POLICY MANUAL

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Department of Primary Responsibility: Academic Division – Graduate Medical Education

Subject: DUTY HOURS/RESIDENT SUPERVISION

Distribution: Program Directors, Residents, Department Chairs

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POLICY:

It is the policy of the Ochsner Clinic Foundation that all residents in training at this institution work in an educational environment that promotes patient safety, quality academic growth resident well-being. All residency and fellowship programs will be monitored for compliance with the ACGME Duty Hours in the Learning and Working Environment Requirements, as listed below.
(ACGME Common Program Requirements, effective July 1st 2011)
(ACGME Specialty-specific Duty Hour Definitions, published February 4, 2012)

Resident Duty Hours in the Learning and Working Environment

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 program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment. The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.
The learning objectives of the program must: be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and, not be compromised by excessive reliance on residents to fulfill non-physician service obligations.

The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following:

a. assurance of the safety and welfare of patients entrusted to their care;
b. provision of patient- and family-centered care;
c. assurance of their fitness for duty;
d. management of their time before, during, and after clinical assignments;
e. recognition of impairment, including illness and fatigue, in themselves and in their peers;
f. attention to lifelong learning;
g. the monitoring of their patient care performance improvement indicators; and,
h. honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.

All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. 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.

1. Transitions of Care
    a. Programs must design clinical assignments to minimize the number of transitions in patient care.
    b. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.
    c. Programs must ensure that residents are competent in communicating with team members in the hand-over process.
    d. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care.

2. Alertness Management/Fatigue Mitigation
    The program 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. adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.

Each program must have a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties.
The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely return home.

a. In the unlikely event a resident is too fatigued that he/she cannot drive home, they may take a taxi and provide the original receipt to Graduate Medical Education for reimbursement.
b. Specified Call Rooms are readily available for residents to take advantage of if they are too fatigued to drive home.
c. Programs are required annually to achieve 100% compliance in participation of the Academy of Sleep Medicine's SAFER Program, submitting sign-in sheets to the Graduate Medical Education office.

3. Supervision of Residents

In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.

a. This information should be available to residents, faculty members, and patients.
b. Residents and faculty members should inform patients of their respective roles in each patient's care.

The program must demonstrate that the appropriate level of supervision is in place for all residents 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 or fellow. 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.

4. Levels of Supervision

To ensure oversight of resident 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. Direct supervision required until competency demonstrated for;

A. Patient Management Competencies
1) Initial evaluation and management of patients in the urgent and emergent situation, including urgent consultations, trauma, and emergency department consultations (ATLS required)
2) Evaluation and management of postoperative complications, including anuria, cardiac arrythmias, change in neurologic status, change in respiratory rate, compartment syndromes, hypertension, hypotension, hypoxemia, and oliguria
3) Evaluation and management of critically-ill patients, either immediately post-operatively or in the intensive care unit, including the conduct of monitoring and orders for medications, testing and other treatments.
4) Management of patients in cardiac or respiratory arrest (ACLS required)

B. Procedural Competencies
1) Carry out advanced vascular access procedures, including central venous catheterization, temporary dialysis access, and arterial cannulation.
2) Repair of surgical incisions of the skin and soft tissues
3) Repair of lacerations of the skin and soft tissues
4) Excision of lesions of the skin and subcutaneous tissues
5) Tube thoracostomy
6) Paracentesis
7) Endotracheal intubation
8) Bedside debridement

Indirect Supervision – with direct supervision immediately available - the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision. With direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision. Indirect supervision allowed for;

A. Patient Management Competencies
1) Evaluation and management of a patient admitted to hospital, including initial history and physical examination, formulation of a plan of therapy, and necessary orders for therapy and tests
2) Pre-operative evaluation and management, including history and physical examination, formulation of a plan of therapy, and specification of necessary tests
3) Evaluation and management of post-operative patients, including the conduct of monitoring and orders for medications, testing and other treatments
4) Transfer patients between hospital units or hospitals
5) Discharge patients from hospital
6) Interpretation of laboratory results

B. Procedural Competencies
1) Perform basic venous access procedures, including establishing of intravenous access
2) Placement and removal of nasogastric tubes and Foley catheters
3) Arterial puncture for blood gases

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.

a. The program director must evaluate each resident's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.
b. Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.
c. Senior residents or 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 or fellow.

Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.

a. Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available. [See ACGME Specialty-specific Duty Hour Definitions, published February 4, 2012]
Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.

5. Patient Safety and Quality Improvement

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:

1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;
2) coordinate patient care within the health care system relevant to their clinical specialty;
3) incorporate considerations of cost awareness and risk benefit analysis in patient and/or population-based care as
4) appropriate;
5) advocate for quality patient care and optimal patient care systems;
6) work in interprofessional teams to enhance patient safety and improve patient care quality; and,
7) participate in identifying system errors and implementing potential systems solutions as further specified by the respective Review Committees in the Specialty-specific Duty Hour Definitions, published February 4, 2012.

Programs must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment. The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs. Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following: assurance of the safety and welfare of patients entrusted to their care; provision of patient- and family-centered care; assurance of their fitness for duty; management of their time before, during, and after clinical assignments; recognition of impairment, including illness and fatigue, in themselves and in their peers; attention to lifelong learning in preparation for meeting/exceeding MOC, Part IV requirements; the monitoring of their patient care performance improvement indicators; and, honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.

6. Clinical Responsibilities

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.
[See ACGME Specialty-specific Duty Hour Definitions, published February 4, 2012]

7. Teamwork

Residents must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty. [See ACGME Specialty-specific Duty Hour Definitions, published February 4, 2012] Ochsner Clinic Foundation offers the privilege for residents to train in an interdisciplinary system. Teamwork is essential to improved quality care metrics. All members of the caregiver team should be provided instruction in:

1) recognition of and sensitivity to the experience and competency of other team members;
2) time management;
3) prioritization of tasks as the dynamics of a patient's needs change;
4) recognizing when an individual becomes overburdened with duties that cannot be accomplished within an allotted time period;
5) communication, so that if all required tasks cannot be accomplished in a timely fashion, appropriate methods are established to hand off the remaining task(s) to another team member at the end of a duty period;
6) signs and symptoms of fatigue not only in oneself, but in other team members;
7) compliance with work hours limits imposed at the various levels of education; and,
8) team development.

8. Resident Duty Hours

Maximum Hours of Work per Week

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.

Duty Hour 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.

1) In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.
2) Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.

9. Moonlighting

Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program. 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. PGY-1 residents are not permitted to moonlight. (Reference GME Policy #8242-011)

10. Mandatory Time Free of Duty

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.

11. Maximum Duty Period Length

1) Duty periods of PGY-1 residents must not exceed 16 hours in duration.
2) Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.

It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.

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

In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. Under those circumstances, the resident must:

a. appropriately hand over the care of all other patients to the team responsible for their continuing care; and,
b. document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

12. Minimum Time Off between Scheduled Duty Periods

PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods. Intermediate-level residents [as defined by the Review Committee] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty. Residents in the final years of education [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

This preparation must occur within the context of the 80- hour, maximum duty period length, and one-day-off-in seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [as defined by the Review Committee] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.

13. Maximum Frequency of In-House Night Float

Residents must not be scheduled for more than six consecutive nights of night float.
[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.]

14. Maximum In-House On-Call Frequency

PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

15. At-Home Call

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.

a. 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 care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”.

MONITORING/ENFORCEMENT:

Monitoring of compliance with duty hour requirements will be conducted by the GMEC through Internal Reviews, and at least semi-annually duty hour time-study surveys of all programs. Programs which demonstrate a lack of compliance with duty hour regulations or which have been identified through internal reviews, resident complaints or previous surveys to be either out of compliance or at substantial risk of being out of compliance will be surveyed at least twice yearly (at least once within six months of the yearly institutional survey).

At any time residents with concerns about their work environment may bring a concern directly to the GMEC by informing the Chairman of the GMEC of their concern and/or to the Corporate Compliance Hotline. The matter will be investigated and the GMEC will determine whether to conduct a spot survey of that program.

APPLICATIONS FOR DUTY HOURS EXTENSION:

Programs wishing to apply for the 10% extension of the weekly 80-hour limit must follow the format below. A formal application with supporting documentation must be made to the GMEC. That application will be considered. If further information is deemed necessary, the GMEC may appoint an ad hoc internal review of the program to determine the validity of the request. The final decision for approval of an extension rests with the individual program’s RRC. If the OCF GMEC approves the request, it will send a supporting letter to the program director, to be included with the program’s request to the RRC for an extension.

Eligibility Criteria

1. The program must be accredited in good standing, i.e., without a warning or a proposed or confirmed adverse action.
2. The program must have had a favorable internal review by the GMEC.

Required Documentation

The program's responsibility is to make a clear showing that the exception is necessary for educational reasons. The proposal from a program to the RRC must include the following documentation:

1. Patient Safety: Information must be submitted that describes how the program and institution will monitor, evaluate, and ensure patient safety with extended resident work hours.
2. Educational Rationale: The request must be based on a sound educational rationale which should be described in relation to the program's stated goals and objectives for the particular assignments, rotations, and level(s) of training for which the increase is requested. Blanket exceptions for the entire educational program should be considered the exception, not the rule.
3. Moonlighting Policy: Specific information regarding the program's moonlighting policies for the periods in question must be included.
4. Call Schedules: Specific information regarding the resident call schedules during the times specified for the exception must be provided.
5. Faculty Monitoring: Evidence of faculty development activities regarding the effects of resident fatigue and sleep deprivation must be appended.
6. The current accreditation status of the program and of the sponsoring institution should be provided in the formal request.

Monitoring

a. Prior to the end of the initial year for the exception, the GMEC will monitor and reevaluate the educational purpose for the exception. The form of the monitoring is determined by the RRC, e.g., a progress report, a time study, a resident survey, a site visit, or other method.
b. At the time of each internal review, the GMEC will reevaluate the patient safety aspects and educational rationale for the exception and may continue, deny, or modify the exception.

Signatures

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