FORWARD

Welcome to the Department of Internal Medicine, Texas Tech University Health Sciences Center – Paul L. Foster School of Medicine (TTUHSC-PLFSOM) and the medicine service at University Medical Center (UMC). We want you to have the best possible learning experience with us, whether as a full-time resident in Internal Medicine or as a resident from another training program serving briefly on our service.

The purpose of this handbook is:

- to outline the policies and procedures governing house staff activity in the Hospital and at the Clinic
- to provide valuable information to you in the conduct of those activities
- to acquaint you with the general resources of the Department of Internal Medicine.

You are urged to read the entire manual before you start your residency program.

Best wishes on your residency educational experience.

Sincerely,

Internal Medicine Residency Program Director

Faculty

Staff

ADMINISTRATIVE GUIDELINES

I. ADVANCEMENT

A. Advancement from PGY-l to PGY-2:

1. Successfully complete PGY-1 rotations.
2. The Clinical Competency Committee, part of the Housestaff and Student Affairs Committee (HSAC) will be responsible for reviewing any unsatisfactory evaluations and for determining if remediation is necessary prior to advancement.
3. Pass the Clinical Evaluation Exercise as determined by assigned Department of Medicine faculty.
4. Competent to supervise PGY-1 residents and medical students as determined by the Department of Medicine faculty evaluations.
5. Able to perform resident duties with limited independence per Department of Medicine faculty evaluations.
6. Successfully perform all entry-level procedures, with documentation on file in the Department of Medicine.
7. Demonstrate sufficient progress in the components of clinical competence and capable of functioning as a team leader.
8. Specifically, the resident should have the necessary skills in data gathering, medical knowledge, clinical insight, and critical thinking to assume a team leadership role.
9. He/she should demonstrate elements of practice-based learning and systems-based practice learning in clinical encounters.
10. Fulfillment of milestone checkout in ambulatory clinic (see form in Appendix)
11. Demonstration of participation in annual research project.

B. Advancement from PGY-2 to PGY-3:

1. Successfully complete PGY-2 rotations.
2. Has taken and passed USMLE Step 3 examination by November of PGY-II year
3. The Clinical Competency Committee, part of Housestaff and Student Affairs Committee (HSAC) will be responsible for reviewing any

unsatisfactory evaluations and for determining if remediation is necessary prior to advancement.

4. Competent to supervise PGY-1 and PGY-2 residents and medical students per Department of Medicine faculty evaluations.
5. Seeks appropriate consultation when indicated.
6. Able to perform resident duties with minimal supervision per Department of Medicine faculty evaluations.
7. The resident should be capable of making independent decisions based on previous clinical experiences.
8. He/she should have the ability to recognize and manage "new" clinical problems (scenarios not previously encountered) skillfully.
9. Demonstration of participation in annual research project.

B. At every level of advancement and at the time of completion of training, the resident must demonstrate the following:

1. Interpersonal and communication skills are satisfactory or superior, as documented by faculty evaluations in inpatient and ambulatory settings.
2. Works well with patients, fellow residents, faculty, consultants, ancillary staff and other members of the health care team in a manner that fosters mutual respect and facilitates the effective handling of patient care issues as demonstrated by satisfactory patient, faculty, and staff professional behavior evaluations.
3. Any disciplinary action plans as a result of unprofessional behavior must have been successfully completed.

C. Completion of Residency program:

1. Successfully complete PGY-3 and all required rotations.
2. The Housestaff and Student Affairs Committee (HSAC) will be responsible for reviewing any unsatisfactory evaluations and for determining if remediation is necessary prior to completion of the residency program.
3. Able to perform independently in the practice of general internal medicine as determined by the evaluation results from the Department of Medicine faculty.
4. Successfully perform and passed all ABIM required procedures, with documentation on file in the Department of Medicine.

5. Have the sufficient medical knowledge base, problem-solving skills, and clinical judgment that enables resident to provide satisfactory patient care.
6. Has demonstrated practice-based learning and systems-based practice learning in clinical encounters.

D. Absence of impaired function due to mental or emotional illness, personality disorder, or substance abuse:

1. Any disciplinary actions or treatment programs implemented on impaired function must have been successfully completed and reinstatement approved by the HSAC and the Residency Program Director.

II. ANNUAL SCHEDULES

A. Required rotations are: Wards, all internal medicine subspecialty rotations, Ambulatory Clinic, ICU rotations, ER rotation, Geriatrics, Neurology, Night Float, and each year residents will rotate in Research/PBLI (Practiced Based Learning & Improvement and Systems Based Practice).

B. 33% of the resident's time must be in outpatient settings. We need to document at least 130 continuity clinic sessions in a three year residency program to satisfy the ambulatory medicine requirement by ACGME.

C. Personal preferences for subspecialty rotations in a specific month intended for a fellowship in a subspecialty will be considered.

D. Other preferences regarding having electives may be considered while being fair to everyone.

E. Elective and Non-Elective assignments during November, December and January will be based on resident rotations during these months in the previous year(s).

F. Out of town rotations can be arranged. (See section on Away Rotations)

G. Any requests for schedule changes, special days off, or any other requests for changes, must be submitted in writing and approved by all parties involved.

III. BEEPERS

A. It is the **resident's responsibility** to ensure that their beeper **is working properly at all times**. If there is any doubt, frequent tests should be made with the operator. Residents who fail to answer pages will be subject to disciplinary action.

B. The Senior Ward resident and MICU team On-Call have a 'Code' beeper and are responsible for all in-patient emergencies. The code beeper is vital and should be handed in person to the next resident on call. Do not delegate this task to anyone.

IV. DICTATION POLICY

A. The dictation of discharge summaries are to be assigned as follows:

1. If the patient was in the ICU/CCU, transferred to the ward, but then discharged by the next calendar day, the ICU/CCU intern should do the dictation. If the patient is on the ward longer than 1 calendar day, the ward intern should dictate the chart.
2. If a patient is admitted one month and then discharged by the 2nd of the following month, then the previous month's intern should dictate the summary.
3. All ICU/CCU patients who have a stay of more than 15 days should have an interim summary dictated by the ICU/CCU intern.
4. All ward patients who have a stay of more than 15 days by the end of the month should have an interim summary dictated at the end of the month.
5. If the patient was discharged home or transferred to another facility from the ICU/CCU, then the intern has to dictate the discharge summary.

V. DISCIPLINARY ACTION

A. Every resident assigned duty will be given a priority code:

1. **Non-Mandatory** – but may be Optional, Recommended, Strongly Encouraged, etc.
2. **Mandatory**

B. The nature of priority will be related to the relative level of importance in the training program. A table is available (see link below) and may be used as a live document for reference. http://www.ttuhsc.edu/fostersom/internal/documents/Disciplinary_Action_Table.pdf

C. Mandatory duties that are out of compliance will be linked to the following disciplinary process and will be placed in the resident' respective educational file:

1. **1st Incident** – Notice of Concern

2. **2nd Incident** – Observation
3. **3rd Incident** – Probation – *for review & approval by the Housestaff & Student Affairs Committee (HSAC)*
4. **4th Incident** – Dismissal from the program – *for review & approval by the Housestaff & Student Affairs Committee (HSAC)*

D. Every disciplinary action will be notified to the individual, to his/her respective advisor, and to other entities such as the Graduate Medical Education (GME) office as applicable.

E. Probation and/or dismissal from the program actions will be presented to the HSAC for review and approval. Residents have the right to a "Due Process" when dealing with disciplinary actions.

F. If violation is related to sub-standard performance on any of the six competencies, the respective algorithm (see link below).
http://www.ttuhsc.edu/fostersom/internal/documents/algorithm.pdf .

G. The Residency Program Director will use the appropriate disciplinary forms:

1. Disciplinary Action Notice-Performance and Deficiency Alert and Review Form 1:
   http://www.ttuhsc.edu/fostersom/gme/documents/Disciplinary_Action_Notice_Performance_Deficiency_Alert_and_Review_Form1.pdf
2. Disciplinary Action Notice-Performance and Deficiency Alert and Review Form2
   http://www.ttuhsc.edu/fostersom/gme/documents/disciplinary_action_notice_performance_and_deficiency_alert_and_review_form2.pdf

VI. DOCUMENTATION - Article

Proper documentation is an essential component of good patient care. ***Here is an article by Lee J. Johnson, JD with some helpful tips***:

Q: *We're always told to document, document, document. But aren't there some things that shouldn't be in the patient's medical record? Aren't there times when it's safer* **not to** *document?*

You're right. Here's a good rule of thumb: Document only facts that you see or hear concerning the patient's diagnosis or treatment. (In fact, they're required by law in most states.) This allows other physicians or nurses who see the patient to read what you've observed, thus ensuring continuity of care. But patient information that's not related to diagnosis or treatment should not be in the chart.

