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Overall Program and Educational Goals
Pediatric Residency Program
Texas Tech Health Sciences Center Paul L. Foster School of Medicine

It is our belief that Pediatricians are responsible of promoting health, treating illness and preventing injuries in infants, children and teenagers. This effort is not just limited to the patient but involves the family and the community as well.

Our main goal is to teach our residents, throughout their three years of training in general pediatrics, to achieve, develop and carry out the appropriate care for the patient, obtain the medical knowledge, understand professionalism, communicate and building up strong patient-physician relationships. We want our residents to practice medicine utilizing all the resources to become experts in an increasingly complex medical system.

Our program will provide physicians with educational experiences to obtain the necessary knowledge, skills and attitudes to become well-rounded pediatricians, and will prepare residents to be competent general pediatricians able to provide comprehensive and coordinated care to a broad range of pediatric patients.

- The residency training in pediatrics will provide three years of consecutive training involving progressive responsibilities for patient care.
- All pediatric residents are expected to be prepared to take the Board Certifying Exam in the year of their graduation, and pass on first attempt. Residents will show progress towards meeting these goals by demonstrating continuous improvement on the yearly in-training exam offered by the American Board of Pediatrics

The residents will be trained in the competencies and skills needed to practice general pediatrics of high quality in the community.

Pediatric residents trained in the program will practice with humanism, cultural sensitivity and concern for the wellbeing of patients and their families and they will become advocates for the children.

- Residents will strive to create a sense of altruism and unselfish dedication to the care of children and service to the community.
- Residents will develop a long life desire to learn and improve

Our residents will function with other members of the health care team to create an environment of collegiality and will exercise a multi-disciplinary approach to the care of children.

- Residents will excel in providing leadership and advocacy for children in their communities.
- Residents will learn to teach, to become a member of a team and to critically analyze problems to find resolutions.

Finally, the expectation from our residents are many but it is our main desire to prepare Pediatricians who are not only excellent clinicians but caring human beings as well, and most of all to enjoy every moment of learning in an environment created toward their successful career.

Our educational goals are defined with the required six competencies in mind, to provide physicians with a complete training that will enable them to be competent Pediatricians.

Revised June 2012
Effective July 1, 2012

Goal 1: Patient Care

- Patient care is the foundation of pediatric residency training. Residents will learn to effectively and compassionately treat health problems and promote healthy lifestyles. Residents will develop the knowledge, skills and attitudes necessary to practice family-centered and community-centered care.

Goal 2: Professionalism

- Residents trained in the program will demonstrate a commitment to carry out professional responsibilities, adhere to ethical principle, and show cultural sensitivity and concern for the wellbeing of patients, their families and their communities. Residents will strive to build a sense of altruism and unselfish dedication to the care of children and service to the community.

Goal 3: Communication Skills

- Residents will demonstrate interpersonal and communication skills that result in an effective information exchange with patients, their families, and other professional associates. Residents will work with other members of the health care team to create an environment of collegiality and will exercise a multi-disciplinary approach to the care of children.

Goal 4: Evidence Base Medicine

- The residency training will prepare physicians for careers as lifelong learners. Residents will be comfortable with evidence-based clinical care. This will allow them to integrate principles of clinical epidemiology with skills in medical informatics and therefore improve decision-making at the bedside.

Goal 5: Medical Knowledge

- The residency training will prepare physicians to not only excel as clinicians but will provide the basis for further training in any pediatric specialty and/or academia. Furthermore, it will prepare them to be role models and an important resource in any community where they eventually practice. Formal teaching usually occurs within the didactic curriculum, but most learning takes place within clinical experiences. Therefore this competence is closely linked with competence in patient care.

Goal 6: System-Based Practice

- We train our residents to demonstrate an awareness of and responsiveness to the larger context and system of health care and to recognize other resource so that they provide the best health care to their patients.

Administrative and Clinical Chief Duties
Competency Based Responsibilities
Policy 1

Each year, three PGY-3 chief residents are appointed based on demonstrated excellence in leadership, teaching, and clinical performance. The chief residents represent a vital link between residents and faculty. They play a major role in education, organize many of the departmental conferences, and perform diverse administrative functions. The chief resident position involves administrative, teaching, and clinical responsibilities.

One Chief will serve as the Administrative Chief for a four month period concomitantly with one of the other Chiefs providing support as Clinical Chief.

DESCRIPTION OF DUTIES AND RESPONSIBILITIES

Administrative Chief:

All three chief residents in agreement with the Program Director are responsible for developing a yearly schedule for all interns and residents. This schedule needs to reflect the requirements put forth by the ACGME and RRC for pediatric house officers while at the same time providing appropriate coverage for inpatient and outpatient services. House officers from other programs (family practice, etc.) will also need assignment within this schedule. The development of the monthly schedule and the cumulative tabulation of the call schedule will be the responsibility of the acting Administrative Chief. In the event that scheduling conflicts should arise due to illness, pregnancy/maternity leave, death of a family member, etc., the chief resident should assist that person in his/her attempts to arrange alternate coverage.

Chief residents are also liaisons between the faculty and the house officers.

While their primary goal should be advocating on the residents' behalf, there may be times when disciplinary action is necessary, and the chief resident is responsible for initial interventions. The program director should be notified of any significant or ongoing problems.

Chief residents are an integral part of the resident recruitment process. All current and incoming chief residents will be part of the Recruitment Committee. The committee meets weekly during the heart of interview season to discuss the candidates and formulate the rank list. The chief residents are responsible for presenting the "Nuts and Bolts" of the program with interviewees. The chief residents should also assist in any efforts to provide

interviewees with the opportunity to get to know current residents (i.e., lunches or recruitment parties) outside of the hospital setting.

One of the primary roles of the chief resident is that of teacher. He/She will conduct morning report in a manner that is geared toward intern/resident learning. The chief residents are also responsible for scheduling of all house staff teaching conferences (Noon Conference, M+M, and Case Conference) in accordance with ACGME/RRC requirements. In addition, the chief residents may round with the inpatient teams.

There are some clinical responsibilities for the chief resident. Occasionally, he/she may be asked to help with coverage in the Clinic. All clinical work done on a supervisory level will need to be co-signed by the appropriate faculty. Though the need for chief resident coverage of house staff absences should be minimal, scheduling conflicts may arise that require the chief resident to cover a shift or service.

Clinical Chief:

The Clinical Chief will provide guidance and will dedicate time and effort to those residents that need extra help in all clinical and academic areas. The Clinical Chief will be responsible for meeting with the involved resident and respective advisor to identify deficiencies and formulate an improvement plan to present to the Program Director. Clinical Chief will take over the administrative functions when the Administrative Chief is not available.

COMPETENCIES FOR CHIEF RESIDENTS

PATIENT CARE

-On call duties in the inpatients facilities 4-5 times a month

-Supervise and direct transition of care for patients on the different inpatient units at least 2-3 times a week, including:

Inpatient pediatric floor

NICU and IMCU

Well baby unit

-Supervise and complement clinical teaching activities for resident, including faculty rounds once a week on the different inpatient units at least once a week in each unit or more often as required for residents support

-Continue with clinic responsibilities once a week

INTERPERSONAL AND COMMUNICATION SKILLS

-Act as the voice of the residents

- Assists with service orientation of students, residents and rotators in conjunction with the senior resident assigned to the service

-Attend monthly faculty meetings and communicate residents' issues as needed

-Communicate with ancillary staff regarding residents' evaluation of performance in the outpatient and inpatient services

-Conduct monthly residents meetings regarding intradepartmental and interdepartmental issues

-Represent the department of Pediatrics and welcome and inform residency applicants during recruitment season

-Coordinate and participate in orientation activities for new residents

PRACTICE-BASED LEARNING AND IMPROVEMENT

-Lead in an activity which fosters positive changes and improvement.

-Attend and participate in the Evaluation, Curriculum, Duty hours and Policy committees

-Participate in the didactic curriculum

-Schedule, coordinate and participate in monthly resident lectures to improve knowledge, skills and performance.

-Schedule, coordinate and participate in monthly Radiology conference

-Schedule, coordinate and participate in the preparation and improvement of the M&M, Grand Rounds and Perinatal Round table conferences in conjunction with the corresponding faculty

-Schedule, coordinate and participate in mock codes

PROFESSIONALISM

-The chief residents are responsible for developing a yearly schedule for all interns and residents

-Serve as an advocate for the residents' interest and protect the integrity of the program

-Identified and provide intervention for resident-student interactions and provide mediation in cases of conflict

-Monitor resident-resident, resident-faculty, and resident-student interaction and provide mediation en case of conflict

-Provide information and participate in activities required by the Institutional GME office

SYSTEM-BASED PRACTICE

-Schedule and coordinate monthly Journal Clubs

-Coordinate and participate in QI projects and QA cases

-Coordinate and participate in the application of evidence-based medicine for all the didactics for residents

-Coordinate and participate in the application of evidence-based medicine for all the case presentations from the residents

Advisor Policy

Policy 2

Each resident is paired with a faculty advisor who acts as his/her advocate throughout the training program. Faculty advisors are chosen by the resident early in the intern year, and help guide the resident not only through the professional challenges of residency, but also the personal growth issues all residents face as they complete training. Advisors help residents navigate the system and provide guidance when needed as to career choices, options for training beyond residency, and help and support during training.

This policy outlines the major responsibilities of faculty advisors and their resident advisees.

1. If an advisor has not been chosen by the September 1st deadline or if need arises the Program Director will temporally assign one.

2. PGY-1 residents will be given 60 days to choose their advisor. A list of available advisors will be provided to the incoming residents during orientation. Residents are expected to request approval for their chosen advisor. Faculty advisors are encouraged to take not more than five advisees at a time but it is up to the advisors discretion to accept more. Residents must submit and meet with their faculty advisor by September 1st.

3. Part-time faculty may be considered for advisors by request from a resident in writing to the Program Director/Associate Director.

4. Faculty advisors **may be changed once per academic year**. The request may be initiated either by the resident or the faculty. Requests for change of faculty should be submitted in writing to the Associate Program Director. If additional change is necessitated, the justification of the request should be submitted in writing to the Associate Program Director or the Program Director.

5. Faculty advisors oversee advisees' accomplishments towards promotion and are expected to meet with their advisees at least 3 times a year (or, on a quarterly basis).

6. Faculty advisors should keep a confidential record about their meetings with advisees. This record will **not** be shared with third parties (e.g. Program Director) unless special circumstances necessitate it (e.g. suspicion of drug abuse, criminal conduct, etc.).

7. Faculty advisors and residents keep a record of the **dates** they meet and present the dates and completed form for documenting meetings between residents and their advisors to the Program Director or Associate Program Director at least twice a year (by request from the PD/Associate PD).

8. Faculty advisors approve advisees' Individual Learning Plans (PediaLink) and monitor their advisees' progress per the ILP. The Program Director reviews the ILP after approval by the Advisor.

9. In general, advisors advise on strategies to learn and do clinical work, as well as leadership and teamwork. Suggested meeting reasons/topics include:

    - Scheduled meeting
    - Follow-up meeting
    - Urgent meeting
    - Academic progress

- ITE/Certifying exam
- Curriculum
- Evaluations
- Portfolio
- Patient care questions
- Promotion questions
- Job search
- Leadership
- Teamwork
- Research/study
- Teaching
- Stress management
- Personal questions
- Other

10. Faculty advisors are expected to participate in resident midyear and annual evaluation meetings with Program Director/Associate Director.

