GOALS AND PRINCIPLES OF RESIDENCY

EVALUATIONS
Residents will be evaluated at the end of each rotation by faculty and nurses and periodically by patients. All residents will be asked to anonymously evaluate the program annually. Each year residents will evaluate the services they rotated on for a cumulative service evaluation to evaluate the educational value of each service. Chief residents are additionally asked to evaluate the program in writing anonymously prior to their departure. Residents will be asked to anonymously evaluate each attending, chief resident and the service in general at the end of each rotation.

All evaluations are designed around the six core competencies as outlined by the Accreditation Council of Graduate Medical Education (ACGME) below:

PGY-1 Core competencies

A. Medical Knowledge.
1. Learn in-depth the fundamentals of basic science as they apply to the clinical practice of Medicine.
   a. The resident must prepare for and attend the daily didactics structures. The resident should read all assigned texts and documents.
   b. The resident should prepare for and participate in monthly Selected Readings in Medicine conferences by reading assigned material and answering questions during discussion. The resident will participate in yearly assessment of medical knowledge.
   c. The resident should participate in scheduled delivery and presentation of lectures from the curriculum as assigned by chief residents.
2. Develop technical skills appropriate to level of training.
   The resident will attend simulation skills training sessions on scheduled times and periodically. The resident will demonstrate proficiency in basic skills.

B. Patient Care.
1. The resident should assume care of all patients on the hospital ward and be responsible for admission/discharge of all patients on the hospital wards and day care units. The resident should assume care of all patients on the hospital wards and intensive care units.
2. The resident should perform a complete and accurate history and physical examination on every new admission to the service within 24h.
3. The resident should perform all invasive procedures on ward and ICU patients, with appropriate supervision from faculty or a senior resident.
4. The resident should arrange for appropriate diagnostic and imaging tests on ward patients.
5. The resident should insure proper disposition and follow-up of all patients discharged from the hospital.

C. Interpersonal and Communication Skills.
1. The resident should be able to clearly, accurately, and succinctly present patient information to faculty and senior residents regarding newly admitted patients.
2. The resident should keep the senior resident and faculty aware of all progress of all patients and will alert the senior resident and faculty of new problems on the service.
3. The resident should clearly, accurately, and respectfully communicate with nurses and other hospital employees.

4. The resident should clearly, accurately, and respectfully communicate with referring and consulting physicians, including residents.

5. The resident should clearly, accurately, and respectfully communicate with patients and appropriate members of their families about identified disease processes (including complications), the expected courses, operative findings and operative procedures.

6. The resident should maintain clear, concise, accurate and timely medical records including (but not limited to) admission history and physical examination notes, consultation notes, progress notes, written and verbal orders, operative notes, and discharge summaries.

7. The resident should be able to clearly and accurately teach medical students about the procedures performed on this rotation when qualified and credentialed to do so by hospital and program policy.

8. The resident will ensure that all student ward notes are accurate, reflect a proper plan, and are countersigned by a physician each day.

D. Practice-Based Learning and Improvement

1. The resident will write an accurate, detailed and legible admission and preoperative assessment note on all patients.

2. The resident must enter all procedures and operative cases in which he/she is the physician of record.

3. The resident must document or dictate an accurate and descriptive narration of any operative procedure (medical or surgical) in which he/she is the primary operator within 24 hours of the procedure.

4. The resident must be prepared to participate in discussions at morbidity and mortality conferences for cases in which they were involved with critical portions of the care.

E. Systems-Based Practice

1. The resident should be able to appropriately utilize, in a timely and cost efficient manner, ancillary services including social services, discharge planning, physical therapy, nutrition services and pharmacy.

2. The resident should be able to justify all diagnostic tests (including laboratory studies) ordered and document when needed.

F. Professionalism

1. The resident must be honest with all individuals at all times in conveying patient care issues.

2. The resident should place the needs of the patient above all the needs or desires of him/herself.

3. The resident should maintain high ethical behavior in all professional activities.

4. The resident should remain compliant with all required training.

5. The resident must demonstrate a commitment to the continuity of patient care through carrying out professional responsibilities or through assuring that those responsibilities are fully and accurately conveyed to others acting in his/her stead (e.g. checkout procedures).

6. The resident must understand the institutional policy on duty hours and remain compliant with all duty hour regulations.

