**This policy has been adopted by the Internal Medicine program as written.**



| **TMP-01:** Resident/Fellow Supervision and Chain of Command Policy | Originally Issued | Latest Revision | Latest Review | Page |
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**Philosophy**:

The institution believes in an environment of graduate education which embraces safe, effective and compassionate patient care, under supervision, commensurate with the resident's level of advancement and responsibility.

**Policy**:

Each residency/fellowship program must establish written program-specific supervision policies consistent with the institutional policy and the respective ACGME Common and specialty-/subspecialty-specific Program Requirements. Each program must also establish a formal policy governing resident chain of command to facilitate optimal patient care and resident education.

**Resident Supervision**

It is the policy of WRHE to have the appropriate level of supervision in place for all residents/fellows who care for patients. Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member.

For many aspects of patient care, the supervising physician may be a more advanced resident. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident delivered care with feedback as to the appropriateness of that care.

**Levels of Supervision**

- To ensure oversight of resident/fellowship supervision and graded authority and responsibility, the program must use the following classification of supervision:
  - Direct Supervision – the supervising physician is physically present with the resident and patient during key portions of the patient interactions; or,
    - PGY-1 residents must initially be supervised directly, as defined by the individual residency programs.
    - The supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunications technology.
  - Indirect Supervision:
    - The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate Direct Supervision.
  - Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

- The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.
    - The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones.
    - Faculty members functioning as supervising physicians should delegate portions of care to residents/fellows, based on the needs of the patient and the skills of the residents/fellows.
    - Senior residents/fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident/fellow.

- Programs must set guidelines for circumstances and events in which residents/fellows must communicate with the supervising faculty members.
    - Each resident/fellow must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.
        - Initially, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available. [Each residency may describe the condition and achieved competencies under which PGY-1 residents' progress to be supervised indirectly with direct supervision available].

- Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident/fellow and to delegate to the resident the appropriate level of patient care authority and responsibility.

- When residents/fellows are on an away rotation it is the responsibility of the Program Director to identify the supervising physician at the away rotation site. The supervising physician will provide the appropriate level of oversight to the resident/fellow.

**Clinical Responsibilities/Progressive Responsibility**

- The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services.

- With each year of training, the degree of responsibility accorded to a resident, both professional and administrative, must be increased progressively. This includes responsibility in such areas as patient care, performance of procedures, leadership, teaching, organization and administration. This goal can be achieved by having senior residents supervise junior residents, or act as consultants to junior residents, particularly in the specialty areas.

- The senior/chief resident must have major or primary responsibility for patient management and performance of procedures. In addition, the senior/chief resident should have administrative responsibility as designated by the Program Director. The responsibility or independence given to residents should depend on their knowledge,

judgment, manual skill, and experience. Additional personnel must be available within appropriate time intervals to perform or to supervise necessary technical procedures.

- Optimal clinical workload will be further specified by each Program.

**Documentation of Competence**

- The Program Director will provide the GME office with a description of the types of diagnostic or therapeutic procedures a given resident is competent to perform. This information will be uploaded to individual resident "credentials" files accessible to ancillary staff on the intranet homepage. The Training Program shall provide guidance to attending staff as to the procedures and activities, which are appropriate for each resident and the degree of supervision required. For those activities that cannot be delegated to residents to initiate and perform independently, the faculty member will determine on a case basis the level of supervision required and/or whether a resident may function as a teaching assistant.

- Generally, high risk or technically complex procedures cannot be performed without direct supervision. Procedures that are routine in nature and are part of standard patient care may be assigned to residents to initiate and perform independently once competence has been demonstrated. The faculty member will determine, on a case-by-case basis, the level of supervision required.

**Circumstances and Events in Which Residents Must Communicate with the Supervising Faculty Member**

There are circumstances, regardless of level of training, where the appropriate Attending Physician should be contacted. First and foremost are any circumstances, at any time where the resident or fellow, who is providing direct patient care, has questions or concerns with regards to either the clinical situation or the appropriateness of care. In addition, any of the following should prompt Attending Physician notification:

- Patient, a family member, nurse, allied professional, or a physician requests or suggests that attending be notified.
- Initiation of a new or unplanned inpatient consults (e.g. Medicine, ID, and Surgery).
- Transfer to ICU or a higher level of care than that currently being provided.
- Hemodynamic instability or unanticipated arrhythmia with significant clinical consequences.
- Cardiac arrest.
- Unplanned intubation or need for ventilatory support (including noninvasive mechanical ventilation, e.g., CPAP, BIPAP).
- Significant neurological changes (e.g., change in mental status, CVA, seizure, new onset weakness/paralysis).
- Medication or treatment errors that may or may not require clinical intervention (e.g., invasive procedure, increased monitoring, or new medications).
- Any blood products transfusion (i.e. PRBC's, Platelets, FFP) not previously discussed with or anticipated by the attending physician.
- Unanticipated clinical problem or change in patient's status requiring a significant change in treatment plan.
- Patient leaving hospital against medical advice.
- New application of restraints (TJC requirement).
- Change in code status.

- Patient death.
- Fall with clinical consequences.
- Any event requiring activation of Rapid Response Team (RRT).
- Planned patient discharge or transfer to another service/facility that didn't occur.
- Any concern that a situation is more complicated than a resident or fellow can manage.
- All invasive bedside procedures (i.e. Paracentesis, Thoracentesis, Lumbar puncture).
- Results of pending tests that require urgent intervention.
- Accepting transfer patients from another institution
- Transferring patients to another institution
- Accepting a patient transferred from another Service
- Scheduling a surgical case including a call to OR to add a case to the schedule
- Insertion of an incision wound vacuum
- Initial antibiotic treatment of a wound infection
- Initiation of therapeutic anticoagulation for DVT or PE
- Undertaking any Invasive diagnostic study
- Resident/fellow believes decisions can best be accomplished after communication with an attending
- Decision to admit patient to hospital
- Request for a patient consult
- Critical results of lab, radiology, or cardiac diagnostic tests
- Wound complications (e.g. infection, dehiscence)
- Visit to ED within 30 days of hospital discharge

**Chain of Command**

Implied in the hierarchical structure of resident supervision is also an upward "chain of command" with regards to concerns about the care being provided in a clinical setting. This concern could reflect an uncertainty on the part of the resident as to what to do, it could reflect concerns regarding the nursing care being provided, or it could reflect uncertainty or disagreement regarding the decision making or technical skills of a more senior provider. A junior resident should seek the help and counsel of a more senior resident. Similarly, a more senior resident should discuss the situation with the on-call Attending Physician. Should the concerns involve an attending physician then the resident should contact the Program Director.

In the event there is inadequate resolution, the Program Director may contact the Chairman of the Department or CMO. If the issues of concern relate to the Graduate Medical Education Program then the DIO should be involved. It is the responsibility of the Program Director to ensure that all residents within a training environment are aware of who they can contact should there be any issues regarding the quality of the care provided, or patient safety.

