LOS ANGELES GENERA MEDICAL CENTER POLICY

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RESDIENT WORKING AND LEARNING ENVIRONMENT	7/01/03	**551.1**
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Policy Owner(s): Designated Institutional Officer
Executive Sponsor(s):

Departments Consulted:	Reviewed & approved by:	Approved by:
All Medical Departments with Graduate Medical Education Programs	Attending Staff Association Executive Committee Senior Executive Officer	Chief Medical Officer Chief Executive Officer

PURPOSE

This document constitutes the policy for the Los Angeles General Medical Center and for the Graduate Medical Education Committee (GMEC), which establishes resident/fellow policy and procedures in the learning and working environment.

POLICY

Providing residents with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each residency program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energies. Learning and working hour assignments must recognize that faculty and residents collectively have the responsibility for the safety and welfare of the patients.

Our educational program occurs in the context of learning and working environments at all participating sites that emphasize the following principles:

1. Demonstrates excellence in the safety and quality of care rendered to patients by residents/residents/fellows under the supervision of faculty members who serve as roles models of excellence, compassion, professionalism, and scholarship.
2. Models the effacement of self-interests in a humanistic environment that emphasizes and supports joy in curiosity, problem-solving, academic rigor, and discovery.
3. Commitment to the well-being of the students, residents/fellows, faculty members, and all members of the health care team
4. Cares for patients with appropriate faculty supervision and conditional independence, allowing the residents/fellows to attain the knowledge, skills, attitude, and empathy required for autonomous practice.
5. Develops physicians who focus on excellence in the delivery of safe, equitable, affordable, quality care; and the health of populations they serve.
6. Values the strength that a diverse group of physicians and other providers brings to medical care
7. Establishes the foundation for practice-based and lifelong learning.

DEFINITIONS

Learning and Working Hours All clinical and academic activities related to the residency program i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Learning and working hours do not include reading and preparation time spent away from the learning and working site or at-home call but do include time spent performing patient care work (charting and phone consults) at home.

In-House Call Those hours beyond the normal workday when residents are required to be immediately available within the assigned institution.

At-Home Call Call taken from home and/or outside the assigned institution.

Resident: refers to residents in primary specialties and fellows in sub-specialties. Resident and fellows are used interchangeably

Residency: refers to any graduate medical education training program. Residency and Fellowships are used interchangeably

ACGME: Accreditation Council for Graduate Medical Education

Core Requirements: Statements that define structure, resource, or process elements essential to every graduate medical educational program.

Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. USC/Los Angeles General, as the Sponsoring Institution, and its programs that are in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.

Sponsoring Institution: defined by ACGME as University of Southern California/Los Angeles General Medical Center (USC/Los Angeles General).

PROCEDURE

VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability

VI.A.1. Patient Safety and Quality Improvement

VI.A.1.a) Patient Safety

VI.A.1.a). (1) Culture of Safety

VI.A.1. a). (1). (a) The program, its faculty and residents/fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)

VI.A.1. a). (1). (b) The program is structured to promote safe, interprofessional, team-based care. (Core)

VI.A.1. a). (2) Education on Patient Safety

The program provides formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)

VI.A.1. a). (3) Patient Safety Events

VI.A.1. a). (3). (a) Residents/fellows, faculty members, and other clinical staff members must:

VI.A.1. a). (3). (a). (i) know their responsibilities in reporting patient safety events at the clinical site; (Core)

VI.A.1. a). (3). (a). (ii) know how to report patient safety events, including near misses, at the clinical site; and (Core)

VI.A.1. a). (3). (a). (iii) be provided with summary information of their institution's patient safety reports. (Core)

VI.A.1. a). (3). (b) Residents/fellows must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)

VI.A.1.a). (4) Resident/fellows Education and Experience in Disclosure of Adverse Events

VI.A.1. a). (4). (a) All residents must receive training in how to disclose adverse events to patients and families. (Core)