For example, you should keep billing records separate and should not include them when responding to an attorney's request for patient records. Here are more details on how to handle different types of patient data:

Opinions. The clinical diagnosis is the only opinion that belongs in the medical record. Although personal comments, personal opinions, conjecture, and other information about the patient may be helpful for your future reference, they shouldn't be in the record. Examples might be: "Hypochondriac", "Litigious", "Does not pay his bills", "Has a tendency to complain", "Patient is a friend of". One doctor got in trouble in a malpractice case because he had described the patient in the chart as a "cry-baby…should not be coddled".

Always record the patient's actual behavior, not your **assumptions** or conjecture about it. Instead of "Patient was drunk", for instance, write "Patient appeared unsteady, and speech was slurred". The same rule applies to nurses. If your nurse enters an exam room and sees the patient lying on the floor, she should write, "Patient found on floor" not, "Patient fell off exam table".

Frivolous comments also do not belong in patient charts, either. If you're annoyed by a patient, or in a bad mood, do not record that in the chart. Doodles or "happy faces" are also inappropriate. They will be difficult to explain if the patient suffers a cardiac arrest soon afterward.

Blame. Comments blaming another physician or nurse for an adverse event do not belong in the record. In one case, when failure to attend to the patient resulted in a serious decline in his condition, everyone tried to blame someone else. The nurse's note read: "Called doctor at 2:10, beeped him at 2:15, called his home at 2:30, doctor did not come in". The doctor, in turn wrote: Nurse never explained seriousness of patient's condition". The same doctor, trying to shift the blame to a colleague, wrote: "Conflicting order, and unable to contact him". ***That*** doctor wrote: No known attempt made to contact me at home or office". These comments only made the case easier for the plaintiff's attorney.

Administrative complaints. If doctor has a problem with a hospital's staff, facilities, or equipment, he should address his complaints to the hospital's administration. In fact, ***not*** reporting such problems could lead to liability. But the doctor should not record such complaints in the patient's chart. I have reviewed charts in which doctors have complained about incompetent nurses and colleagues. In one chart, the doctor noted, "The case was taken out of my hands, over my objections". Such comments do not belong in the record. The plaintiff's attorney and the jury do not need to know.

58MEDICAL ECONOMICS/JULY 23, 2004 **www.memag.com**

VII. EVALUATIONS

A. Each resident is evaluated monthly by the attending physician(s) for the service.

B. Patient's medical charts and resident orders are regularly evaluated by the faculty.

C. Every month, senior resident evaluates his/her junior residents during Ward and ICU services. Junior residents will also evaluate their senior residents.

D. The students on the ICU and Ward service evaluate the residents for the month.

E. The senior resident evaluates the medical students on the team for the month.

F. The residents and students evaluate their faculty attending monthly.

G. The nurses on the floor and ICU evaluate the residents biannually.

H. The clinic staff (Clinical) evaluate the residents biannually

I. The patients in the clinic evaluate their continuity clinic resident biannually.

J. All residents who are new to the program are given a clinical competency examination **after 6 months of training**. Promotion to the next level of training is dependent on satisfactory completion of this exam.

K. Evaluations are kept in each resident's file and are available for review by residents.

L. Each resident is assigned a faculty advisor. (See Faculty Advisor Policy below)

M. The Clinical Competency Committee meets biannually to review each resident's file to monitor the progression of the resident through the continuum of education and reports their findings and recommendations to the program director.

N. Each resident meets with the program director/associate program director biannually to discuss evaluations, performance, procedures, stress management, and the competencies. In addition, any problems or issues that the resident may be experiencing will be discussed during this meeting.

O. Different outcomes based data evaluation tools will be developed as needed.

VIII. FACULTY ADVISOR ASSIGNMENT POLICY

A. Advisor Assignment

Residents are assigned to faculty advisors according to the ACGME - Residency Review Committee (RRC) policy. The process of assigning each resident to a faculty member is done by taking into account each resident's fellowship goals.

B. The primary goal and objective of this policy is:

1. To help residents recognize their strengths and weaknesses (e.g., knowledge, skills, and behaviors).
2. To evaluate resident performance in a timely manner throughout each year of residency training. Each advisor is encouraged to meet with their assigned resident **at least twice per year** (preferably **November** and **April**) or as needed. In addition, it is also encouraged that both informal 'on-the-spot' feedback be given as deemed appropriate by faculty.

C. Change of advisor request and agreement policy

Considering that, over time, residents may opt to modify their interests, the following policy has been established. Requests for change of faculty advisor will be accepted and processed as follows:

1. Requests will be accepted during the **first two months** of each academic year. Advisor Request Form is to be completed and submitted for approval. (Link below is where you may find a copy of the advisor request form.) http://www.ttuhsc.edu/fostersom/internal/documents/advisor_request_form.pdf
2. Both faculty and resident are to agree mutually, sign the advisor request form, and submit the completed form to the residency office.
3. Each faculty will be assigned to a **maximum of 3 residents** at any given time.

XIX. LEAVE

A. It is each resident's responsibility to submit their leave requests and required documentation **at least 3 months prior to anticipated leave**. Residents are to discuss their planned leave with their faculty, senior and chief residents. Any administrative, educational, or vacation leave that is **not used** during each academic year, **will not carry over nor will substitutions be considered**.

B. At the beginning of each academic year, all residents are to submit their leave requests by the following dates:

1. **May** is the deadline for **July thru September** requests
2. **August** is the deadline for **October thru December** requests
3. **October** is the deadline for **January thru March** requests
4. **December** is the deadline for **April thru June** requests

C. Approval of all leave requests will depend on timeliness of submission.

D. No travel or other plans should be made prior to receiving approval.

E. **ROTATION CREDIT:** In order to get credit for a rotation, residents must be on duty at least **3 weeks (15 working days)** during a **ONE-MONTH rotation.**

F. **NO LEAVE** is allowed during the **In-Training Exam in October,** during a **two-week rotation**, during the **last 2 weeks in June for PGY-1's & 2's**, nor while assigned to **ER**, **WARDS**, **ICU**, **CARDIOLOGY, HEM/ONC** or **NIGHT FLOAT** rotations.

G. Residents are to **avoid** scheduling their USMLE Step 3 Exam or any interviews during ER, WARDS, ICU, Cardiology or Night Float rotations.

H. Requests for vacation in **DECEMBER** will be reviewed & approved on a case by case basis.

I. **The ABIM allows only 30 calendar days of leave per year**.

1. Board eligibility will be jeopardized if residents go over the 30 days.
2. Residents should not take more than **30 Calendar Days of Leave per year** (ABIM requirements).
3. If the 30-day limit is exceeded, contract will be extended and resident will be considered off-cycle.

J. **MATERNITY LEAVE**: Sick & Vacation leave is to be used first (prior to using FMLA). If leave time exceeds 30 calendar days, then the ABIM 30-day rule will apply.

K. Residents may only take a maximum of 1 week off per monthly rotation {1wk=5 working days}.

L. Residents may overlap 2 consecutive weeks if scheduled for back to back **1 month elective** rotations.

M. Residents are eligible to receive up to 12 working days per year of Sick Leave.

N. **EARLY DEPARTURE:**

Residents continuing on to a fellowship program may request early departure leave. This leave request ***is exclusive*** for residents committing to a ***fellowship program only***. Residents **not going** into a fellowship program **may not request vacation in JUNE.** Residents may request early departure leave and are expected to comply with these requirements:

1. Early departure requests are due by **March**. Timely submission of early departure requests and **approved coverage is mandatory!**

2. Residents must be on duty **<u>at least 15 working days</u>** to get credit for their rotation in June.
3. **<u>Residents must set aside administrative or vacation days (maximum of 5 working days)</u>** for use towards their fellowship early departure leave request.
4. Residents must submit a letter from the fellowship program indicating the date resident is to report for duty.

O. ADMINISTRATIVE LEAVE:

1. Administrative leave should be planned and requested during ***eligible*** **elective** or **clinic** months **<u>only</u>**. An ***eligible*** **elective** is one where leave <u>is allowed.</u>
2. **PGY-1** Residents are eligible to receive **<u>2 days of Administrative Leave</u>** during their first year of residency to take their USMLE Step 3 Exam.
3. **PGY-2** Residents are eligible to receive **<u>5 days of Administrative Leave</u>** per year ***(not cumulative)*** to take their *<u>USMLE Step 3 Exam</u>* - if not taken during the first year of training or for other administrative purposes at the discretion of the Program Director. In addition, PGY-2 Residents **<u>must set aside administrative or vacation days (maximum of 5 working days)</u>** for use towards their **interviews** and **<u>must submit their requests by NOVEMBER</u> as interview months are *usually held during the months of January, March or April*.**
4. **PGY-3** Residents are eligible to receive **<u>5 days of Administrative Leave</u>** per year ***(not cumulative).*** In addition, PGY-3 Residents **<u>must set aside Administrative or Vacation days (maximum of 5 working days)</u>** for ***Early Departure*** or for other administrative purposes at the discretion of the Program Director.
5. **<u>Leave requests</u>** must be submitted **<u>at least three months in advance</u>**.