11. On some occasions, where personal advice is needed, advisors may help within limits they feel comfortable with, or may recommend to the Program Director (or the Associate Program Director) that the resident be directed to the Resident Assistance Program.

12. Recommending a resident to the Resident Assistance Program is **required** in all occasions of perceived emotional or learning impairment (e.g. depression, distress, dyslexia, etc.).

13. Faculty advisors work with the advisees towards improvements, as needed (e.g. meeting together with the advisee and the rotation director/attending).

Resident - Faculty Mentor Meeting Form

Policy 3

This form must be maintained by the faculty mentor for each meeting with resident advisees.

Date: _____

Please, check:

☐ One-on-one meeting ☐ Advisee group meeting

Present: Name of Faculty Mentor: _____

Name of Resident: _____ PGY-___

Reason for the meeting (please check all that apply)

☐ Scheduled meeting	☐ Policy questions
☐ Follow-up meeting	☐ Individual Learning Plan
☐ Urgent meeting	☐ Job search
☐ Academic progress	☐ Leadership
☐ ITE/Certifying exam	☐ Teamwork
☐ Curriculum	☐ Research/study
☐ Evaluations	☐ Teaching
☐ Portfolio	☐ Stress management
☐ Patient care questions	☐ Personal questions
☐ Other	

Confidential note by faculty (optional): _____

_____

_____

_____

Mandatory Attendance to Didactics

Policy 4

This policy establishes guidelines on 100% mandatory attendance to didactics. The Department of Pediatrics requires **attendance at all didactic activities**. 100% attendance is required to successfully get credit for a rotation.

Exceptions include

- Post call days
- Vacation days
- Providence Ward coverage
- Night shift
- Emergency situations (written explanation to the program director/chief resident)
- Patient care issues (In case the supervising faculty deems that the resident stays on clinical duty because of patient care, the faculty will notify the program director/chief resident directly).

All lectures will be available on the following website:

https://sharepoint.ttuhsc.edu/sites/TTUHSC/elpaso/som/ped/default.aspx

Please be advised that night shift residents are responsible for viewing the didactic videos/power points.

Awards Policy
Policy 5

This policy is established to guide the recognition of faculty, residents and staff at the Residency Program at the Department of Pediatrics by Departmental Awards. This policy shall be reviewed annually by the Policy Committee.

1. **Awards for Teaching of Medical Students:**
   A. Best Faculty – Teacher; awarded annually

   B. Best Resident - Teacher; awarded annually

2. **Award for Best In-training Score:** mounted "Certificate of Recognition." This award is presented to the resident with highest in-training exam score in each PGY-level.

3. **Award for Research:** mounted "Certificate of Recognition." This award can be given yearly to one faculty and a maximum of 3 residents.

4. **Best Resident of the Year:** This award will be given to one resident per PGY level for academic and clinical service achievements. Criteria that are considered are: a high in-training score, active participation in resident life, demonstrates leadership in teaching, clinical service and research and well respected among fellow-residents. This award will be based on the following criteria:
   - Academic performance;
   - Research projects;
   - Leadership;
   - Child advocacy/work with the community;
   - Clinical service excellence;
   - Teaching skills;
   - Professionalism and interpersonal skills

5. **Best resident of the year** as chosen by his/her peers: This award will be given to a third year resident and will be based on :
   - Leadership;
   - Team work;
   - Citizenship;
   - Professionalism and interpersonal skills
   - Representing the ideology/principles of the department

6. **Resident Award for "Best Faculty":** This award will be given to the faculty selected by the residents with most significant impact on resident training. This will be voted on by the resident

A schedule for award nomination shall be announced annually, and a uniform **nomination form** will be used for all nominations.

The Policy Committee Chair is responsible for the timely distribution of the nomination form and the timely announcing of all award nominations, and may assign this responsibility to a selected faculty member or committee.

Continuity Clinic Policy

Policy 6

All residents are <u>required</u> to have a <u>minimum of 36</u> Continuity Clinic half-days per academic year. The recommended number of Continuity Clinic half-days per year is 42.

PGY-1 Residents

- Each PGY-1 pediatric resident will be assigned to a site (Patient Care Pod) for continuity clinic commencing of his or her PGY-1 year.
- Residents will be assigned to the designated site one afternoon per week excluding Wednesdays, which are reserved for the didactic lecture program.
- Resident is assigned to a continuity clinic team. Continuity clinic is organized on a team concept. One faculty will lead the team.
- Patients are scheduled and resident attendance is expected throughout the year except on approved vacation, post-call or when ill. When resident is on vacation, post-call or ill, the rest of the team members will attend to his/her patients.

PGY-2 Residents

- Each PGY-2 pediatric resident is assigned to one afternoon continuity clinic per week.
- The PGY-2 will continue to follow established patients from the previous year, hence ensuring continuity.
- There will be no continuity clinic assignments on Wednesdays because of the didactic lecture program.
- PGY-2 resident continuity clinic assignments begin the first week of July, and are organized on a team concept. One faculty will lead the team.

PGY-3 Residents

- Each PGY-3 pediatric resident will be assigned to one afternoon continuity clinic per week, following the team concept as described for PGY-1 and PGY-2.

CONTINUITY CLINIC statistics are monitored for each resident and discussed during scheduled semiannual and annual evaluations. Residents are expected to manage a standard number of patients per half-day clinic at each level:

PGY-1 minimum of **<u>3</u>** **PGY-2** minimum of **<u>4</u>** **PGY-3** minimum of **<u>5</u>**

Coverage for Residents Who Call in Sick

Policy 7

The purpose of this policy is to establish guidelines for coverage in case a resident calls in sick during his/her call.

The Floater assigned for the block will take the designated duty of the resident who calls in sick.

a. The floater will cover the designated duty, but the person covered should "repay" the worked hours during the coverage call upon their return to service, i.e., if a resident missed a call duty because he/she was sick, he/she will be assigned another call, and efforts will be made for the Floater who covered to be given one call less in the future.

b. The Chief Resident will keep a call tally to ensure fair call distribution amongst all.

Dress Code Policy for Residents and Students

Policy 8

The purpose of this policy is to establish guidelines for appropriate dress on TTUHSC premises for pediatric Residents and Students. This Dress Code Policy is based on TTUHSC Policy 0.13 and provides standards for all Residents and Students within the Department of Pediatrics in order to project a professional image to the public.

A. General Appearance:

1. Clothing should be worn appropriate to the work/training place. Examples of articles of clothing that are considered inappropriate include the following: **shorts, sweat-suits, mini-skirts, flip-flops, spaghetti straps, and clothing that expose the midriff and torso.**

2. Shoes must be worn appropriate to department and job requirements. In general, flip-flops and slipper-type wear are not acceptable.

3. TTUHSC Pride Day is every Friday. Residents and Students may show their pride by wearing black/red shirt, dress shirt with the official logo, or the TTUHSC polo shirt. Jeans may only be worn on Pride Day with TTUHSC logo shirts.

B. Uniform Attire:

1. Uniforms (scrubs and white coats) must be professional in appearance.

2. The color of scrubs for pediatric residents is light blue. Residents must wear **blue** scrubs at UMC and Children's Hospital. Outside UMC and Children's Hospital, e.g. in clinic, residents should wear their white coat over the scrubs.

3. Gray scrubs may be worn by Residents at Providence or at TTUHSC campus only if wearing a white lab coat.

4. Residents and Students should change their scrubs with clean ones after each duty shift.

C. Responsibilities:

1. Residents and Students are accountable for being knowledgeable of the Dress Code Policy and maintaining a professional appearance at all times.

2. Identification Badges will be worn on the outside of the uniform, lab coat, or street clothes at all times while engaged in TTUHSC business. The photo ID badge will be helpful in the event of an emergency.

3. Departmental Administrators and Managers are responsible for enforcing the dress code policy and ensuring that all employees of their department are informed of the policy.

4. Residents and Students not complying with this policy will be sent home to return in appropriate attire.

5. Adherence to this dress code policy is considered part of PROFESSIONALISM.

Duty Hours Policy
Policy 9

A. Maximum Hours of Work per Week

1. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all Moonlighting.
   - If the resident is called to hospital from home, the in-house hours are counted towards the 80-hour limit.
   - At-home call is not counted towards the 80-hours per week.
   - Internal Moonlighting is considered part of the 80 hours per week.

B. Maximum Duty Period Length

1. Duty periods of PGY-1 residents must not exceed 16 hours in duration.
2. Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24+4 hours of continuous duty in the hospital.
   - Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
   - Post-call residents may not admit new patients after 24-hours of duty.

C. Minimum Time Off between Scheduled Duty Periods

1. PGY-1 residents should have 10 hours free of duty between scheduled duty periods.
2. Intermediate-level residents (PGY-2) should have 10 hours free of duty between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.

D. Mandatory Time Free of Duty

1. One day (one continuous 24 hour period) in 7 must be free of educational and clinical responsibilities when averaged over a 4 week period.

E. Maximum Frequency of In-House Night Float

1. Residents must not be scheduled for more than six consecutive nights of night float/shift and not more than 4 total weeks of night float per year.

F. Maximum In-House On-Call Frequency

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

G. Circumstances when Residents in their final years of education may remain or return in < 8 Hours

1. The majority of RRCs defined these circumstances as "required continuity of care for a severely ill or unstable patient, or a complex patient with whom the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.
   There are no circumstances under which pediatric residents may stay on duty without eight hours off.

H. Others

1. Each resident must submit his/her duty hour log and must report his/her hours at the end of each block rotation. Duty Hour Report is due in the Residency Staff Office by the end of the 5th business day after the end of the block rotation being reported.

2. If at any time a resident is close to approaching the 80-hr limit, the resident must report immediately to the Chief Resident.

Work Environment Statement

The Department of Pediatrics and the Pediatric Residency Program is committed to providing a work environment that promotes the safety, health, well being and educational success of every resident and follows the policies for such set forth by the Institution regarding the work environment.

In accordance with ACGME, the program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas.
Implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting and to that end, must:

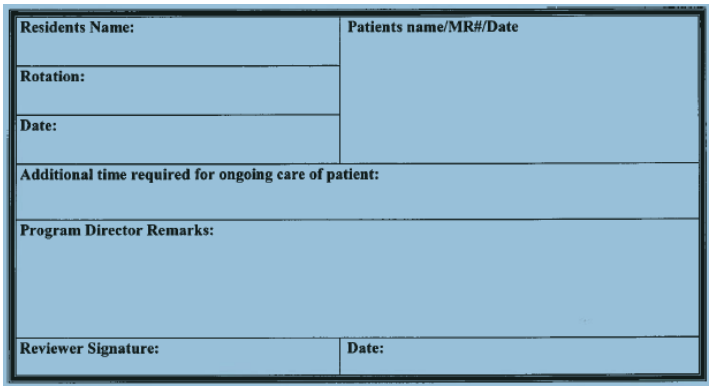
(1) distribute these policies and procedures to the residents and faculty;

(2) monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;

(3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,

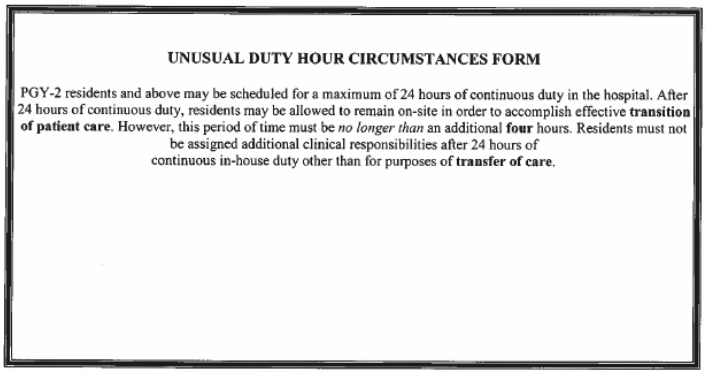
(4) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.

BLUE CARD:



Residents Name:	**Patients name/MR#/Date**
Rotation:	
Date:	
Additional time required for ongoing care of patient:	
Program Director Remarks:	
Reviewer Signature:	**Date:**

UNUSUAL DUTY HOUR CIRCUMSTANCE FORM:



UNUSUAL DUTY HOUR CIRCUMSTANCES FORM

PGY-2 residents and above may be scheduled for a maximum of 24 hours of continuous duty in the hospital. After 24 hours of continuous duty, residents may be allowed to remain on-site in order to accomplish effective **transition of patient care**. However, this period of time must be *no longer than* an additional **four** hours. Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty other than for purposes of **transfer of care**.

Evaluation and Promotion Policy

Policy 10

EVALUATION CRITERIA

1. Residents will be required to attend all scheduled monthly didactic activities. Attendance is mandatory for Grand Rounds and Perinatal M&M; a list of mandatory attendance is outlined in the Mandatory Attendance to Didactics policy. "Excused absences" are defined as illness, post-call, and vacation.

2. Residents are required to successfully complete objectives and competencies for each rotation. Each resident will receive a written monthly evaluation from one or more attendings (or a composite evaluation from all attendings) for a specific rotation.

3. Residents are required to complete at least one research/scholarly product for promotion to PGY-3 and graduation, as outlined in the Resident Research Review Policy.

Residents will be routinely informed of their rights to due process, grievance process and the process for remediation of performance if necessary.

CONTINUITY CLINIC statistics will be monitored for each resident and discussed during semiannual and annual evaluations. Residents are expected to manage a standard number of patients and caps per half-day clinic at each level:

PGY-1	**PGY-2**	**PGY-3**
minimum of 3 per session	minimum of 4 per session	minimum of 5 per session

STUDENT EVALUATIONS of RESIDENTS

Student evaluations of Residents will not be used as a criterion for promotion, but are provided to the Program Director as an added source of feedback on resident performance. Multiple observations by several evaluators are useful in identifying trends or patterns of performance and behavior.

PROMOTION

As part of the monthly evaluation for each rotation, residents will be evaluated on their ability to function at the appropriate training level on each of the 6 ACGME competencies.

The promotion and contract status of each resident must be determined no later than March 1st for the following academic year.

INCENTIVES FOR PERFORMANCE

Moonlighting: No external moonlighting is allowed in the Department of Pediatrics

Internal Moonligting: Eligible residents will be allowed to participate in Internal Moonlighting. See Internal Moonlighting Policy for details.

Additional Incentives
Additional incentives will be provided and Faculty will choose recipients at each level. Incentives may include additional funds for textbooks or attendance to an AAP meeting (3rd year).

At the end of each academic year, a resident from each level of training will be selected as **Resident of the Year**, based on the following criteria:

- Academic performance;
- Research projects;
- Leadership;
- Child advocacy/work with the community;
- Clinical service excellence;
- Teaching skills;
- Citizenship – attitude and relationships.

ACADEMIC REMEDIATION

Reprimand
Marginal performance (one "2" on any of the competencies) in the evaluation form will result in a formal letter:

1) Letter of counseling and/or remediation plan
2) Letter of reprimand.

Failure to meet hospital regulations for medical record completion will result in a reprimand.
Any violation of ethics (i.e. fabrication or lying, inappropriate conduct) will result in an immediate reprimand and could result in suspension or dismissal. A conduct violation may occur anytime during a rotation and should be documented immediately.

Positive as well as negative reinforcement will be provided to residents before the end of each rotation (i.e. mid-month). Evaluations will be based on professional and academic performance.

The Clinical Chief along with the Mentor will be responsible for a remediation plan based on the resident's deficiencies. Once the remediation plan has been drafted it will be presented to the Faculty for sign off. The Clinical Chief will then work closely with the resident.

Failure of a Rotation
A resident who receives two "2's" or more or one "1's" or more on an evaluation is considered to have failed the rotation.

Observational Status—Corrective Action
Failure of a rotation will result in placement of a resident on **observational** status for a period between 30-60 days. If remediation does not occur during the period of observation, the Resident will be placed on probation.

Probationary Status
Probationary status can be for 30-60 days. Failure to correct deficiencies during probation may result in extended probation or dismissal.

Deficient or unsatisfactory performance in a rotation must be verified and documented by attendings and/or the chief resident on the monthly evaluation form. These deficiencies must be discussed with the resident by the rotation attending during the rotation, and with the program director, resident advisor and chief resident in the quarterly evaluation meeting. A plan of remediation must be given to the resident and his/her progress monitored accordingly.

It is the responsibility of the Residency Program Office to report marginal or failing performance in any area on the resident's monthly written evaluation to the Program Director.

The Chief Resident will be informed about any issue with individual resident's academic progress or concerns about discipline, so early collaboration for correcting the issues could be achieved. **All residents under academic remediation should be working with the chief resident, their advisor, Program Director and/or Associate Program Director.**

Dismissal

A resident may be dismissed from the Residency Program by the Dean of the School of Medicine, following a recommendation by the Program Director. Refer to "2011 Housestaff policies and Procedures."

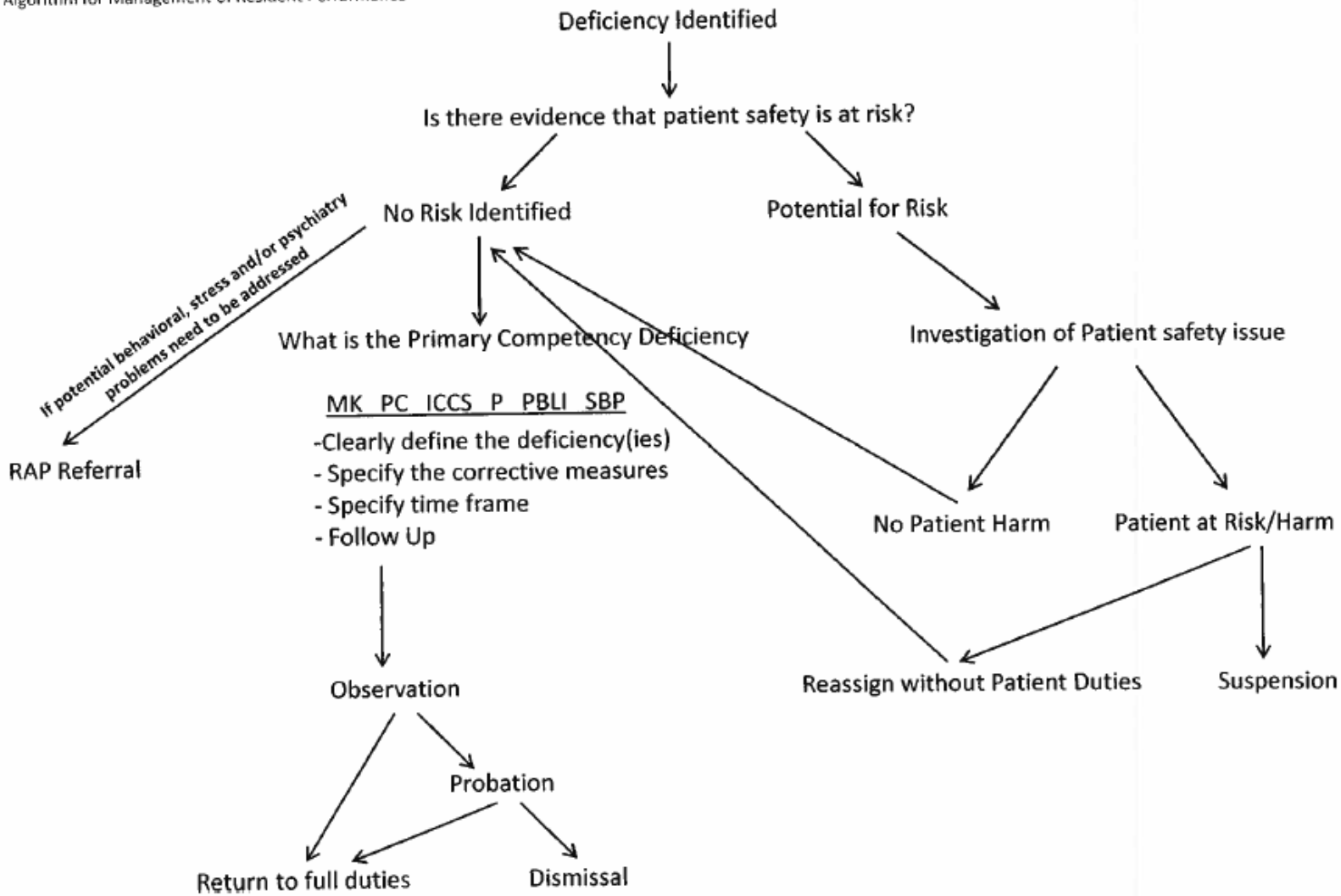
According to Texas Tech Administrative Housestaff Guidelines:

"By recommendation of the Program Director, a resident may be dismissed for unsatisfactory performance or conduct. Examples include, but are not limited to the following:

1. performance which presents a serious compromise to acceptable standards of patient care or jeopardizes patient welfare;
2. unethical conduct - (refer to TTUHSC policy for sexual harassment);
3. illegal conduct;
4. excessive tardiness and/or absenteeism

The recommendation for dismissal shall be in writing, outlining the areas deemed unsatisfactory and the reasons why dismissal is recommended. Dismissal in these situations implies poor performance or maleficence and is subject to appeal."

Algorithm for Management of Resident Performance



Faculty Evaluation and Review Policy

Policy 11

The Faculty of the Department of Pediatrics involved in resident teaching will undergo formal evaluations each annually for each academic calendar year. Performance criteria for the assessment of faculty serve to maintain the academic and professional goals and objectives of the Department and the Residency Program.

Several criteria will be used to assess a faculty member's performance and determine whether his or her contribution to the academic programs and to the department and institution is consistent with this general requirement for a commitment to teaching and academic medicine.

Faculty will be assessed based on six criteria deemed necessary to perform the functions of clinical faculty and maintain high academic standards for the program.

1. Clinical Knowledge

Faculty will be assessed on their demonstration of applied fund of knowledge, logical reasoning for problem solving and diagnostic evaluation. Demonstrated fund of clinical knowledge will be assessed during formal (end-of-rotation evaluation) and informal instruction.

2. Commitment to Resident/Student Education

The role of attending physician for teaching purposes is defined as instruction or supervision of medical students or residents in both patient care and non-patient care settings. Students, residents and the program director will evaluate faculty members on their commitment to medical education.

Lectures, seminars, conferences or tutorials by the faculty member, or participation in the teaching of core curriculum are considered formal instruction. Preparation time will be considered part of the faculty commitment to such an assignment. Attendance at conferences, rounds and other teaching exercises as an observer or casual participant is not considered formal instruction by the faculty.

3. Clinical Teaching

Faculty will be assessed on their ability to provide adequate supervision during patient care activities, logical reasoning for problem solving and diagnostic evaluation, and teaching bedside skills (H&P, procedures, establishing rapport with patients).

4. Scholarly Research

Faculty will be assessed on their conduct of or participation in individual or departmental research projects. Research is a significant academic activity for purposes of faculty development and continuing education. In conducting and reporting their research, faculty members are expected to abide by the high standards of care and scientific integrity expected of members of the profession.

