



Pediatric Residency Policies and Procedures Manual

July 2011-June 2012

University of Kansas
School of Medicine

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ACADEMIC

Mission Statement

With our KU Medical Center partners, our mission is to optimize the health and well-being of children and their families through excellence in patient care, education and research.

Program Goals

Pediatricians are responsible for promoting health and treating disease and injuries in infants, children and teenagers. To do so means not only caring for the child but also for parents and families and often for entire communities as well.

Our residents will be trained to provide family-centered care that is evidence based and compassionate. They will learn to identify problems that may cause ill health in children and to determine treatment plans to alleviate these problems by using their skills and those of colleagues. Included in caring for children are the following skills and attitudes our Program expects all residents and faculty members to uphold:

- Dedication to putting the patient first
- Possession of a life-long desire to learn and improve
- Continuous use of quality improvement
- Communication skills that enhance the patient-physician relationship
- Willingness to advocate for patients in an increasingly complex medical system
- Desire to carry out the professional responsibilities of a pediatrician

The curriculum of the Department of Pediatrics Residency Program is designed to assist physicians in acquiring the knowledge, skills, attitudes, and clinical judgment necessary to meet these responsibilities. Residents show progress towards meeting these goals by demonstrating continuous improvement on the in-training exam offered by the American Board of Pediatrics. Successful completion of the Pediatrics Board Examination is a goal for each resident. A wide variety of educational and clinical experiences will be available during training to help you accomplish this goal.

Throughout residency, you will learn the non-testable skills- how to work together, how to teach, how to communicate with patients and other health care professionals, how to critically look at a problem and work to solve it, and how to develop the professionalism expected of physicians. You will have opportunities to learn about advocacy, ethics and the business side of medicine. Additionally, based on your future career plans be they fellowship, academic medicine or private practice, there is flexibility in both the clinical and educational programs to allow individualization of your training in order to prepare you for your practice beyond residency. Such experiences are vitally important if our graduates are to meet the ever-changing demands of pediatric practice.

Together with your fellow residents, students and faculty, work hard, enjoy what you do and never forget that you make a difference in the lives of children. On behalf of the entire staff of the Pediatric Medical Education Center (PMEC), welcome!

Compact Between Resident Physicians and their Teachers

The Program has adopted the AAMC (Association of American Medical Colleges) compact between Resident Physicians and their Teachers. The Compact is a declaration of the fundamental principles of graduate medical education (GME) and the major commitments of both residents and faculty to the educational process, to each other and to the patients they serve. The Compact's purpose is to provide institutional GME sponsors, program directors and residents with a model statement that will foster more open communication, clarify expectations and re-energize the commitment to the primary educational mission of training tomorrow's doctors.

Additional information about the Compact can be found at the AAMC website, www.aamc.org/residentcompact

Commitments of Teaching Faculty

- As role models for our residents, we will maintain the highest standards of care, respect the needs and expectations of patients, and embrace the contributions of all members of the healthcare team.
- We pledge our utmost effort to ensure that all components of the educational program for resident physicians are of high quality, including our own contributions as teachers.
- In fulfilling our responsibility to nurture both the intellectual and the personal development of residents, we commit to fostering academic excellence, exemplary professionalism, cultural sensitivity, and a commitment to maintaining competence through life-long learning.
- We will demonstrate respect for all residents as individuals, without regard to gender, race, national origin, religion, disability or sexual orientation; and we will cultivate a culture of tolerance among the entire staff.
- We will do our utmost to ensure that resident physicians have opportunities to participate in patient care activities of sufficient variety and with sufficient frequency to achieve the competencies required by their chosen discipline. We also will do our utmost to ensure that residents are not assigned excessive clinical responsibilities and are not overburdened with services of little or no educational value.
- We will provide resident physicians with opportunities to exercise graded, progressive responsibility for the care of patients, so that they can learn how to practice their specialty and recognize when, and under what circumstances, they should seek assistance from colleagues. We will do our utmost to prepare residents to function effectively as members of healthcare teams.
- In fulfilling the essential responsibility we have to our patients, we will ensure that residents receive appropriate supervision for all of the care they provide during their training.
- We will evaluate each resident's performance on a regular basis, provide appropriate verbal and written feedback, and document achievement of the competencies required to meet all educational objectives.
- We will ensure that resident physicians have opportunities to partake in required conferences, seminars and other non-patient care learning experiences and that they have sufficient time to pursue the independent, self-directed learning essential for acquiring the knowledge, skills, attitudes, and behaviors required for practice.
- We will nurture and support residents in their role as teachers of other residents and of medical students.

Commitments of Residents

- We acknowledge our fundamental obligation as physicians—to place our patients' welfare uppermost; quality health care and patient safety will always be our prime objectives.
- We pledge our utmost effort to acquire the knowledge, clinical skills, attitudes and behaviors required to fulfill all objectives of the educational program and to achieve the competencies deemed appropriate for our chosen discipline.
- We embrace the professional values of honesty, compassion, integrity, and dependability.
- We will adhere to the highest standards of the medical profession and pledge to conduct ourselves accordingly in all of our interactions. We will demonstrate respect for all patients and members of the health care team without regard to gender, race, national origin, religion, economic status, disability or sexual orientation.

- As physicians in training, we learn most from being involved in the direct care of patients and from the guidance of faculty and other members of the healthcare team. We understand the need for faculty to supervise all of our interactions with patients.
- We accept our obligation to secure direct assistance from faculty or appropriately experienced residents whenever we are confronted with high-risk situations or with clinical decisions that exceed our confidence or skill to handle alone.
- We welcome candid and constructive feedback from faculty and all others who observe our performance, recognizing that objective assessments are indispensable guides to improving our skills as physicians.
- We also will provide candid and constructive feedback on the performance of our fellow residents, of students, and of faculty, recognizing our life-long obligation as physicians to participate in peer evaluation and quality improvement.
- We recognize the rapid pace of change in medical knowledge and the consequent need to prepare ourselves to maintain our expertise and competency throughout our professional lifetimes.
- In fulfilling our own obligations as professionals, we pledge to assist both medical students and fellow residents in meeting their professional obligations by serving as their teachers and role models.

Resident Code of Professional and Personal Conduct

The University of Kansas School of Medicine has undertaken a "Professionalism Initiative," conceived to raise awareness of professionalism within the KU medical community as a whole, from the first day of medical school, throughout one's career in the health sciences. The Professionalism Initiative guidelines for professional attitudes and behaviors for all medical professionals, regardless of position or seniority in the medical community, are incorporated into the Resident Code of Professional and Personal Conduct.

The Department of Pediatrics and the Pediatric Residency Program support this *Resident Code of Professional and Personal Conduct* which can be found in the **University of Kansas Graduate Medical Education Policy and Procedure Manual**. <http://gme.kumc.edu/policiesandprocedures.html>

Remediation, Probation and Disciplinary Action Policy

Unsatisfactory performance based on the resident evaluation, poor academic performance, inappropriate or unprofessional behavior, or other deviations from acceptable performance as judged by teaching staff and/or Program Director, will result in corrective action as necessary to maintain the quality of patient care, the quality of the Program, the steady operation of the institution and the well-being of the resident. Corrective action usually begins with attending, chief resident or Program Director discussing a deficiency with the resident involved. The Program Director has the authority to administer an appropriate disciplinary action including the following: Warning Status, Probation (short or long term), Suspension, Non-Renewal of Contract, Termination or other discipline as determined by the Program Director.

