UNIVERSITY OF IOWA HOSPITALS AND CLINICS

POLICY
FOR
EMERGENCY MEDICINE PHYSICIAN ASSISTANT RESIDENT SUPERVISION AND DUTY HOURS

Emergency Medicine ensures that it provides appropriate supervision for all residents, as well as a duty hour schedule and a work environment that optimizes quality patient care, fortifies the educational trajectory of house staff members, and address all applicable program requirements. On-call duties are necessary components of the UIHC clinical care systems and educational programs; these duties are managed to ensure adequate periods of rest with appropriate levels of supervision to deliver safe, effective patient care. (The terms "resident" or "house staff member" used in this policy shall refer to resident and fellow physicians and dentists at all house staff levels.)

DUTY HOURS

The program monitors duty hours logged in the appropriate documents stored on the residency programs Google Drive. All residents adhere to duty hour requirements and any educational experience found to be interfering with this requirements will be modified or eliminated.

Specific duty hour requirements are as follows:

1. **MAXIMUM HOURS OF WORK PER WEEK**:
   - The duty hours of any resident must be limited to 80 hours per week when averaged over a 4-week period, inclusive of all in-house call activities and any moonlighting activities. Any time spent in UIHC or at another institution for clinical and academic purposes, related to the residency or fellowship program, both inpatient and outpatient, shall count toward the weekly maximum. Additionally, the weekly maximum shall include time spent for administrative duties related to patient care, the transfer of patient care, scheduled academic activities such as conferences, research related to the program, and any time the resident spends on-site after being called to the hospital. Not included in the weekly maximum is time spent outside of UIHC (or outside another institution related to the program's academic purposes) for academic preparation, reading, and studying.
   - Emergency Medicine Residents should not work more than 60 scheduled hours per week when on an Emergency Medicine rotation, and no more than 80 duty hours per week total. Duty hours comprise all work time and conferences.

2. **MAXIMUM DUTY PERIOD LENGTH:**
   - For non- ED rotations, the schedule shall not exceed a maximum of 24 hours of continuous duty in the hospital, with no more than 4 additional hours used for any transitional activities (i.e. maintaining continuity of medical and surgical care, transferring patient care, or attending educational sessions).
   - For non-ED rotations, no new patients should be accepted during the 4 hour extension period.
   - In unusual circumstances, a resident may remain beyond their scheduled period of duty to continue to provide care to a <u>single patient</u>. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring or humanistic attention to the needs of a patient or family.

Residents must appropriately hand over the care of all other patients to the team responsible for their continuing care.

- Any resident exceeding maximum duty period lengths will document their justification on the duty hours recording document.
- All clinical staff, including residents and faculty, personally sign out their active patients in the ED to the oncoming team. In addition, they will document the time and details of this handoff in the ED clinical note.

3. **MAXIMUM FREQUENCY OF OVER-NIGHT IN-HOUSE ON-CALL DUTIES:** In-house call must not be scheduled more frequently than every third night when averaged over a 4-week period.

4. **MAXIMUM FREQUENCY OF IN-HOUSE NIGHT FLOAT:** Residents must not be scheduled for more than six consecutive nights of night float or as specified further by the program's RRC, as applicable.

5. **MANDATORY TIME FREE OF DUTY**: Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks) in general.

    - **Emergency Medicine Residents** must have one day free of duty, including moonlighting, in seven while working in the Emergency Department (NOT averaged over a four week period). This day off shall not include home call nor shall the resident be required to carry a pager. A day is defined as 24 consecutive hours.

6. **MINIMUM TIME OFF BETWEEN SCHEDULED DUTY PERIODS**: Based on the level of the resident, there are identified levels of time off between scheduled duty periods.
    - There must be at least an equivalent period of continuous time off between scheduled work periods for Emergency Medicine Residents (when on Emergency Medicine rotations and when actively caring for patients in the Emergency Department).
    - The Program Director monitors time off between scheduled duty periods.

7. **HOME CALL / JEOPARDY**: Residents returning to the hospital for jeopardy must count their time spent in the hospital towards the 80-hour maximum weekly hour limit. The frequency of home call / jeopardy is not subject to the every-third-night limitation but must satisfy the requirement for 1 day in 7 free of duty, when averaged over 4 weeks.
    - Home call activities must not be so frequent as to preclude rest and reasonable personal time for each resident.
    - Residents are permitted to return to the hospital while on home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period."

8. **MOONLIGHTING:** Moonlighting is governed by the *Moonlighting Policy.* All requirements of that policy must also be followed, including visa and license requirements. Moonlighting is allowed with prior approval of the Program Director. It should be noted:
    - Moonlighting is never required and must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
    - The resident must obtain permission of his/her Program Director prior to the beginning of such activities.
    - Time spent by residents in internal and external moonlighting must be counted toward the 80-hour maximum weekly hour limit or 60 hours while on an ED rotation. Failure to completely

document all time in moonlighting activities will result in suspension of the moonlighting privilege.

