Housestaff Work Hours and Supervision

ROWAN UNIVERSITY POLICY

Title: Resident/Fellow – Housestaff Work Hours and Supervison
Subject: Individual Schools Policies (RowanSOM)/Jefferson Health/Our Lady of Lourdes
Policy No: 2018:102
Applies: GME Housestaff
Issuing Authority: Director of GME
Responsible Office: Dean
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***Last Reviewed:* ACGME Common Program Requirements 2017**

I. PURPOSE

This policy and procedure delineates the mechanisms for acceptable and limitations of duty hours and supervision for residents at Rowan University School of Osteopathic Medicine/Jefferson Health NJ/Our Lady of Lourdes Medical Center for ACGME and AOA approved training programs.

II. SCOPE

This policy is directed to all members of the house staff and program administration.

III. DEFINITIONS OF TERMS

Housestaff - refers to all interns, residents and subspecialty residents (fellows) enrolled in a Rowan University School of Osteopathic Medicine/ Jefferson Health/Our Lady of Lourdes Medical Center Sponsoring Institution joint residency training programs. A member of the housestaff may be referred to as a housestaff officer.

IV. RESPONSIBILITY / REQUIREMENTS

This policy applies to all Chairpersons, Program Directors, Medical Staff and Housestaff of Rowan University School of Osteopathic Medicine/Jefferson Health NJ/Our Lady of Lourdes Medical Center for AOA and ACGME approved training programs

V. POLICY

This policy applies to all Chairpersons, Program Directors, Medical Staff and Housestaff of Rowan University School of Osteopathic Medicine/Jefferson Health NJ/Our Lady of Lourdes Medical Center for AOA and ACGME approved training programs

House Staff Duty Hours

1. Maximum Hours of Clinical and Educational Work per Week
    a. Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting.
2. Mandatory Time Free of Clinical Work and Education

a. The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being.
b. Residents should have eight hours off between scheduled clinical work and education periods. There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements.
c. Residents must have at least 14 hours free of clinical work and education after 24 hours of inhouse call.
d. Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days.

3. Maximum Clinical Work and Education Period Length
    a. Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.
    b. Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. Additional patient care responsibilities must not be assigned to a resident during this time.
4. Clinical and Educational Work Hour Exceptions
    a. In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:
        i. to continue to provide care to a single severely ill or unstable patient;
        ii. humanistic attention to the needs of a patient or family; or,
        iii. to attend unique educational events.
    b. These additional hours of care or education will be counted toward the 80-hour weekly limit.
5. Moonlighting (also see separate Moonlighting policy and required forms)
    a. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety.
    b. Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit.

        PGY-I residents are not permitted to moonlight

6. In-House Night Float
    a. Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements [The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the individual specialty Review Committee.]
7. Maximum In-House On-Call Frequency
    a. Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period).
8. At-Home Call
    a. Time spent on patient care activities by residents on at-home call must count toward the 80hour maximum weekly limit. The frequency of at-home call is not subject to the every-third night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks.
    b. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
    c. Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80hour maximum weekly limit.

House Staff Supervision

1. Supervision and Accountability
    a. Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care.

b. Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care. This information must be available to residents, faculty members, other members of the health care team, and patients.
c. Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care.
d. The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. [Individual Review Committees may specify which activities require different levels of supervision.]

2. Levels of Supervision
To promote oversight of resident supervision while providing for graded authority and responsibility, each training program must use the following classification of supervision:
a. Direct Supervision — the supervising physician is physically present with the resident and patient.
b. Indirect Supervision: with Direct Supervision immediately available — the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
c. With Direct Supervision available — 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.
d. Oversight — the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.
    i. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones.
    ii. Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident.
    iii. Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.
    iv. Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s)
    v. Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence.
e. Initially, PGY-I residents must be supervised either directly, or indirectly with direct supervision immediately available.
    i. [Each Specialty Review Committee may describe the conditions and the achieved competencies under which PGY-I resident's progress to be supervised indirectly with direct supervision available. All Programs are required to develop program specific procedures for supervision based on these requirements.]
f. Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility.