1.0 Purpose

To provide an Institutional statement regarding House Officers' clinical experience and education hours and their learning and working environment as mandated by the ACGME.

2.0 Procedure

2.1 Definitions

2.1.0 Clinical experience and education hours: all clinical and academic activities related to the Residency Program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. These hours do not include reading and preparation time spent away from the work site.

2.1.1 In-house call: time beyond the normal workday when House Officers are required to be immediately available in the assigned Institution.

2.1.2 Moonlighting: patient care activities external to the educational program that residents/fellows engage in at sites used by the educational program (internal moonlighting) and other healthcare sites. 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 prohibited from moonlighting. Any resident on J-1 or H-1B visa is prohibited from moonlighting.

2.1.3 Home call (pager call): call taken from outside the assigned Institution. This call is not subject to the every night limitation. If the House Officer is called into the hospital from home, those hours are counted toward the 80-hour limit.

2.1.4 New patient: a patient for whom the House Officer has not previously provided care.

3.0 Background

Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident.

3.1 The specialty education of physicians is experiential, and necessarily occurs within the context of the health care delivery system.

3.2 Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident physician to assume personal responsibility for the care of individual patients.

3.3 For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions.

3.4 As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence.

3.5 This concept-graded and progressive responsibility-is one of the core tenets of graduate medical education.

3.6 Supervision in the setting of graduate medical education has the goal of assuring the provision of safe and effective care to the individual patient; assuring each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establish a foundation for continued professional growth.

4.0 Off Service House Officer call schedules and duty assignments will be constructed in strict adherence to ACGME guidelines.

4.1 The Off Service House Officer MUST report his/her clinical experience and education hours to both their primary Program Coordinator and their host Program Coordinator's office on a weekly basis.

4.2 Non-compliance with clinical experience and education hours requirements MUST expeditiously be reported to both the primary Training Program Director and to the host Program Director to permit corrective actions to be taken.

5.0 Augusta University fully supports the Residents policies established by the Accreditation Council for Graduate Medical Education (ACGME) concerning the learning and working environment.

6.0 Professionalism, Personal Responsibility and Patient Safety

Programs and the sponsoring institution must educate residents and faculty members concerning the professional responsibilities of physicians to report to work 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.

6.1 The program director must endure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.

6.2 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.

6.3 The program director and sponsoring institution must ensure a culture of professionalism that supports patient safety and personal responsibility.

6.4 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;

- the monitoring of their patient care performance improvement indicators; and,
- honest and accurate reporting of clinical experience and education hours, patient outcomes, and clinical experience data.

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

6.6 Physicians must recognize that under certain circumstances, the best interest of the patient may be served by transitioning that patients' care to another qualified and rested provider.

7.0 Clinical Experience and Education

7.1 Time spent on clinical experience and education must be limited to 80 hours per week, averaged over a four week period, inclusive of all in-house call activities and all moonlighting.

7.2 Maximum Clinical Experience and Education Period Length

- 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.
- 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.
- Residents should have eight hours off between scheduled clinical work and education periods. There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements.
- Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.
- Residents 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.
- Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.
- Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. Additional patient care responsibilities must not be assigned to a resident during this time.
- In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; humanistic attention to the needs of a patient or family; or, to attend unique educational events. These additional hours of care or education will be counted toward the 80-hour weekly limit.
- A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale. In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the ACGME Manual of Policies and Procedures. Prior to submitting the request to the Review Committee, the program director must obtain approval from the GMEC and DIO.

7.3 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 in not subject to the every third-night limitation, but must satisfy the requirement for one-day-in-seven free of clinical experience and education responsibilities, when averaged over four weeks.

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

7.4 Alertness Management/Fatigue Mitigation Program

This program must:

- educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;
- educate all faculty members and residents in alertness management and fatigue mitigation processes;
- 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 complete his/her clinical responsibilities.
- the sponsoring institution must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigues to safely return home (See Attachment B).

8.0 Supervision of House Officers

8.1 All patient care must be supervised by qualified faculty. The Program Director must ensure, direct and document adequate supervision of House Officers at all times. House Officers must be provided with rapid, reliable systems for communicating with supervising faculty.

8.2 Faculty schedules must be structured to provide House Officers with continuous supervision and consultation.

8.3 The program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment, and must ensure that resident are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.

8.4 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.

8.5 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:

- 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 their peers;
- attention to lifelong learning;
- the monitoring of their patient care performance improvement indicators and;
- honest and accurate reporting of duty hours, patient outcomes and clinical experience data.

8.6 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 patients care.

- This information should be available to residents, faculty members, and patients.
- Residents and faculty members should inform patients of their respective roles in each patients care.

8.7 The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.

8.8 Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member.

8.9 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.

8.10 In some circumstances, supervision may include post-hoc review delivered care with feedback as to the appropriateness of that care.

8.11 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.
- Indirect Supervision:

  1) 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.

  2) With direct supervision available- the supervision 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.

- Oversight- the supervision physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

8.12 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. When available, evaluation should be guided by specific national standards-based criteria.
- 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.
- 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.

8.13 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 and intensive care unit, or end-of-life decisions.

- 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.

1) In particular, PGY1 residents should be supervised either directly or indirectly with direct supervision immediately available (each Review Committee will describe the achieved competencies under which PGY1 residents' progress to be supervised indirectly, with direct supervision available).

8.14 Faculty supervision assignments should be 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

8.15 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 (Optimal clinical workload will be further specified by each Review Committee).

9.0 Transitions of Care

9.1 Programs must design clinical assignments to minimize the number of transitions in patient care.

9.2 The sponsoring institutions and all programs must teach and monitor effective, structure hand-over processes to facilitate both continuity of care and patient safety.