Except in instances where patient care is threatened or there has been other serious professional misconduct, the Program Director will inform the Chair of the Department and the GME office of any anticipated disciplinary action beyond Warning Status. Formal procedures for Probation, Suspension, Termination and Non Renewal of Contract are outlined in the Institutional GME Policies and Procedures manual.

Should a resident be found to be deficient in **any** of the competencies and not meeting advancement or promotion specifics, the resident will usually be placed on Warning Status (usually 1-3 months) unless the deficiency is severe enough to warrant Probation or Suspension without Warning Status.

At the initiation of a remediation period, the resident will meet with the Program Director, the Associate Director, or their designee wherein:

- 1) expectations and deficiencies will be stated
- 2) specific knowledge, skills or behaviors that must be demonstrated will be outlined
- 3) other behaviors that the individual can do to improve will be explored and planned
- 4) responsibilities may be altered for a period of time
- 5) portions of the Program may be required to be repeated
- 6) an attempt will be made to determine if there are outside factors, which may explain why a problem has developed.
- 7) professional or personal counseling with an educational specialist, psychologist or psychiatrist may also be recommended

This meeting will be documented. The outline of the Warning Status/Probation/Suspension will be given to the resident for his/her agreement of the meeting content, and a final copy will go into the resident's personnel file. A copy will also be sent to the residents advisor if appropriate. The resident may ask for another resident to be present at this meeting to serve as a resident advocate. Any rotation specific deficiencies as determined by the responsible faculty will be documented, including a remediation plan, in writing within 60 days of the end of the rotation.

Should the resident continue to be deficient despite appropriate counseling, professional assessment and input (if indicated), and faculty efforts, a period of Probation (usually 3 months) is indicated. A written letter of probation will state:

- 1) deficiencies that the individual has been counseled for and that sufficient improvement has not been made,
- 2) that because of this the individual is being put on probation,
- 3) time of probation,
- 4) expectations during this period,
- 5) what will be done to assist the individual in meeting these expectations,
- 6) mechanism(s) will be to determine improvement and
- 7) consequences or options are to be if expectations are not met.

The deficient resident will receive this letter, a copy will go into his/her personnel file and a copy will be submitted to the KU GME office. Reporting of remediation actions depends on when in residency remediation occurs. Warning Status is a Program level remediation and although it may be reported to the Institutional GME office, it is not reported to boards or on licensing or verification requests. Periods of probation may be reported to the American Board of Pediatrics and verification and licensing requests.

A resident put on probation who has successfully accomplished remediation in the probationary period but who has received intermittent low satisfactory or isolated unsatisfactory marks during the academic year (and particularly following a probationary period), may be asked to repeat the year. This is particularly so, if the Residency Committee feels the resident can receive no better than a marginal grade on the American Board of Pediatrics assessment and/or if the Department will in all likelihood be unable to certify that the resident can sit for the board examination should the resident's performance trend continue. Although marginal evaluations at certain points in training in the area of medical knowledge and patient care may not negatively affect the resident's ability to sit for the board exam at the end of training, any marginal evaluation in the area of professionalism may result in the resident not being permitted to sit for the pediatric certifying examination.

The probationary period is intended to emphasize to the resident the importance of satisfactorily meeting the residency training requirements and expectations of the Department including prompt seeking of assessment, counseling, or assistance, should there be any possibility of personal problems, learning disability, or outside factors that may be contributory to the resident's performance. The Program Director with assistance from faculty with first hand knowledge of the resident's areas of sub-competent performance is responsible for the definition of expected remediation, establishment of a defined time in which this must be accomplished, alerting his/her attending faculty during this period of probation to the importance of helping the resident with defined problems and for an honest evaluation of the resident's performance.

Residents on probation must achieve a satisfactory evaluation from their attending faculties on assigned clinical service rotations during their probationary period. Probationary actions will only be shared with those needing to know, and normally will not be disclosed to other residents or students. Should the resident fail the above probationary period, then at the discretion of the Program Director a letter extending the probation may be issued, or a letter dismissing the resident from the Program on a designated date will be issued, assuming that dismissal was a consequence of probationary failure as stated above. Accompanying this letter must be a statement of the resident's right of appeal.

The remediation and probationary policies of the Department are in line with the policies of the University of Kansas School of Medicine Resident Policies and Procedures Manual. Additional information on the *Remediation and Probation and Corrective Actions: Suspension and Termination* can be found in the *University of Kansas Graduate Medical Education Policy and Procedure Manual*.
<http://gme.kumc.edu/policiesandprocedures.html>

Adopted by Pediatric Residency Committee July 2010

Resident with Disruptive Behavior Policy

The Program has adapted a Disruptive Resident Policy to address behaviors in which residents do not conduct themselves in a professional or cooperative manner.

I. Policy

It is the policy of the University of Kansas Pediatrics Residency Program that all residents conduct themselves in a professional and cooperative manner, and shall not engage in disruptive behavior.

Disruptive behavior includes but is not limited to:

- Conduct that interferes with the provision of quality patient care
- Conduct that interrupts hospital or clinic operations
- Conduct that constitutes sexual harassment
- Making or threatening reprisals for reporting disruptive behavior
- Shouting or using vulgar or profane or abusive language
- Abusive behavior towards patients or staff
- Physical assault or inappropriate physical affection
- Behavior that is intimidating, belittling or implies incompetence
- Refusal to accept medical staff assignments or to cooperate with other staff members

Residents are expected to:

- Accept and incorporate feedback in a non-resistant and non-defensive manner
- Address dissatisfaction through appropriate offices
- Cooperate and communicate with all providers
- Be truthful in all written and verbal communication

Residents identified as demonstrating disruptive behavior may be at risk for the following actions: written warning or letter of counseling, probation, suspension or termination.

II. Purpose

To ensure residents conduct themselves in a professional, cooperative and appropriate manner while providing services as a member of the medical staff.

To encourage the prompt identification and resolution of alleged disruptive behavior by all involved or affected persons through informal, collaborative efforts at counseling and rehabilitation.

To provide a formal procedure for the further investigation and resolution of disruptive behavior by residents which has not been appropriately modified by prior informal efforts.

To provide for the appropriate discipline of residents only after the informal efforts` and formal procedures described in this policy have been unsuccessful in causing the physician to appropriately modify behavior in compliance with this policy.

III. Process

1. Any written or oral report of alleged disruptive resident behavior must be sent to the program director, who shall initiate an informal investigation as he/she deems appropriate to identify or rule out the existence of disruptive behavior.
2. During the investigation, the program director will meet with the resident to review the alleged behavior and the requirements of this policy. Both the program director and the resident may be accompanied at this meeting by other practitioners that the program director or resident feel as necessary to explain the disruptive behavior. At the completion of the investigation, the program director will make a determination as to whether the resident engaged in disruptive behavior.
 - a.) If the program director determines that the resident has not engaged in disruptive behavior, he/she will advise the resident and the person to whom the allegedly disruptive behavior was directed of such determination, and will prepare a written report to be filed in the resident's confidential personnel file, with a copy given to the resident.

