Recovery after a period on nights

MECA provides for the following minimum provision:

> *"13.3.7 As a minimum provision, a minimum break comprising the balance of the calender day upon which the employee ceased the last night duty plus a further two calendar days must be provided immediately following a period of 5 night duties or more.*

The basis for 3 sleeps before returning to work is to ensure sufficient recovery time to repay sleep debt and return the employee to work able to properly perform their duties. Three sleeps following 4 night shifts is evidenced as being required for this purpose, and 2 sleeps after 2 consecutive night shifts. After 3 night shifts the evidence is less definitive.

In order to ensure the health and safety of RMOs with respect to night shifts and recovery time, a risk assessment process for determining minimum recovery time is recommended. In making this assessment, the following factors should be considered:

1. The number of consecutive night shifts.
2. The ability to consistently achieve uninterrupted sleep whilst on night shifts. Note: to repay sufficient sleep debt each night to reduce accumulated debt post nights to a level where only 2 sleeps recovery time is required, 3- 4 hours uninterrupted sleep per night is likely to be required.
3. Length of the night shifts. The "ideal" maximum length of a night shift from a fatigue perspective is8hours. 10 hours are frequently worked by resident doctors hence the need to restrict consecutive shifts and thereby limit sleep debt accumulation. If 12 hour nights are being considered, the number of consecutive night shifts as well as recovery time should be assessed. We would recommend a maximum of 3 nights comprising one 10 hour night shift plus 2 consecutive 12 hour night shifts in this regard, with 3 sleeps recovery time.
4. Actual hours awake (not simply rostered). Sleep debt is repaid by sleeping, so time taken to travel home and get to bed should be considered as should time from waking to get to work. For example, some surgical rosters with a 0730 start might see doctors awake at 0600 to get to work on time.
5. Rostering pre and post nights. Given fatigue and sleep debt is cumulative, adequate opportunity to repay any sleep debt before starting nights should be factored in. Coming back from nights straight onto a long day should also be carefully considered due to the risk of sleep debt accumulating again as a result of the late-to-bed effect of a long day.
6. How well supported the doctor is at night. Immediate (medical) supervision and support is a factor that reduces the risk associated with night shifts. Good handover is also important and should be a feature of all shift systems including protected time and appropriate facilities/support to ensure effective handover of patient care.
7. How busy the doctor is at night. Naps should be encouraged when and where possible (whilst recognising the time taken to reawaken fully after a nap).
8. The evidence available with respect to sleep debt and recovery times

How the doctors feel after their set of nights (subjective fatigue assessment).