7. The resident should be professionally attired at all times while engaged in patient care.
8. The resident should be professionally groomed at all times when engaged in patient care.
9. The resident should demonstrate sensitivity to issues of age, race, gender and religion with patients, families, and members of the health care team.
10. The resident should at all times treat patients, families, and all members of the health care team with respect.
11. The resident should reliably be present in pre-arranged places at prearranged times except when actively engaged in the treatment of a medical or surgical emergency. The resident must notify the appropriate supervisor if he or she will be unable to be present.
12. The resident must attend the following mandatory conferences.
   - Departmental Grand Rounds
   - Multidisciplinary Grand Rounds
   - Selected subspecialty conferences according to elective or selective rotations
   - Multi-Department Morbidity
   - Morbidity and Mortality Rounds
   - Selected Readings Conference

EVALUATIONS OF RESIDENTS
Written evaluations are solicited from faculty members, nurses, OR nurses, and peers, at the conclusion of each resident rotation. Residents will be evaluated throughout the year based on the following parameters:

- Record review
- Chart stimulated recall
- Global ratings
- Standardized patients
- OSCEs
- 360˚ Assessment
- Evaluation by faculty, residents, nurses and patients
- Exams (MCQs)
- Case logs

If an evaluation of a resident indicate a below average rating, the resident's performance will be discussed by the Departmental Education Committee and a copy of that evaluation is forwarded to the Program Director and to the GME office. Upon review of the evaluation, the Program Director may request additional documentation or provide this documentation at the next Committee meeting and the resident’s performance will be discussed. The Departmental Education Committee may recommend the following:

1) The resident will be carefully monitored in the upcoming months due to recent evaluations. This discussion will be documented in the minutes of the meeting.
2) Review of the resident by the Academic Review Sub-Committee (GME).

Faculty evaluations of residents:
Residents will be evaluated by the faculty/preceptor at the end of each rotation. Evaluations will be reviewed periodically, usually bimonthly, by the faculty and Program Director. Faculty evaluations and results from written examinations will be utilized in determining the progress of the resident. The Program Director will meet with the resident at least quarterly to review performance. Any necessary remediation or counseling will be determined by the Program Director and when indicated, individuals may be placed on probation or suspended. Evaluations will be kept on file in the resident’s personnel file and will be accessible to the resident through the Graduate Medical Education office.
Resident Self Evaluation
Residents will complete a self-evaluation annually which will be discussed with their mentor. At the meeting to discuss the self-evaluation a performance plan will be implemented. Each year your mentor will discuss your improvements, strengths and weaknesses.

Other Evaluations of Residents:
Residents will be evaluated by means of a 360-degree approach which will include evaluations by peers (senior residents), nurses, and patients. The results of these evaluations will also be discussed with the resident during quarterly meetings with the advisor and the Program director.

Resident Evaluation of Faculty Teaching:
Residents will turn in written anonymous evaluations of the program, rotations, and faculty on an on-going basis. The results of these evaluations will be reviewed by the Program Director and appropriate feedback will be given to individual faculty members. The information will also be used by the Core Curriculum Committee to revise and alter the educational content of the program and its rotations. A copy of all these evaluations shall be forwarded to the GME office.

Annual Program Evaluation by Resident
Each year all residents will complete an anonymous evaluation of the program identifying strengths and weaknesses. This evaluation will be used to improve the educational components of the residency program.

Confidentiality Process:
All evaluations, counseling and probationary actions involving a resident will be kept in a confidential manner in the respective departmental office and in the GME office. Under no circumstances will such actions be discussed in a public forum. Additionally, all evaluations of faculty by residents will be treated as confidential by the Program Director.

Residency Program Assessment Policies and Procedures: The Program Director is responsible for monitoring the clinical and technical competence and professionalism of residents in the program. The Program Director will work in conjunction with the Departmental Education Committee and the Graduate Medical Education (GME) to provide educational oversight for residents and medical students.
Evaluations of residents will be completed by the teaching faculty addressing each of the six core competencies. Any evaluation that indicates below average or questionable behavior will be brought to the attention of the Program Director for close monitoring and/or discussion at the next committee meeting. The Program Director has the responsibility for recommending promotion and certification based on faculty, nursing, peer, student, and patient evaluations. The Program Director is responsible for initial counseling of residents regarding any remedial or adverse action which may be needed. Residents will be evaluated on individual specialty requirements, program requirements, and compliance with policies at LAU-UMCRH and its affiliated facilities, and other sites where residents may rotate. The Departmental Education Committee has the responsibility of oversight to ensure that these requirements are met. It is the responsibility of this committee to review,
with the Program Director, any resident’s clinical, technical or professional performance which has been rated unsatisfactory. Should the committee feel that action is warranted, they may refer the matter to the GME for their review. It is the primary responsibility of the GME to review the performance of any resident who has been referred by the Departmental Education Committee and to make recommendations to the Program Director with regard to what specific action/s they deem appropriate. Where circumstances necessitate, the membership of the Departmental Education Committee and/or the GME may be altered to avoid a potential conflict of interest, or to protect the privacy of the resident.