5. Professionalism

Membership on departmental and School committees, as well as advisory or consulting roles related to the department, School or University, constitutes valuable academic activities to be recognized in evaluating the contribution of the faculty member.

In addition, faculty will be evaluated for compliance with applicable professional, ethical, Department and University rules and policies and for their constructive and positive contribution to the academic and clinical enterprise.

Continued Appointment

Based on whether assessment criteria are met, the Program Director in collaboration with the Department Chair will determine appropriate course of action and/or professional recommendations for each faculty member.

Confidentiality Statement

The evaluation of the faculty by the residents will be absolutely confidential. The Department Chair will have Faculty evaluations in an aggregate format annually at the time of their evaluation.

The Program Director will review all evaluations with the utmost regard to residents' anonymity and address issues accordingly.

Internal Moonlighting

Policy 12

1. The Pediatric Department does not endorse or approve of employment of Pediatric residents in non-departmental medical activities.

2. The Pediatric Department may offer additional remuneration to residents in good standing or additional hours of time spent engaged in departmental activities which are elective educational experiences beyond the minimal educational requirements. These activities must have faculty supervision and have educational value to the resident and also be appropriate for the resident's level of training. Participation in these activities is voluntary. Residents on probation may not participate.

3. **The experience is provided as a reward to high-performing residents. PGY-3 residents are priority in this process**.

4. Departmental activities that qualify in this category include:

    i. Senior residents (PGY-2) after completion of one ICN rotation during their 2nd year and having passing USMLE step 3 may be offered additional experience in **Neonatal Intensive Care** at EPCH or Newborn Nursery at UMC through voluntary assignment. Remuneration will be on a per evening or per weekend day basis. Supervision will be provided directly by the faculty neonatologist. **Eligible residents for NICU Internal Moonlighting must be pre-approved by the Program Director and Neonatology Faculty.**

    ii. PGY-1 residents are not permitted to participate in Moonlighting.

5. The Pediatric Chief Resident will schedule residents for these voluntary activities with oversight provided by the Residency Program Director. The Residency Director will place attention on the total number of hours worked by residents per month in all duty areas to assure that no resident will exceed the Residency Review Committee duty hour limit.

6. It is the duty of the Resident to **report immediately to the Chief Resident** if his/her duty hours for the week are close to the maximum allowed (80).

7. Internal Moonlighting hours are part of the 80-hour week limit.

8. A written approval by Program Director for resident Internal Moonlighting eligibility will be placed in the files of all residents who have expressed interest to be considered for remuneration.

9. The resident's performance will be monitored for the effects of moonlighting and any adverse effects will lead to withdrawal of the program director's approval of such activity. Failure of a trainee to comply with institutional as well as program requirements relative to internal moonlighting could lead to disciplinary action at the discretion of the program director.

Leave Policy
Policy 13

VACATION AND PROFESSIONAL LEAVE

The distribution of resident vacation leave time is as follows:

PGY-1	15 business days vacation Up to 3 days for **USMLE III***
PGY-2	15 business days vacation Up to 3 days for **USMLE III*** Up to 4 business days conference Up to 5 days fellowship interview time**
PGY-3	20 business days vacation Up to 4 business days conference Up to 5 days total fellowship or job interview**

* First attempt during the residency. Any subsequent attempts for the USMLE exam, time should be taken out of vacation.
** Four days total during the residency. Additional time should be taken out of vacation.

Vacations are limited to not more than one (1) week at a time during the PGY-1. PGY-2 and PGY-3 residents may submit a request for a (2) week consecutive vacation. These requests will be reviewed by the Policy Committee and must receive approval prior to any changes in the schedule. All requests must not conflict with the overall Pediatric Residency program schedule.

Requests for block periods of ***vacation*** or ***extended leave of absence*** must be submitted in writing and presented to the Policy Committee and the Program Director for approval. All extended time for leave will be looked at on an individual basis.

Vacation time may not be carried over from one academic year to another and **may not** be taken during the following dates: **June 15-30** (except for graduating seniors), **July 1-15, and December 14 - January 7**.

Vacation cannot be scheduled during the ER, Nursery, Developmental, Adolescent rotations, or during any of the four major clinical electives. According to the Special Requirements for Residency Training in Pediatrics established by the Accreditation Council for Graduate Medical Education, these four critical subspecialty elective rotations must be no less than four weeks in duration.

Vacation is not permitted during the Ward rotation. All other vacation requests will depend on staffing and must be approved by the Chief Resident and then the Program Director.

-At the PGY-1 level vacations can only be taken out of the clinic rotations, or minor elective

-At the PGY-2 level vacations can only be taken out of clinic rotations, or non-essential (minor) electives

-At the PGY-3 level vacations can only be taken out of clinic rotations, non-essential (minor) electives, or a one week vacation out of community health rotation

Rotators from other Institutional Departments will be subject to the same policy.

The total number of residents who will be given leave at one time will be limited to three (3) per level and not more than 3 at one time in the clinic.

(On essential rotations vacation is not allowed e.g. major sub-specialty electives, ER, PICU, NICU, Urgent care, Adolescent medicine, Developmental pediatrics, Research and Teaching).

Each resident must spend ***at least 3 weeks*** (15 working days) on their assigned major rotations to be given credit for the respective rotations.

Each resident must spend ***at least two weeks*** (10 working days) on their minor elective rotations service to be given credit for the respective rotations. If a 2-week vacation is scheduled for any block rotation, resident call schedule should be reviewed by the Chief Resident so no calls during weekdays would interrupt the remaining two weeks on the service.

Every effort will be made to give each resident time off on the weekend ***prior to*** and the weekend ***following*** the requested business days of vacation. However, free time on weekend will depend on scheduling availability.

Requests for vacation time from PGY-2 and PGY-3 residents are processed on a **first come, first served** basis and must be presented no later than 1 week (7 days) after the annual schedule is provided. Vacation requests will be submitted directly to the Pediatric Residency office. Residents who do not submit a request will be assigned vacation time at the discretion of the Program Administration. Please note: Attempts will be made to accommodate as many requests for vacation time as possible and as the rotation schedule permits.

For all incoming residents, vacations are assigned per annual schedule.

According to the Texas Tech standard resident contract, **as trainees of TTUHSC, residents are <u>not</u> entitled to time off on state holidays**. A resident is classified as "a trainee or employee who conditionally must be enrolled as a student and as such shall not be required to participate in the institution's (State) retirement program, shall not accrue vacation, holiday, or leave benefits as required by state law regarding 'regular employees,' shall not be entitled to unemployment compensation benefits at termination, and shall not be defined as a regular employee".

USMLE: The Department of Pediatrics will give PGY-1 and PGY-2 residents the opportunity to take 3 days of leave to prepare and take **USMLE III** exam. Residents who take the **USMLE III** exam more than once during their residency must schedule the subsequent attempts out of their **vacation time**.

CONFERENCE: PGY-2 and PGY-3 residents may utilize up to **4 business days** of **professional leave** for conferences or paper presentations each year. A conference itinerary must be attached to the leave request. Conference leave must be requested **at least one month prior** to the conference.

FELLOWSHIP INTERVIEWS: Each resident applying for fellowships may take **up to 4 days total of professional leave** for interviews. Additional interview time will be taken out of **vacation**. Time for ***job interviews*** must be taken out of vacation time if time for fellowship interview time has been used up. Interview leave must be requested **at least one month prior** to the interview and <u>proof of interview</u> must be submitted.

REQUESTS FOR RELIGIOUS OBSERVANCE(S)

Resident's requests for religious observances will be considered only after the resident has met all training requirements; occasional holiday observance requests must be presented to the Policy Committee 3 month in advance, and if granted, the resident must use a vacation day.

TARDINESS

Tardiness will not be tolerated during the Residency training. Up to two (2) excusable occasions of being late per year (e.g. car malfunctioning) will hold no consequences. The resident must report (call) as soon as the excusable occasion occurs to the Chief Resident AND the Attending faculty. ***More than 2 occasions of tardiness will count towards failing of professionalism competency.***

SICK LEAVE

a. Residents will be entitled to sick leave without deduction in salary
b. Residents will receive 12 working days per year and shall accumulate over the entire residency training.
c. Sick leave will accumulate with the unused amount of such leave carried forward each year. Residents are required to notify **the chief resident AND section attending** when calling in sick **and** must obtain a written note from a physician for sick leave if 2 or more work days from a 5-day period are involved. A leave request form must be submitted to the Administration office within 24 hours of sick leave. If calling in sick while on call, the lost call time must be made up and will be approved appropriately by the Chief Resident.

Maternity and paternity leave may be taken out of accumulated sick leave, vacation time, or leave without pay. ***Emergency leave*** also comes out of sick leave (depending on the nature of the emergency) or leave without pay. Three days of ***funeral leave*** are given in the event of the death of an immediate family member. Excessive leave will extend the period of residency.

In case a resident requires more leave and has exhausted accumulated vacation and/or sick leave, it will be considered leave without pay. Any leave without pay must be made up in order to complete program requirements. In addition, any resident who begins the residency off-cycle will complete program requirements off-cycle. For example, if a resident begins the program on September 15th, he/she will complete one year of training on September 14th of the following year.

Leave request forms must be completed at least **three (3) months in advance** for approved VACATION, or USMLE exam, and one (1) month in advance for Conference or interviews.

Each leave request must be signed by the Program Coordinator, the Chief Resident, the rotation attending, the Continuity Clinic appointment clerk and the Continuity Clinic Director.

A leave request must be completed for any leave, including SICK LEAVE, EMERGENCY LEAVE, and FUNERAL LEAVE prior to leave or upon the resident's return, as appropriate.

Emergency and Special request leave (including block time leave) must be submitted to the Policy Committee for approval. The decision of the Policy Committee is final.

NOTE*: PLEASE BE AWARE THAT THE AMERICAN BOARD OF PEDIATRICS REQUIRES RESIDENTS TO SUCCESSFULLY PASS **33 OUT OF 36 ROTATIONS IN ORDER TO SUCCESSFULLY COMPLETE RESIDENCY TRAINING.** IF TOTAL LEAVE TIME (INCLUDING MEDICAL LEAVE AND VACATION) EXCEEDS 1 MONTH PER YEAR, YOUR PROMOTION TO THE NEXT LEVEL OR YOUR GRADUATION MAY BE DELAYED. THIS TIME WILL NEED TO BE MADE UP.*

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE RESIDENCY PROGRAM OFFICE.

A "Change of Leave/Rotation Request" form must be completed and submitted for any change in vacation/rotations.

Resident Fatigue and/or Stress

Policy 14

Resident fatigue and/or stress may occur in patient care settings or in non-patient care settings. Patient safety, as well as the personal safety and well-being of the resident, mandates an immediate action to this condition. The response may vary depending on the appearance and demeanor of the resident and the severity of the perceived condition.

The following is intended as a guideline for recognizing and observing excessive resident fatigue and/or stress in non-patient and patient care settings.

All residents will be trained on stress, fatigue, and burnout at least one a year.

Any release from duty assignments due to stress/fatigue that exceed the requirements for completion of training must be made up in order to meet RRC curriculum guidelines.