Resident/fellow shall:

1. Receive a copy of the Departmental Chain of Command/Organizational Chart from the Program Director.
2. Utilize the Chain of Command/Organization chart as guidelines whenever questions of patient care, administrative protocol, hospital policy or other questions affecting quality of care, patient communication or optimal delivery of care to patients.

Program Director Shall:

1. Develop a program chain of command/organizational chart to meet the above purpose and distribute this in the program.

2. Annually review the Chain of Command/Organizational Chart and educate the resident/fellow physicians on its effective use.

President and Designated Institutional Official of WRHE (DIO) shall:

1. Review the Chain of Command Policy/Organizational Chart for effectiveness and compliance with statutory and accreditation requirements and report to the GMEC.
2. Review each residency/fellowship program's adoption and implementation of this policy's requirements.

**NOTE**:

1. Resident/fellow and attending schedules should be available at each nursing station, departmental office, WRHE and with telephone and paging operators.
2. Attending directory should be available at nursing stations and with the telephone/paging operators.
3. Paging operator can help locate patient's attending if necessary.
4. Questions regarding teaching/non-teaching status default to the immediate care of the patient and subsequently the attending or faculty physician on call. (The chief resident should make the decision regarding initial teaching/non-teaching status).
5. When in doubt, call someone who knows the answer or can provide you with immediate information regarding the care of the patient. Always talk to the patient's attending or personal physician regarding the patient's status.

Institutional Requirement 4.10.

**This policy has been adopted by the Internal Medicine program as written.**



| **TMP-09:** Moonlighting Policy | Originally Issued | Latest Revision | Latest Review | Page |
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Residents are not obligated to be involved in internal hospital moonlighting activities. A resident shall not engage in remunerative activities (outside work) other than work performed pursuant to the RESIDENT AGREEMENT, without obtaining the prior consent of the Program Director and the Department of Graduate Medical Education. The Sponsoring Programs may prohibit moonlighting by residents/ fellows.

1. Residents must possess a full valid license to practice medicine in the State of Ohio to participate in internal or external work activities. Temporary certificates will not meet this requirement for full valid licensure. The practice of medicine in any state requires full valid licensure in that state.

2. The resident must complete the Moonlighting Application and present it to the Program Director to approve. Once approved, the application must be sent to the GME Office.

3. If the resident is granted permission to participate in outside work, the resident shall do so subject to his/her own legal responsibility. The resident acknowledges and agrees that any outside work the resident does during the term of his/her RESIDENT AGREEMENT shall be deemed to be outside the provisions of the RESIDENT AGREEMENT.

4. Professional insurance provided to the resident/fellow is rendered exclusively for services provided in the residency training program. Coverage shall not extend for any other circumstance other than the resident's professional services provided under the residency training program and subject to the RESIDENT AGREEMENT.

5. A resident shall report any and all outside work and log those hours via New Innovations. The Program Director shall monitor hours at least monthly.

6. Failure of the resident to report outside work may result in termination from the program, subject to the Due Process provisions as noted in the policy for Due Process.

7. If resident engages in the practice of medicine outside of work, resident must provide written documentation to the Program Director and Department of Graduate Medical Education that a current policy of professional liability insurance covering the resident's outside work on an occurrence basis has been obtained, with limits of at least One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) in the aggregate, from a carrier rated at least B+ by A.M. Best or its equivalent, that at all times applies to resident's services. It will be the responsibility of the employer for moonlighting to provide the Program Director a description of the duties required for the position and the Program Director to verify the ability of the resident to meet those requirements.

Institutional Requirement 4.11.a, 4.11.a.1-4.

## Resident Request to Participate in Professional Activity Outside of Normal Residency Activity

I, ___________________________, request to engage in professional activity ("moonlighting") which is not a part of my residency program activity.

Site of activity - address ___________________________________________
___________________________________________
___________________________________________

Proposed time period of activity ___________________________________________

I understand that the following criteria must be met to participate and continue to participate once approved by the Designated Institutional Official and Program Director:

- The resident will have completed the PGY I training year if an LCME graduate. International medical graduates are not eligible for licensure until two years of post graduate training are completed.
- The resident will have proof of a permanent unrestricted Ohio license to practice in the State of Ohio.
- The resident must have a valid DEA under his/her own name – the number assigned as a resident on the hospital DEA number may not be used.
- The resident must personally possess or provide evidence of a rider of 1M/3M of occurrence professional liability insurance from a carrier rated B+ or better.
- The resident must obtain approval by the respective Program Director and Designated Institutional Official.
- The resident must present to the Program Director and GME Office a formal job description by the outside employer and the Program Director must verify that the resident has the prerequisite skills for the duties.
- Moonlighting activity is a privilege and not a right. Any outside activity may be discontinued by Western Reserve Health Education if there is any evidence of diminished resident performance or participation in the respective residency program. There will be no due process if the moonlighting privilege is cancelled by the Program Director or WRHE.
- The resident must maintain a schedule of activity which will be filed monthly with the respective residency program and Office of Graduate Medical Education.
- The resident must log all moonlighting time in New Innovations.

I understand that I must present all materials required and proof of compliance to the above criteria and obtain approval before the commencement of my outside professional activity.

_________________________________ ______________________

Resident's signature Date

# Approval for Moonlighting

I have reviewed the resident's request for professional activity outside the residency program. I have also reviewed the job description for the outside activity. The resident's basic skills have been considered as well as the resident's standing in the residency program. My approval of the resident's participation does not serve as sanctioning moonlighting or the specific activity. If, at any time, I have reason to believe that the activity has a negative impact on the resident's participation in the training program, the permission for continued outside professional activity will be revoked.

I will maintain in the residency files a monthly summary of activity which will be added to the number of hours the resident participates in the teaching program.

I approve __________

I disapprove __________

______________________________ ____________________

Residency Program Director's signature Date

I have reviewed the above information.

I approve __________

I disapprove __________

______________________________ ____________________

Designated Institutional Official Date

**This policy has been adopted by the Internal Medicine program as written.**



| **RRP-01:** Resident Responsibilities Policy | Originally Issued | Latest Revision | Latest Review | Page |
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## PURPOSE

The purpose of this policy is the expectation that each Graduate Medical Education (GME) Residency and Fellowship program develops and maintains specific descriptions for progressively increasing levels of patient care responsibility for residents, under the supervision of qualified faculty.

## DEFINITIONS

Resident: Any physician in an accredited graduate medical education program, including interns, residents, and fellows.