9.3 Programs must ensure that residents are competent in communicating with team members in the hand-over process.

9.4 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 patients care.

10.0 Work Environment:

10.1 Food services: House Officers must have access to adequate and appropriate food services. Food is provided to House Officers who take in-house-call.

10.2 Call rooms: Call rooms are provided for House Officers who take in-house call or need a place to sleep as part of their fatigue mitigation strategy.

10.3 Support services: Adequate ancillary support for patient care shall be provided for House Officers at all times.

10.4 Laboratory/pathology/radiology services: These services and the associated information systems must be available at all times and must be adequate to support quality patient care, the education of the House Officer, quality assurance and provided resources for scholarly activity.

10.5 A medical records system that document the course of each patients illness and care must be available at all times and must be adequate to support quality patient care, the education of the House Officer, quality assurance and provide a resource for scholarly activity.

10.6 Security/safety- Appropriate security and personal safety measures must be provided to House Officers at all training locations.

11.0 Teamwork

11.1 Residents must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective inter-professional teams that are appropriate to the delivery of care in the specialty. Each Review Committee will define the elements that must be present in each specialty.

12.0 Oversight:

12.1 Each ACGME- Accredited Residency and Fellowship Training Program must establish formal written policies governing resident duty hours that are consistent with the Institutional and Program Requirements. This policy will be communicated to the House Officer and faculty annually.

12.2 The GME Office must be provided with a copy of the policy on a yearly basis. These formal policies will apply to all participating Institutions where House Officers are trained.

12.3 Clinical experience and education hours must be monitored by each Program and a copy forwarded to the Graduate Medical Education Office who will monitor duty hours at monthly, quarterly and/or random intervals. Each Program Director should review each House Officers rotation schedule to assure compliance with this Institutional policy and the Common Program Requirements.

12.4 Each Program Director should regularly monitor House Officers clinical experience and education hours for compliance with this Institutional policy and the Common Program Requirements. Monitoring of duty hours is required with frequency sufficient to ensure an appropriate balance between education and service.

12.5 The GMEC shall monitor compliance with this policy through the:

- The Annual Program Evaluation process for each program
- Periodic monitoring of individual programs as needed

12.6 Falsification of hours or pressure to cause the falsification of such data is considered egregious behavior for House Officers and can result in disciplinary action to include dismissal. Faculty members are governed by the rules of the Faculty Senate and policies and procedures of Augusta University.

12.7 House Officers must notify their Program Director of requests or pressure to work in excess of hours authorized by this policy.

13.0 Maximum Frequency of In-House Night Float

13.1 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 numbers of months of night float per year may be further specified by the Review Committee).

13.2 Maximum In-House On-Call Frequency

PGY2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

14.0 Duty Hours Exceptions

14.1 An RRC may grant exceptions for up to 10% of the 80-hour limit, to individual programs based on a sound educational rationale. The GMEC must review and formally endorse the exemption prior to submission to the RRC according to the following procedures:

- The Program Director must submit a written request for an exemption to the GMEC Chair. The request must clearly document the following:

1) Patient Safety: Information must be submitted that describes how the Program and Institution will monitor, evaluate and ensure patient safety with extended House Office work hours. This process will include formal reviews with Program Directors, Program Coordinators, and House Officers through email surveys and verbal queries.

2) Educational Rationale: The request must be based on a sound educational rationale which should be 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 House Officers call schedule during t the times specified for the exception must be provided.

5) Faculty Monitoring: Evidence of faculty development activities regarding the effects of House Office fatigue and sleep deprivation must be appended.

6) The Program Director will present the request to the GMEC for discussion.

7) If approved by the GMEC, the Designated Institutional Official (DIO) or the GMEC Chair will provide a documented written statement of Institutional endorsement of the proposal.

8) The Program Director must submit the request to the RRC according to the ACGME's RRC Procedures for granting Duty Hours Exceptions.

9) The paperwork submitted to the RRC must include a copy of this policy and the current accreditation status of the program and the status of the sponsoring institution.

15.0 Well-Being

15.1 In partnership with the Sponsoring Institution, programs have the same responsibility to address well-being as they do to evaluate other aspects of resident competence. This responsibility must include:

1) Protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships;

2) Attention to scheduling, work intensity, and work compression that impacts resident well-being;

3) Evaluating workplace safety data and addressing the safety of the residents/fellows and faculty members;

4) Policies that encourage optimal resident and faculty member well-being; including residents/fellows must be given an opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours.

5) Educating faculty members and residents/fellows in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions and education to recognize those symptoms in themselves and how to seek appropriate care.

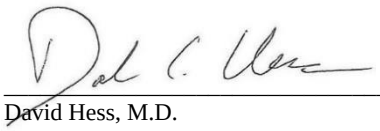
a) Encourage residents/fellows and faculty members to alert the program director or

Other designated personnel when they are concerned that another resident, fellow, or faculty member may be displaying signed of burnout, depression, substance abuse, suicidal ideation, or potential for violence;

b) Provide access to appropriate tools for self-screening; and, Resource and self-screening tools are available on the GME Website: http://www.augusta.edu/mcg/residents/residentwellness.php

c) Provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week.

16) Each program must have policies and procedures in place that ensure coverage of patient care in the event that a resident may be unable to perform their patient care responsibilities. These policies must be implemented without fear of negative consequences for the resident who is unable to provide the clinical work.



7/1/21
David Hess, M.D. Date
Dean, Medical College of Georgia

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Natasha M. Savage, M.D. Date
Interim Associate Dean, Graduate Medical Education and DIO