P. EDUCATIONAL LEAVE:

1. Educational leave should be planned and requested during ***eligible*** **elective** or **clinic** months **<u>only</u>**. An ***eligible*** **elective** is one where leave <u>is allowed.</u>
2. **PGY-1, PGY-2, and PGY-3** residents are eligible to receive **<u>3 days of Educational Leave</u>** per year ***(not cumulative)*** to attend conferences.
3. Conferences must be **<u>approved at least three months in advance</u> and <u>prior to registration</u>**. Documentation of attendance will be required. If

extra days are needed, **additional leave** is to be requested **as vacation** (if available). If no vacation time is available, request will only be approved for time available.

4. Leave requests must be submitted **<u>at least three months in advance</u>**.

Q. SICK LEAVE:

1. Sick leave with pay may be taken when sickness, injury or pregnancy prevents the resident from performing his/her duty or when a member of his/her immediate family (spouse, child or parent) is actually ill and requires the resident's attention.
2. The use of sick leave is strictly limited to the time necessary to provide care and assistance as a direct result of a documented medical condition.
3. A resident who must be absent from duty because of illness is responsible for notifying the Program Director, Chief Resident, Internal Medicine Staff, and their attending at the earliest practical time.
4. To be eligible for sick leave with pay during a continuous period of more than three working days, residents must provide to their Program Director a doctor's certificate/note or other written statement regarding the illness.
5. At the discretion of the Program Director, residents may be required to undergo examination by an emergency room physician or an appointed internist.
6. Time taken for illness on days that fall prior to or after vacation leave will require a physician's statement/note. Otherwise, this sick time taken prior to or after vacation leave will be counted as vacation. **If all vacation leave has been exhausted**, then the sick time taken prior to or after vacation leave will be considered as **<u>leave without pay.</u>**

R. VACATION LEAVE:

1. Vacation leave should be planned and requested during ***eligible*** **elective** or **clinic** months **<u>only</u>**. An ***eligible*** **elective** is one where leave <u>is allowed.</u>
2. **<u>PGY-1 & PGY-2 Residents</u>** – Eligible to receive 3 weeks {3wks=15 working days}
3. **<u>PGY-3 Residents</u>** –Eligible to receive 4 weeks {4wks = 20 working days}
4. Residents may only take a **maximum of <u>one week</u>** per rotation. If residents are assigned back to back ***eligible*** elective rotations, then residents may request two consecutive weeks during those **two elective**

rotations.

5. For **Early Departure requests**, see **Early Departure guidelines** above.

S. LEAVE OF ABSENCE:

1. Trainees may take up to one month (30 days) per year of parental or family leave, or for serious illness (including pregnancy-related disabilities).
2. If all 30 days are taken, resident will have exhausted all accrued leave.
3. If more than 30 days are taken, training must be extended to make up any absences exceeding one month per year.
4. Vacation leave is essential and ***must not be forfeited*** to compensate for extended illness, ***late starts***, parental leave, or other purposes.
5. **Absences without notice, without approval** or **no leave form on file** may result in disciplinary action and will be charged as **leave without pay**.

X. OUT OF TOWN OR ADVANCED ROTATION POLICY

A. During the Internal Medicine residency training (from the 2nd Year up to the first 6 months of 3rd Year), a ***single one-month rotation*** outside of Texas Tech University HSC Paul L. Foster SOM will be considered by the department in ***special areas of interest***. The out-of-town rotation must be with an accredited institution within the United States. Away rotations **may not be requested** during the months of **June, July, October, or December.**

NOTE: Since this process is lengthy, residents are urged to initiate course of action 6 months prior to the projected month of departure. All required documentation is to be completed and submitted at least three months prior to the scheduled out of town rotation.

B. **ELIGIBILITY CRITERIA**

1. Resident must be in good academic standing to be eligible for applying.
2. The rotation desired must demonstrate academic merit by identifying the goals and objectives of the rotation. (see *Step 2 – Program Letter of Agreement*)
3. The rotation must meet three criteria:
   - **a.** The rotation must not be available at University Medical Center

     AND
   - b. The rotation must be required for the residency training (i.e. research)

     AND

c. Upon returning from the away rotation, residents must submit a Summary Report and present a related Scholarly Activity such as a Case Report, Noon Conference Presentation, or a Topic Review.

4. ***Observerships*** **are not considered an eligible academic activity.**

C. **STEP 1 – TTUHSC-IM Resident & Residency Office Responsibility**

1. Inform the residency coordinator and confirm the month, location, and hospital of planned away rotation.

2. Residency coordinator will request proof of liability insurance from Lubbock.

3. Residency coordinator will prepare the **Request for Approval of Rotation Letter** for the out-of-town institution. Documents to be included with this letter are:

a. Professional Liability Coverage (Letter from Lubbock)

b. Program Letter of Agreement

c. Calendar of Daily Activities

d. Evaluation

D. **STEP 2 – OUT-OF-TOWN INSTITUTION RESPONSIBILITY**

If the out-of-town institution ***accepts*** our Internal Medicine resident, the institution's department or Graduate Medical Education (GME) office is to prepare a **Program Letter of Agreement** *(attached – may also be emailed)*.

1. The Program Letter of Agreement (PLA) is to include:

a. The names, phone numbers, email addresses of the Program Director and supervising physician(s) who will be overseeing the resident's daily activities.

b. The institution's required liability coverage amount for the one-month away rotation.

c. The institution's eligibility requirements for licensing. *(Please indicate if resident is or is not required to apply for an institutional permit.)*

i. If institution requires a provisional (1-month) institutional license or permit, then the institution must send

documentation, instructions, and any other information required to obtain this license or permit.

d. The PLA and enclosures are to be returned to:

Texas Tech University
Paul L. Foster School of Medicine
Department of Internal Medicine
Attn: Residency Coordinator
4800 Alberta Avenue
El Paso, TX 79905

e. When completing the Program Letter of Agreement (PLA), the institution is to follow the format and enter all information accordingly.

f. The PLA must identify the goals and objectives for the rotation and how this rotation will develop the resident's academic experience in context with the resident's ongoing training program.

g. The institution is to prepare and submit a Calendar of Daily Activities *(attached – may also be emailed).*

h. At the end of the rotation, the supervising physician(s) must **complete and discuss** the **evaluation form** *(attached – may also be emailed)* **with the resident**. The completed evaluation may be given to the resident or mailed to our office **no later than 5 days** after the end of the rotation.

E. STEP 3 – TTUHSC & UNIVERSITY MEDICAL CENTER (UMC) APPROVAL

2. The residency coordinator will prepare and submit a Letter of Request to the Assistant Dean of the Graduate Medical Education (GME) office for review and approval. The ***Program Letter of Agreement*** is to be submitted with this request.

3. The Associate Dean will submit the Letter of Request to University Medical Center of El Paso for their review and approval.

4. Once approval is granted, UMC will forward the approved letter to the GME office. A copy of the approved letter will be forwarded to the Internal Medicine office.

XI. PROCEDURE POLICY AND CERTIFICATION

A. For Board certification, the American Board of Internal Medicine (ABIM) requires that residents be judged competent in 1) the knowledge and understanding of basic procedures commonly performed in medical patients and 2) the safe performance of some of them.

B. Procedures are an important component of clinical competence and must be adequately documented to meet ABIM specifications. Potential future inquiries for job application process regarding procedures competence will be answered (upon resident request) based on this documentation.

C. This policy describes the different procedures and competencies required, and the way to acquire competency, perform procedures and document both. **It is the responsibility of the resident to follow this policy in order to document his/her procedure competency before completion of his/her residency.**

D. **Procedures** *(not required)* **where competency in <u>knowledge and understanding</u> must be demonstrated:**

1. Abdominal paracentesis
2. Arterial line placement
3. Arthrocentesis
4. Central venous line placement (includes dialysis catheters)
5. Incision and drainage of an abscess
6. Lumbar puncture
7. Nasogastric intubation
8. Thoracentesis
9. Pulmonary artery catheter placement

E. **To acquire competency in knowledge and understanding** (includes indications, contraindications, complications, specimen handling, interpretation of results and informed consent) reading materials are available via UpToDate and the NEJM.