Attending Physician

- If an attending physician recognizes a resident is demonstrating evidence of excess fatigue and/or stress, he or she should consider immediate release of the resident from any further patient care responsibilities.
- The attending physician must immediately notify the chief resident and program director of the decision to release the resident from further duties.
- The attending physician will privately discuss with the resident the possible causes of stress/fatigue in order to identify ways to reduce the resident's fatigue/stress.
- After private counseling of a resident under excess stress and if the attending physician believes the resident's stress may negatively affect patient safety, the attending must immediately release the resident of further duties. When the attending physician recognizes a resident is exhibiting excess fatigue, the attending must advise the resident to rest for at least a 30-minute period before operating a motorized vehicle. The resident should be encouraged to rest in a call-room or call someone to provide transportation back home.
- A resident who is released from further patient care duties due to stress or fatigue cannot appeal the decision of the responding attending physician.
- A resident who is released from further patient care duties due to stress or fatigue cannot resume patient care duties without permission of the program director.

Resident Responsibility

- Residents who perceive they are experiencing excess fatigue and/or stress have the professional responsibility to immediately notify their attending faculty, chief resident, and program director without fear of reprisal.
- Residents who recognize a peer resident is exhibiting signs of excess fatigue and/or stress must immediately report their observations and concerns to the attending physician, the chief resident, or program director.

Program Director Responsibility

- Upon removal of a resident from duties in coordination with the chief resident, the program director must determine the need for immediate change in duty assignments for peer residents in the program.

- The program director will review the call schedule, duty hours, patient care responsibilities, and explore resident personal issues that may contribute to the manifestation of stress/fatigue in the resident.
- The program director and the departmental chair/rotation director will develop methods to help reduce resident stress/fatigue.
- The program director will meet with the resident in person. If counseling by the program director is judged to be inadequate, the resident will be referred to the Resident Assistance Program (RAP). If the problem is recurrent or not resolved after two consecutive rotations, the program director will have the authority to release the resident indefinitely from patient care duties pending evaluation from the RAP representative.
- If the resident is advised to continue counseling, the program director will be notified by the RAP representative.
- A resident who is released from further patient care duties due to stress or fatigue cannot resume patient care duties without permission of the program director.

Minimum Responsibilities

Policy 15

All residents on all services are required to:

1. Write a complete history and physical exam on each patient including appropriate history of present illness plus PMH, FH, SH and ROS, thorough physical exam, problem list with differential diagnosis, assessment and treatment plan
2. Maintain accurate, timely, and legally appropriate medical records
3. Be familiar with and achieve competence in the EMR used
4. Meet all charting requirements established by medical services in all areas
5. Document all procedures and progress notes clearly describing patient's status, relevant investigations, etc.
6. Prepare appropriate, timely and concise discharge and transfer notes with clear documentation of management and follow-up plans
7. Write legible orders in a clear, concise, understandable format; all verbal/telephone orders must be read back immediately (read-back must be documented in patient chart) and must be signed within 24 hours
8. Write prescriptions which meet all state regulations, guidelines and medical staff requirements
9. Complete all forms regarding:
    a. Billing
    b. Consults
    c. Consent
    d. Financial assistance
    e. School placement
    f. Authorization
    g. Physical exams
    h. Deaths
10. Perform procedures appropriate to service and training level
11. Provide adequate communication to the family about their patients in a timely fashion
12. Assure adequate follow-up of all patients
13. Teach junior residents, medical students and rotators
14. Report to sections on time
15. Conduct additional reading or research in preparation for cases and patient management
16. Attend all morning report, lecture, small group, and any other mandatory meetings or events unless excused by an attending

Administrative Chief or Chief Resident is required to:

1. Coordinate teaching activities in each section
2. Assist with service orientation of students, residents and rotators in conjunction with the senior residents assigned to the services
3. Assure senior coverage in the Ward, Clinic, Nursery, Providence and Hotline
4. Identify and provide intervention for resident performance and behavior issues in coordination with attending faculty, program director and resident's faculty advisor
5. Monitor resident-resident, resident-faculty, and resident-student interactions and provide mediation in cases of conflict
6. Monitor resident attendance to lectures
7. Evaluate medical students, faculty, PGY-1, PGY-2 and PGY-3 residents

8. Participate in Evaluation, Curriculum, and Policy committees
9. Develop annual didactics curriculum
10. Develop monthly call schedules and record a distribution tally on the "Resident Call Distribution" form
11. Coordinate monthly resident meetings
12. Coordinate Resident Grand Rounds/ Case Reviews including assignments of tasks to residents
13. Oversee the coordination of monthly M&M and Prenatal Roundtable conferences in conjunction with neonatologists.
14. Arrange coverage in cases of resident absence
15. Act as liaison between residents and faculty
16. Attend monthly faculty meetings

Floater is required to:

Resident floaters attend high risk deliveries 7 a.m. – 1 p.m. on weekends. Resident floaters write admission orders for patients and immediately notify Nursery Senior Resident or NNP to ensure continuity of care. They also do H&P on admitted patients to ICN or IMCN from 7 a.m. to 1 p.m. on weekends

Responsibilities are not limited to those listed above, and may include assisting in other services as needed. The floater may be reassigned to other duties at the discretion of the Chief Resident.

EPCH HOSPITAL PEDIATRIC UNIT – Ward

FACULTY SUPERVISION and TEACHING RESPONSIBILITIES
Each faculty is required to:

1. Supervise senior residents in the areas of inpatient care and educational activities
2. Ensure appropriate patient care by interns
3. Make sure residents are documenting correctly
4. Make sure billing/fee tickets are done appropriately
5. Ensure that patient satisfaction is maximized by addressing issues directly with the chief of pediatrics
6. Coordinate with residents and nursing staff case management, discussions, and discharge planning
7. Make sure that patients receive appropriate treatment and follow-up in clinic
8. Conduct teaching rounds on daily basis or arrange for substitute
9. Provide residents with mid-rotation progress performance evaluation; identify process of remediation if necessary
10. Complete monthly evaluations in a timely manner
11. Report unsatisfactory or superior performance of residents on service to advisors
12. Coordinate section meetings and morning report including the designation of which patients will be discussed and the resident who will carry the discussion
13. Call consultants and answer consults to pediatrics while on the floor
14. Provide coverage for patients on the Ward throughout the day
15. Review resident charts and procedures

WARD SENIOR RESIDENT (PGY-2 or PGY-3) is required to:

1. Conduct pre-rounds
2. Know all patients on the Ward
3. Teach/supervise junior residents, medical students and rotators
4. Orient rotators from other departments with the direction of the administrative chief (chief resident)
5. Identify and co-manage patients which may be sent to the PICU
6. Coordinate bed-side check-out rounds
7. Evaluate medical students, PGY-1 and PGY-2 residents, and faculty
8. Ward seniors are also responsible for assigning patients to interns, MS-III and MS-IV on their team**.**
9. Admit patients from the ER
10. Know all patients on the floor
11. Answer ER/inpatient consults
12. Supervise interns, medical students and rotator
13. Take over as the resident with primary responsibility of a patient when the interns reach their capped number of patients

PGY-1 RESIDENT is required to:

1. Admit patients-must write H and Ps and progress notes on all patients
2. Perform organized and consistent H and P on every patient
3. Order and follow up on labs
4. Research material for patient care prior to rounds
5. Review patient status before rounds and compile information for efficient and appropriate oral presentation on rounds
6. Evaluate medical students, PGY-2 and PGY-3 residents and faculty
7. Work in conjunction with assigned MSIII to teach appropriate skills (i.e. taking the H & P, writing orders)
8. PGY-1 floor resident should participate in the critical care management during calls, to enhance medical knowledge

MEDICAL STUDENT (MS IV) is required to:

1. Follow patients in conjunction with assigned senior resident
2. Follow an average of 3 – 4 patients daily
3. Complete 1 work-up
4. Complete a total of 4 calls (2 weekdays, 1 Friday, 1 Saturday)
5. Attend daily rounds, Morning Report, and all pediatric lectures
6. Evaluate residents and faculty

MEDICAL STUDENT (MS III) is required to:

1. Follow patients in conjunction with assigned PGY-1 Intern
2. Write H & Ps on assigned patients and submit one for evaluation
3. Follow patients under supervision of PGY-1; needs to follow an average of 3-4 patients per day; can acquire 1 to 2 patients per day and 2 per night if on call

4. Attend all morning reports, student lectures, and Friday Small Group series.
5. Evaluate residents and faculty
6. Complete 3 weekday calls as described in Ward Orientation information

A **written discharge summary** should be provided upon patient transfer to the floor.

- Dictated report should be done by the PICU resident if patient is discharged within 48 hours after transfer to the floor.

- Dictation should be performed by the resident on the floor if discharge occurs after 48 hours after been transfer.

Residents are responsible for keeping their duty hours log. If at any time they approach the 80-hr limit, the resident must report immediately to the Chief Resident.

All individuals assigned to this rotation must report to the Ward at 7:00 a.m. and leave at 5 pm after proper bedside check-out of patients as a team (PGY-1 AND Senior).

PROVIDENCE HOSPITAL WARD

FACULTY SUPERVISION and TEACHING RESPONSIBILITIES

The attending faculty is required to:

1. Supervise senior residents in the areas of inpatient care and educational activities
2. Make sure residents are documenting correctly
3. Ensure that patients satisfaction is maximized by addressing issues directly with the chief of pediatrics
4. Coordinate with residents and nursing staff case management, discussions and discharge planning with the consent and direction of the Attending Physician
5. Make sure that patients receive appropriate treatment and follow-up in clinic
6. Conduct teaching rounds on daily basis or arrange for substitute
7. Provide residents with mid-rotation progress performance evaluation; identify process of remediation if necessary
8. Complete monthly evaluations in a timely manner including the collection of data from clinical faculty
9. Report unsatisfactory or superior performance of residents on service to advisor and Program Director
10. Coordinate section meetings including the designation of patients who will be discussed and which resident will carry the discussion ***(case conferences).***
11. Call consultants and answer consults to pediatrics while on the floor
12. Provide coverage for patients on the Ward throughout the morning
13. Review resident charts and procedures
14. Attend Providence Steering Committee

SENIOR RESIDENT (PGY-2 OR PGY-3) is required to:

1. Admit patients as directed by the PCP and/or attending physician
2. Round and consult with appropriate clinical faculty
3. Research material for patient care prior to rounds
4. Review patient status before rounds and compile information for efficient and appropriate oral presentation
5. Evaluate patients, develop plan, call clinical faculty and follow-up with him/her
6. When census reaches 10 patients per intern, the senior resident is responsible for calling the attending faculty and/or nursing staffs

PGY-1 RESIDENT is required to:

1. Admit, follow-up and discharge all Ward patients (in coordination with senior resident)
2. Write progress notes on all patients
3. Research material for patient care prior to rounds
4. Review patient status before rounds and compile information for efficient and appropriate oral presentation
5. Evaluate patients, develop plan, call clinical faculty and follow-up with him/her
6. PL1 floor resident should participate in the critical care management during calls, to enhance medical knowledge

All individuals assigned to this rotation must report to the Ward at 7:00 a.m. and leave at 5:00 p.m. after proper bedside check-out of patients as a team (PGY-1 AND Senior).