## POLICY

- **Clinical Care**
  - Residents are expected to provide competent and compassionate patient care, and to work effectively as a member of the health care team. This implies professional demeanor and conduct both in direct patient care and in communication with family members, other health care professionals, and support staff. The highest level of professionalism is expected at all times. Residents are directly responsible to the faculty attending to whom they have been assigned for all matters related to the professional care of patients. Under the supervision of attending physicians, general responsibilities of the resident physician may include:
    - Initial and ongoing assessment of patient's medical, physical, and psychosocial status
    - Perform history and physical
    - Develop assessment and treatment plan
    - Perform rounds
    - Record progress notes
    - Order tests, examinations, medications, and therapies
    - Interpret results of tests
    - Arrange for discharge and after care
    - Write or dictate admission notes, progress notes, procedure notes, and discharge summaries
    - Provide patient education and counseling health status, test results, disease processes, and discharge planning
    - Perform procedures
    - Assist in surgery
  - Residents at all levels should have a strong commitment to patient safety and professionalism. Training programs must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients. Physicians must recognize

that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider. In addition, the program must be committed to and responsible for promoting patient safety and the program director must ensure that residents are integrated and participate in clinical quality improvement and patient safety programs.

  - Programs must design clinical assignments to minimize the number of transitions in patient care. All training programs must develop and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. Residents must be competent in communicating with team members in the hand-over process.

- **Learning and Education**
  - Residents are recognized as adult learners and ultimately the acquisition of knowledge, skills, and professional attitudes is the responsibility of each individual.
  - The institution and the residency programs will provide an ample selection of educational offerings. The expectation is that residents will make every effort to benefit from the education offered, by attending educational conferences as required for each program. The conference programs are designed to provide a didactic forum to augment the resident's reading and clinical experience.
  - An essential component of learning is the development of life-long learning skills; all physicians must practice disciplined ongoing acquisition of medical knowledge. The resident is expected to develop a personal program of reading. Besides the general reading in the specialty, the resident should do directed daily reading relating to problems that they encounter in the care of patients. The resident is responsible for reading prior to performing or assisting in procedures that they have not yet had the opportunity to see.
  - The ACGME has defined the following six areas as General Competencies and stipulates that programs require their residents to develop them to the level of a new practitioner by the completion of training:
    1. Patient Care
    2. Medical knowledge
    3. Practice-based learning and improvement
    4. Interpersonal and communication skills
    5. Professionalism
    6. Systems-based practice

    - For a full listing of the six General Competencies and their respective sub-competencies, residents are referred to the specialty-specific curricula provided by their program and the ACGME website.

- **Discipline-Specific Education**
  - A primary responsibility of graduate medical students is to meet the educational goals of their specific programs. In all ACGME-sponsored GME programs, the residency program director is responsible for the organization and implementation of discipline-specific educational objectives. The resident is expected to manifest active involvement in learning, and has responsibility for the following:

    - Familiarity with the program's educational objectives and residency curriculum
    - Development of competence in the six areas listed above
    - Development of a personal growth program of learning to foster continued professional growth
    - Experience with quality assurance/performance improvement

  - All residents must provide data on their educational experience to their Program Director and GME office as requested. The provision of regular feedback on faculty, program and overall educational experiences via confidential written or electronic evaluations is an essential part of the continuous improvement of the educational programs within our institution and is required by the ACGME.

  - Active participation in departmental and hospital committees provides an opportunity for residents to become familiar with administrative aspects of health care and involvement with such experiences is strongly encouraged.

- **Teaching Others**
  - Residents are also expected to teach and mentor junior residents, medical students, and other learners with whom they interact. Collaborative learning is an important part of graduate medical education and residents' involvement with the education of other members of the health care team is vitally important.

- **Graduated Levels of Responsibility**
  - Graduate medical education is based on the principle of progressively increasing levels of responsibility in caring for patients under the supervision of the faculty. The overriding consideration must be the safe and effective care of the patient that is the responsibility of the faculty attending. The faculty is responsible for evaluating the progress of each resident in acquiring the skills necessary for the resident to progress to the next level of training. Factors considered in this evaluation include the resident's clinical experience, judgment, professionalism, cognitive knowledge, and technical skills. At each level of training, there is a set of competencies that the resident is expected to master. Examples of expected competencies and responsibilities for each level of training include the following:

    **PGY I** - Individuals in the PGY I year are supervised by senior level residents or faculty either directly or indirectly with direct supervision immediately available. If indirect supervision is provided, such supervision must be consistent with Residency Review Committee (RRC) policies and specific criteria which PGY I residents must meet in order to be eligible for indirect supervision must be established. Examples of tasks that are expected of PGY I physicians include: perform a history and physical, start intravenous lines, draw blood, order medications and diagnostic tests, collect and analyze test results and communicate those to the other members of the team and faculty, obtain informed consent, place urinary catheters and nasogastric tubes, assist in the operating room and perform other invasive procedures such as arterial line or central line insertion under the direct supervision of the faculty (or senior residents at the discretion of the responsible faculty member). The resident is expected to exhibit dedication to the principles of professional preparation that emphasize primacy of the patient as the focus of care. With the assistance opromoteigned mentor or the program director, the first-year resident must

develop and implement a plan for study, reading and research of selected topics that promotes personal and professional growth and be able to demonstrate successful use of the literature in dealing with patients. The resident should be able to communicate with patients and families about the disease process and the plan of care as outlined by the attending. At all levels, the resident is expected to demonstrate an understanding of the socioeconomic, cultural, and managerial factors inherent in providing cost effective care.

**PGY II** - Individuals in the second post graduate year are expected to perform independently the duties learned in the first year and may supervise the routine activities of the first-year residents. The PGY II may perform some procedures with indirect supervision (such as insertion of central lines, arterial lines) once competency has been documented according to established criteria. Specific procedures allowed with indirect supervision at the PGY II level will vary with training program and must be guided according to published criteria established by the faculty and program director. The PGY II should be able to demonstrate continued sophistication in the acquisition of knowledge and skills in his/her selected specialty and further ability to function independently in evaluating patient problems and developing a plan for patient care. The resident at the second-year level may respond to consults and learn the elements of an appropriate response to consultation in conjunction with the faculty member. The resident should take a leadership role in teaching PGY I residents and medical students the practical aspects of patient care and be able to explain more complex diagnostic and therapeutic procedures to the patient and family. The resident should be adept at the interpersonal skills needed to handle difficult situations. The PGY II should be able to incorporate ethical concepts into patient care and discuss these with the patient, family, and other members of the health care team.

**PGY III** - In the third year, the resident should be capable of managing patients with virtually any routine or complicated condition and of supervising the PGY I and PGY II in their daily activities. The resident is responsible for coordinating the care of multiple patients on the team assigned. Individuals in the third post graduate year may perform additional diagnostic and therapeutic procedures with indirect supervision once competency has been documented according to established criteria. Specific procedures allowed with indirect supervision at the PGY III level will vary with training program and must be guided according to published criteria established by the faculty and program director. The PGY III can perform progressively more complex procedures under the direct supervision of the faculty. It is expected that the third-year resident be adept in the use of literature and routinely demonstrate the ability to research selected topics and present these to the team. At the completion of the third year, the resident should be ready to assume independent practice responsibilities in those specialties requiring three years of training. In those specialties requiring longer training, the resident should demonstrate skills needed to manage a clinical service or be a chief level resident.