Any of the following will be considered cause for dismissal and/or disciplinary action.

- Failure to be present during duty hours or when on call.
- Intoxication or being under the influence of alcohol or substances of abuse while on duty or on call.
- Conviction of a felony or violation of the law.
- Falsification of medical records.
- Repeated violation of Department rules after counseling.
- Repeated patient neglect resulting in injury or harm to the patient.
- Performance of invasive procedures without appropriate authorization, except indefinite life-threatening situations.
- Failure to maintain academic standards and educational requirements of the Department.
- Falsification of data on the application.
- Performing operating room procedures without proper attending supervision.
- Failure to give emergency help to all patients at all times throughout the hospital, regardless of whether or not that patient is on the service.
- Recommendation by faculty evaluation process.
- Repeated failure to answer pages during assigned duty hours.
- Repeated delinquent administrative responsibilities. (Medical Records, Duty Hours, etc.)

All documents and minutes of meetings will be forwarded to the Graduate Medical Education office for review and filing.

**RESIDENT ADVISING AND MENTORING**

Each resident will be asked to select a mentor for the duration of their training. Residents are to notify the Graduate Medical Education office by October 1st whom they have selected to be their mentor. Residents are required to meet with their mentor at least twice annually or as often as needed to review their progress and discuss strengths and weaknesses. The mentor will complete an evaluation after review of your file and discussions with the resident. These evaluations will suffice as a semiannual review to assess your progress in the program. Residents must notify the program coordinator of meetings they have scheduled with their mentors so the coordinator can make the file and evaluations available at the time of the meeting. Should remediation be necessary the mentor plays a key role in developing a plan for the resident whereby improvement can be assessed and measured. Mentors also help residents prepare for presentations for local, national, regional and/or international meetings.
Graduate Medical Education

It is the residents' responsibility to set up meetings with their mentor throughout the year. It is anticipated that our residents will demonstrate professionalism by assuming responsibility in coordinating these meetings with the assistance of the residency coordinator.

The mentor/advisor shall:

- Meet on a regularly scheduled basis with each resident, at least once every quarter to offer professional mentorship.
- Advise and assist the resident in the definition and resolution of interpersonal and system problems that may arise.
- Assist the resident in identifying and evaluating strengths and weaknesses in his/her clinical abilities and training on an ongoing basis.
- Oversee and guide the resident's overall educational and professional progress.
- Follow up with the resident on suggestions and recommendations and document any actions taken.

EXPECTATIONS OF RESIDENTS

It is expected that all residents:

- Answer pages promptly
- Respond courteously and appropriately to hospital staff and consulting physicians/house staff
- Complete consults to the ER within one hour
- Arrive to the clinics on time
- Attend all mandatory conferences (see conference section)
- Complete administrative responsibilities in timely fashion
- Document procedure notes or dictate operative reports immediately after the procedure is completed. Discharge summaries should be dictated or written at the time of or prior to patient discharge from the hospital. Discharge summaries should be concise and accurate, including all relevant information only.
- Take responsibility for, and be actively involved in, their own education. Every day, it is your responsibility to ensure that you are prepared to optimize your learning for that day. Patients must be seen and evaluated by the resident (and intern if possible) as soon as possible after admission and on a daily basis. This should be clearly documented by a daily progress note. This is critical to maintaining continuity of care and a sound educational process.
- It is expected that all residents caring for a patient:
  - Read about the case and understand the differential diagnoses, therapeutic indications and prognosis
  - Have a basic knowledge of possible complications for all therapeutic approaches.
  - Discuss with the attending faculty any questions they may have.

Residents should make their best attempt to meet this same standard for urgent and emergency cases for the good of their patients as well as their own education. It is also expected that residents read about the co-morbid conditions of those on their inpatient service.
STANDARDS OF PROFESSIONAL BEHAVIOR

These standards describe behaviors expected from all members of the School of Medicine (SOM) community, in educational, clinical, research and administrative settings. Professionalism is expected during all interactions, whether face-to-face or via telephone, video, email, or social networking technologies.