- b.) If the program director determines that the resident has engaged in disruptive behavior, he/she will meet with the resident to counsel the trainee concerning compliance with this policy and to assist the resident in identifying methods for structuring professional and working relationships and resolving problems without disruptive behavior. It is the intent of this policy to allow the program director latitude to develop any plan for resolution that is deemed appropriate with the goal to achieve a modification of the resident's behavior.
3. Following the meeting(s) with the resident, the program director may, at his or her discretion, arrange for and participate in a meeting between the resident and the person(s) toward whom the disruptive behavior was directed. In determining whether to arrange such a meeting, the program director is to consider the wishes of the person(s) who reported the disruptive behavior. If no such meeting is arranged, the program director will meet with the person(s) toward whom the disruptive behavior was directed, to advise of the resolution of the matter.
4. Following the meeting(s) with the resident and the person(s) toward whom the disruptive behavior was directed, the program director will prepare a written summary of the reported behavior, and document the following:
 - a.) the date and time of the questionable behavior
 - b.) if the behavior affected or involved a patient, the patient's name and medical record number
 - c.) the circumstances that precipitated the behavior
 - d.) a factual, objective description of the behavior
 - e.) the consequences of the behavior for patient care or medical operations
 - f.) the dates, times, and participants of any meetings with the resident, staff, etc. about the behavior
 - g.) acknowledgement of receipt by resident attestation and signature

The summary will be filed in the resident's confidential personnel file, with a copy given to the resident and the resident's advisor if appropriate.
5. The program director will also develop a plan for monitoring future compliance with or violation of this policy and will document findings of these reviews in writing to the resident's confidential personnel file, with copies given to the resident.
6. If repetitive reports of alleged disruptive behavior are made concerning the same resident, the program director will prepare a memo referring the matter to the Resident Academic and Professionalism Sub-Committee, the composition of which varies depending on the circumstances of the disruptive behavior. The committee will meet with the resident and attempt to further assist the resident in identifying methods for structuring professional and working relationships and resolving problems without disruptive behavior. Referrals for counseling with required reports to the committee may also be part of this process. It is the intent of this policy to allow the committee latitude to develop any plan for resolution that is deemed appropriate with the goal of rehabilitating the resident. This committee will also develop a plan for monitoring future compliance with or violation of this policy. At its discretion, the committee may consult with those person(s) who were the object(s) of the disruptive behavior. Finally, this committee will send a written report to the program director.
7. The committee report shall remain in the resident's confidential personnel file with a copy given to the resident.
8. Failure of the committee to satisfactorily resolve the behavior problem will result in the referral of the matter for further review and possible discipline.

Adapted from Stony Brook University Medical Center- Disruptive Resident Behavior Policy;
<http://www.stonybrookmedicalcenter.org/gme/policy/disruptivebehavior/>
 Accessed May 26, 2010

Adopted by Pediatric Residency Committee July 2010

Other Resident Well-Being Policies (Resident Assistance and Access to Counseling, Risk Management, and Disaster Policy and Residents with Disabilities)

Additional information for Resident Well-Being Policies including those for *Resident Assistance and Access to Counseling, Risk Management and Disaster Policy* and *Residents with Disabilities* can be found in the **University of Kansas Graduate Medical Education Policy and Procedure Manual**. <http://gme.kumc.edu/policiesandprocedures.html>

Impaired Physician and Substance Abuse Policy

The Department of Pediatrics and the Pediatric Residency Program follows the Institutional policies regarding impaired residents and residents with substance abuse.

Additional information specifically related to the *Prevention of Illegal Drug and Alcohol Use* as well as *Impaired Physician and Substance Abuse Policy and Alcohol, Drugs and Tobacco* under *Resident Code of Professional and Personal Conduct*, can be found in the **University of Kansas Graduate Medical Education Policy and Procedure Manual**. <http://gme.kumc.edu/policiesandprocedures.html>

Resident, Faculty and Program Evaluations

The Department of Pediatrics and the Pediatric Residency Program procedures regarding the specification of satisfactory performance including expectations and responsibilities and duties are outlined in the ***Pediatric Residency Handbook***. Examples of evaluations including Resident Evaluations, Faculty Evaluations, Program Evaluations and other 360 evaluation examples are provided in the ***Pediatric Forms Manual***. Additional information regarding *Evaluation* can be found in the **University of Kansas Graduate Medical Education Policy and Procedure Manual**. <http://gme.kumc.edu/policiesandprocedures.html>

Conference Attendance Policy

All residents are responsible for ensuring they sign-in for each conference.

Core Conferences: Each resident is required to attend 75% of the required Core Conferences (Mon, Tues, Thur) per block rotation. From the total number of Core Conferences each resident is required to attend on a monthly basis, conferences missed due to vacation, ED rotations and outside rotations will be excluded from the total. If you have rotational conflicts that result in missing more than 25% of required conferences, those absences should be discussed with the Program Director who will determine if the absence is excused or not.

All Other Conferences: Attendance at all other teaching conferences is strongly encouraged and each resident is required to attend at least 50% of other conferences including Grand Attending Rounds, Grand Rounds, Friday Noon Conferences and Morning Teaching Conferences quarterly.

Attendance will be monitored by sign in sheet, EEDS reader where available and by random attendance audits during conferences. Conferences viewed from satellite locations should be reported to the Residency Coordinator for inclusion in attended conferences.

During the Residency Review, residents' attendance will be examined. Residents with unsatisfactory conference attendance will be asked to view archived Core Presentations, to view other archived educational presentations, complete other medical education projects and/or take professionalism call.

It is the responsibility of the resident to inform the Residency Coordinator of missed conferences for reasons beyond what has been described above. These absences will be reviewed and the Program Director will determine if they are excused absences or not.

Residents should not be paged out of required conferences. Several initiatives are in place to reduce the page outs from conference including batching of pages at the end of conference and having the attending take pages during core. If patient care cannot wait until after a core session, one senior resident should be responsible for handling the patient care issue.

Residents are expected to return to scheduled rotations after all didactic sessions.

Adopted by Pediatric Residency Committee July 2010

Breakfast and Lunch Policy

Lunch is provided for all noon conferences and breakfast for all morning conferences. For three conferences, Grand Attending Rounds, Grand Rounds and Friday Noon Conferences, food is provided for all attendees, not exclusively residents, so early arrival is encouraged to guarantee a meal.

In alignment with the University's Vendor Policy, pharmaceutical representatives are not permitted to provide meals. As the presenter for a resident conference, if you would like a particular lunch served at your conference please discuss this with the Residency Coordinator the week of your conference. There is a budget for conference lunches and breakfasts and catering/delivery choices may be limited based on the budget.

It is the responsibility of **ALL** residents to clean up after themselves. An assigned cleaning schedule will be posted if meal clean up becomes a problem. If rooms are not cleaned after conferences food will not be allowed at any conference.

Cleaning includes **ALL** of the following:

- All remaining food is disposed of properly (trash it, bring it to the floor for the on-call team or bring it to the clinic conference rooms)
- Utensils are washed
- Dirty plates, empty soda cans and dirty napkins are thrown away
- All chairs are straightened and all paper and food trash is picked up
- Computer and projector are turned off and remote is returned to admin office

CLINICAL

Supervision of Residents

In accordance with the GME Handbook, the Faculty of the Department of Pediatrics will “*provide an organized educational program with guidance and supervision of the resident that facilitates professional and personal growth while ensuring safe and appropriate patient care. A resident will be expected to assume progressively greater responsibility through the course of a residency, consistent with individual growth in clinical experience, knowledge and skill. The University of Kansas School of Medicine gives residents significant but appropriately, well-supervised latitude in the management of all patients and provides a comprehensive experience in their specialty area in order for them to become independent and knowledgeable clinicians with a commitment to the life-long learning process that is critical for maintaining professional growth and competency.*”

Additional information on the *Supervision Policy* can be found in the ***University of Kansas Graduate Medical Education Policy and Procedure Manual***. <http://gme.kumc.edu/policiesandprocedures.html>

The Pediatric Residency’s *Supervision of Resident Policy* is in line with the Institutional policy regarding supervision of residents. Every patient seen by a resident is seen under the supervision of a staff physician who assumes complete responsibility for those patients for whom they are the attending physician. The staff physician is also responsible for education of the residents. Attending supervision may be direct or indirect. Indirect supervision occurs when the responsible staff is aware of the patient and is available to assist or provide direct supervision if needed but is not physically present. In these situations, a senior resident may provide direct supervision of a more junior resident. Supervision is always available from more senior residents and attendings. Residents should always obtain help in any clinical situation in which they are inexperienced or uncomfortable. In all instances, the level of resident supervision must ensure the highest quality, safety and effectiveness of patient care. The level of supervision must be appropriate for individual resident’s progressive responsibility as determined by the residents’ level of education, competence and experience.

Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care of the individual patient; assuring the development of the skills, knowledge and attitudes in the resident to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth. For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty who give value, context and meaning to those interactions. As residents gain experience and demonstrate growth in their ability to care for patients they assume roles that permit them to exercise those skills with greater independence including graded and progressive responsibility.

Residents in the Pediatrics Residency Program practice only under the supervision of attending physicians who are licensed and credentialed by our participating institutions including the KU Children’s Center and affiliate clinics, University of Kansas Hospital, and Children’s Mercy Hospital in Kansas City, Missouri. All patients cared for by resident physicians will have an identifiable supervising faculty member or other approved licensed independent practitioner who assumes ultimate responsibility for the actions of the resident to whom portions of care will be delegated based on the needs of the patient and the skills of the residents. A patient’s responsible supervising attending physician or licensed practitioner should be identified to residents, faculty members and patients. Residents and faculty should inform patients of their respective roles in each patient’s care.

Program Director and Attending Physicians

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 are 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.

Supervisory Senior Residents

Supervisory residents will provide care as part of a team led by an attending physician. Given that independent development of progressive treatment and management plans is important for senior residents, the attending accepts responsibility for all decisions made by the senior. Senior residents will also serve in the supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the resident.

Junior Residents

The junior and the supervising resident will provide care as a team. Given that independent development of treatment and management plans is important for juniors, the supervising resident accepts responsibility for all decisions made by the junior.

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 patients

- 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 inotropic 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.

General Pediatrics Inpatient Admission Communication: It is expected that the call team (Junior and Senior if possible) call the attending at minimum between 9pm-10pm nightly to follow up any admissions previously discussed and to review the overnight care plans. The Night Service Senior or Post-Call Senior is expected to call the attending between 6am-6:30am to discuss any admissions not previously discussed and other overnight care questions so as to facilitate ongoing patient care between morning check out at 6:30am and rounds at 9:00am. (*Oversight Supervision*) In addition, all admissions should also be discussed with the general pediatrics attending in as reasonable a time from the admission as patient care necessitates.

Hematology-Oncology, PICU and NICU Admission Communication: All admissions are to be discussed with the attending at the time of admission. (*Indirect Supervision with direct supervision available*)

The role of the supervisory resident:

- To supervise the juniors, subinterns, and medical student in the care of patients both newly admitted and existing patients
- To make the patient's parent or legal guardian aware of the name of the attending and his/her role as the responsible caregiver for the child as well as their role as resident in the patient's care
- To document in the medical record the accepting attending for each patient
- 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 immediately 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 by 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

Adopted by Pediatric Residency Committee, July 2008

Reapproved by Pediatric Residency Committee, July 2010

Reapproved by Pediatric Residency Committee, July 2011

2011 ACGME Requirements-Resident Supervision

A. Supervision of Residents

- In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.
- This information should be available to residents, faculty members, and patients.
 - Inpatient: Patient information sheet included in the admission packet and listed on the "white board" in each patient room
 - Outpatient: Provided during introduction verbally by residents and/or faculty
- Residents and faculty members should inform patients of their respective roles in each patient's care.
- The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.

B. Methods of Supervision

- 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.
- Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician in his/her "final years of training", 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.
- 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 the following specific criteria and when available should be guided by specific national standards-based criteria.
- Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents
- "Residents in their final years of training" or fellows should serve in a supervisory role of PGY 1 and "intermediate residents" in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow

C. Levels of Supervision Defined

To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision established by the ACGME.

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.

Per Program Specific RRC Requirements	RRC APPROVED LICENSED INDEPENDENT PRACTITIONER SUPERVISOR (PR VI.D.1)
	Physician assistants, nurse practitioners, psychologists, physical and occupational therapists, speech and language pathologists, dietitians/nutritionists, counselors, and audiologists are just some of the providers who see their own patients and may serve as teachers and/or supervisors for residents as appropriate in ambulatory (i.e. school-based health centers, child development clinics) and inpatient (i.e. NICU) settings. Some states may have regulatory rules that won't allow LIPs to supervise residents.
	OPTIMAL CLINICAL WORKLOAD (PR VI.E.)
	This depends on all the factors listed in the requirement. The program director must make an assessment of the learning environment with input from the faculty and residents. Minimum patient loads should usually be five on the general inpatient unit, and four in PICU and NICU. However, there may be situations in which lower patient loads may be acceptable. Programs will need to justify lower patient loads with evidence such as severity of illness indicators or other factors.
	MEMBERS OF THE INTERPROFESSIONAL TEAM (PR VI.F.)
	Nurses, physician assistants, advanced practice providers, pharmacists, social workers, child-life specialists, physical and occupational therapists, speech and language pathologists, audiologists, respiratory therapists, psychologists, and nutritionists are examples of professional personnel who may be part of the interprofessional teams.
	COMPETENCIES TO ALLOW PGY1 RESIDENTS TO PROGRESS TO INDIRECT SUPERVISION (PR VI.D.5.a).(1)
	PGY-1 residents must always be supervised either directly or indirectly with direct supervision immediately available.
	DEFINING RESIDENT LEVELS "INTERMEDIATE LEVEL" & "FINAL YEARS OF TRAINING" For establishing the minimum rest period between duty periods (PR VI.G.5.b&c)
	PGY-2 residents are considered to be at the intermediate level. PGY-3 residents are considered to be in the final years of education.
	CIRCUMSTANCES WHEN RESIDENTS IN THEIR FINAL YEARS OF EDUCATION MAY REMAIN OR RETURN IN < 8 HOURS (PR VI.G.5.c).(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.
	DEFINED MAXIMUM NUMBER OF CONSECUTIVE WEEKS AND MAXIMUM NUMBER OF MONTHS PER YEAR OF IN-HOUSE NIGHT FLOAT (PR VI.G.6.)
	Residents should not have more than one consecutive week of night float and not more than four total weeks of night float per year.
	Program-specific guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty (PR VI.D.5)
	See following PGY level charts and in the <i>Resident Supervision Policy</i> in the Pediatric Residency Policies Manual.
Source of specific criteria and/or specific national standards-based criteria used to evaluate each resident's abilities (PR VI.D.4.a)	
The Pediatric Milestones project is ongoing and anticipated to be part of not only the new Specialty Program Requirements for Training in Pediatrics (draft for public comment expected to be posted in June 2011) but a significant ongoing project for a multitude of groups invested in graduate education in pediatrics. There are currently no national standards-based criteria used to evaluate each resident's abilities. General standards for promotion from PGY level to PGY level for the KU Pediatrics residency program are outlined in the Pediatric Residency Handbook.	