EPCH PICU

FACULTY SUPERVISION and TEACHING RESPONSIBILITIES
Each faculty is required to:

1. Provide direct supervision and teaching involved in the care of patients at all times.
2. Ensure appropriate patient care by residents
3. Ensure the resident is exposed to and learns how to perform procedures encountered during the rotation
4. Coordinate with residents and nursing staff case management, discussions, and transfers to the ward once the patient's condition is stable.
5. Conduct teaching rounds on daily basis
6. Provide residents with mid-rotation progress performance evaluation; identify process of remediation if necessary
7. Complete monthly evaluations in a timely manner
8. Make sure residents are documenting correctly
9. Make sure billing/fee tickets are done appropriately
10. Report unsatisfactory or superior performance of residents on service to program director
11. Conduct a monthly morning report

RESIDENT is required to:

1. Review patient status before rounds and compile information for efficient and appropriate oral presentation
2. Research material for patient care prior to rounds
3. Round and discuss with attending physician the plan of care
4. Procedures should be done with direct faculty supervision
5. Keep a complete patient and procedure log
6. Discharge or transfer patients to the ward only after discussing plan with attending physician
7. Supervise medical students
8. Obtain a mid-rotation and end for rotation evaluation to ensure satisfactory performance.

EPCH HOSPITAL NURSERY/NICU

NICU Intern Responsibilities

In the NICU, the first-year resident formulates and implements diagnostic and management plans under the supervision of senior resident and or faculty. During their first rotation, interns will be assigned sick newborns only (Hyperbilirubinemia, asymptomatic sepsis workups, TTN, IUGR, hypoglycemia, prolonged transition, healthy pre-terms, poor feeders, babies with RPR positive mothers, polycythemia, infants of drug dependent mothers and newborns with social issues).

By their second rotation, they will be assigned to take care of 1-2 ICN patients.

PGY-1 RESIDENT is required to:

Pre-Rounds

- Obtain sign-outs on your patients from post-call team.
- Collect and review all data from the previous twenty-four (24) hours from Cerner (i.e., vitals, I/O's, labs).
- Obtain information on your patients from nurse in-charge. Nurses could provide valuable information/input.
- Document problem-based progress notes on all assigned patients on Site of Care.
- Research material for patient care and compile information for efficient and appropriate oral presentation on rounds.

Rounds

- Present each patient in an organized, problem-oriented fashion, including assessment and plans for each problem.
- Take note of plans to be carried out while co-residents order them through CPOE.
- Discuss plans with the patient's family (if they are at the bedside during rounds).
- Assist in entering orders through CPOE while the other resident is presenting.

Day

- Create a "detailed work list" and follow through on plans from rounds.
- Update Site of Care notes and incorporate plans decided on rounds.
- Reassess patients as needed.
- Discuss final plans or unanticipated changes with the senior resident or supervising faculty.
- Perform admissions as assigned with orders through CPOE done promptly. Each admission should have a complete H&P with diagnostic and management plans on Site of Care in a timely manner.
- Perform discharges. Each discharge should have a complete discharge summary, prescriptions, instructions, and follow-up appointments as applicable.
- Prepare off service notes when finishing the rotation.
- Update patient's family regarding status of the patient and plan of care.
- Participate in the resuscitation of the newborn by attending low risk and high risk deliveries with senior resident, NNP and or supervising faculty.
- Participate in prenatal counseling by observing the senior resident and or faculty answer prenatal consults.
- Perform appropriate diagnostic and therapeutic procedures after obtaining consent from the mother with supervision from the senior resident and or supervising faculty.
- Prepare sign-outs for the on-call team with pertinent details regarding medications, anticipated labs and tests AND what the plan is for those results.
- Attend High Risk Clinic on Monday afternoons from 1pm-5pm except when post call or on continuity clinic day.

- Maintain appropriate presence in the NICU. Communicate if leaving the NICU to senior resident or colleague.

On-Call

- Attend sign-out rounds.
- Follow through on sign-out plans and determine which patients require a baseline exam and reassessment later in the evening.
- Consult with senior resident or faculty before admitting a patient or initiating non-emergency care. Communicate any questions/problems.
- Discuss all admissions with your senior resident and or faculty. Perform admissions as assigned.
- Communicate overnight events with interns/seniors in the morning.
- Address Well Baby and sick newborn patient and nursing concerns.
- Evaluate and examine patient when notified of changes in status or concerns.

Miscellaneous

- Attend didactic sessions and conferences (Friday noon lecture, M&M).
- All residents are expected to read on newborn care and their infant's problems on a regular basis.
- Prepare power point presentations on assigned neonatology topics for neonatology lecture sessions.
- Supervise the education and patient care of 3rd and 4th year medical students rotating through the nursery.
- Foster a professional demeanor in all situations.
- Residents are expected to assist each other to complete tasks when the need arises.
- Evaluate medical students, senior residents and faculty.

Senior Resident Responsibilities
In addition to responsibilities outlined above, the residents' experience in the second year expands in scope to include supervisory duties and direct care of critically ill neonates. Residents are supervised by staff neonatologists.

PGY-2 RESIDENT is required to:

PATIENT CARE
- Conduct pre-rounds with junior residents and medical students. Check their orders.
- Notify and consult with neonatologists regarding all newly admitted or transferred patients to Intensive Care Nursery. Discuss any significant changes in patient status or plans with the attending.
- Attend all high risk deliveries and lead neonatal resuscitation as required.
- Respond to perinatal consultations and notify neonatologists ASAP.
- Anticipate patient discharge and assure that all plans are in place well before discharge.
- Review intern H&Ps and notes periodically as needed.
- Supervise intern as he/she performs admissions/discharges/procedures and other patient care related activities.
- Prepare complete sign-outs on all patients for the on-call team with pertinent details regarding medications, allergies, anticipated tests and what the plan is for those results and off service notes when finishing the rotation.
- Ensure that all patient exams, notes, orders and discharges have been completed before signing out.

Team Leadership/Teaching

- Assume an active role in teaching medical students/interns and other members of the medical team.

- Prepare PowerPoint presentations on assigned topics for neonatology lecture sessions or M&M conferences.
- Manage patient distribution to members of both teams including labeling of patients team at the patient's bedside and the board.
- Assist students and interns in pre rounding and preparing data and presentations for rounds.
- Evaluate medical students, PGY-1 residents and faculty
- Notify Chief Resident and maintain patient coverage during residents' planned absences or planned days off
- Create a team environment in which students and interns feel comfortable raising questions and concerns.
- Demonstrate that you are readily available through visibility on the wards as well as by touching base with your team members as warranted.

MEDICAL STUDENT (MS IV) is required to:
MS IV is expected to function as a sub-intern and assume responsibilities as that of a PGY-1 under the supervision of senior resident and faculty.

- Complete a total of 4 calls (2 weekdays, 1 Friday, 1 Saturday).
- Prepare and present 50 min. Power Point presentation on a pediatric topic of your choice as approved by attending and presented during Friday Didactic session. It is the students' responsibility to contact the chief resident or Dr Ambat to coordinate the presentation.

MEDICAL STUDENT (MSIII) is required to:
- Admit at least one patient in intermediate nursery while on call under the management of the supervising resident
- Write an H&P for submission to and evaluation by faculty
- Examine:
    - 2 normal newborns (2 H&Ps) per day
    - Additional 2 at night while on call
- Carry a minimum of three patients with an intern
    - Should follow at least 2 patients in the IMCN
    - Do one H&P in the IMCN

Students assigned to this rotation must report to the NICU by 7:00 a.m. in order to be organized and ready to present on rounds.

PEDIATRIC EMERGENCY ROTATION

FACULTY SUPERVISION and TEACHING RESPONSIBILITIES
Each faculty is required to:

- Give proper orientation and discuss goals and expectations
- Provide direct supervision and teaching of pediatric resident involved in the care of the patient at all times
- Ensure appropriate patient care by residents
- Make sure that the residents are exposed to variety of cases and learn how to manage acute illness or injury in different pediatric age groups
- Ensure that the resident learn how to perform minor procedures
- Make sure residents are documenting correctly
- Make sure billing/fee tickets are done appropriately
- Ensure that patient satisfaction is maximized
- Make sure that patients receive appropriate treatment and follow-up in clinic

- Provide residents with mid-rotation progress performance evaluation; identify process of remediation if necessary
- Complete monthly evaluations in a timely manner
- Report unsatisfactory or superior performance of residents on service to advisors and to the Program Director
- Review resident charts and procedures

Resident Responsibilities

- Report to scheduled shift promptly
- Incoming and outgoing residents should perform a thorough bedside check-out
- Identify patients who need immediate attention
- Perform an appropriate problem-oriented history and physical examination
- Appropriate documentation with attention to positive and pertinent negative findings
- Retrieve patient laboratory data in a timely fashion and follow-up on results
- Discuss and consult with faculty the plan of care
- Procedures should be done with direct faculty supervision
- Ensure that the patient is provided with optimum care and patient should verbalize understanding of the plan of care
- Discharge patient only after discussing with the faculty supervisor
- Make sure that patient is provided proper instructions and follow-up
- Keep a complete patient and procedure log and let supervising faculty sign the procedures performed
- Obtain mid-rotation and end of rotation evaluation to ensure satisfactory performance

UMC Well Baby Nursery rotation

PATIENT CARE

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents are expected to:

- Use a logical and appropriate clinical approach to the care of newborns, applying principles of evidence-based decision-making and problem-solving
    - Identify the series of events the neonate goes through from birth until discharge by describing the prenatal, perinatal and postnatal periods.
    - Identify the newborn transitional period including cardiopulmonary changes, monitoring procedures and disease prevention
- Describe the operation and management of the newborn nursery including admission, transfers, discharge planning, infant feeding, safety and infection control
- Perform initial assessment, follow-up and discharge of the newborns using history, physical exam and routine screening procedures
    - Describe maternal risk factors
    - Interpret laboratory results
    - Identify normal vital sign and lab parameters
- Perform procedures appropriate for the newborn nursery

- Removal of extra digits and skin tags
- Circumcisions

Provide sensitive support to patients and their families in the newborn nursery

MEDICAL KNOWLEDGE

Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Residents are expected to:

- Demonstrate a commitment to acquiring the knowledge needed for the care of newborns in the nursery
  - Recognize the physical findings and treatment of common newborn conditions and to proceed in the appropriate management and disposition
  - Identify issues concerning infant nutrition: breast feeding, formula feeding
- Know and or access medical information efficiently, evaluate it critically, and apply it to newborn care appropriately

PRACTICE-BASED LEARNING AND IMPROVEMENT

Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents are expected to:

- Use scientific methods and evidence to investigate, evaluate, and improve patient care practice in the nursery setting
- Identify standardized guidelines for diagnosis and treatment of conditions to the newborn nursery, and adapt them to the individual needs of specific patients
- Identify personal learning needs, systematically organize relevant information resources for future reference, and address plans for lifelong learning about newborn care.

INTERPERSONAL AND COMMUNICATION SKILLS

Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates. Residents are expected to:

- Provide effective patient education, including reassurance, for conditions common to the newborn nursery
- Communicate and work effectively with staff, health care professionals, specialists to create and sustain information exchange and teamwork for patient care
- Develop effective strategies for teaching students, colleagues and other professionals
- Maintain accurate, legible, timely, and legally appropriate medical records for newborns

PROFESSIONALISM

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to:

- Demonstrate personal accountability to the well-being of patients
    - Following up on lab results
    - Writing comprehensive notes
    - Seeking answers to patient care questions
- Demonstrate a commitment to professional behavior in interactions with staff and professional colleagues
- Adhere to ethical and legal principles and be sensitive to diversity

SYSTEMS-BASED PRACTICE

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. Residents are expected to:

- Demonstrate sensitivity to the costs of clinical care in the nursery, and take steps to minimize costs without compromising quality
- Recognize and advocate for families who need assistance during the hospital stay and after discharge
- Recognize one's limits and those of the system; take steps to avoid medical errors

TTUHSC Outpatient Clinic

Supervision - Supervision refers to the dual responsibility that an attending physician has to enhance the knowledge of the resident and to ensure the quality of care delivered to each patient by any **resident**. Such control is exercised by observation, consultation and direction. It includes the imparting of the attending physician's knowledge, skills, and attitudes by the attending physician to the resident and ensuring that patient care is delivered in an appropriate, timely, and effective manner.