F. **To acquire competency in performing these procedures** (competency in performance *<u>is not required</u>* by ABIM, but the program offers the opportunity to develop and document it):

1. Requires at least 5 procedures (of each type) performed by a resident as the main operator, <u>supervised</u> and evaluated as '<u>Satisfactory</u>' on both Cognitive and Technical Skills by a qualified supervisor (see next section), and appropriately <u>documented.</u>
2. <u>Supervision</u>: **It is the responsibility of the performing resident to obtain**

appropriate supervision. Qualified supervisors are, in order of priority:

a. IM or ED faculty

b. IM resident with already documented competency in performing the given procedure

c. 3rd year IM resident on-call for urgent procedures when no other supervisor available

d. registered nurses can supervise nasogastric intubations.

e. All procedures are to be approved exclusively by a qualified supervisor that personally observed performance of procedure(s).

3. **Documentation:** There will be a two-step process for documentation of procedures.

a. The IM Procedure Form is to be used. The form is available at UMC nursing stations and at the IM department website. Only the top portion of the Procedure Form must be completed, signed by performing physician, signed by qualified supervisor, *and should remain in the patient medical record.*

b. Once the form is completed, residents are to enter the procedure in the ***New Innovations database*** for supervisor approval. A record of performed and documented procedures will be kept in each resident's file.

4. For procedures performed during Emergency Medicine (EM) rotation, use of the IM Procedure Form is preferred. If form is not available, a copy of the EM procedure form signed by the EM Faculty will be acceptable.

5. Residents performing a procedure **and qualified/certified to supervise** it do not need to have a qualified supervisor sign the form. When entering procedure(s) in New Innovations, residents must select their own name from the drop-down menu under 'attending/supervisor'. ***These procedures will also be credited.***

G. Procedures where competency in knowledge and understanding, *and performance* must be demonstrated are:

1. Advanced cardiac life support x 5

2. Pap smear and endocervical culture x 5

3. Drawing venous blood x 5

4. Drawing arterial blood x 5

5. Placing a peripheral venous line x 5

H. To acquire competency in knowledge, understanding and performance for each procedure, the policy is as follows:

1. Advanced cardiac life support:

a. All residents must complete and keep current ACLS certification course

b. 3rd year residents in MICU rotation attending to code blue should document their participation in at least 5 events by using the ACLS form available at the IM website

c. The MICU attending is required to review resident's ACLS performance. To accomplish this, PGY-3 residents must submit, in person, the ACLS Form and a copy of the code record to the ICU attending within 72 hours of the event. MICU attending will complete and sign ACLS form after reviewing and discussing it with resident. The completed form, submitted to IM office, will constitute documentation and credit for this procedure.

2. Pap smear and endocervical culture (5):

a. Residents will be scheduled for Pap Smear/Endocervical Cultures during their Research or Clinic Rotation. A handout will be provided for details.

3. Drawing venous blood (5)

4. Drawing arterial blood (5)

5. Placing a peripheral venous line:

a. Requires performance of a minimum of 5 procedures of each

b. The same policy for documentation and supervision from section A applies, with the exception that additional qualified supervisors are: registered nurses for 3 and 5, phlebotomists for 3, and respiratory therapist for 4.

c. The departments of nursing, respiratory care and laboratory are in agreement to provide supervision when availability permits.

d. It is the responsibility of the resident to perform and document these procedures during their patient care activities and in accordance to this policy, before completion of resident's training.

I. Other, not required, procedures: any other procedure to be performed by a

resident requires approval and supervision of the respective faculty.

J. For information on **Invasive Procedures** outside of the **operating room (OR),** please visit our Internal Medicine website (link below) for memo from University Medical Center.
http://www.ttuhsc.edu/fostersom/internal/documents/invasive_procedures.pdf

XII. ROTATIONS

A. Educational goals, learning objectives and expectations for each rotation are to be discussed between faculty and residents at some point during the rotation.

B. Faculty members in each division are responsible for evaluation of resident performance in a timely fashion and in person.

XIII. ROTATION CREDIT

Residents requesting credit for rotations done prior to their Texas Tech IM residency must meet the following criteria and approval process.

A. Credit for rotation months may only be approved and granted during a resident's internship training year.

B. Requests for credit must be submitted by no later than December of the internship year and credit may not be granted before 6 months of being in the program.

C. Resident must be:

1. off-cycle
2. at a disadvantage when applying for fellowships or future jobs
3. requesting credit for rotation months done prior to starting his/her internship at Texas Tech University HSC – PLFSOM

D. Resident's previous rotations must have been satisfactorily completed and be from an accredited U.S. Program or one that is recognized by the Texas Higher Education Coordinating Board and the ACGME.

E. Credit may be granted for no more than 3 months and no more than the time necessary to place the resident back 'on-cycle'.

F. Resident must be in good academic standing and have no episodes of observation or probationary action during their internship.

G. The resident must have passed all of his/her rotations and received satisfactory scores (5 or above) on all competencies during his/her internship rotations.

H. Resident must have passed his/her In-Training Exam with a 60%tile or higher.

I. The Program Director will review all criteria for eligibility and present the request to the Housestaff/Student Affairs Education Committee (HSAEC) for their review and approval.

J. If approval is granted, the program director will prepare and submit a letter to the Associate Dean for Graduate Medical Education and subsequently to the ABIM, ACGME, and the Texas Medical Board.

ACADEMIC ACTIVITIES

I. MORNING REPORT – MANDATORY!

Morning Report (MR) is the most important educational activity of the residency training. Residents must have an average of 85% attendance in this activity. Taking into consideration residents' and faculty's input, this is the current working version of this academic activity. The overall coordinator of this academic activity is the **chief resident, senior resident, and/or faculty in attendance.**

A. PURPOSE

1. The main objective of Morning Report is education.
2. Reviewing and planning patient management
3. Fostering presentation skills
4. Developing intellectual curiosity and research
5. Promoting decision-making skills and self-directed learning

B. **ORGANIZATION**

1. Format and case selection
2. Curriculum-based content
3. Leadership and tone
4. Recordkeeping

5. Patient follow ups
6. Attendance tracking

C. FORMAT AND CASE SELECTION

1. For Rules and Regulations, please visit: http://www.ttuhsc.edu/fostersom/internal/documents/morning_report_rules_and_regulations.pdf
2. To start at 11:30 am and finish promptly at 1:30 pm.
3. On-call team will be in charge of presenting a case that day.
4. Cases will be selected by the assigned faculty for that team in coordination with the chief resident and team's senior resident.
5. Cases should preferably be presented in power point format. A volunteer resident will write on the side board the most relevant information.
6. For the 1st day of any month, presenting team will use the ***'Yale Curriculum"*** in lieu of a clinical case starting with Chapter 1 at the beginning of the academic year.

D. CURRICULUM-BASED CONTENT

1. The cases presented should reflect the content of the ABIM exam.
2. To achieve this, tracking of the covered topics will be kept and adjusted accordingly.
3. The decision to present ambulatory cases will be made based on the need to cover ABIM topics not frequently encountered in the inpatient setting.

E. LEADERSHIP AND TONE

1. The case will be presented by the **intern or rotating resident,** as applicable, except in July and August when it will be presented by the Senior Resident.
2. The discussion can be led by the **Attending Physician, the Chief Resident or any other Faculty attending this activity.**
3. An attempt should be made to formulate answerable clinical questions after each Morning Report, and a **resident, usually the one presenting the case (intern)** should be assigned to look them up. This can be formally presented as Power Point Presentation or printed material.

4. **Residents** should be responsible for inviting subspecialty faculty when appropriate to enhance the learning experience. This may include Radiology or Pathology.
5. **<u>Medical Students</u>** are welcome to attend MR, since it constitutes an excellent learning opportunity for them; however MR is primarily addressed to residents.

F. RECORDKEEPING

1. Cases should be recorded in a logbook, by the **Chief/Senior Resident or Research Rotation Resident** with the purpose of enhancing the selection of a wide array of topics and avoid duplication.
2. **Chief/Senior resident or Research Resident** should be responsible for updating and keeping the log book in a safe location **<u>to avoid any</u>** ***HIPAA violations.***

G. PATIENT FOLLOW-UPS

1. A significant number of patients might not have a diagnosis at the time of presentation; therefore, case follow-up is important to maximize education.
2. Each Monday the **Chief Resident or other assigned senior** will review the previous week cases for follow-up when applicable.
3. **Members of the team involved in the care of the referred patient** will provide the updated information.
4. If no one is available, the case will be left open and reviewed the following week.

H. ATTENDANCE

1. The **chief resident or the senior resident** should generate a sign-in sheet on a daily basis.
2. Attendance will be recorded daily and residents will have up until 11:45 am to sign in.
3. After 11:45 am the **assigned team attending physician** will retrieve and deliver the sign-in sheet to the residency office.
4. **If the resident is unable to remain at MR at least until 12:30 am he/she will NOT receive any credit.**

5. **Residents** should notify the chief resident if they are going to be late because of patient care issues. However no credit for attendance will be given if the resident is unable to attend the main portion of the academic activity.