PGY 1

LEVEL of SUPERVISION	ACTIVITIES /PROCEDURES (as defined by RRC* & Program)
DIRECT	<p><u>Procedures:</u> All procedures until signed off as competent to perform independently including but not limited to intubation, IV's, venipuncture, UAC and UVC, LP, bladder catheterization, Gyn exam, wound care and suturing, SQ/ID/IM injections, developmental screening, procedural sedation, pain management, reduction and splinting of simple injuries, circumcision</p> <p><u>Rotations:</u> 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.</p>
INDIRECT A (with direct supervision immediately available)	<p><u>Procedures:</u> Once signed off as competent, any of the above listed procedures.</p> <p><u>Rotations:</u> 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</p> <p><u>Common Circumstances:</u> admissions, care of complex patient, ICU/higher level of care transfer, DNR or other end of life decision (further examples of outlined in the <i>Resident Supervision</i> policy in Pediatric Residency Policy Manual.</p>
INDIRECT B (with direct supervision available-as determined by program specific RRC guidelines PR VI.D.5.a).(1))	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* & Program)
DIRECT	<u>Procedures:</u> Any procedure not previously signed off as competent at the end of the PGY 1 year.
INDIRECT A (with direct supervision immediately available)	<p><u>Procedures:</u> Umbilical catheterizations, neonatal intubations, conscious sedation</p> <p><u>Rotations:</u> NICU rotation</p>
INDIRECT B (with direct supervision available)	<p><u>Rotations:</u> Continuity Clinic, Outpatient Subspecialty Clinics, PICU-KU, Term Nursery, Inpatient Pediatrics, Call, Home-Call (Mommy Call)</p> <p><u>Common Circumstances:</u> admissions, care of complex patient, ICU/higher level of care transfer, DNR or other end of life decision (further examples of outlined in the <i>Resident Supervision</i> policy in Pediatric Residency Policy Manual.</p>
OVERSIGHT (with direct supervision available)	<u>Rotations:</u> Community Medicine- community sites, Home Call (Mommy Call)

RESIDENTS IN FINAL YEARS OF TRAINING	
LEVEL of SUPERVISION	ACTIVITIES /PROCEDURES (as defined by RRC* & Program)
DIRECT	<u>Procedures</u> : Any procedure not previously signed off as competent at the end of the PGY 1 year.
INDIRECT A (with direct supervision immediately available)	<u>Procedures</u> : Umbilical catheterizations, neonatal intubations, conscious sedation <u>Rotations</u> : NICU, PICU-CMH
INDIRECT B (with direct supervision available)	<u>Rotations</u> : Continuity Clinic, Outpatient Subspecialty Clinics, ED, PICU-KU, Term Nursery, Inpatient Pediatrics, Call, Home-Call (Mommy Call) <u>Common Circumstances</u> : admissions, care of complex patient, ICU/higher level of care transfer, DNR or other end of life decision (further examples of outlined in the <i>Resident Supervision</i> policy in Pediatric Residency Policy Manual.
OVERSIGHT (with direct supervision available)	<u>Rotations</u> : Home Call (Mommy Call)

*** Further delineation of progressive responsibilities for patient care including activities, procedures and faculty responsibilities for supervision, as expected to be outlined in the new 2012 ACGME Program Requirements for Graduate Medical Education in Pediatrics, to be incorporated into this document when available**

Answering Service Guidelines- Nighttime and Daytime

Nighttime Page Operators' procedure for Contacting Those on First Call

1. Contact the resident on Home Call by beeper unless requested to do otherwise. The parent will be instructed to expect a call back within 30 minutes **and** to call the answering service back if they have not heard back.
2. If the patient calls back after 30 minutes and has not been contacted by the resident, then page the resident again with notation in the text message that this is the second page and that they need to call the operator back. The resident will notify the answering service that the second page was received before calling the parent back.
3. If no response in 10 minutes after the second page then dial the home number listed on the on-call schedule.
4. If unable to reach the resident at home, page the Ambulatory Faculty listed as on backup call. A notation that the faculty should contact the page operator that they did receive the call will be included on the page.
5. If unable to contact the faculty member or resident at home, the senior resident on call for the floor will be paged with the message at 917-3333.
6. If it is a Spanish patient with a translator on the line, the resident will be notified of this with a text message to alert them to call back to the operator. The operator should wait for the resident to call back before getting the translator on the line but sometimes the page will be that the translator is holding.

Residents' procedure for Triageing Phone Calls

1. When a patient calls the answering service, they should be asked to identify their provider.
2. All patients should be triaged to the resident on back-up call who will take calls from 4:30 p.m. to 10:00 p.m. Monday through Friday and from 8:00 a.m. to 10:00 p.m. on Saturdays, Sundays and holidays. After that the calls will go to the senior resident on call for the floor. Please make sure you have enough phone call cards for your call. All calls must be documented on a green phone card.
3. Faculty is back up for the resident calls for questions and help and should be called if the resident does not respond to a page. If for any reason the backup resident is called into the hospital to work, the page operator and the faculty member should be notified that the faculty member will be taking the phone calls.
4. After 10:00 p.m., the senior resident on call for the floor, beeper 917-3333, will take all the calls for all the patients until 8:00 a.m. when the clinic opens or the weekend/holiday call hours start. Faculty backup for this time period is the General Attending on the floor.
5. If a patient calls early in the morning for an appointment, please direct them to call their providers office at either the satellite location or the main location after 8:00am to obtain an appointment.
6. The page operators must be notified of any changes to the Home Call schedule made after the final monthly call schedule has been distributed. It is the residents' responsibility to notify the page operator. The page operators' number is 588-6368. You may be directed to call another number on your pager but this is the number to give parents to call.
7. Return completed cards to Dr. Gilmer as soon as possible after your call, preferably the morning after.

IF THE OPERATORS OR RESIDENTS EXPERIENCE ANY DIFFICULTIES WITH THE RESIDENTS OR STAFF PLEASE CONTACT PROGRAM DIRECTOR.

Daytime Call Answering Guidelines

All daytime phone calls will be routed through the main clinic scheduling number. The nature of the call will be ascertained and one of the following will occur:

- If the phone call is regarding a prescription refill, the patient will be instructed to contact their pharmacy for a refill fax request to be sent to 913-588-6338 (General Pediatrics Office)
- If the phone call is to schedule an appointment, a scheduler will schedule the appointment
- If the phone call is for general advice, the call will be transferred to the triage nurse at 913-588-6375
- If the patient wishes to speak directly with the resident, an e-mail will be sent to the resident that includes the patient's name, the care giver's name, a brief description of the nature of the call, and a contact phone number. A copy of the email will also go to Dr. Lauer (slauer@kumc.edu) and the Residency Coordinator
- If the caller chooses to wait to receive a return call from the resident, the family will be told the following:

“Due to the nature of the resident's schedules, it may be up to 24 hours before you receive a return call. If you do not receive a return phone call within 24 hours, please call 913-588-6917.”

With this protocol for daytime phone calls, it is imperative that residents check their email regularly.

Dress Code

The University of Kansas Hospital projects an image of professionalism in our community. The grooming and dress of our employees conveys a message of respect, credibility, and quality of service. In a Hospital setting, appearance and cleanliness are extremely important in meeting the standards for infection control and safety. Employees have the opportunity to create a positive impression by consistently presenting themselves as models of cleanliness, modesty and conservative good taste.

The following standards should be practiced consistently:

Grooming Standards

- Practice daily oral hygiene
- Bathe daily and use effective deodorant
- Heavily scented toiletries should be avoided
- Fingernails should be clean, well-groomed, and of a reasonable length
- Make-up should be conservative and in good taste
- Hair styles as well as mustaches and beards should be clean, neatly groomed, and moderate
- Use of jewelry should be minimal and conservative
- Fingernails should be clean, well groomed and of a reasonable length. Due to infection control issues, employees who are providing direct patient care may not wear artificial fingernails or extenders and must keep fingernails trimmed to ¼ inch above each finger in keeping with APIC standards. ** This policy may apply to other positions in the Hospital as determined by the Vice President of the department.