**PGY IV** - Individuals in the fourth post graduate year assume an increased level of responsibility as the chief or senior resident on selected services and can perform the full range of complex procedures expected of the chosen specialty under the direct or indirect supervision of the faculty. The fourth year is one of senior leadership and the resident should be able to assume responsibility organizing the service and supervising junior residents and students. The resident should have mastery of the information contained in standard tests and be facile in using the literature to solve specific problems. The resident

will be responsible for presentations at conferences and for teaching junior residents and students on a routine basis. The PYG IV should begin to have an understanding of the role of practitioner in an integrated health care delivery system and to be aware of the issues in health care management facing patients and physicians.

**PGY V or Higher** - The fifth-year resident (generally surgical residents) takes responsibility for the management of the major surgical teaching services, under the supervision of the faculty. The PGY V can perform most complex and high-risk procedures expected of a physician with the supervision of the attending physician. The attending physician should be comfortable allowing the PGY V resident to manage all common problems expected to be encountered during independent practice. During the final year of training the resident should have the opportunity to demonstrate the mature ethical, judgmental and clinical skills needed for independent practice. The PGY V gives formal presentations at scientific assemblies and assumes a leadership role in teaching on the service. The mores and values of the profession should be highly developed, including the expected selfless dedication to patient care, a habit of lifelong study and commitment to continuous improvement of self and the practice of medicine.

**Fellowship Training** - Subspecialty fellowship programs range from one to three years in duration. Fellow responsibilities include considerable autonomy, especially in the tasks already mastered in the core program. Fellows will be focused on becoming proficient in the skills defined by the subspecialty they are pursuing. As the fellow progresses through the training program, progressive responsibility is given in the skills that make up the information content of the specialty at the discretion of the faculty.

## I. PURPOSE:

The purpose of this policy is to define a safe process to convey important information about a patient's care when transferring care responsibility from one physician to another. In the course of patient care, it is often necessary to transfer responsibility for a patient's care from one physician to another. Hand-off refers to the orderly transmittal of information, face to face, that occurs when transitions in the care of the patient are occurring. Proper hand-off should prevent the occurrence of errors due to failure to communicate changes in the status of a patient that have occurred during that shift. In summary, the primary objective of a "hand-off" is to provide complete and accurate information about a patient's clinical status, including current condition and recent and anticipated treatment. The information communicated during a hand-off must be complete and accurate to ensure safe and effective continuity of care.

## II. SCOPE:

These procedures apply to all WRHE resident physicians and dentists who are learners in a clinical environment and have responsibility for patient care in that environment.

## III. POLICY:

1. Hand-offs must follow a standardized approach and include the opportunity to ask and respond to questions.
2. A hand-off is a verbal and/or written communication which provides information to facilitate continuity of care. A "hand-off" or "report" occurs each time any of the following situations exists for an inpatient, emergency room patient, clinic patient, observation patient, or any other patient:
3. A hand-off is verbal and written communication which provides information to facilitate continuity of care. A "hand-off" or "report" occurs each time any of the following situations exists for an inpatient, emergency room patient, clinic patient, observation patient, or any other patient:
    a) Move to a new unit
    b) Transport to or from a different area of the hospital for care (e.g. diagnostic/treatment area)
    c) Assignment to a different physician temporarily (e.g. overnight/weekend coverage) or longer (e.g. rotation change)
    d) Discharge to another institution or facility
4. Each of the situations above requires a structured hand-off with appropriate communication.

**IV. CHARACTERISTICS OF A HIGH-QUALITY HAND-OFF**:

1. Hand-offs are interactive communications allowing the opportunity for questioning between the giver and receiver of patient information.
2. Hand-offs include up-to-date information regarding the patient's care, treatment and services, condition, and any recent or anticipated changes.
3. Interruptions during hand-offs should be limited in order to minimize the possibility that information would fail to be conveyed or would be forgotten. Hand-offs are to be given in an area that is quiet and reduces distractions.
4. Hand-offs require a process for verification of the received information, including repeat-back or read-back, as appropriate.

**V. HAND-OFF PROCEDURES:**

1. Hand-off procedures will be conducted in conjunction with (not be limited to) the following physician events:
    a. Shift changes
    b. Rest breaks
    c. Changes in on-call status
    d. When contacting another physician when there is a change in the patient's condition
    e. Transfer of patient from one care setting to another
2. Hand-off procedures and information transfer forms and guidelines for physicians are developed and implemented by each service according to the needs of that service. The hand-off forms or guidelines may be in either paper or electronic format and must include clinical information agreed upon by physicians on that service, as being integral to the provision of safe and effective patient care for that patient population.
3. Each service will develop and implement a hand-off process that is in keeping with the shift or rotation change practices of its physicians and that facilitates the smooth transfer of information from physician to physician.
4. Each service hand-off process must include an opportunity for the on-coming physician to ask pertinent questions and request information from the reporting physician.
5. Each hand-off process must be conducted discreetly and free of interruptions to ensure a proper transfer.
6. A Resident physician must not leave the hospital until a face-to-face hand-off has occurred.
7. Telephonic hand-off is not acceptable.

**VI. STRUCTURED HAND-OFF**:

1. Within each service, hand-offs will be conducted in a consistent manner, using a standardized hand-off form or structured guideline.
2. Hand-offs, whether verbal or written, should include, at minimum, specific information listed below (as applicable):
    a) Patient name, location, age/date of birth
    b) Patient diagnosis/problems, impression
    c) Important prior medical history
    d) DNR status and advance directives
    e) Identified allergies
    f) Medications, fluids, diet
    g) Important current labs, vitals, cultures
    h) Past and planned significant procedures

i) Specific protocols/resources/treatments in place (DVT/GI prophylaxis, insulin, anticoagulation, restraint use, etc.)
j) Plan for the next 24+ hours
k) Pending tests and studies which require follow-up
l) Important items planned between now and discharge

3. A receiving physician shall:
    a) Thoroughly review a written hand-off form or receive a verbal hand-off and take notes
    b) Resolve any unclear issues with the transferring physician prior to acceptance of a patient

4. In addition, the Program shall select a standardized format (e.g., **S.B.A.R.R.**, **I-PASS**) to use to deliver and receive the information:
    **a) SBARR**
        i. **Situation**: What is the problem?
        ii. **Background**: Pertinent information to problem at hand
        iii. **Assessment**: Clinical staff's assessment
        iv. **Recommendation**: What do you want done and/or think needs to be done?
        v. **Readback**: Oncoming resident confirms follow-up.

    **b) I-PASS**
        i. **I - Illness Severity:** Stable, Unstable
        ii. **P- Patient Summary:** Summary statement; events leading up to admission; hospital course; ongoing assessment; plan
        iii. **A- Action List** – To do list, timeline and ownership
        iv. **S**- **Situation Awareness and Contingency Planning:** Know what's going on; plan for what might be happening.
        v. **S**- **Synthesis by Receiver:** Receiver summaries what was heard; asks questions; restates key actions/to do items.

