- **impact of leave cover arrangements for other trainees**
- **rural versus urban settings.**

Given the above, the Committee proposes an approach to ensure that inpatient workloads do not compromise RANZCP training and trainee wellbeing. A crucial component of this is the regular engagement of Directors of Training, Service/Clinical Directors, Training Committees, the Committee for Training, and trainees in monitoring trainee workloads, given the impact on both training and patient care when patient numbers are excessive. Inpatient numbers should include all patients under the trainee's care, whether based in the inpatient unit, or elsewhere in the hospital.

The suggested approach is outlined below:

- That services have an established, documented process for regular monitoring of trainee workloads in acute adult inpatient terms. This could be an agenda item in a regular medical officer meeting, or in another regular forum.
- Term orientation should include orientation to the above process, and how and with whom trainees can escalate concerns if workload is excessive.

- Whilst noting the variation in service structures, staffing and patient mix, the following table provides some guidance as to suggested workload, in terms of recommendations regarding numbers, but acknowledgement of a range which accommodates the variations noted earlier.
- The recommended inpatient numbers is consistent with projections produced by the National Mental Health Service Planning Framework.
- A maximum inpatient number approaching 15 patients for a fulltime trainee or 8 for a half-time trainee flags to the trainees and services when workload is excessive, and should be a flag to Service Managers, Clinical Directors, Training Committees and Directors of Training to urgently review the training post's workload. The Committee's *Rotation Accreditation Standards* document will assist in this review.
- Workloads above recommended inpatient numbers should be monitored closely by the supervisor, and discussed with the Service Manager/Clinical Director. If workload concerns cannot be addressed satisfactorily, the post should be referred to the Director of Training and/or Training Committee.
- Whilst noting there may be short periods when inpatient numbers may be temporarily increased beyond the recommended number, the relevant Training Committee should be notified if the maximum number is reached for more than 14 days.
- Trainees or supervisors may escalate workload concerns to the Director of Training and/or Training Committee, if these are not resolved at the local service level.
- Training Committees have the opportunity to review workload for posts at the point of initial accreditation and at re-accreditation. As noted above, they may also review workload concerns that have not been resolved, despite escalation and review at a local level.

The Committee acknowledges that achieving the inpatient workloads proposed in these guidelines will need consultation with, and the cooperation of, Service Managers and Clinical Directors. As such, it is intended that these guidelines will assist in conversations between Directors of Training, Clinical Directors and Service Managers.

Proposed Appropriate Acute Adult Inpatient Workloads for RANZCP Trainees

Trainee Acute Inpatient Duties	Recommended Inpatient Numbers
Fulltime	**8-10**
Halftime	**4-5**

The inpatient workloads proposed in this table should be read in conjunction with the influencing factors listed on page two.

References

Amoafa E, Hanbali N, Patel A, Singh P. (2015) What are the significant factors associated with burnout in doctors? *Occupational Medicine* 65: 117-21.

Beyondblue (2013). National mental health survey of doctors and medical students [internet].Beyondblue; October 2013. Available from: https://www.beyondblue.org.au/docs/default-source/research-project-files/bl1132-report---nmhdmss-full-report_web

Dyrbye LN, West CP, Satele D, Boone S, Tan L, Sloan J, et al. (2014) Burnout among US medical students, residents, and early career physicians relative to the general US population. *Academic Medicine* 89 (3): 443-51.

Eckleberry-Hunt J, Kirkpatrick H, Taku K, Hunt R. (2017) Self-report study of predictors of physician wellness, burnout, and quality of patient care. *Southern Medical Journal*; 110: 244-48.

Kealy D, Halli P, Ogrodniczuk JS, Hadjipavlou G. (2016) Burnout among Canadian psychiatry residents: A national survey. *Canadian Journal of Psychiatry* 61 (11): 732-36.

Lee RT, Seo B, Hladkyj S, Lovell BL, Schwartzmann L. (2013) Correlates of physician burnout across regions and specialties: A meta-analysis. *Human Resources for Health* 11: 48.

Ripp JA, Privitera MR, West CP, Leiter R, Logio L, Shapiro J, et al. (2017) Well-being in graduate medical education: A call for action. *Academic Medicine* 92: 914-17.

Schumacher DJ, Slovin SR, Riebschleger MP, Englander R, Hicks PJ, Carraccio C. (2012) Beyond counting hours: The importance of supervision, professionalism, transitions of care, and workload in residency training. *Academic Medicine* 87: 1-6.

Slavin SJ, Chibnall JT. (2016) Finding the why, changing the now: Improving the mental health of medical students, residents and physicians. *Academic Medicine*; 91: 1194-96.

Thanarajasingam U, McDonald FS, Halvorsen AJ, Naessens JM, Cabanela RL, Johnson MG, et al. (2012) Service census caps and unit-based admissions: Resident workload, conference attendance, duty hour compliance, and patient safety. *Mayo Clinic Proceedings* 2012; 87 (4): 320-27.

Vidyarthi AR, Auerbach AD, Wachter RM, Katz PP. (2007) The impact of duty hours on resident self reports of errors. *Journal of General Internal Medicine* 22(2):205-09.