SUPERVISION

Curriculum:

- This Program has established a curriculum that delineates the resident's responsibilities for patient care, provides progressive responsibility for patient management, and offers supervision of each resident throughout the duration of the program
- This written curriculum is contained within the resident manual. The resident manual is distributed to all residents at the beginning of the academic year in electronic format which all residents are responsible for reviewing.

Distribution of Program Policy:

- Given to each resident by the Program at the outset of each training year
- This policy is always available in the electronic resident manual distributed to residents at the beginning of the academic year
- Applicable at all sites where the residents rotate, and each site must provide adequate supervision and engage residents and fellows in standardized transitions of care consistent with the setting and type of patient care.

Supervisors:

- Responsible practitioner - Each patient must have an identifiable, appropriately-credentialed and privileged physician (or licensed independent practitioner) who is ultimately responsible for each patient's care; in every setting, the care of patients is supervised by faculty to the appropriate level of supervision.
- Resident's access to identified supervisor: Emergency Medicine Physician Assistant Residents are either directly supervised or indirectly supervised with direct supervision immediately available at all times while working in the Emergency Department (ED). While in the Emergency Department, supervising providers are available via overhead announcement or via the Voalte One™ communication system. Supervision in other clinical areas is per the individual department.
- Role clarification in patient care: Each resident and faculty member must inform every patient of their respective roles in each patient's care.
- Guidelines for residents to communicate with supervisors: While working clinically in the ED, Emergency Medicine Physician Assistant Residents are required to discuss/communicate with supervising physicians after each patient encounter. This communication must occur before any patient dispositions are determined or invasive procedures performed.
  Following patient evaluation, residents are required to discuss the patient with their supervising physician to confirm final disposition (admission versus discharge). Transitions of care (shift change) between residents are directly supervised by the supervising physician on duty in the ED. Communication in other clinical areas is per the individual department.
    - Inpatient: Inpatient duties for Emergency Medicine Residents are per the individual department through which they are rotating.

    - Outpatient: Faculty members from The Department of Emergency Medicine are assigned to the Emergency Department on a daily basis. Patients in the Emergency Department are evaluated initially by the residents and then staffed by the faculty.
- Rotations: Each rotation, on- or off-site, has direct supervision available. For external rotations, an agreement with that site specifies the supervising physician.
- On-call schedules: These schedules are available to residents. Schedules are electronically distributed at the beginning of each month. Hard copies are also posted in the Emergency Department. These call schedules ensure that appropriate supervision is readily available to those on duty.

Levels of Supervision: The program ensures that residents assume progressively increasing responsibility according to each resident's level of education, ability and experience. The appropriate level is determined by the teaching staff, as approved by the Program Director, and accorded to each resident at the appropriate level of responsibility. Faculty supervision assignments are of sufficient duration to assess the knowledge and skills of each resident so that the supervising faculty can appropriately delegate to each resident the authority and responsibility for portions of care based on the needs of the patient and the skills of the residents. These supervision standards encompass the concepts of graded authority, responsibility and conditional independence that are the foundation of delegation of authority to more senior house staff members.

The program uses the following classifications of supervision to assign the privilege of progressive authority and responsibility, conditional independence and a supervisory role in patient care to each resident, as appropriate:

- Direct Supervision – The supervising faculty is physically present with the resident and patient.
- Indirect Supervision
    - With direct supervision immediately available – The supervising faculty is physically present within the hospital or other site of patient care, and is immediately available to provide direct supervision.
    - With direct supervision available – The supervising faculty is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide direct supervision.
- Oversight – The supervising faculty is available to provide review of patient encounters with feedback provided after care is delivered.

Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow, based on the needs of the patient and the skills of the particular resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care.

Professionalism Expectations: It is expected that each resident must know the limits of his/her scope of authority and the circumstances under which he/she is permitted to act with conditional independence. The Program Director clarifies these limits during initial program orientation, then again on a regular basis throughout their training as part of the semi-annual evaluation process.

Evaluations: Evaluations are performed by the Program Director (or faculty members, as appropriate) and assess each resident's abilities based on specific criteria.

- These criteria are: The Emergency Medicine Milestones – The EM Milestones are a matrix of the knowledge, skills, abilities, attitudes, and experiences that should be acquired during specialty training in Emergency Medicine. The Milestones Project was a Joint Initiative of the Accreditation Council for Graduate Medical Education and the American Board of Emergency Medicine. The Milestones were designed by representatives of multiple national Emergency Medicine organizations.
- Evaluations must include summative evaluations as follows:

- Summative evaluations must assess whether the resident has demonstrated sufficient competence to enter practice. Based on the concepts of graded and progressive responsibility, supervision must assure the provision of safe and effective care to the individual patient, assure each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine, and establish a foundation for continued professional growth.

Protection from Retaliation: Concerns of inadequate supervision may be reported to the Program Director, Program Coordinator, any faculty member, or the Compliance HELPLINE at 384-8190. All calls are confidential and may be made anonymously, as chosen by the caller. The UIHC protects all