** According to the Association for Professionals in Infection Control (APIC) artificial nails or extenders have been found to harbor pathogenic organisms and have been implicated in the transmission of organisms to patients.

Clothing Standards

- All garments must be fresh and clean
- Uniforms: as designated by respective department or specialty units
- Shoe soles should be non-marking and without metal caps
- Socks or hose must be worn
- Appropriate undergarments must be worn

- Unacceptable Clothing
 - Athletic shoes and t-shirts are generally not acceptable except as designated specifically by department uniform code
 - Tight fitting or revealing garments
 - Blue jeans, sweat clothing, shorts, halter-tops, leggings, mini-skirts
 - Items of clothing imprinted with advertising or objectionable language

Additional information for *Dress* can be found under *Resident Code of Professional and Personal Conduct* in the ***University of Kansas Graduate Medical Education Policy and Procedure Manual***.

<http://gme.kumc.edu/policiesandprocedures.html>

ADMINISTRATIVE

Resident Appointment, Eligibility and Selection of Residents

The Department of Pediatrics and the Pediatric Residency Program select and appoint pediatric residents following the policies for such set forth by the Institution.

Additional information on *Eligibility, Transfer, Application, Selection and Appointment of Residents* can be found in the *University of Kansas Graduate Medical Education Policy and Procedure Manual*.

<http://gme.kumc.edu/policiesandprocedures.html>

The Resident Agreement

The Department of Pediatrics and the Pediatric Residency Program follows all procedures related to Resident Agreements as outlined in *The Resident Agreement* and *Severance of the Resident Agreement* in the *University of Kansas Graduate Medical Education Policy and Procedure Manual*.

<http://gme.kumc.edu/policiesandprocedures.html>

Resident Standing, Promotion and Program Completion

The Department of Pediatrics and the Pediatric Residency Program procedures outlining resident responsibilities and criteria for advancement are outlined in the *Pediatric Residency Handbook*.

Additional information regarding *Resident Standing, Promotion and Program Completion* can be found in the *University of Kansas Graduate Medical Education Policy and Procedure Manual*.

<http://gme.kumc.edu/policiesandprocedures.html>

Step 3 Policy

All residents are required to apply for a temporary license to practice medicine in Kansas prior to beginning practice at the University of Kansas Medical Center. In order to get licensed by July 1st, new residents will be expected to submit all necessary paperwork by the deadlines set by the PMEC. Failure to do so may result in your license not being issued by July 1st. If such a delay is the fault of the resident, the resident may be required to use vacation and sick time for the off work between July 1st and the day they become licensed. Residents upon receipt of license have full legal authority to authenticate death certificates. Your license, both temporary and permanent will be kept in your portfolio in the residency office.

Licensure and Step 3: The temporary license is not sufficient licensure to practice outside of KUMC. Residents must have passed USMLE III in order to obtain a permanent license.

It is a requirement of the institution that all residents sit for Step 3 before promotion to the PL3 year and that residents pass Step 3 before the certificate for residency completion be issued. However programmatic requirements may be more stringent, therefore...

The Program has three additional requirements.

- 1) Residents must sit for Step 3 prior to the end of the PL1 year.
- 2) Residents must register for a Step 3 date before February 1st. Decisions about promotion to the PL 2 year are made in February. Residents not registering for Step 3 by February 1st are at risk for non-promotion.
- 3) Residents must pass Step 3 prior to promotion to the PL3 level.

A permanent license is not required for residency training unless you wish to participate in locum tenens in your senior years. A permanent license will be required before sitting for boards in the fall after graduation. Everything having to do with your permanent license depends on successful completion of Step 3, the cost of which is covered by the program.

Adopted by Pediatric Residency Committee July 2010

Reapproved by Pediatric Residency Committee June 2011

Access to Resident Files Policy

A wide variety of information is stored in our **Resident Portfolios**. There are two sections of the Resident Portfolio: the public section with contracts, employment forms, certification cards, anything that is public in nature and a peer-review/confidential section with everything else including but not limited to evaluations, critical incidents, procedures, ERAS applications, etc...

Resident portfolios are kept in the Residency Offices so that they are easily accessible by the Program leadership which includes the residency coordinators, the Program Directors and department chair. More senior residents have a good deal of their portfolios in paper form stored in labeled notebooks. More recent evaluations are stored electronically. Junior residents will have most of their information stored electronically. Residents, like patients, have a right to confidential information.

Resident files are divided into two distinct sections, a public file and a peer-reviewed, confidential file. For internal use, the full file is accessible as described below. For external use, only the public file is available for review.

- * *Public (Manila) File:* Certifications, Licensing, HR/GME Forms, Application / Diploma
- * *Peer-Reviewed, Confidential (Red) File:* Evaluations, Presentations / Projects, Director Correspondence, Letters of Recommendation, Correspondence / Misc

Efforts are underway to secure these notebooks even further. Once secured, access to portfolios will be granted by the Residency Coordinators based on the following guidelines. Any viewing of portfolio information must be done in the Residency Office. Copying of portfolio information by anyone other than the resident will not be allowed without the permission of the Program Directors.

Residents

- Residents will have access to their own portfolios. Residents may access their file in the presence of the coordinator or director of the Residency Program.

Resident Advisors

- Resident advisors will have access to their advisee's quarterly reviews and monthly evaluations.
- At the Residency Coordinator's discretion, advisors may view other material in their advisee's portfolio.
- If the Residency Coordinator is not comfortable allowing the resident advisor access to the requested material, a written request should be made to the Program Directors by either the Resident Advisor or the Residency Coordinator. The request should explain what material is being requested and for what purpose. Granting of requests to view the additional portfolio information is at the discretion of the Program Director.

Residency Committee Members

- Residency committee members will have access to all residents' quarterly review summaries.
- At the discretion of the Residency Coordinators, members of the residency committee may view other material in the residents' portfolios.
- If the Residency Coordinator is not comfortable allowing the residency committee member access to the requested material, a written request should be made to the Program Directors by either the Residency Committee Member or the Residency Coordinator. The request should explain what material is being requested and for what purpose. Granting of requests to view the additional portfolio information is at the discretion of the Program Directors.

Other Faculty

- At the discretion of the Residency Coordinators, other faculty members may have access to individual residents' quarterly review summaries.
- If the Residency Coordinator is not comfortable allowing the faculty member access to the requested material, a written request should be made to the Program Directors by either the faculty member or the Residency Coordinator. The request should explain what material is being requested and for what purpose. Granting of requests to view the portfolio information is at the discretion of the Program Directors.

All requests for additional access to resident portfolios, both to the Residency Coordinator and to the Program Directors, will be tracked for each resident. Again, like patients, our residents deserve the courtesy of knowing when their personal information is being accessed and for what purposes.

Adopted by Pediatric Residency Committee, July 2005

Revised September 2005

Reaccepted by Pediatric Residency Committee, July 2010

Additional information on *Resident and Fellow Files* under *Resident Code of Professional and Personal Conduct* can be found in the ***University of Kansas Graduate Medical Education Policy and Procedure Manual***.

<http://gme.kumc.edu/policiesandprocedures.html>

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 the policies for such set forth by the Institution regarding the work environment.

Additional information on *Equal Opportunity, Ombudsman Guidelines for Residents and Harassment Policy and Resident Fatigue and Stress* can be found in the **University of Kansas Graduate Medical Education Policy and Procedure Manual**. <http://gme.kumc.edu/policiesandprocedures.html>

Resident Duty Hours

The policy was adopted from the following Common Program Requirement effective July 1, 2003. The policy was amended based on the Revised Common Program Requirements effective July 1, 2011.