II. MONTHLY EXAM GUIDELINES

A. Monthly exams are directly related to the resident's Medical Knowledge Self-Assessment Program MKSAP on-line competency training. A monthly exam will be self-administered by all residents on the honor system, preferably using the booklet for the rotation the resident is currently doing. The general medicine exam can be done throughout the ward months assigned during the first year. A copy of the print out should be forwarded to our residency program coordinator for filing in the residents permanent academic chart. Passing score is 80% correct. There is no penalty for doing more than one booklet per month.

B. Source: **MKSAP Books** *(Current available on-line version)*

GENERAL INTERNAL MEDICINE EXAM

Residents rotating in the following rotations will take this exam.

IM Wards	
IM Clinic	**Orthopedics**
Dermatology	**Pathology**
ENT	**Psychiatry**
Geriatrics	**Radiology**
Ophthalmology	**Research**

PULMONARY/CRITICAL CARE EXAM

Residents rotating in the ICU will take this exam.

SPECIFIC SUBSPECIALTY EXAM

Residents rotating in the following subspecialties will take this exam.

Cardiology	**Infectious Diseases**
Endocrinology	**Nephrology**
Gastroenterology	**Pulmonology**
Hematology/Oncology	**Rheumatology**

EXEMPT rotations:

i. **ER**
ii. **Night Float**
iii. **Out of Town (Away Rotation)**

MAKE-UP exams:

Make-up exams will be given to residents for the following reasons AND will be given during the first week of the following month.

i. **On Post-Call**
ii. **On Vacation**
iii. **Day Off**
iv. **No Pass**
v. **Other reason – as applicable**

III. NOON CONFERENCES – MANDATORY!

A. Residents must attend an average of 85% of scheduled noon conferences. If resident does not attend 85% of these educational sessions, resident WILL NOT BE PROMOTED NOR WILL HE/SHE BE ABLE TO SIT FOR THE INTERNAL MEDICINE BOARDS!

B. Halfway through the year you will be notified if you are considered at risk, but it is your responsibility to check on your attendance record.

C. Journal Clubs and M&Ms will be scheduled every month; we will let everybody know in advance, allowing enough time for the faculty and residents to review the relevant literature.

D. Residents and interns will have an option of presenting a subject at the noon conference time, preferably during their electives, supported by their corresponding attending.

E. Lectures and presentations may be uploaded into our New Innovations or Sharepoint websites.

F. **It is very important for you to arrive on time to noon conferences.**

IV. SPONSORSHIP OF SCHOLARLY ACTIVITIES

A. Residents that are invited to submit entries in competitions and seeking sponsorship from the Department of Internal Medicine will be considered only if the competition(s) are at National Meetings.

INTERNAL MEDICINE AMBULATORY CLINIC

I. GENERAL INFORMATION:

Our Internal Medicine clinic is open for patients Monday through Friday. Hours are from 8:00 am to 12:00 pm and from 1:00 pm until 5:00 pm. Residents are expected to be prompt for their clinics and should arrive no later than 8:30 am or 1:00 pm during their scheduled days. This may require leaving Morning Report or Noon Conference should this activity run late.

A. All scheduled patients need to be seen. **Residents will not refuse to see any patient.** If a problem arises, it should be addressed with the Clinic Director, Faculty and Clinic Manager.

B. Residents who fail to attend clinic without reasonable excuse will be subject to disciplinary actions.

C. If a problem of communication with a patient arises due to a language barrier, nursing personnel will be available for translation. For those patients that speak languages other than Spanish or for the deaf, you may use the Inter American Interpreting Services LLC (915) 274-1713.

D. All patients' visits should be written in a Problem Oriented Format (using Electronic Medical Record compliance-approved templates). History and Physical findings, laboratory, X-rays and procedures reports pertinent to the patients' problems need to be documented. An up to date problem and medications list needs to be kept in paper or electronically.

E. Referral and Consultation forms from other services to Internal Medicine must be co-signed by a Faculty.

F. Clinics are not scheduled when on Vacation, Administrative or Academic Leave. A Leave Request form should be filled out (at least two months prior to departure), authorized, and signed by designated staff.

G. Also there are no clinics during Emergency Department and Night Float rotations.

II. CONTINUITY CLINICS:

A. Residents are assigned to a morning or an afternoon clinic every week. In these clinics, residents follow their own patients throughout the duration of their training. As per ACGME, there should be a total of 130 continuity clinics per each resident during their 3 year training period.

B. A faculty attending will always supervise residents and must co-sign each report or progress note after careful review.

C. PGY-1 Residents must present the patient to a faculty who then examines the patient at least during the first six months or when considered necessary.

D. Any complicated cases or patients with diagnostic problems should be presented to the Faculty at any time.

E. Transfer of patients between residents will be handled by the Clinic Manager and faculty.

F. The number of patients to be seen by each resident will be determined by our "Housestaff/Medical Student Affairs Education Committee" (HSMSAEC) to make sure that a balance between teaching and service is maintained.

III. OUTPATIENT CLINIC ROTATIONS:

A. During this rotation, residents must be on time as specified above. If for any reason a resident is to be late or absent, the Chief Resident, Clinic Manager and Director of Academic Programs should be contacted immediately.

B. **Urgent Care follow-up clinic**: these clinics are available for our established clinic patients who need to be seen sooner than scheduled with their primary care residents. A clinic faculty usually signs a form authorizing this visit to avoid unnecessary appointments or issues that can be handled over the phone.

C. Patients with acute self-limited problems or patients too unstable to await a routine appointment for resident or Subspecialty Clinic may be scheduled for one return visit to Urgent Care/ED follow-up or General Care/walk-in clinic. Approval by a faculty is required.

D. Patients needing chronic long-term follow-up should be referred to the appropriate clinic in their zip code area or to the Resident's Clinic.

E. Consultation Forms should be completed when patients are referred to other services (Surgery, Orthopedics, OB-GYN, etc.) and to Internal Medicine Subspecialty Clinics. Residents are to use the name of their faculty as the

requesting physician. The three **R's** of consultation refer to: **R**eferring Physician, **R**equest in writing, and a **R**eport back to the referring physician.

F. All Residents will be evaluated by the General Medicine Faculty at the end of their rotation.

IV. SUBSPECIALTY CLINICS:

A. Subspecialty Clinics are conducted to provide with expert consultation skills to the Primary Care Resident. Residents rotate though these clinics during their Outpatient Clinic Rotation. The clinics are held every day during the week, mornings and afternoons from 8:30 am to 12:00 pm and from 1:00 pm to 5:00 pm.

B. Subspecialty Clinics do not provide Primary Care unless authorized by the sub-specialist for this purpose.

C. Patients referred to these clinics should be given a formal consult form and they should include the name of the faculty. At the same time, an additional appointment should be made for the patient to return to the Primary Care Resident for ongoing follow-up.

V. ADMISSIONS TO THE HOSPITAL FROM OUTPATIENT CLINICS:

A. When a patient is admitted to the Hospital, a faculty needs to give approval prior to admission of the patient.

B. In the case of a direct admission to the General Medicine Floor, the resident needs to contact the PGY-2 resident on call and a brief report should be given to him/her. Admitting orders should be written in the usual fashion (as instructed by Faculty) and given to the patient together with copies of pertinent records to hand carry to the floor.

C. If the patient needs to be evaluated in the Emergency Department (ED) the patient will be transferred for appropriate care. Pertinent records should be copied and given to the patient to hand carry to the ED.

D. Critically ill patients should be transferred to the ED by EMS services.

CONSULTS

I. GUIDELINES AND GENERAL INFORMATION:

Effective August 1, 2008, consultations for inpatients requested by non-medicine services will be provided by the Hospitalist faculty/team.

A. Medical Secretaries can be contacted for General Medicine Consults. Consult requesters can also contact the on call Hospitalist Faculty by paging him/her directly or thru the UMC operator.

B. If a physician calls the medicine secretaries for a general internal medicine consult the secretaries should provide the information for paging the Hospitalist Faculty on call for medicine consults.

II. MAIN FEATURES OF THE CHANGES IN HOSPITALIST UMC SERVICE:

A. University Medical Center created a Hospitalist Service in 2013, they are in charge of the triaging of admissions and assignment of patients to be evaluated by the Teaching (Texas Tech) team.

B. The UMC Hospitalist team is independent of the Academic Teaching team and our residents will only cover those patients in case of Rapid Response or Code. They have a separate sign out and there is always a UMC hospitalist in house who should attend to those events as well.

IN-PATIENT SERVICES

ICU

I. ICU ROUNDS

At 8:00 A.M. on weekdays, the ICU team members and on-call resident will meet to discuss night admissions. In this way, the physicians "on call for the day" will be well informed. Keep in mind that there may be attendings with different ways of running ICU. The senior ICU resident will gently remind the faculty when an intern or resident has to leave rounds to protect them from breaking duty hours rules i.e. no more than 16 hours of continues duty, 10 hours of rest between duty periods or more than 24 hours on duty plus 4 hours for transition of care.

II. WEEKEND CALL SCHEDULE

A. The total number of weekend calls is divided by the number of residents in order to allocate the total number of calls for the entire year. Schedules are made by the chief residents.

B. Night float resident will not do any weekend calls on that month.

C. In June, we will give the last weekends to residents who are not joining fellowships or PGY-2s. *The resident in ER night float or ER weekend in July will take over the first day at 00:00, in order to avoid liability issues.* Our malpractice insurance finishes the last contract day at midnight.

D. Changes to the call schedule will only be done by the Chief Resident to avoid confusion and risk of having nobody show up for call that weekend.

III. TRANSFERS FROM ICU

A. The ICU senior resident needs to decide which patients to be transferred as early in the morning, preferably by 8 AM.

B. Transfers should be initially referred to the Internal Medicine Hospitalist Ward

team and he/she will be assign patients to the teaching on-call team as appropriate

C. ICU intern or senior should directly notify the receiving team senior of all transfers.

D. ICU resident should write a brief and informative transfer note.

E. ICU senior should teach intern proper paperwork related to a transfer.

CARDIAC CARE UNIT (CCU)

I. CARDIAC CARE UNIT

The purpose of the full Cardiovascular Services Unit is to provide our Internal Medicine and rotating residents with training in acute cardiac services including, but not limited to, acute coronary syndrome, post-operative cardiac care, and other cardiology diagnoses requiring this high level of care.

A. During weekdays from 7:00 a.m. to 7:00 p.m. the assigned CCU Cardiology resident will be responsible for the care of these patients along with the cardiology faculty.

B. At 7:00 p.m. the CCU Cardiology resident will check out all the patients to the CCU Cardiology night shift resident **and** to the On-Call Cardiology faculty.

C. The cardiology night shift resident will admit (write an H&P) any patients during this call period and notify the On-Call Cardiology faculty at the time of the admission.

D. At 7:00 a.m., the next day, the cardiology night shift resident will check out the patients to the daytime CCU Cardiology resident and faculty.

E. On weekends, the same protocol will apply except that the CCU Cardiology resident covers for 24 hours and checks out to the next Weekend On-Call Cardiology resident at 7:00 am.

F. The Saturday coverage will be by the cardiology consult resident and Sunday by residents on other services.

II. WEEKEND CALL SCHEDULE for CCU

A. The total number of weekend calls is divided by the number of residents in order to allocate the total number of calls for the entire year. Schedules are made by the chief residents.

B. Night float resident will not do any weekend calls on that month.

C. In June, we will give the last weekends to residents who are not joining fellowships or PGY-2s. *The resident in ER night float or ER weekend in July will take over the first day at 00:00, in order to avoid liability issues.* Our malpractice insurance finishes the last contract day at midnight.

D. Changes to the call schedule will only be done by the Chief Resident to avoid confusion and risk of having nobody show up for call that weekend.

WARDS

I. IN-PATIENT RESIDENCY SERVICES

A. The Internal Medicine In-Patient residency services are divided into four ward teams, one ICU, and one CCU team.

B. Each team functions as a separate service and each resident is clearly assigned to one of these services. The physicians, on a given service, are responsible for the care of the group of patients assigned to that team. Each service is staffed by one faculty attending physician, one upper level resident, and two or more first-year residents. Third and fourth-year medical students and pharmacy students may be on a team, as well. However, the teaching ratio must not exceed a total of 8 residents or students to one teaching attending.

II. SUPERVISION OF RESIDENTS

A. All patient care must be supervised by qualified faculty. The Program Director shall manage the supervision of residents. Residents must be provided with prompt, reliable systems for communicating with supervising faculty.

B. Faculty schedules must be structured to provide residents with continuous supervision and consultation.

C. Faculty and residents must be educated to recognize the signs of fatigue. Individual departments shall adopt and implement policies to prevent and counteract the potential negative effects of fatigue. We use the Learning to address Impairment and Fatigue to Enhance patient safety (LIFE) curriculum to cover these issues, available on-line in our GME website. This curriculum is mandatory and is usually done during the orientation for the PGY-1 residents.

III. ATTENDING ROUNDS

A. Attending rounds are scheduled between faculty and residents at a mutually agreed upon time and place.

B. Attending rounds are **MANDATORY**. No one is excused without permission of the attending physician. All house staff residents are expected to participate.

C. All house staff are expected to participate in the rounding activities except when PGY-2 on call needs to admit or write orders on a patient in the ED.

D. Cases should be presented in an organized and concise fashion. All pertinent data (physical exam, lab) should be available.

E. House staff should come to rounds prepared to discuss their cases, including pathophysiology and differential diagnosis, in an intelligent manner.

F. Attending rounds are also Teaching Rounds. Teaching rounds with the attending physician are held daily.

G. House officers are expected to have all current information regarding their patients available at the beginning of Teaching Rounds.

H. Medical students may present patients on rounds, but the corresponding first-year resident is responsible for detailed knowledge of the patient.

I. The attending physician will make every effort to finish rounds before noon in order to release the team members in time for the morning report/noon conference session.

J. It is the responsibility of the upper level resident to be certain that all of the major problems are considered during the course of morning rounds with the attending physician.

IV. MANAGEMENT ROUNDS

A. Management rounds are held daily by the attending physician and at least the upper level house officer. They are not mandatory.

B. Management rounds consist of review of patients followed by the team to include pertinent data, hospital course, discharge planning, etc.

V. WORK ROUNDS

A. Work rounds will be conducted *optionally* by members of each team without the

attending being present.

B. Activities will include clinical assessment of each patient and the collection of the pertinent data.

C. These rounds can also be implemented for the sign-out of patients at the end of the day to the on-call team.

VI. WEEKENDS AND HOLIDAYS

During weekends and holidays, teams will round as arranged between faculty and senior residents.

VII. END OF MONTH PATIENT DISTRIBUTION

A. The PGY-2's will inform the chief resident how many patients will be left on their service for the following day (the 1st of the next month).

B. The chief resident will distribute or keep the patients as assigned to their current teams. If an intern stays in the ward the following month, he/she stays in the same team with his/her patients. If an intern has to change teams, he/she will keep his/her patients.

VIII. HANDOFF PROCESS

A. ***It is mandatory for all*** Ward, CCU, and ICU residents to hand off their patients to the on-call team before leaving the hospital for the day by using the appropriate documentation forms (available on line). A verbal exchange is required in person or by telephone. The Attending MD will monitor this hand-off on regular basis to confirm that importance information is not being skipped.

B. If patient problems arise during the evening or night, these will be discussed with the patient's resident the next morning i.e. rapid response interventions, transfers to the ICU, cardiac arrest or significant changes in the status of the patients.

IX. CAPS AND SPILLOVERS

A. The Hospitalist Service (formerly known as Non-Teaching Service) team will take the overflow admissions.

B. During each call day, each intern can receive up to 5 new admissions and up to 2 in-house transfers, up to a total of 10 patients whatever happens first.

C. The on-call team caps at 10 patients for double-intern teams and 7 patients for

single-intern teams.

X. ADMISSIONS FOR RESIDENTS AT UNIVERSITY MEDICAL CENTER

A. Admissions are to be shared equally between the first-year residents on-call, usually on an alternating basis. Exceptions to this sequence will be decided by the senior admitting resident or the chief resident.

B. A first year (PGY-1) resident must not be assigned ***more than five new patients per admitting day (24-hour period)***. In addition, up to two transfers may be accepted if they are in-house transfers from the medical services on each admitting day.

C. PGY-1 residents must not be responsible for the ongoing care of ***more than 10 patients.***

D. Senior residents (second or third-year) on inpatient services must assume primary patient responsibility for <u>admissions in excess</u> of the numbers permitted for first year residents (such as in a single intern scenario).

E. Senior Residents will admit patients when an intern left and the second intern capped, they will take care of the orders and a brief admission note. The intern will write a full HandP when time allows during or after rounds and have his/her attending co-sign. Senior Resident is responsible to present these admissions to the Faculty in case Intern was unable to see them in time.

F. When supervising more than one first-year resident, the supervising resident on Ward or ICU must not be responsible for the **<u>supervision or admission</u>** of **more than 10 new patients** and ***four transfer patients*** per admitting day. When supervising one first-year resident, the supervising resident **must not be responsible** for the *<u>ongoing care</u>* of **more than 14 patients**.

G. When supervising more than one first-year resident, the supervising resident must not be responsible for the *<u>ongoing care</u>* ***of more than 20 patients.***

H. The patient overflow will be taken by the hospitalist service team.

XI. ADMITTING, TRANSFER, AND READMISSION POLICIES

A. The senior admitting resident will be responsible for admission of patients to the Medicine Service or Medicine ICU. When the admitting resident has a question

regarding the admission of a patient (he/she should contact either the clinical chief resident or the attending physician on call).