Members of the SOM Community will:

- Recognize their positions as role models for others in all settings.
- Carry out academic, clinical and research responsibilities in a conscientious manner, make every effort to exceed expectations and make a commitment to life-long learning.
- Treat everyone in the SOM community with sensitivity to diversity in culture, age, gender, disability, social and economic status, sexual orientation, and other personal characteristics without discrimination, bias or harassment.
- Maintain patient, research subject, and student confidentiality.
- Be respectful of the privacy of all members of the SOM community and avoid promoting gossip and rumor.
- Interact with all other members of the SOM community in a helpful and supportive fashion without arrogance and with respect and recognition of the roles played by each individual.
- Provide help or seek assistance for any member of the SOM community who is recognized as impaired in his/her ability to perform his/her professional obligations.
- Be mindful of the limits of one’s knowledge and abilities and seek help from others whenever appropriate.
- Abide by accepted ethical standards in scholarship, research and standards of patient care.

ON-CALL ACTIVITIES
The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal work day when residents are required to be immediately available in the assigned institution.

- a. In-house call must occur no more frequently than every third night, averaged over a four-week period.
- b. Continuous on-site duty, including in-house call, must not exceed 36 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.
- c. No new patients, as defined in Specialty and Subspecialty Program Requirements, may be accepted after 36 hours of continuous duty.
- d. All call schedules are generated by the Chief Resident.
- e. All changes in the call schedule at any hospital must be authorized by the chief resident and the service attending and the Program Director.
- f. Senior Residents must be readily available at all times for consultation and patient care at night and throughout the year.

SIGN-OUTS:
Sign out round consists of transmitting information about patients to the residents on call. They are to be conducted:

- At the time of transferring a patient from one ward/department/service to another
Effective communication is central to patient safety. There is abundant evidence of negative consequences of poor communication and inadequate handoffs. The purpose of the current study was to conduct a systematic review of articles focused on physicians’ handoffs, conduct a qualitative review of barriers and strategies, and identify features of structured handoffs that have been effective.

Five attributes of certain sign-outs contributed to problems, and present opportunities for practical interventions to improve teaching and practice:

1. Sign-outs truncated or omitted due to work demands or time constraints resulting from duty hour limits, with documentation replacing all or some of the interactive exchange.
2. Diagnostic and care activities unfinished at the end of the outgoing’s shift and carried through a shift-change, which put them a higher risk of being “dropped.”
3. Sign-outs participants perceived as challenging because residents may not know or trust each other, with lack of confidence in the outgoing physician’s judgment a critical factor
4. Sign-outs under cross-coverage, due to larger patient loads, lower familiarity with patients and an expectation of less information needing to be shared.
5. Coordination problems and lack of a sense of who was responsible for patients, both among the residents and on the part of other professionals.

STRUCTURE OF SIGNOUTS:
1. Sick or DNR
2. Identifying data
3. General hospital course
4. New events (of the day/12-24 hours) update the clinical data
5. Overall health status/clinical conditions/co-morbidities
6. Upcoming possibilities/ possible problems/contingency plans/rationale
7. Tasks – Pending tests, anticipate results, Plan/Rationale
8. ?s

ELEMENTS OF AN EFFECTIVE FACE TO FACE SIGN-OUT:

Checklist for Elements of a Safe and Effective Written Sign-out—ANTICipate

Administrative data
- Patient name, age, sex
- Medical record number
- Room number
- Admission date
- Primary inpatient medical team, primary care physician
- Family contact information

New information (clinical update)
- Chief complaint, brief HPI, and diagnosis (or differential diagnosis)
- Updated list of medications with doses, updated allergies
- Updated, brief assessment by system/problem, with dates
- Current “baseline” status (eg, mental status, cardiopulmonary, vital signs, especially if abnormal but stable)
Recent procedures and significant events

**Tasks** (what needs to be done)

Specific, using if-then statements
- Prepare cross-coverage (e.g., patient consent for blood transfusion)
- Alert to incoming information (e.g., study results, consultant recommendations), and what action, if any, needs to be taken during the cross-coverage

**Illness**

Is the patient sick?

