UCF/HCA GME Consortium Policies for Resident Supervision and Clinical/Educational Work Hours

Purpose/Intent: The GMEC must develop and implement written policies and procedures regarding resident duty hours and supervision (Institutional IV.I-J, CPR VI.)

Policy Summary: These policies ensure compliance with institutional and common program requirements. Any program specific requirements are provided in separate program policy.

Professionalism and responsibility for safe work environment and transitions in care policies:

1. Residents and faculty are educated on the professional responsibilities of physicians, including the obligation to be appropriately rested and fit when providing patient care.
    a. Residents and faculty will complete an online or in-person module on alertness management, sleep deprivation and fatigue. They will also participate in an educational program related to physician impairment and substance abuse.
2. Residents are expected to take responsibility for determining if they are fit for patient care duties and to recognized signs of impairment, including illness and fatigue.
3. Each program has fatigue mitigation processes to manage potential negative effects of fatigues, including naps and back-up call schedules, as appropriate to each program. Each program has processes to manage continuity of care.
4. Participating hospitals provide sleep facilities and transportation options for those too fatigued to safely return home (see GMEC work environment policy).
5. Residents and faculty must demonstrate responsiveness to patient needs that supersedes self-interest, and must recognize that patient interests are best served by transitioning care to another qualified and rested provider. They must be prepared to transition patient care to other qualified and rested clinical providers in order to promote safe medical care.
6. All residencies have policies to ensure and monitor effective structured hand-over processes that promote continuity of care and patient safety.
7. Schedules must be available that inform all members of health care team of attending physicians and residents currently responsible for each patient's care.

Supervision policies:

8. All residencies are governed by specific policies for supervision and residents are all informed of these policies at the beginning of the residency. The overall policies include:
    a. All patients have an identifiable and appropriately credentialed and privileged attending physician (or licensed practitioner approved by ACGME for that specialty) who takes ultimate responsibility for that patient's care.
    b. This attending physician information is available to the patient, and all clinical staff.
    c. Residents and faculty members inform patients of their respective roles in each patient's care.
9. Levels of supervision are defined by ACGME common program requirements:
    a. Direct: supervising physician is physically present with resident and patient

b. Indirect: may include
    i. Direct supervision immediately available in patient care site
    ii. Indirect with direct supervision immediately available (supervising physician is physically located within patient care site)
    iii. Indirect with direct supervision available by phone or other electronic means, and attending can be available to provide direct supervision
c. Oversight: supervising physician reviews encounters and procedures after care is delivered and provides feedback

10. Each resident is delegated responsibility for portions of patient care based on evaluations of the resident's ability (when possible by national standards) by program director, the clinical competency committee, and key faculty. Residents are informed about the limits of authority and when he/she is permitted to act with conditional independence and in supervisory role
    a. Initially, PGY-1 residents are either supervised directly or indirectly with direct supervision immediately available, unless otherwise specified by ACGME program requirements and program policies
    b. Senior residents and fellows should serve in supervisory role for junior residents
    c. Clinical responsibilities are based on PGY level, resident education and competencies, and specific patient care and safety concerns. Each Program director evaluates their residents using specific criteria and milestones.
    d. Faculty supervision assignments are of sufficient duration to assess knowledge and skills of resident and to delegate appropriate level of patient care authority to the residents.

11. Each Resident must follow the protocol defining Common Circumstances Requiring Supervising Faculty Involvement:

    In addition to the general circumstances encountered below, residents may at any time request direct faculty supervision if uncertainty exists or if felt to be required by the resident. Residents are encouraged to communicate with supervising faculty any time they feel the need to discuss any matter relating to patient care.

    Listed below are circumstances and events where residents **must** communicate with supervising faculty:

    a. ICU and Critical Care transfers (both to and from unit)
    b. Substantial change in the patient's condition
    c. Issues regarding code status (including DNR) and end of life decisions
    d. If the resident is uncomfortable with carrying out any aspect of patient care for any reason (for example, a complex patient)
    e. If specifically requested to do so by patients or family
    f. Prior to accepting transfers from other hospitals
    g. To determine discharge timing

h. Prior to performing any invasive procedure requiring written consent
i. To discuss consultations rendered
j. If any error or unexpected serious adverse event is encountered.
k. When, after directly triaging a patient, they question appropriateness of an admission or transfer.

Resident clinical and educational work (duty) hours and call

12. Clinical and education work(duty) hours are limited to 80 hours per week averaged over a 4 week period, and this includes all in-house clinical and educational activities, clinical work done from home, and moonlighting activities (if applicable).
    a. Moonlighting Policy: see separate UCF COM/HCA GME Consortium Moonlighting policy.
13. Clinical work done at home: residents are to track time per week for work done at home (such as completing EMR work, phone calls, excludes study and reading). Each program may provide additional guidance as to how this time should be entered.
14. Time free of clinical work and mandatory education: all programs shall provide reasonable time for rest and well-being
    a. Each resident has a minimum of one day free of duty (without any home call responsibilities) per week (when averaged over 4 weeks).
    b. Residents should have 8 hours off between scheduled clinical work and mandatory education. Residents may rarely choose to stay or return to work but these must be documented as duty hours.
    c. Residents each have a minimum of 14 hours free of clinical and educational work after 24 hours of in-house scheduled time.
15. Clinical and educational work periods for residents must not exceed maximum of 24 hours of continuous duty, and residents are not assigned any additional responsibilities after 24 hours.
    a. Alertness management strategies are encouraged in the context of patient care, for example strategic napping at night or after 16 hours of duty.
    b. A limited amount of extra time (<4 hours) may occasionally be allowed for safe effective transitions in care and/or resident education (no new patients can be assigned).
16. Exceptions where resident stays or returns to work early may be made occasionally. Note these exceptions are for certain situations outlined below and are documented by the resident and reviewed and tracked by each program director and count toward 80 hours. Note that other duties must be handed off. The reasons for exceptions are:
    a. to care for a severely ill or unstable single patient
    b. for humanistic attention to patient or family,
    c. for academically important events.
17. Residents assigned to emergency medicine (EM) rotations (from any residency program) have additional duty hour restrictions.

a. Residents shall not work longer than 12 continuous hours in EM, and must have at least equivalent period of continuous time off between scheduled shifts.
b. Residents should not have more than 60 hours/week seeing EM patients, and not more than 72 total duty hours/week.
c. One day (24 hours) free per 7 days must be free, and this cannot be averaged over 4 weeks.

18. Residents in final years of training must take on additional responsibility so that they will be able to enter unsupervised practice.
19. Call frequency: Residents are not scheduled for in-house call more often than every 3rd night (when averaged over 4 week period). Some residency programs including internal medicine do not allow averaging of call.
20. Night Float must occur within context of one-day-off-in-seven and 80 hour rules. Further restrictions on night float may be specified by each program.
21. At-home call: Call is not so frequent as to be taxing or preclude rest. Time spent in the hospital or doing clinical work at home counts toward the 80-hour per week maximum.
22. Any requests for exceptions are considered initially by the CGMEC prior to submission to any ACGME residency review committee.
23. Any extension of duty hours or request for early return to service requires completion of the appropriate departmental form within the duty hour period in which the extension/early return was taken. There are only 3 possible ACGME approved explanations (provided in #16 and on the form) for a duty hour extension or early return to service.
24. Each program director regularly reports duty hour issues and noncompliance to each hospital GMEC subcommittee, with those reports copied to the CGMEC. Compliance is monitored by the local GMEC. Variances are reported to the CGMEC with the expectation of immediate corrective action to be reported at the following meeting of the CGMEC or earlier as necessary.