B. Transfers are considered full-admissions for the purpose of the cap unless it is a "bounce back" from ICU to one's team within a 72 hour period. If patient gets transferred within the 72 hour period, then it would count as a half-admission.

C. For the purpose of the ACGME inter-service transfers (e.g. ICU transfers to a medical ward and night float to admitting team transfers) count as full admissions if the receiving residents are required to perform full patient evaluations.

D. If a patient is readmitted when the original team is on call, the patient will be assigned to that team and it will count as a half admission. (see Bounce Backs section)

E. When the original team is not on call, the patient will be admitted to one of the on-call teams and will be transferred to the original team the following morning.

F. The patient will be considered as an admission for the intern on call during the night, but not for the team accepting the patient the next morning.

G. The senior level resident from the accepting team will be responsible for presenting the admission to the faculty attending.

H. The ICU PGY II should not receive more than 10 admissions per call.

I. The PGY II team leader should give a warning call, to the attending physician, chief resident and/or the program director when a team carries 18 patients or more. The idea is to start dealing with the problem before it reaches a critical point and results in disposition of patients to other facilities or home.

J. Residents should rely on social worker and case managers to assist in placement, home IV antibiotics, and other elements of discharge planning.

K. Indigent patients may receive benefits from the Visiting Nurses Association (VNA) agency and/or Hospice Services on "scholarship" basis.

L. Not every patient admitted needs to have follow-up at Texas Tech IM clinic.

XII. ADMISSION AND TRANSFER – TIME FRAMES

A. Transfers from the ICU to the short-call team should be on the floor before 6:00am the next day.

C. Transfers from the ICU to long-call team should be on the floor by 12 noon the next day.

D. Transfers from outside facilities to short-call should be on the floor by 1:00 PM, the same day.

E. Admissions to short-call from clinic should be on the floor no later than 1:00 PM, the same day.

F. All cases not arriving to the floor within these time frames will go to the next team on call.

G. Do not rely on these rules to "turf" patients to other teams. Everybody should make every possible effort to make things happen. If there are no telemetry beds, re-evaluate patients on the floor who may not need it anymore. Discharge stable patients.

XIII. ADMISSION OF UROLOGY PATIENTS

Urology, Surgery, Internal Medicine, and Emergency Medicine have agreed* to the following guidelines regarding urology patients:

A. Urologic Trauma

   1. All urologic trauma will be admitted to the Trauma service.

B. Fournier's gangrene and scrotal cellulitis

   1. Admit to Surgery service, Urology will be involved in debridement and act as consultant.

C. All other adult urology patients will be admitted to IM (whichever service is on-call).

   1. For primary urologic issues (like kidney stones), contact the urologist on-call. When admission is indicated, the patient will be admitted to Internal Medicine with Urology acting as consultant.
   2. For complicated patients with concurrent urologic issues, the IM team will consult Urology.

D. Remember that Gyn-Oncology manages most of their patients' urologic issues primarily, so they should be contacted first.

E. Outpatient urologic patients may be referred to the urology clinic (Thursday mornings) in the usual manner (the "Urology Clinic Referral" sheet in Cerner). This clinic is only for unfunded patients, but we often don't have that information when we discharge from the ED. Patients found to have Medicare, Medicaid, "Healthcare Options", or private insurance will subsequently be

referred to the list of urologists at the bottom of the "Urology Clinic Referral" in Cerner.

F. Unfunded patients presenting to the ED for urological needs that do not require an admission need to be referred to the Urology Clinic at the Women's Health Center (WHC), Annex Bldg, 4th Floor. This can be done through a referral to Angie Rodriguez, 544-1200 ext. 1295.

G. Unfunded patients who have undergone a Urology procedure that are being discharged and require a follow up appointment need to be referred to the Urology Clinic at the WHC. The appointment can be made through the Central Scheduling Department located on the 1st Floor at UMC (by the Registration Department), 544-1200 ext. 2255.

XIV. TRANSFER OF PATIENTS TO OTHER HOSPITALS

The attending physician on the team or the attending "on call" should always be notified and approval granted before moving patients to other facilities.

XV. BOUNCE BACKS

A. Any patients that are distributed to the new floor teams will be considered as bounce backs for the entire month, even if they were discharged on the same day of the redistribution. Bounce back patients are not considered new patients.

B. Teams may receive bounce backs until 4 PM. Any bounce back after that will be taken care of by the team on call, until the next day.

C. Post call teams may receive bounce backs until 12 PM. Any bounce back after that will be taken care of by the team on call, until the next day.

D. Post call teams will not receive any bounce backs after 7 AM on weekends.

E. Above rules apply to bounce backs from ER or ICU.

F. Patients getting admitted after the last day of that month are not considered bounce backs, even if the intern or resident may have continued on the floor.

G. The senior resident of the team taking care of a bounce back patient will write a short admission note, accounting for the reason of readmission, outlining the admitting problems and management plans.

1. He or she will order necessary tests and will follow up on the results, checking them out to the PGY-II in charge of patient next morning.
2. The intern of the team taking care of a bounce back patient will write the

official H&P format, in an abbreviated fashion for official purposes.

3. The patient will be counted as an admission for the intern on call during the night, but not for the team accepting the patient the next morning.

H. If the team on-call caps and there is a bounce back patient to be admitted, the moonlighting PGY-II will write his/her H&P and give the patient to the intern of the accepting team next morning.

XVI. ORDER WRITING BY RESIDENTS AND ATTENDINGS

A. Internal medicine residents must write all orders for patients under their care, with appropriate supervision by the attending physician.

B. In those unusual circumstances (e.g.-complicated chemotherapy orders) when an attending physician writes an order on a resident's patient, the attending must communicate his or her action to the resident in a prompt fashion.

C. ***All orders have to be dated and timed***.

D. Name stamps are also required.

E. Prescriptions and hospital orders must have name of faculty attending who supervised that order or prescription.

XVII. VERBAL ORDERS

A. In an effort to comply with JCAHO requirements, verbal orders are to be signed within 48 hours and should include date and time.

B. Faculty and fellow residents may sign on behalf of other residents as long as they agree with the order.

XVIII. DAYS OFF DURING WARD ROTATIONS

A. Everyone will get four days off during ward rotations (two-week days and two weekends).

B. The exception is the ICU resident who will get four weekends and no weekdays off unless absolutely required.

C. Interns will have preference over the senior residents in getting their off days. A resident may or may not get two week days off, but an intern has to get at least two week days off, and a two weekends off. No exceptions allowed.

XIX. IN-PATIENT RESPONSIBILITIES

PGY-1 (Intern Resident):

A. Primary care physician examines patients daily before attending rounds and documents with daily progress note. Orders and collects data on patients. Reports to and discusses patients daily with upper level resident.

B. Intern admits patients to floor or ICU or Telemetry, depending on the service. Collects all data, writes orders and performs procedures with supervision of upper level resident when appropriate. Patients admitted to the medicine floor will be discussed with the covering PGY2 resident, and admissions to ICU will be discussed with the PGY3 resident.

C. The intern on the Medicine Service is primarily responsible for the diagnosis and treatment of the patients assigned to his or her care. The responsibility of the intern shall include the following:

1. Performing and recording a complete history and physical examination on newly admitted patients.
2. Contacting the responsible upper level resident to review the salient features of the patient's problems and to decide jointly on a course of diagnostic and therapeutic action.
3. Writing appropriate orders and if applicable notifying the resident who is the primary care resident physician at the ambulatory care clinic.
4. Maintaining contact, through daily work rounds and by other methods of communication when necessary, with the responsible upper level resident and attending physician for the most efficient ongoing care of patients.
5. Recording pertinent admission and daily progress & discharge notes in a problem oriented format in the chart.
6. Formulating, in conjunction with the upper level resident physician, a program for continuing care and medical follow-up for the patient at the time of discharge from the hospital and recording such plans in appropriate discharge note.
7. Dictating in a comprehensive and organized manner a final summary preferably at the time of patient discharge. After the patient is discharged, the intern will assure appropriate patient follow-up in their own outpatient clinic unless the patient has been previously followed by another resident, outside clinic or private physician.

PGY-2 or 3 (Senior or Upper Level Resident):

A. Supervises care rendered by PGY-1.

B. The upper level resident should have a plan of treatment for every patient on the team. The upper level resident MUST conduct daily work rounds with the team, examine patients, and discuss problems.

C. Covers Medical Service for admissions. When appropriate, the PGY-2 should seek advice of the PGY-3.

D. PGY-2 or 3 is responsible for supervision of all patient care on medical floors at night.

E. PGY-2 or 3 resident is also provides medical consultations for patients in the hospital, should attend all codes and assist PGY-1 as necessary.

F. The upper level resident on an inpatient service has the major educational role and is the responsible house officer for patients under his or her care.

G. The upper level resident must support the activities of the intern by frequent consultation and discussion.

H. The upper level resident shall follow certain specific responsibilities:

   1. Assuring there is a history and physical examination on each patient under his or her care.
   2. Record a brief admission note on every new patient, outlining the admitting problems and management plans.
   3. Supervise the interns in the diagnosis and care of the team's patients, and discuss the team patients at all conferences.
   4. Select in coordination with a faculty member and present patients for discussion at morning report.
   5. Responsible for maintaining the team's organization (including paperwork), teaching, and patient care.
   6. Responsible for organizing and conducting daily work rounds. These rounds should be conducted with the entire team. Patients should be briefly interviewed and examined concerning on-going or new problems. Work rounds are non-faculty teaching rounds.
   7. Make every effort to teach PGY-1's and medical students.
   8. In difficult situations, upper level resident should consult with the clinical chief resident or the attending physician.
   9. Should schedule follow-up of patients to his/her clinic who are discharged from the inpatient service that were under the care of an intern rotating

from another service.

PGY- 3 ICU Resident:

A. Responsible for admissions and triage to ICU.

B. PGY-3 has the code beeper and is responsible for running codes.

C. PGY-3 resident should be available to assist PGY-2 on wards if necessary.

D. PGY-3 supervises patient care in the ICU at night. Any disputes or problems concerning the Medicine Service should be resolved by PGY-3.

XX. DUTY HOURS

Residents are to enter all work hours into the My Evaluation online program.

A. *Strict adherence to duty hours is MANDATORY.*

1. Maximum of 80 hours per week.
2. Minimum of one day off per week.
3. Maximum on-call every third night.
4. Minimum of 10 hours rest between shifts.
5. Maximum of 30 continuous hours.

B. Duty Hours Compliance Policy:

1. Period of compliance is during a 6-month cycle
2. 1 to 2 Violations ***(incomplete or no hours entered)*** – Notice of Concern Card
3. 3 Violations ***(incomplete or no hours entered)*** – Observation Letter
4. 4 Violations ***(incomplete or no hours entered)*** – Placed on Probation
5. 5 to 6 Violations ***(incomplete or no hours entered)*** – Recommend Termination

XXI. ON-CALL SCHEDULE

A. The "on call" schedule places a specific service on "short" call and "long" call on any given day. "Short" call generally will be from 7 a.m. to 3 p.m., (except on Friday's when "Short" call ends at 1:00 p.m. and on weekends at 11:00am) and "long" call will be from 3 p.m. to 7 a.m. The Program Director, Assistant Program Director and the Chief Resident should be notified in advance if changes must be made in the call schedule.

B. On-call schedules are determined by the Administrative Chief Resident in cooperation with the Program Director and Assistant Program Director.

C. **Residents are <u>not</u> to change their on-call assignments without making arrangements for coverage <u>nor</u> without approval of the Chief Resident**. The

Chief Resident will inform the Program Director, Assistant Program Director and coordinator of on-call changes. **Residents who violate this policy will be subject to disciplinary action, including suspension.** If a change in the call schedule is made, the residents involved must notify the hospital operator and Texas Tech answering service of the changes.

D. It is the on-call resident's responsibility to ensure that their beeper is working at all times. If there is any doubt, frequent tests should be made with the operator.

XXII. BACK-UP CALL SCHEDULE

A. Back-up call is ***mandatory!*** Any changes on this schedule should be discussed with the chief residents. Any resident scheduled for back-up call **should not** leave town unless chief residents are made aware, coverage is arranged, and changes are approved.

B. The back-up call schedule will be ready by the beginning of the month.

C. Separate back-up schedules are needed for PGY II and PGY III.

D. Distribution of back-up calls will be done equally.

E. No need for back-up for PGY I.

F. Back-up is to be done by PGY II and PGY III residents doing electives except in circumstances mentioned above.

G. Night float, ER and ICU residents may not do back-up calls, but this is not binding.

H. Weekend calls will be considered when making the back-up schedule. A resident should not be on back-up call immediately before or after a weekend call.

I. A PGY III will call a PGY III back-up only for things that a PGYIII needs to do. For example, the night float resident will call the PGY III back-up only to do the work that a night float person is expected to perform as a PGY III. The night float resident may also call the PGYIII back-up to do consults in ER, consults from other services, and to take care of complicated procedures in the ICU.

J. PGY II will call a PGY II for duties that are expected of a PGY II.

K. Back-up person will cover in case of unexpected sickness or other emergencies.

L. On some weekends, there may not be enough PGY II residents to do backup calls. In such a situation, the PGY II resident on the floor who is not pre-call or post-call may be the backup for that day. It will however, be avoided as much as possible.

M. **Anybody who calls the backup person MUST pay back in the same manner.**

Since the backup call person is getting up in the middle of the night to come in, backup person is to be paid back at least 12 hours of weekend call, even if he/she covered for three or four hours in the night.

N. This applies to people becoming sick, as well. One night float call is equivalent to another night float call, or one complete weekend call.

XXIII. MOONLIGHTING

A. Moonlighting **outside** the context of the Internal Medicine Residency training program is **PROHIBITED**. Please click on link below for details about the Institutional/GME policy: http://www.ttuhsc.edu/fostersom/gme/documents/external_moonlighting_policy.pdf

B. **RESIDENTS ARE NOT ALLOWED TO MOONLIGHT WHEN ON WARDS, ICU, OR CCU ROTATIONS.**

C. Internal Moonlighting is allowed for eligible residents as follows:

1. PGY3 – Allowed to moonlight.
2. PGY2 – Must have passed, is scheduled to take, or has taken Step 3 exam.
3. PGY1 – Residents may cover only (at the end of the first year) in June and are eligible at the discretion of the program director.

D. Should an internal moonlighting opportunity become available within the training program, assignment to resident's schedule will be incorporated considering the resident's current rotation schedule to avoid excessive working time that would interfere with his/her ability to achieve the goals and objectives of the educational program.

E. Additionally, any hours worked in such a capacity will be considered and recorded as part of the **80 weekly duty hour requirements**.

F. Compensation for internal moonlighting will be based on additional hours worked as scheduled by the program director.

XXIV. HOSPITALIST (NON-TEACHING) SERVICE: CARE OF PATIENTS BY RESIDENTS

A. Internal medicine residents do not routinely provide care for patients in the hospitalist service.

B. When medically indicated, the faculty attending or physician assistant in the hospitalist service may request the on-call residents to provide care to certain patients at night or on weekends. Such care will be appropriate for patients with

acute medical problems of concern and for emergency circumstances. If patient problems are anticipated, these cases should be presented to the on-call team in advance at the end of the day. The handoff should be done verbally and in writing.

XXV. REFERRAL OF HOSPITAL DISCHARGES TO OUTPATIENT CLINIC

This applies to eligible patients based on their prior affiliation to the clinic or teaching potential.

A. The first-year resident will write an order for appointment of the patient to a specific physician in Internal Medicine Clinic or to the appropriate clinic in the patient's zip code area. The patient should be furnished with the name of the physician who will see him/her in follow-up **IN WRITING** (in a consult form or prescription pad if consults are not available).

B. In order to provide continuity of care, the resident who has previously followed the patient in Clinic should again follow the patients after discharge (if the patient requires long-term care at Texas Tech). Appointment clerks have been instructed to check the patient roster and automatically reappoint the patient to his/her previous resident.

C. If the patient has not been previously followed in our clinic or if his/her resident physician has recently completed training, the patient should be appointed for follow-up with the first year resident who treated him/her on the wards.

D. When a new patient has been followed on the wards by a rotator or sub-intern, the patient should be referred to the Upper Level Resident's Internal Medicine Clinic.

E. From 7:30 A.M. until 4:00 P.M. a clerk will be available in the Medicine Clinic to arrange for the appointments of patients discharged from the Ward. Sometimes, however, patients are discharged after 4:30 P.M. or during the weekend or holidays. When this happens, the patient should be instructed by the ward clerk or the nurse on the ward, to call during above hours for an appointment clearly specifying the resident that will see him/her in the clinic. If overbooking is necessary, the resident will put it in writing in the consult or prescription pad with the name of approving faculty attending.

F. If the patient requires follow-up in a Subspecialty Clinic, this does not exclude follow-up in the IM Resident's Clinic. Also, it is preferable that the respective subspecialty staff member see the patient in consultation during hospitalization, in

order to approve the referral to the Subspecialty Clinic. Appointments to Subspecialty Clinic are made through the same appointment clerk.

G. In case of problems or questions contact the Program Director or the Clinic Manager in the Outpatient Clinic.