Supervision may be provided in a variety of ways including person-to-person contact with the resident in the presence of the patient, person to person contact in the absence of the patient, and through consultation via the telephone or such Telecommunication devices as appropriate.

The intent of this policy is to ensure that patients will be cared for by clinicians who are qualified to deliver care and that this care will be documented appropriately and accurately in the patient record. This is fundamental, both for the provision of excellent patient care and for the provision of excellent education and training. Faculty supervision of residents assures resident education. The quality of patient care, patient safety, and the success of the educational experience are inexorably linked and mutually enhancing. Incumbent on the clinical educator is the appropriate supervision of the residents as they acquire the skills to practice independently and simultaneously provide the highest standard of patient care. Additionally, it should be understood that documentation of patient care acceptable for purposes of third-party billings, is governed by guidelines that are defined by payers, such as the Centers for Medicaid and Medicare Services (CMS) or third-party insurers.

The type of supervision (physical presence of attending physicians) required by residents at various levels of training, must be consistent with the requirement for progressively increasing resident responsibility during a residency program and the application program requirements of the individual departmental, as well as common, standards of patient care. The levels of supervision are:

1. ***Direct Supervision****:*
   • This means the supervising physician is physically present with the resident and patient.

2. Indirect Supervision A (with direct supervision immediately available):
   • This means the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide ***Direct Supervision***.

3. Indirect Supervision B (with direct supervision available):
   • This means the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide ***Direct Supervision***.

4. *Oversight:*
   • This means the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

In order to ensure patient safety and quality patient care while providing the opportunity for maximizing the educational experience of the resident in the ambulatory setting, it is expected that an appropriately privileged attending physician will be available for supervision during clinic hours. Patients followed in more than one clinic will have an identifiable attending physician for each clinic. Attending physicians are responsible for ensuring the coordination of care that is provided to patients.

Outpatient supervision: The supervision/attending physician must require residents to present each outpatient's history, physical exam and proposed decisions. All required supervision must be documented in the medical record by the resident and/or the supervising/attending physician according to Medical Staff rules and regulations.

Emergency supervision: During emergencies, the resident should provide care for the patient and notify the supervising/attending physician as soon as possible to present the history, physical exam and planned decisions. All required supervision must be documented by the resident and/or the supervising/attending physician according to Medical Staff rules and regulations.

1. Clinical responsibilities must be conducted in a carefully supervised and graduate manner, tempered by progressive levels of independence to enhance clinical judgment and skills.

   1.2 This supervision must supply timely and appropriate feedback about performance, including constructive criticism about deficiencies, recognition of success, and specific suggestions for improvement.
   1.3 Resident supervision must support each program's written educational curriculum.
   1.4 Resident supervision should foster humanistic values by demonstrating a concern for each resident's well-being and professional development.
   1.5 Faculty and residents must be educated to recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects.
2. Residents are supervised by teaching staff in accordance with these established guidelines.
3. Faculty call schedules are structured to assure that support and supervision are readily available to residents on duty.

Completion of Evaluations

Policy 16

Resident

Upon completion of every rotation, the resident is responsible for submitting the following evaluations:

Rotation Evaluation
Faculty Evaluation
Self Evaluation
Resident Peer Evaluation (if applicable)

All evaluations are due no later than the **5th of the month** following the rotation (For instance, evaluations for Block 1 July 1-31, are due **August 5th**). Failure to complete all evaluations by the due date will result in an **incomplete status** for the specified rotation.

Faculty evaluations by residents are anonymous. Evaluations of faculty will be compiled and made available for the faculty to review at the end of the year.

The Annual Pediatric Resident Survey is anonymous and results will be compiled before review to assure anonymity.

Faculty

Evaluations of residents will be assigned to faculty by the fourth week of a rotation. A reminder to complete the evaluations will be sent out at the end of the rotation and again by the fifth of the following month to ensure timely completion.

Upon completion of every rotation the faculty is responsible for submitting assigned resident evaluation by the 5th of the month following the rotation.

The program director will be provided with a report by the 6th of the month that will list any faculty members that have not submitted assigned resident evaluations. The program director will personally contact each faculty and ask them to complete the pending evaluations.

Once the resident evaluation is completed by the faculty, an email will be sent to the resident stating the evaluation has been completed and is ready for them to review.

The resident will be advised to address any questions or concerns regarding the content of the evaluation directly with the evaluating faculty.

Resident Research and Scholarly Activity Requirement for Promotion/Graduation

Policy 17

This Policy establishes a requirement for research as a requirement for resident promotion/graduation.

The faculty Resident Research Review Committee determines a resident's eligibility for promotion based on this criterion.

1. Resident research review occurs in the month of January of their PGY-2 year.

2. Each PGY-2 resident must have at least ONE acceptable resident research project proposal or other scholarly activity proposal in order to qualify for promotion.

3. Residents who fail to complete this requirement will NOT be considered for promotion and may be placed on unpaid administrative leave pending completion of the requirement.

4. Resident advisors will be notified of the resident's deficiency. The resident advisor will monitor the resident's progress towards the completion of this requirement.

5. Each resident must have at least ONE acceptable resident research project or other scholarly activity completed in order to meet the requirement for graduation.

6. Acceptable resident research projects are:
    - Submitted poster/abstract to local, state, regional or national professional conferences
    - Submitted manuscript for peer review to a professional journal
    - Submitted "Letter to the Editor" to a peer-reviewed professional journal
    - Submitted research proposal to a federal or private grant agency (proof of submission required; IRB submission to Texas Tech required)
    - Poster presentation at a local, state, regional or national professional conference
    - Oral or workshop presentation at a local, state, regional or national conference
    - Scientific demonstration at a local, state, regional or national conference
    - Published Letter to the Editor in a peer-reviewed professional journal
    - Published Case Report in a peer-reviewed professional journal
    - Published research article in a peer-reviewed professional journal
    - Participation as "Investigator" or "Participating Physician" in IRB-approved project or funded grant (resident report on personal study accomplishment/contribution required)
    - Resident community project design and implementation (IRB submission to Texas Tech required; resident report on personal project accomplishment/contribution required)
    - Other projects or scholarly activities approved by the Resident Research Review Committee.

Supervision of Residents

Policy 18

While the Program Director and faculty assign to each resident the privilege of progressive responsibility, authority, and supervisory role in patient care based on specific criteria, the attending physician has the ultimate responsibility for all medical decisions regarding his/her patients including those made by senior residents, junior residents and medical students under their supervision. The attending physician may determine additional service specific levels of supervision and teaching required for each trainee based on the resident's level of training, experience and competence. Faculty is expected to devote sufficient time to fulfill their supervisory and teaching responsibilities. This includes supervision assignments of sufficient duration, both block and longitudinal assignments, to assess the knowledge and skills of each resident in order to delegate to him/her to appropriate level of patient care authority and responsibility.

Attending Physician Supervision

- Within the scope of the training program, all residents, without exception, will function under the supervision of attending physicians. A responsible attending physician must be immediately available to the resident in person, pager, or mobile phone and able to be present within a reasonable period of time (generally considered to be within 30 minutes of contact), if needed.
- It is expected that an appropriately privileged attending will be available for supervision during clinic hours. Patients followed in more than one clinic will have an identifiable attending physician for each clinic. Attending physicians are responsible for ensuring the coordination of care that is provided to patients.
- The attending physician is responsible for official consultations of each specialty team. When trainees are involved in consultation services, the attending physician will be responsible for supervision of these residents.

The role of the Attending:

- To have ultimate responsibility for all medical decisions regarding his/her patients
- To be responsible for providing supervision of all care provided by residents including the handoff process between resident care teams
- To develop a plan for the medical management of each patient in conjunction with the residents and consulting services
- To be responsible for the implementation of diagnostic and therapeutic plans as well as their documentation in the medical record.
    - Inpatient: The attending will document their involvement and agreement with the resident's plan with a note written within 24 hours of admission that demonstrates that the attending took a history and performed an exam needed for care and decision making in the case.
    - Outpatient: The attending will document their involvement and agreement with the resident's plan with a note at the time the patient is seen. The note should be in line with the Medicare Primary Care Clinic Exemption rules.
- To respond promptly and professionally to any question or concern from residents no matter what time of day or day of the week
- To encourage residents to seek guidance at any time the resident needs help in the care of patient.

- To be readily available to provide supervision and consultation at all times, or to have a clearly designated covering physician at any time for the level of supervision required by each resident at each training level on each clinical service
    - *For all inpatient services:* During daytime hours, supervising attendings are expected to be able to be physically present with residents and patients *(Direct Supervision)* as well as physically within the confines of the site of patient care and immediately available to provide direct supervision. *(Indirect Supervision with direct supervision immediately available)* After hours and on weekends, supervising attendings must be available for a telephone/pager consult at any time and able to come promptly to the hospital or clinic to provide on-site supervision and consultation to the resident.*(Indirect Supervision with direct supervision available)*
    - *For all outpatient services:* Supervising attending are expected to be readily available including physical presence at the site of patient care with either immediate availability to provide direct supervision (continuity clinics, same day sick/acute care clinic, specialty clinics) or immediately available via phone and available to provide direct supervision (specialty consults.)
- To communicate with the resident expectations for when to be contacted in the care of the patient. While communication with the attending should be frequent and ongoing, the timeliness of communication will vary with the severity and urgency of the patient. At minimum, significant changes, events or circumstances in the patient's condition must be communicated to the supervising attending.

Examples of significant changes requiring faculty involvement: admission, transfer to and from ICU, need for intubation or other ventilator support, DNR or other end of life decision, cardiac arrest, changes in hemodynamic status requiring intervention fluid or ion tropic support, neurological changes, medication errors requiring clinical intervention, clinical problem requiring an invasive procedure, care of medically complex patient, or any incident that compromises patient safety.

The role of the supervisory resident:

- To supervise the juniors, sub interns, and medical student in the care of patients both newly admitted and existing patients
- To develop a diagnostic and therapeutic plan for each patient under the supervision of the attending physician and to ensure that the plan is carried out
- To write a note at the time of each admission or when a patient' s condition changes that demonstrates the senior's involvement in the plan for the patient and that includes a history and exam findings that are needed for care and decision making in the case
- To manage the team as a whole and facilitate the interactions between the attending, team, consultants, nurses, and other members of the health care team
- To communicate clearly, effectively and promptly with the attending from admission through discharge
- To be available for any urgent or emergent situations that arise in the care of patients
- To be immediately available to actively participate in the treatment and management of patients cared for by junior residents
- To know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence for each individual clinical assignment

The role of the junior resident:

- The junior shall not accept responsibility for care of any patient until their supervising resident and attending have been notified and accept responsibility for the patient
- To keep the supervising resident immediately informed and in agreement with all management plans
- To know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence for each individual clinical assignment
- If a junior resident is not comfortable with the decisions of the supervising resident, the senior resident is not immediately available because of another patient care responsibility or if the junior has further questions, the junior will call the attending physician

Classification of Supervision

- Direct Supervision: the supervising physician is physically present with the resident and patient
- Indirect Supervision with Direct Supervision Immediately Available: the supervising physician is physically within the hospital or other site of patient care and is immediate available to provide Direct Supervision
- Indirect Supervision with Direct Supervision Available: the supervising physician is not physically present within the hospital or other site of patient care but is immediately available my means of telephonic and/or electronic modalities and is available to provide Direct Supervision
- Oversight: the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered

Levels of Supervision

- The training program is structured to encourage and permit residents to assume increasing levels of responsibility commensurate with their individual progress in experience, skill, knowledge and judgment.
- Residents are given progressive responsibility for the care of the patient. The determination of a resident's ability to provide care to patients without a supervisor present or to act in a teaching capacity will be based on documented evaluation of the resident's clinical experience, judgment, knowledge, and technical skills. The attending physician may decide which activities the resident will be allowed to perform within the context of the assigned levels of responsibility.
- To ensure that any resident is not left unsupervised (when attending physician is not present)
    - Third-year residents may supervise second-year residents and interns.
    - Second and third-year residents may supervise interns.
- In the event that any junior resident or intern requires supervision, the senior residents in their respective rotation must be available at all times by pager and/or ~~(~~mobile phone~~)~~ for immediate contact.
- The Chief Resident is responsible for assigning appropriate resident staffing of inpatient and outpatient services, and acts as liaison between residents and faculty.