## VII. MONITORING AND EVALUATION

1. To evaluate the effectiveness of hand-off transitions, the program director or their designee is required to monitor its trainees' performance through regular and ongoing feedback processes that have been established in the specialty program and as described in ACGME Common Program Requirements.
2. Residents must demonstrate competence in the performance of this task. There are numerous mechanisms through which a program might elect to determine the competency of trainees in handoff skills and communication. These include:
    i. Direct observation of a handoff session by a supervising faculty, chief resident, or supervising resident.
    ii. Evaluation of written handoff materials by supervising faculty, chief resident, or supervising resident.
    iii. Didactic sessions on communication skills include in-person lectures, web-based training, review of curricular materials and/or knowledge assessment.
    iv. Assessment of handoff quality in terms of ability to predict overnight events.
    v. Assessment of adverse events and relationship to sign-out quality through:
        1. Survey
        2. RL reporting of events
        3. Chart review

3. Programs must develop and utilize a method of monitoring the transition of care process and update as necessary. Monitoring of handoffs by the program to ensure:
   i. There is a structured, standardized process in place that is routinely followed such as IPASS or SBARR
   ii. There is consistent opportunity for questions.
   iii. The necessary materials are available to support the handoff (including, for instance, written sign-out materials, access to electronic clinical information).
   iv. A quiet setting free of interruptions is consistently available for handoff processes that include face-to-face communication.
   v. Patient confidentiality and privacy are ensured in accordance with HIPAA guidelines.
   vi. Programs may include a standardized question on the end of rotation/assignment faculty evaluation of resident. i.e. "Did you or a supervising resident/fellow observe this resident during a handoff process? If yes, is this resident competent in communicating in the handoff process?"
   vii. Handoff evaluation template may be used by programs if so desired. (Attachment A)
4. GMEC ensures and monitors program compliance through annual program evaluations, ACGME resident and faculty survey results as well as internal anonymous evaluations of the program. as well as periodic reports that may be presented to the GMEC that may pertain to handoffs.

(Attachment A)

**Handoff Provider Evaluation Form**

Name______________________________Date_______

Please circle all that apply

**Setting:**

| | | |
|---|---|---|
| >4 Interruptions<br>Noisy Chaotic | Satisfactory | No Interruptions<br>Quiet |

**Organization/Efficiency:**

| | | |
|---|---|---|
| Disorganized<br>Rambles | Satisfactory | Pertinent/Succinct<br>Standardized HO |

**Communication skills:**

| | | |
|---|---|---|
| Not face to face<br>Does not assign Responsibility<br>Unclear<br>No time for questions | Satisfactory | Elicits Questions<br>Clarifies responsibility<br>Asks for read back<br>Concrete language |

**Clinical Judgment:**

| | | |
|---|---|---|
| No recognition of sick Patients<br>No anticipatory guidance | Satisfactory | Sick patients recognized<br>Anticipatory guidance Provided |

**Professionalism:**

| | | |
|---|---|---|
| Hurried, Inattentive<br>Inappropriate comments | Satisfactory | Focused on Task<br>Comments appropriate |

**Overall: Unsatisfactory** **Satisfactory** **Superior**

**Signature of evaluator:**_______________________________

**Handoff Recipient Evaluation Form**

Name______________________________Date_______

Please circle all that apply

**Setting:**

| | | |
|---|---|---|
| >4 Interruptions<br>Noisy Chaotic | Satisfactory | No Interruptions<br>Quiet |

**Organization/Efficiency:**

| | | |
|---|---|---|
| Disorganized<br>Poorly prepared | Satisfactory | Prepared |

**Communication skills:**

| | | |
|---|---|---|
| No read back<br>Does not accept Responsibility<br>Vague language<br>No interaction | Satisfactory | Reads back tasks<br>Accepts responsibility<br>Concrete language<br>Asks questions |

**Clinical Judgment:**

| | | |
|---|---|---|
| No recognition of sick Patients<br>No request for anticipatory guidance | Satisfactory | Sick patients recognized<br>Requests anticipatory guidance |

**Professionalism:**

| | | |
|---|---|---|
| Hurried, Inattentive<br>Inappropriate comments | Satisfactory | Focused on Task<br>Comments appropriate |

**Overall: Unsatisfactory** **Satisfactory** **Superior**

**Signature of evaluator:**_______________________________

**This policy has been adopted by the Internal Medicine program as written.**



| **WBP-01:** Clinical and Educational Work Hours | Originally Issued | Latest Revision | Latest Review | Page |
|---|---|---|---|---|
| | 4/5/1995 | 6/2017 | 6/2024 | 1 of 3 |

**Philosophy**:

The Graduate Medical Education program should provide an environment of mutual support, compassion and concern for those residents serving in and out of the institution.

**Resident Maximum Hours of Clinical and Educational Work**:

The ACGME common program requirements state the following:

1. Maximum Hours of Clinical and Educational Work per Week

    Clinical and Educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting.

    a) Clinical and Educational Work Exceptions

    A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.

2. Moonlighting

    a) Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program and must not interfere with the resident's fitness for work nor compromise patient safety.

    b) Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.

    c) PGY-1 residents are not permitted to moonlight.

3. Mandatory Time Free of Clinical Work and Education

    Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

4. Maximum Clinical Work and Education Period Length

    a) Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.

    b) Up to four hours of educational time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education.

    (1) Additional patient care responsibilities must not be assigned to a resident during this time.

    (2) Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

    (3) Clinical and Educational Work Hour Exceptions:

In rare circumstances, after handling off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:

i. to continue to provide care to a single severely ill or unstable patient;

ii. humanistic attention to the needs of a patient or family; or,

iii. to attend unique educational events.

(4) These additional hours of care or education will be counted toward the 80-hour weekly limit.

(5) A Review Committee may grant rotation specific exceptions for up to 10% or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.

5. Mandatory Time Free of Clinical Work and Education

. a) The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being.

b). Residents should have 8 hours off between scheduled clinical work and education periods.

(1). There may be circumstances when residents choose to stay fewer than eight hours free of clinical experience and education. The must occur within the context of the 80-hour and the one-day-off-in-seven requirements.

c). Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.

d) Resident must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days.

6. Maximum Frequency of In-House Night Float

Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. [The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]

7. Maximum In-House On-Call Frequency

Residents must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

8. At-Home Call

a) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.

1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

b) Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient care must be included in the 80-hour maximum weekly limit.

**Policy**:

Each residency training program must establish formal process governing resident maximum hours of clinical and educational work and working environment that are optimal for patient care and resident education and in compliance with national standards set by the ACGME or other appropriate accreditation bodies.

**Procedure/Responsibilities:**

Resident shall:

1. Develop a program of self-study and growth with guidance from the teaching faculty
2. Participate in all programmatic activities commensurate the level of advancement and demonstrated responsibility

Program Director shall:

1. Periodically review maximum hours of clinical and educational work and on call schedules to assure compliance with the ACGME General Essentials and RRC special requirements
2. Monitor activities outside the resident training program that may be deleterious to the educational process and professional development
3. Provide a report at least annually to the GMEC on request of the President and Designated Institutional Official of WRHE
4. Develop a program policy to meet the above purpose or adopt this departmental policy for the program

Designated Institutional Official shall:

1. Review and, if necessary, adjust maximum hours of clinical and educational work and on-call schedules as part of the Institutional Review process for ACGME compliance
2. Review each residency program's formal policy and compliance with residency maximum hours of clinical and educational work annually and report to GMEC.