Additional information on *Resident Duty Hours and Call Schedules* can be found in the **University of Kansas Graduate Medical Education Policy and Procedure Manual**. <http://gme.kumc.edu/policiesandprocedures.html>

High Quality Education and Safe and Effective Patient Care

- Didactic and clinical education must have priority in the allotment of residents' time and energies.
- On-call schedules for teaching staff must be structured to provide resident supervision and faculty support/consultation is readily available to residents on duty.
- Duty hour assignments in teaching settings must recognize that faculty and residents collectively have responsibility for the safety and welfare of the patient.
- Faculty and residents must be educated to recognize the signs of fatigue and to apply preventive and operational countermeasures. The Program Director and faculty must monitor residents for the effects of sleep loss and fatigue, and to respond in instances when fatigue may be detrimental to resident performance and well being.
- Programs must provide residents appropriate backup support when patient care responsibilities are especially difficult and prolonged, and if unexpected needs create resident fatigue sufficient to jeopardize patient care during or following on-call periods.

Resident Duty Hours

Duty hours are defined as all clinical and academic activities related to the residency Program (patient care, administrative duties related to patient care, provision of transfer of care, time spent in-house on call, and scheduled academic activities such as conferences.) Duty hours do not include reading and preparation time spent away from the duty site.

Hours per week

- Residents **must** not be scheduled for more than 80 hours per week, averaged over four weeks.
- When residents take call from home and are called into the hospital, the time spent in the hospital **must** be counted toward the weekly duty hour limit
- Moonlighting and locum tenens time **must** be counted toward the weekly duty hour limit.

Days/Time Off

- Residents **must** have at least one full (24 hr) day out of seven free of patient care duties, averaged over four weeks.
- Residents *should* have a minimum rest period of 10 hours and **must** have a minimum of 8 hours between daily duty periods and **must** have a minimum of 14 hours free of duty after 24 hours of in house duty.

Duty Periods

- PGY-1 Residents: Continuous time on duty is limited to 16 hours for PGY-1 residents. No additional time is permitted for administrative duties related to patient care, educational or provision of transfer of patient care.

Duty Periods

- PGY-2/PGY-3 Residents: Continuous time on duty (including call) is limited to 24 hours for PGY-2 and PGY-3 residents.
 - Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00pm and 8:00am is encouraged.
 - An additional 4 hours may be used for administrative duties related to patient care, education and provision of transfer of patient care.
 - Senior level residents may not assume responsibility for any new patients after 24 hours.
 - In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions 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. Under those circumstances, the resident must:
 - Appropriately hand over the care of all other patients and document the reasons for remaining to care for the patient in question and submit that documentation to the program director.
 - Each submission for additional service will be reviewed by the program director and tracked both individually and program wide.
- Back up support systems must be provided when patient care responsibilities are unusually difficult or prolonged or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.

Call Periods

- Residents **must** not be assigned in-house call more often than every third night, averaged over four weeks.
- Residents assigned to night service must not be scheduled for more than 6 consecutive nights.
- At home call is not subject to the every third night limitation. However, at home call must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking home-call must also be provided with 1 day in 7 completely free from all educational and clinical responsibilities averaged over a 4-week period.

Approved by Pediatric Residency Committee November 2008

Reapproved by Pediatric Residency Committee, July 2010

Reapproved by Pediatric Residency Committee, July 2011

Duty Hours Time Entry: Reporting, Monitoring and Accountability Policy

Reporting of Duty Hours

Expectation: Residents are expected to enter all hours worked into E*Value by noon on Monday for the preceding week. A two-week cycle for reporting hours is not sufficient for rapid response to duty hour issues especially for the inpatient services.

Benefits

- Compliance with GME requirements for billing purposes
- Early identification of hours problems that CAN be fixed during a block rotation

Monitoring of Duty Hours

Enforcement

- Compliance will be checked Monday afternoon. Any resident who has not entered hours will be emailed to complete their time entry.
- Hours will again be checked first thing Tuesday morning. Failure to enter hours at this point will result in a Violation.

Accountability of Duty Hours Worked

Expectation: Residents are expected to follow all ACGME Duty Hour regulations. Residents are also expected to be honest in reporting hours violations so that personal and systematic changes can be made to assure Program wide compliance with duty hours.

Enforcement

- 1st Hours Violation
 - Meeting with Chief Resident
 - Notice sent to Senior Resident, and Attending
 - Discussion of how to fix system or personal barriers to compliance
- 2nd Hours Violation
 - Meeting with Dr. Gilmer
 - Notice sent to Senior Resident, Attending and Advisor
 - Letter placed in Resident File- such behavior may be reported on future verifications and letters of recommendation
- 3rd Hours Violation
 - Meeting with Academic and Professionalism Committee with possible Probationary Status for Unprofessionalism

Benefits

- Compliance with ACGME Duty Hour regulations
- Programmatic culture change to view Duty Hours as a professionalism issue

Approved by Pediatric Residency Committee November 13, 2008

Reapproved by Pediatric Residency Committee July 8, 2010

Reapproved by Pediatric Residency Committee June 9, 2011

Duty Hour Violations Report and Exceptions Report Policies

Duty Hour Violations Report

Violations of Duty Hours although not desired occur and may be permitted in special circumstances with appropriate documentation. Both Duty Hours Violations and Duty Hours Exceptions Reports will be generated and maintained by the program.

Reports demonstrating compliance with and noting specific violations are required by the ACGME. To that end, the program will generate a monthly, no less than quarterly, Duty Hours Violation Report. This report will include:

- Date of violation
- Violation
- Rotation
- Resident
- Explanation as provided by the resident
- Signature of resident
- Signature of Program Administrator
- Forward to Program Director

Program Administrator Responsibilities

- Run monthly, no less frequently than quarterly, Duty Hour Violation Reports
- Correct false positive violations
- Page residents with violations to complete their section of the Violation Report or to document “unusual circumstances”

Resident Responsibilities

- Understand all duty hours expectations
- Respond to emails to correct false positive violations
- Respond to pages to complete Exceptions Report within 48 hours
- Provide explanations for violations and sign Exceptions Report
- Provide documentation for any unusual circumstances related, when on their own initiative, the resident remains beyond their scheduled period of duty to continue to provide care to a single patient
- Failure attend to duty hours violations within 48 hours will result in matter being forwarded to Program Director

Program Director Responsibilities

- Document review of systemic causes of duty hours violations with residents and faculty as appropriate
- Review each episode of unusual circumstance related additional duty resulting in duty periods beyond 28 hours

Enforcement

- 1st Hours Violation
 - Meeting with Program Administrator
 - Discussion of how to fix system or personal barriers to compliance
- 2nd Hours Violation
 - Meeting with Dr. Gilmer
 - Notice sent to Senior Resident, Attending and Advisor
 - Letter placed in Resident File- such behavior may be reported on future verifications and letters of recommendation
- 3rd Hours Violation
 - Meeting with Academic and Professionalism Committee with possible Probationary Status for Unprofessionalism

Duty Hour Exceptions Report

Duty Hours Exceptions Permitted by Pediatric Review Committee

- In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions 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. Under those circumstances, the resident must:
 - Appropriately hand over the care of all other patients and document the reasons for remaining to care for the patient in question and submit that documentation to the program director.
 - Each submission for additional service will be reviewed by the program director and tracked both individually and program wide.