To ensure oversight of resident supervision and graded authority and responsibility, the program uses the following classification of supervision defined by the ACGME:

2. ***Direct Supervision****:*
    • This means the supervising physician is physically present with the resident and patient.

2. Indirect Supervision A (with direct supervision immediately available):
    • This means the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide ***Direct Supervision***.

3. Indirect Supervision B (with direct supervision available):
    • This means the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide ***Direct Supervision***.

4. *Oversight:*
    • This means the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

PGY -1	
LEVEL OF SUPERVISION	**ACTIVITIES/PROCEDURES (as defined by RRC* and the Program)**
DIRECT	Procedures: All procedures Rotations: PGY-1 residents must be supervised either directly or indirectly with direct supervision immediately available on every clinical rotation or service. Supervision can be by a more senior resident.
INDIRECT (with direct supervision immediately available)	Procedures: Once signed off as competent, any of the above listed procedures. Rotations: PGY-1 residents must always be supervised either directly or indirectly with direct supervision immediately available. Supervision can be by a more senior resident. Continuity Clinic, Outpatient Subspecialty Clinics, ED, Inpatient Pediatrics, Term Nursery, NICU, Call Special Circumstances: admissions, care of complex patient, ICU/higher level of care transfer, DNR or other end of life decision
INDIRECT (with direct supervision available)	PGY-1 residents must always be supervised either directly or indirectly with direct supervision immediately available.

INTERMEDIATE LEVEL RESIDENTS	
LEVEL OF SUPERVISION	**ACTIVITIES/PROCEDURES (as defined by RRC* and the Program)**
DIRECT	Procedures: Any procedure not previously signed off as competent at the end of the PGY 1 year.
INDIRECT (with direct supervision immediately available)	Procedures: Umbilical catheterizations, intubations, LP Rotations: NICU; Inpatient; PICU; ER; Call; Specialties
INDIRECT (with direct supervision available)	Rotations: Inpatient call; Term Nursery; Specialties Special Circumstances: admissions, care of complex patient, ICU/higher level of care transfer, DNR or other end of life decision

RESIDENTS IN FINAL YEARS OF TRAINING	
LEVEL OF SUPERVISION	**ACTIVITIES/PROCEDURES (as defined by RRC* and the Program)**
DIRECT	Procedures: Any procedure not previously signed off as competent at the end of the PGY 1 year.
INDIRECT (with direct supervision immediately available)	Procedures: Umbilical catheterizations, neonatal intubations, conscious sedation Rotations: NICU; PICU; ER; Inpatient
INDIRECT (with direct supervision available)	Rotations: DE; PICU; Inpatient call; Floater; Specialties Special Circumstances: admissions, care of complex patient, ICU/higher level of care transfer, DNR or other end of life decision
OVERSIGHT (with direct supervision available)	Rotations: Teaching; Floater; Community

Pediatric Department
Residents' Procedure Grid

For all procedures direct or indirect supervision will need to be provided. Review and feedback must be given after the care has been delivered.

Attending faculty will be notified prior to procedures at all levels. If a procedure listed has a numerical designation, then that procedure must have been successfully completed for attestation of competency, after which indirect supervision will suffice.

Procedure Grid	Successful Attempts
Endotracheal Intubation	4
Umblical Artery Catheterization	3
Umblical Vein Catheterization	3
Lumbar Puncture	4
Arterial Blood Gases	
Percutaneous Arterial Line	
Percutaneous Intravenous Line	
Supra Pubic Tap	
Bladder catheterization	
Venepuncture	
Intraosseus placement Line	
Chest Tube	
Red Blood cell transfusion	
Cardiopulmonary Resuscitation	
Ventricular Tap	
Completion of PALS and NRP Courses	

- In all cases of procedures, the attending physician or a competent senior resident will provide direct supervision until competency for the procedure has been assured. After that, indirect supervision will be provided.

This grid does not preclude the performance of a procedure during an emergency. During an emergency, a procedure may be performed while the supervisor is on their way to the bedside.

Transition Policy

Policy 19

This policy establishes guidelines on the mechanism of transferring information, responsibility, and authority from one set of care givers to another. The following guidelines have been established to maximize patient safety and need to be used on every patient:

Goals of a sign-out:

- Accurate transfer of information about a patient's state and plan of care, from one set of providers to another.
- Caregivers should have a clear mental picture of the patients for whom they are assuming care, know the current status and plan of care.
- Also should have a sense of what problems and issues may arise during the next shift.

Protocol for sign-out:

3. Transfer needs to be face-to-face and must include the whole team.
4. Patient priority of transfer will start from the sickest patient to the least.
5. Communication must be clear for facilitating questions, clarification and collaborative cross checking.
6. Start and finish times must be well defined.
7. Sign-out must take place in a quiet and secure location.
8. There must be no interruptions or distractions during the sign-out period of time.
9. The roles and responsibilities of all participants should be clear.
10. The focus should be on patient safety.
11. Communication should be effective (I-PASS model should be used.)
12. The emphasis should be on abstraction, synthesis and summation of information.
13. All participants should be physically present the entire time.
14. Uncompleted tasks should be completed after sign out has finished.
15. Nursing staff and Faculty should be instructed not to page/call Residents at this time except for emergencies.
16. Interns should give sign-out with Senior Residents listening and/or clarifying.
17. Medical students should primarily listen.

18. Off-task activities should be minimized.

19. Only essential information should be exchanged verbally. (Other info. Can be written on a sign out sheet.)

20. Only those things crucial to the child's care should be discussed.

21. Unnecessary replication of large amounts of information either verbally or on paper that already exists in patient's chart should be avoided.

The following are the specific times that must be protected for adequate and effective sign in/sign out and transition of care:

El Paso Children's Hospital (EPCH) Floor

- 7:00a.m. to 7:30 a.m. all days
- 4:30p.m. to 5:00 p.m. weekdays
- 8:00p.m. to 8:30 p.m. all days (night shift)

Nursery

- 7:00a.m. to 7:30 a.m. all days
- 6:30p.m. to 7:00 p.m. all days
- 10:30 p.m. to 11:00 p.m. all days

Providence Floor

- 7:00a.m. to 7:30 a.m. all days
- 5:30p.m. to 6 p.m. all days

This time should be free of interruptions including phone calls that are not of an emergent nature.

ACGME Policy on Transitions of Care

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

- Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.

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

- The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care.

Policy on Mandatory Communication with Faculty

Policy 20

This Policy sets guidelines for which circumstances and events a Resident must communicate with the appropriate Supervising Faculty regardless of the level of training.

Special circumstances mandating communication with Faculty are:

1 – Transfer of patient to Intensive care units.

2 – End of life decisions.

3 – DNR.

4 – Care of complex patients.

5 – Patients requiring a higher level of care.

6 – Respiratory/Cardiac Arrest

7 – Activation of Rapid Response Team

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER
Paul L. Foster School of Medicine
GRADUATE MEDICAL EDUCATION
Standard Policy and/or Procedure

TITLE: Adverse Action Appeals Policy
PURPOSE: To provide a formal means by which trainees may request an appeal for an adverse action of **non-promotion**, **probation** or **dismissal** from training.

PROCEDURE STATEMENT: Over the course of training in graduate medical education, a trainee is expected to acquire progressive and increasing competence in the knowledge, skills and attitudes of the specialty in which he/she is training. An adverse action may be taken as a consequence of a deficiency being identified.
The following procedure outlines the appeals process for trainees when an adverse action, as qualified in the purpose statement, takes place. There will only be a **single appeal request** allowed per each adverse action taken.
Appeals Process:
1. Within two (2) working days after a decision is made to take an adverse action regarding a trainee, the Program Director should inform the affected individual **in person**. The Program Director should also inform the trainee of the right to appeal within the time frame specified in #3 below.

2. Within one (1) working day of formal notification to the resident, the program director should notify the DIO in writing of the adverse action taken.

3. After receiving notification of an adverse action, the trainee will have five (5) working days from the date of notification to request a review of the adverse action by submitting a written request for appeal to the Designated Institutional Official (DIO).

4. In the event the trainee elects not to appeal the adverse action or the trainee fails to make the request for appeal within the prescribed five (5) working days, the trainee will be deemed to have waived the option to appeal the adverse action.

5. Upon receipt of an appeal for adverse action, the DIO will request supporting documentation from the program director and organize an Appeals Review Committee within three (3) working days.

6. The DIO will request the committee to hold a review meeting and generate a report within seven (7) working days of the date the appeal was received by the committee

The committee will be comprised of two faculty members of the Graduate Medical Education Committee and the president or designated representative of the House Staff Association. These members shall not be from the same department as the trainee. The DIO will serve as an ex-officio member. The committee will assign a chair for purposes of providing a Summary Report with recommendations and/or action plan.

8. The Chair of the Appeals Review Committee will send a formal notification to the trainee and the Program Director of the scheduled meeting (date, time and location).

9. Both the trainee and the Program Director shall have the right to address the Appeals Review Committee and may introduce evidence considered to be relevant and material to the case. All evidence offered must be reasonably related to the facts and statements concerning the reasons for the adverse action.

10. All documentation and discussions shall be deemed confidential.

11. **Excluding Probation Appeals**, legal counsel for either party may attend the appeals meeting and serve in an advisory capacity, but will not be allowed to actively participate in the hearing. If legal counsel is to attend the hearing, appropriate notification, with a minimum of 24 hours, should be made to the chair of the committee.

12. The committee's responsibility is to uphold, modify, or overturn the decision made by the program director. In addition, a specific action plan may be made by the committee as appropriate.

13. The Appeals Review Committee's Report will be provided to the DIO within the seven (7) working days as delineated in #6 above.

14. The DIO will communicate all report findings to the program director.

15. If the recommendation for **non-promotion or probation** is upheld by the committee, then the program director has the ultimate decision-making authority.

16. If the recommendation by the Appeals Review Committee is to overturn the **non-promotion or probation**, the committee should provide a specific action plan to be followed by the program director. Progress of the action plan should be reported by the program director to the DIO until the matter is resolved.

17. Recommendations for **dismissals** will be reported to the Dean of the School. If a recommendation for dismissal is upheld, the Dean of the School shall review the recommendation of the committee **and** make a decision which will be communicated in writing to the trainee, Program Director, and DIO within five (5) working days.

18. Notification of any decision will be communicated to the trainee via hand delivery with signature acknowledgment or by certified mail/return receipt requested.

19. A final determination by the Dean of the School of Medicine to **uphold a dismissal** action shall conclude the due process.