Institutional Requirement 4.11.

**This policy has been adopted by the Internal Medicine program as written.**



| **WBP-03:** Fatigue Management Plan for Patient and Employee Safety | Originally Issued | Latest Revision | Latest Review | Page |
|---|---|---|---|---|
| | 7/2012 | 6/2017 | 6/2024 | 1 of 3 |

**PURPOSE:**
Programs and sponsoring institutions must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients. The purpose of this policy is to establish procedures to ensure employees are educated about the risks of fatigue associated with extended work hours and to protect patients from preventable adverse events associated with employee fatigue.

**STATEMENT:**
It is the policy of Sharon Regional Medical Center (SRMC) and Western Reserve Health Education (WRHE) to provide quality patient care and to provide this care in a safe environment. It is also the intent of TRMC and WRHE to provide a safe work environment for our care givers, insuring that safe quality care is protected.

**SCOPE**:
This policy is applicable to all WRHE residents.

**SECTION 1: Fatigue Mitigation**
The ACGME common program requirements state the following:

1. Programs must:
    a. Educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;
    b. Educate all faculty members and residents in alertness management and fatigue mitigation processes; and,
    c. Encourage resident to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning.
2. Each program must ensure continuity of patient care, consistent with the program's policies and procedures in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue.
3. The program must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home.

**SECTION 2: TEN SIGNS AND SYMPTOMS OF FATIGUE**

Fatigue resulting from an inadequate amount of sleep or insufficient quality of sleep over an extended period con lead to a number of problems, including:

-lapses in attention and ability to stay focused
-reduced motivation
-compromised problem solving
-confusion
-irritability
-memory lapses
-impaired communication
-slowed or faulty information procession and judgment
-diminished reaction time
-indifference and loss of empathy.

**SECTION 3: ADVERSE EFFECTS OF RESTRICTED SLEEP ON PATIENT SAFETY AND THE HEALTH OF HEALTHCARE WORKERS**

| Sleep Duration in 24 hour period | Adverse Effects on Patient Safety | Adverse Effects on Health |
|---|---|---|
| <7 hours of sleep | More likely to report struggling to stay awake during work shift | Increased risk of developing cardiovascular disease and DM among nurses.<br>Increased risk of becoming obese over a 10-year period. |
| | | |
| ≤6 hours of sleep | Risk of making an error is 3.4% during a work shift among nurses who slept ≤6 hours in 24 hours prior to shift (Dawson, personal communication) | Increased prevalence of DM and altered glucose metabolism.<br>Risk of obesity is 23% greater than subjects sleeping 7-9 hours. |
| | | |
| <5 hours of sleep | Increased subjective and objective sleepiness, and reduced performance on cognitive tasks | Increased risk of developing DM demonstrated in nurses. Risk of obesity is 50% greater than among subjects sleeping 7-9 hours. |
| | | |
| ≤4 hours of sleep | | Altered levels of appetite-regulating hormones (leftin, cortisol, and thyrotropin).<br>Risk of obesity is 73% greater than among subjects sleeping 7-9 hours. |

**SECTION 4: STRATEGIES TO FIGHT FATIGUE**
-engage in conversations with others (not just listening and nodding)
-doing something that involves physical action (even if it is just stretching)
-strategic caffeine consumption (don't use caffeine when you are already alert and avoid caffeine near bedtime)
-If the resident is too fatigued (via self-assessment or by program director/faculty assessment) to work the resident may use or be asked to use the call room facilities to sleep or will be provided with safe transportation options to safely return home.

**SECTION 5: STRATEGIES TO PREVENT ADVERSE EVENTS**
-educate staff about sleep hygiene
-provide opportunities for staff to express concerns about fatigue.

**SECTION 6: PERSONAL RESPONSIBILITIES FOR MINIMIZING FATIGUE AND AVOIDING FATIGUED RELATED ADVERSE EVENTS**

- Employees will apply 100% of their expertise and knowledge when performing duties at work. This means that the activities at the end of the shift will command ones full attention just as those activities at the beginning of a shift.
- Employees are responsible in assuring that they are receiving adequate sleep in order to maximize their performance and minimize chance of a fatigue related adverse outcome.
- Employees are to notify their supervisor if they believe that they are not able to function at 100% of their capacity.

## PURPOSE

The ACGME Common Program Requirements stipulate that programs must have a Clinical Competency Committee (CCC) that performs resident assessments. Assessment by consensus of a diverse group of faculty reinforces when a resident is doing well and identifies areas of concern for a resident having problems, or identifies weaknesses in the educational curriculum, rotations, schedules, or supervision. The purpose of this policy is to establish an institutional policy related to the composition and responsibilities of the Residency's Clinical Competency Committee. This policy also outlines the responsibilities of the Clinical Competency Committee. This policy is in accordance with the requirements of the ACGME, the program specific Residency Review Committee (RRC) and this Graduate Medical Education Committee (GMEC).

## CLINICAL COMPETENCY COMMITTEE

In accordance with this policy and the AGCME requirements, each CCC is to be comprised of a diverse group of faculty that reviews resident performance on an ongoing basis with a shared understanding of the resident performance through a reasonable process. The CCC assessment will help to reinforce areas of competency and strength, as well as poor performance in isolated situations from a pattern of poor performance. Recommendations by the CCC to the Program director (PD) should aid in the clarification of specific areas of concern for an individual resident as well as weakness in the program's educational curriculum, clinical experiences, rotations, schedules, and supervision. These recommendations should be addressed by the Program Evaluation Committee (PEC).

## SCOPE

The CCC applies to all house staff in Western Reserve Health education sponsored ACGME training programs.

## IMPLEMENTATION

The implementation of this policy is the responsibility of the Designated Institution Official (DIO), the office of the GME, and the Program directors (PD).

## STRUCTURE AND MEMBERSHIP

A. All residency programs will implement CCC in accordance with ACGME requirements.
B. CCCs will meet with a frequency that may exceed that required by the ACGME but not less than twice a year in accordance with ACGME requirements.
C. Documentation of the meeting with minutes is required.
D. The CCC will provide guidance and assistance in preparing and reporting the milestones of each individual resident semi-annually to the ACGME during the ACGME designated windows.
E. Each program will have a CCC with a structure that meets ACGME requirements. CCC members are appointed by the PD. The PD may participate with the CCC.

- Membership will vary by department and residency size but must include at least three (3) faculty.
- All members must be actively involved in residency education.
- All members must participate in committee deliberation regularly (minimum attendance of 75%)
- Programs are encouraged to consider the following when appointing CCC members.
    - The Chair of the CCC is Not the PD or Chair of the Department.
    - Representative from all divisions/services
    - Representatives from all major training sites is encouraged.
    - Large CCCs may have staggered terms for members.
    - In small departments, the CCC may include whole faculty.
    - Chief residents who have completed core residency programs in their specialty may provide input to the CCC Chair and/or PD OUTSIDE the context of the CCC meeting, through an evaluation system.
    - In order to ensure that residents' peers are not providing promotion, disciplinary, and/or graduation decisions, residents are NOT involved in the recommendations from the CCC and may NOT serve as CCC members or attend CCC proceedings.
    - The CCC may include non-physicians (eg practice managers, head nurse etc.)

F. The Program Coordinator (PC) may participate in the CCC proceedings.

- The coordinator may aggregate the data on each resident, manage the meeting logistics, keep meeting minutes, and record the decisions made by the committee.
- PCs should provide information to CCC members before the meeting for "pre-work."
- PCs may provide objective input to the CCC.

G. The functions of the CCC may include but are not limited to:

- Review all resident assessment tools such as
    - Faculty evaluations
    - Resident self-evaluations
    - 360-degree or multisource evaluations from nurses, colleagues, students, patients, other ancillary health care personnel
    - Conference Attendance sheets and/or audits.
    - ITE scores
    - In house exams (in writing or oral)
    - Procedure logs/Case logs/ patient experience numbers
    - Research activities/ Publications/ QI projects/ Poster presentations
    - Professionalism issues
    - OSCE/ Simulation/ Resident Portal Educational information
    - Any other assessment information available
    - Unsolicited comments
    - Previous CCC information and milestone summary reports
    - Duty hour compliance or violations
    - Compliance/administrative evaluations
- Review Summative evaluations
- Assist in completing the specialty specific milestones reporting from the PD to the ACGME semiannually for each trainee.
- Make recommendations to the PD regarding the resident:
    a) promotion

b) remediation including but not limited to: intensify mentoring/structured reading/ added rotations/ repeat activities or rotations/ extend education/ counseling to consider another profession.
c) academic warning
d) probation
e) termination/Dismissal
f) non-renewal

H. The PD has the final responsibility for the program's evaluation and promotion decisions subject to WRHE policies and procedures.

I. See Exhibit A for example CCC minutes.

## EXHIBIT A

## CCC Meeting Summary Template

*To be completed by CCC and forwarded to PD for review and secure storage*

| **Program:** | **Date of CCC**: |
|---|---|
| **Resident Name:** | **Year in program**: |

The CCC reviewed and discussed the following (check if done):

☐ Duty Hour Monitoring
☐ Procedure Case Logs and/or Clinic #s (☐N/A)
☐ Met SMART Goals in Prior Individualized Learning Plan (ILP)
☐ Scholarly Activity
☐ QI/PI Participation
☐ All Evaluations (medical students, peers, faculty/preceptors 360 - staff, patients, clinics, nursing, etc.)
☐ Resident/Fellow Performance (incl. ITE & overall achievement of Milestones)
☐ Other (please list):

| **Identified Strengths:** |
|---|
| **Opportunities for growth:** |

## ACGME COMPETENCY-RELATED SUMMARY

| | **Meeting milestones** | **Meeting some, but not all** | **Not meeting milestones** (please comment on p. 2 for marked items) |
|---|---|---|---|
| **MK** | ☐ | ☐ | ☐ |
| **PC** | ☐ | ☐ | ☐ |
| **SBP** | ☐ | ☐ | ☐ |
| **PBLI** | ☐ | ☐ | ☐ |
| **ICS** | ☐ | ☐ | ☐ |
| **PROF** | ☐ | ☐ | ☐ |

## RECOMMENDATION FOR PD:

| ☐ (Fall CCC) Continue with standard curriculum |
|---|
| ☐ (Spring CCC) Progress to the next level of training or graduation |
| ☐ Able to advance with a ***program supervised plan*** to address deficiencies identified (**please complete below**) |
| ☐ Change in formal academic standing *(refer to a remediation plan as applicable)*:<br>☐ Notice<br>☐ Warning<br>☐ Probation<br>☐ Return to good standing<br>☐ Other: |

## Reviewed by CCC Chair

| Name (Print): | Signature: |
|---|---|

*******For documentation purposes, below this section to be completed only if concerns are noted*******

## COMPETENCY-RELATED SUMMARY/REPRESENTATIVE COMMENTS:

| Medical Knowledge |
|---|
| Patient Care |
| Systems Based Practice |
| Practice Based Learning & Improvement |
| Interpersonal Communication skills |
| Professionalism |

# Internal Medicine Program Specific Policies

## MICU,WARDS, Night Float Rotations

- Workdays are 6 days per week average (one weekend day off average)
- Coverage for weekend days off will be filled with the residents not on the MICU, floor and night float rotations
- If you need a weekend day off, the chiefs will try to accommodate if possible. BE SURE to notify the program coordinator

-No time off will be granted when on MICU, Wards, or Night Float

**-Exceptions**:

-Fellowship Interviews if unable to schedule another time

-Conferences where you are doing an oral or poster presentation

- Prelim resident interviews looking for 2nd year position if unable to schedule another time.

- IF SCHEDULED TO WORK, YOU CANNOT ASK SOMEONE TO COVER SO YOU CAN HAVE A DAY OFF.

# ACGME RULES PGY-1

-Interns can follow no more than ten (10) patients at any one time.

-No more than five (5) new patients + two (2) transfers can be assigned to an intern.

-No more than eight (8) total patients (new + transfers) can be assigned to an intern over a 2-day period.

# ACGME RULES PGY 2 and 3

-**WITH ONE (1) INTERN ON THE TEAM, THE SUPERVISING RESIDENT CAN FOLLOW**
-No more than fourteen (14) patients at any one-time (this means the intern can follow up to ten (10) patients and the resident, without the intern, can follow an additional four (4) patients.

-With one (1) intern on the team, the supervising resident can only have five (5) new patients + two (2) transfers assigned to the team.

-No more than eight (8) total patients (new + transfer) can be assigned to the team over a 2-day period.

-**WITH TWO (2) INTERNS ON THE TEAM, THE SUPERVISING RESIDENT CAN FOLLOW NO MORE THAN TWENTY (20) PATIENTS AT ANY ONE TIME.**
-With two (2) interns on the team, the supervising resident can only have ten (10) new patients + four (4) transfers assigned to the team during a routine workday.

-No more than sixteen (16) total patients (new + transfer) can be assigned to the team over a 2-day period.

# ADMISSION CAP

-In the event admissions are capped (10 for covering senior resident), then the other service will serve as immediate backup.

When the cap is met, the senior resident needs to contact their own attending physician.

a. (IM -> IM or FM ->FM) to let them know.

b. The attending will then reach out to the other attending as a courtesy to let them know when they are capped until the next morning at 7am.

c. Once that has occurred, then the senior resident can let the ER know admissions are being diverted to the other service.

-In the event both services are capped for whatever reason, IM resident can see the patient, place admission orders to tuck them in, and the NPs can do the H&P and assume care the next morning under the guidance of the IM attending.