**Contingency planning/Code status**

What may go wrong and what to do about it
- What has or has not worked before (e.g., responds to 40 mg IV furosemide)
- Difficult family or psychosocial situations
- Code status, especially recent changes or family discussions

**PHARMACEUTICAL AND INDUSTRY RELATION POLICY**

The GME acknowledges that a responsible and productive alliance between residency training programs and the pharmaceutical industry can be beneficial to the goals of graduate medical education. However, there is increasing awareness of the potential for ethically unsound relationships leading to conflict of interest and negative perceptions by the public. Therefore, the GME established the following policy to guide relations between the residency programs at our institution and the pharmaceutical industry:

- All marketing activities by pharmaceutical companies and their representatives must be approved by the residency program director and the GME office.
- Marketing activities are prohibited in all clinical areas.
- A faculty member will review and/or be present during all presentations given to residents by pharmaceutical companies and their representatives.
- Residents may not receive for personal benefit “incentives” to enroll patients in pharmaceutical company sponsored trials. All relationships concerning the acquisition of patients for drug trials shall occur as contractual agreements between institutions.
LEAVE POLICIES
The resident is responsible for notifying the program of any type of leave. In some instances the LAU-GME office requires that a Leave Request Form be completed. Residents must complete a leave form and submit it to the Program Director prior to any type of leave taken. These forms will be available in the GME office.

Any leave taken without prior approval by the program director will be counted as unexcused absence and is subject to disciplinary action. You will be expected to make up the time at the end of that training year.

Absence from Clinical Duties: All activities that will require absence from clinical duties including vacations, meeting/course presentations and attendance, taking USMLE or other standardized tests, require that residents get approval from the Program Director prior to scheduling activity. Other resident absences such as vacations may take priority. Not getting prior approval for absence from clinical duties may result in your not being able to take.

Unexcused Absence: If a resident does not show up for assigned hours, including night call, without notifying the Chief Resident or Program Director, the absence will be considered unexcused. Unexcused time will be taken as leave from the resident’s leave entitlement. If the unexcused absence is repeated, disciplinary action may be taken by the Program Director depending upon the severity and frequency of the infraction. Arrangements for “payback” to other residents who may be assigned to cover night call or assigned hours will be made at the discretion of the Program Director.

Vacation Leave: PGY-1 are given one month of vacation. Once vacation times have been approved by the Program Director and the Administrative Chief Resident notification of approved leave must be sent in writing.

Vacation Leave requests for the Academic Year may be submitted in advance. Vacation blocks will be spread evenly throughout the year and evenly across all rotations. Requests submitted by the due date will be granted according to seniority. Remaining vacation blocks will be granted on a first come, first serve basis with consideration to service coverage and by rotation call schedule. At a minimum, vacation requests must be submitted by August 1. We encourage Residents to plan ahead and spread vacations throughout the year so as not to lose allowed days. For compliance of the Duty Hour Restrictions as outlined by the ACGME, our program will maintain a minimum of one-in-four call for all residents. These criteria may result in leave request denials. Any exception to this policy will be reviewed on an individual basis. If you decide to change your vacation dates it will be your responsibility to secure an approval in writing from both the director of the surgery program as well as from the specialty coordinator for the rotation you will have to reschedule. No exceptions will be made.

FML - Maternity Leave Policy
It is the resident’s responsibility to notify the program director (in confidence) of her pregnant status as soon as it is known so that coverage issues can be mapped out well in advance. In most instances the resident should schedule her vacation around the time of delivery. The affected parties (i.e., the pregnant resident, or the resident taking leave, and the residents who will be affected by an absence) will work out a solution for coverage (with the administrative chief resident) for the allowed time of FML. A contingency plan will be implemented only in an emergency.
which may require the pregnant resident to go out early due to complications. All affected residents will be aware of the plan for coverage while the resident is out and the resident and the Program Director will generate a plan to make up time off service, should that be necessary. This policy is in accordance with and subject to all provisions in the FML of LAU.

Sick Leave Policy
It is the resident’s responsibility to notify the department if you are going to be out sick. The following is required:

• Call the administrative chief resident so coverage can be arranged.
• Sick days must be submitted to the GME administrative assistant

In the event of illness, the affected resident/fellow is personally responsible for notifying the faculty member of the affected clinic(s)/service(s) and the Departmental Education Office as soon as the resident knows that the illness will cause an absence from clinical responsibilities. Sick leave will be approved only for legitimate illness. A physician’s note is requested to support the resident request for sick leave. If the above policy is not followed, the absence will be counted as unscheduled or unplanned vacation time and will be reviewed as such. It is the responsibility of the resident and the program director to ensure that training requirements are met within the original residency period or alternative arrangements are made. Residents are granted up to 30 calendar days per year in sick leave. It cannot be carried over to the next academic year. Extra compensation is not allowed in lieu of sick leave. Any documented leave and/or vacation that results in more than six weeks off must be made up before you can be advanced to the next level of training.