Approved by Pediatric Residency Committee June 9, 2011

Institutional Duty Hour Monitoring

Duty hours are also monitored at an institutional level. Monthly duty hour reports for all residencies and fellowships are review by the GMEC-Executive Committee and then the GMEC.

Programs with excessive duty hour violations are more carefully monitored with GMEC Duty Hour Action Plans. These intensive monitoring plans are also reviewed by the GMEC-EC and the GMEC.

Fatigue (Transportation/Swing Room) Guidelines and Fatigue Mitigation Files

If you are fatigued and unable to perform your patient care duties, please contact your supervisor (i.e., chief resident, faculty supervisor, program director, Chair and/or GME Office/DIO). Please inform your supervisor of your situation so that they can arrange for alternate coverage to ensure continuity of patient care.

Program call rooms should be utilized for fatigued residents/fellows for rest and/or power napping.

If adequate rest facilities are not available, then you may use the voucher fatigue transportation service. Vouchers for transportation will be available 24/7 in the PMEC for easy access afterhours. For each event 2 vouchers will be needed (one for home and then one for back to work the following morning.)

Protocol for Voucher Use

- The Vouchers will need to be filled in by the resident/fellow and the transportation service driver (designated as KUMC Resident Program Transportation voucher). Please print your name, Department and home address on the voucher.
- When you are ready to leave, please call 10/10 Taxi Service (913-647-0010) and tell them you are using the KUMC Resident Program Transportation voucher and your destination. They will pick you up at the Main Entrance of the hospital. The transportation service is allowed only to pickup you up from the KUH Hospital Main Entrance and drop you off at your home address, without any interval stops. This also applies for the return trip from your home to back to the hospital main entrance the next morning.
- The transportation service will collect each voucher white copy and submit to the GME Office. It is important that you return the YELLOW copy of the voucher to your program director.
- The resident is responsible for discussing the event and fatigue issue with their Program Leadership the following day. This must be documented by the program leadership in the "Fatigue Mitigation File".

Fatigue Mitigation File

- This file should contain documentation for discussions by the program leadership pertaining to reasons behind fatigue preventing ability to perform patient care duties or necessitating use of transportation service.
- The purpose of this file is to track both individual and program-wide episodes of fatigue and additional duty in order to mitigate future recurrences.

Moonlighting and Locum Tenens Policy

Moonlighting

The Pediatrics Residency Program does not permit moonlighting activities. Unapproved employment outside of the University of Kansas Medical Center may result in suspension from the training Program.

Locum Tenens

Residents must obtain prior written approval by the Program Director, Chairman of the Department, and the Executive Dean of the School of Medicine before engaging in any extra- Institutional locums activities. Once a resident has obtained a full, unrestricted permanent license, he/she may participate in locums opportunities depending on their academic status in the Program. Most locum tenens opportunities are sponsored through the institution's Office of Rural Health. For these experiences, the resident's Institutional professional liability insurance covers their activities. However, if residents participate in other locum tenens, they will be responsible for obtaining their own professional liability insurance.

Many of these opportunities involve weekend coverage and days away from rotations are minimal. However, if you will not be present for any part of your scheduled rotation including travel time to and from the locums, that time should be counted as locum time. Residents have 5 days of locum tenens time a year. As with educational days above, if locum time is used during a particular rotation, the resident may not be allowed to take other time off during the rotation. The 2011 Common Requirements require that moonlighting time be counted in the 80-hr week requirement. The Institution position is that locum tenens qualifies as external moonlighting and as such, locum tenens clinical activities, regardless of leave time taken, is subject to the 80-hr weekly maximum. Additional restrictions on locum tenens may also apply. Residents whose performance on the In-Training-Examination is indicative of successful passage of the pediatric board exam will be permitted to participate in locum tenens.

Additional information on the *Moonlighting, Locum Tenens, and Extra-Institutional Practice* can be found in the ***University of Kansas Graduate Medical Education Policy and Procedure Manual.***

<http://gme.kumc.edu/policiesandprocedures.html>

Approved by Pediatric Residency Committee July 2010

Reapproved by Pediatric Residency Committee June 2011

Vendor Relations Policy

The Department of Pediatrics and the Pediatric Residency Program follow the Institutional policy that went into effect May 2008. Highlights of the policy that affect residents are as follows:

I. Gifts and Meals

- A. Personal gifts, regardless of value, from vendor representatives to all KUMC Personnel are prohibited, including, but not limited to loans, economic opportunities, meals, tickets or vouchers for entertainment events, pens, notepads or cash. It is strongly advised that no form of personal gift from a vendor be accepted under any circumstances.
- B. KUMC personnel must consciously and actively divorce clinical care decisions and research activities from any perceived or actual benefits expected from any company. The overriding principle at KUMC is that healthcare providers represent their patients' best interests and not those of vendors. It is not acceptable for patient care decisions to be influenced by the possibility of personal financial gain.
- C. KUMC personnel cannot accept gifts or compensation for prescribing or changing a patient's prescription. KUMC personnel cannot accept gifts or compensation for listening to a presentation by a representative.
- D. KUMC personnel cannot accept compensation, including the defraying of costs, for attending a CME event or other activity or conference (that is, if the individual is not speaking or otherwise actively participating or presenting at the event).⁴
- E. Representatives cannot use KUMC personnel or resources to distribute information about vendor-sponsored events. This includes KUMC e-mail, mailings, e-page or other mass notification methods. Departmental and division offices, including residency and fellowship Programs, will not circulate announcements of vendor-sponsored events or provide e-mail lists or address lists of KUMC personnel, physicians or house staff.

II. Promotional Items and Drug Samples

- A. KUMC personnel will not accept or distribute items (e.g. pens, note pads, and similar "reminder" items). Promotion of drug or medical device products may not be for uses not reflected in United States Food and Drug Administration (FDA) approved product labeling. Under no circumstances can promotional items be used in patient care areas.
- B. Proper discretion will be utilized to assure the distribution of drug samples is for the benefit of the patient, not for product promotion
- C.

Additional information on the *State Ethics Policy* and *KUMC Vendor Relations Policy* under *Resident Code of Professional and Personal Conduct* can be found in the ***University of Kansas Graduate Medical Education Policy and Procedure Manual***. <http://gme.kumc.edu/policiesandprocedures.html>

Grievances and Appeal and Fair Hearings

Should a resident in the Department of Pediatrics have a grievance or be dissatisfied with any aspect of the Program, he/she is encouraged to initially discuss the issue with his/her attending, advisor or the Chief Resident. If this is felt by the resident to be inappropriate or the issue is not satisfactorily resolved, timely discussion with the Program Director or the Chairman is highly recommended. The Institutional GME office is yet an additional avenue for grievances. A resident may have another resident attend these discussions with them to serve as a resident advocate.

Documentation of the issues and a statement of dissatisfaction by the aggrieved resident may be helpful, and is also encouraged, particularly when making an appeal to a Departmental committee or Board of Appeal. A resident may request to appear before Residency Committee (composed of faculty representatives, the Chief Residents, and residents from each level). It should be understood that this committee is an advisory to the Department, the Chairman and the Program Director, and Committee recommendations or decisions only become policy or take effect with the Chairman's or Program Director's assent. Academic, promotional, competency, attitude, behavioral, and impairment issues or grievance would normally be concerns of the Residency Committee. The Chair of this committee is the Residency Director. The Program follows the grievance process as outlined in the Institutional GME manual.

Additional information on *Grievances and Appeal and Fair Hearing* can be found in the ***University of Kansas Graduate Medical Education Policy and Procedure Manual***.

<http://gme.kumc.edu/policiesandprocedures.html>