-NOTE: RESIDENT MUST CALL THE ATTENDING PHYSICIAN

# LEVELS OF SUPERVISION

**Direct Supervision**

-The supervising physician is physically present with the resident during the key portions of the:

-patient interaction; or PGY-1 residents must initially be supervised directly.

**Indirect Supervision**

-The supervising physician is not providing physical or concurrent visual or audio.

-Supervision but is immediately available to the residents for guidance and is available to provide appropriate direct supervision.

**Overnight**

-The supervising physical is available to provide review of procedures/encounters with feedback provided after care is delivered.

-You are supervised by your faculty and senior residents.

# VACATION TIME

-All vacation requests **MUST** be submitted to the **Program Coordinator and the Chief Residents at least** 1 month in advance for review. (Elective rotations only.)

-Asking for vacation requests a week in advance will be denied, unless it is sick leave or an emergency.

-If ill and unable to work, you MUST report off as soon as possible to the Program Coordinator and the Chief Resident taking care of the schedule for the month.
-also, please notify your attending physician or their office.

**-DO NOT SAVE ALL YOUR VACATION TIME FOR THE END OF THE YEAR**

-As we need to cover our services, only PGY-3 and Prelims leaving the program will only be granted time off in June.

-Seniors and Prelims leaving will be able to leave and attend their next orientation in June if they have enough vacation time left to cover the days off that are needed.

-Please remember that when scheduling time off, you need to be present for half of the rotation to get credit for the rotation.

# HOLIDAY BLOCK – COMMON DAYS

-Everyone needs to be back on Common Days – NO PTO TIME

-No combining PTO with your holiday block

-All residents will be scheduled in Inpatient Rotations during Common Days

-Wards, ICU, NF, ID, Pulm, Nephro, Cardio, Radiology, GI, ER, Anesthesia (Half-day shifts)

-Mandatory MKSAP Tests – All topics on Common Days (Chiefs monitor them)

# CLINICS

-Continuity Clinic

-Athen bucket – check daily

-On-call clinic schedule PGY 2 and PGY 3

-Vacation / Conference

-CHF Clinic – Voluntary during electives

**Always check your Athena and inform clinic before you go on vacation so that you DON'T have patients scheduled when you are not in clinic.

# CONFERENCE REIMBURSEMENT & BOARD REVIEW

-CONFERENCE

-One conference per academic year

-One month notification to the program coordinator and chief resident

-Travel request forms need to be submitted before going to the conference.

-Travel reimbursement form and receipts need to be submitted after the conference.

-Concur – All WRHE approved travel reimbursement forms need to be uploaded to Concur.

BOARD REVIEW COURSE

-PGY- 3

-The maximum time for seminars or conferences is **five consecutive working days including travel time.**

-For Research Presentations please refer to the policy in the house manual.

-Upon completion of the trip a travel reimbursement form should be completed by the resident and submitted to the residency program coordinator **within five working days of completion of approved travel.**

-As per the policy, all appropriate receipts as noted should be attached to the Travel Expense voucher.

-Any travel which has not received prior approval from the residency program coordinator **will not be reimbursed**.

-Travel Expense reports submitted without appropriate receipts will be returned to the resident so that documents can be secured and attached to the Travel Expense Voucher prior to processing payment by the hospital.*IF YOU HAVE A CONFERENCE PRESENTATION DURING YOUR FLOOR/ICU/NIGHTS- YOU ARE REQUIRED TO FIND YOUR ON COVERAGE WITH THE HELP OF THE CHIEFS.

# MEDICAL RECORDS

-The Resident Physician is responsible for completing all the medical records in a timely manner consistent with the rules and regulations for medical records which are included in the house staff manual.

-Please refer to the policy “Medical records Policy—Timely Completion of Medical Records By House Staff”

-It is the Programs responsibility to monitor resident Physician Medical records completion with the resident on a timely basis.

-The medical record can be subpoenaed and in a litigation action the medical record is a key tool of the plaintiff’s attorney.

-Many case outcome in court is a result of documentation in the medical record. The record should be a document which describes the patient’s medical events in a systematic manner.

-The record should document your care and treatment of the patient.

**DO**
-Finish notes timely/same day
-Appropriately document in appropriate parts of the note.
-A/P
-Place a note every time there is patient contact.

**DO NOT**
-Criticize other providers or staff
- “one-up” another provider
-Place conjecture

# SUSPENSION POLICY – MEDICAL RECORDS

-Suspensions occur every Wednesday and are determined by the following criteria:

H&Ps not done within 24 hours
Operative Reports/ procedure notes not done within 24 hours
Order signatures not authenticated within 8 days, and other medical records not completed within 30 days.

There are also additional expectations per medical staff policies that:

-New consult notes are completed within 24 hours, and discharge summaries are done within 2 days of discharge.

# TIMELY COMPLETION OF INJURY/EXPOSURE REPORTS

-ALL work-related **exposures and/or injuries** require an injury report to be **completed within 24 hours** of the injury/exposure.

-OSHA requirement

-Notify the Residency Program Coordinator immediately

-PATH – Sharon intranet > Human resources

# RESIDENT WELLNESS

-Wellness meetings quarterly, monthly newsletters, wellness lectures, mindfulness workshops, buddy groups, wellness events

Resources available:
Employee Assistance Program
-Unum
-Toll free, 24/hour access
-1-800-854-1446 : English
-1-800-999-3004 : TTY/TDD
-Unum online access
-www.unum.com/lifebalance
-user ID and password – lifebalance

-Additional resources
-Ohio Physicians Health Program
-this site has great resources for self-assessment
-614-841-9690
-www.ophp.org

# IN-TRAINING EXAMS

-testing begins at 7am

-Schedules emailed

-Testing time is est. 9 hours

-7 hours devoted to exams, several allotted 10-minute breaks and a lunch hour.

-Exam is 300 questions

# MKSAP & U WORLD TESTING

MKSAP testing -PGY 1 & PGY-2

UWORLD – PGY-3

**Testing is mandatory for all levels**

# PROFESSIONALISM

-One of the six pillars of ACGME requirements for all residency programs.

-“If you are on time, you are late.”

-We will post monthly data on attendance.

-We expect issues to be handled personally and in-house.

-If there is no resolution, get the Chief involved.

-If there is still no resolution, it comes to the Senior Residency Program Coordinator.

-If it doesn’t get resolved, it then goes to the PD and the APD.

# SOCIAL NETWORKING GUIDELINES

-DO NOT post patient information or pictures of procedures which would be a potential HIPAA violation.

-DO NOT badmouth colleagues, boss, or the company you work for. (Always assume that this information will reach them. Nothing ever disappears from the internet.) Be sure that you are not performing such activities on a hospital computer or during work shifts.

-DO NOT complain about lack of motivation, workload, or anything you see as a “waste of your talents.”

-DO NOT claim to have family emergencies and sick days (assume you will be time stamped and tagged in all your friends’ party pictures.)

-ALWAYS ASSUME everyone can see what you’re writing, or that it will make its way to them at some point.

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