VI.A.1. a). (4). (b) Residents/fellows should have the opportunity to participate in the disclosure of patient safety events, real or simulated. (Detail)

VI.A.1.b) Quality Improvement

VI.A.1. b). (1) Education in Quality Improvement

VI.A.1. b). (1). (a) Residents/fellows must receive training and experience in quality improvement processes, including an understanding of health care disparities. (Core)

VI.A.1. b). (2) Quality Metrics

VI.A.1. b). (2). (a) Residents/fellows and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)

VI.A.1. b). (3) Engagement in Quality Improvement Activities

VI.A.1. b). (3). (a) Residents/fellows must have the opportunity to participate in interprofessional quality improvement activities. (Core)

VI.A.1. b). (3). (a). (i) This should include activities aimed at reducing health care disparities. (Detail)

VI.A.2. Supervision and Accountability (see DHS Policy #310.2)

VI.A.2.a) Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility

VI.A.2. a). (1) 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. (Core)

VI.A.2. a). (1). (a) This information must be available to residents/fellows, faculty members, other members of the health care team, and patients. (Core)

VI.A.2. a). (1). (b) Residents/fellows and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. (Core)

VI.A.2.b) Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced residents/fellows. Other portions of care provided by the residents/fellows can be adequately supervised by the immediate availability of the supervising faculty

member, more senior residents/fellows either on site or by means of telecommunication technology. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of residents/fellows-delivered care with feedback.

VI.A.2.b). (1) The program ensures that the appropriate level of supervision in place for all residents/fellows is based on each residents/fellows' 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. (Core) [The ACGME Review Committee may specify which activities require different levels of supervision.]

VI.A.2.b).(2) The program has defined circumstances when the physical presence of a supervising physician is required as follows (physical presence is defined as : the teaching physician is located in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service):

EACH PROGRM TO LIST THE SPECIFIC CLINICAL CIRCUMSTANCES FOR PHYSICAL PRESENCE OF AN ATTENDING (example: critical portions of surgical procedures)

VI.A.2.c) Levels of Supervision-To promote appropriate residents/fellows' supervision while providing for graded authority and responsibility, the program uses the following classification of supervision: (Core)

VI.A.2.c). (1) Direct Supervision

VI.A.2.c). (1). (a) – the supervising physician is physically present with the residents/fellows during the key portions of the patient interaction; or (Core) as specified by the program's Review Committee.

VI.A.2.c). (1). (b) – the supervising physician and/or patient is not physically present with the residents/fellows and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology if permitted by the program's Review Committee

VI.A.2.c). (2) Indirect Supervision: the supervising physician is not

VI.A.2.c). (2). (a) 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. (Core)

VI.A.2.c). (2). (b) 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. (Core)

VI.A.2.c). (3) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. (Core)

VI.A.2.d) 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. (Core)

VI.A.2. d). (1) Each program director must evaluate each of their resident's abilities based on specific criteria, guided by the Milestones. (Core)

VI.A.2. d). (2) 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. (Core)

VI.A.2. d). (3) 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. (Detail)

VI.A.2.e) Each program must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). (Core)

VI.A.2. e). (1) 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. (Outcome)

VI.A.2. e). (1). (a) Initially, PGY-1 residents must be supervised either directly, or indirectly with direct supervision immediately available. [Each Review Committee may describe the conditions and the achieved competencies under which PGY-1 residents progress to be supervised indirectly with direct supervision available.] (Core)

VI.A.2.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. (Core)

VI.B. Professionalism

VI.B.1. Each program in partnership with the Sponsoring Institutions, must educate residents and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients. (Core)

VI.B.2. The learning objectives of each program must:

VI.B.2.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; (Core)

VI.B.2.b) be accomplished without excessive reliance on residents to fulfill non-physician obligations; and (Core)

VI.B.2.c) ensure manageable patient care responsibilities. (Core) [As further specified by the ACGME Review Committee]

VI.B.3. The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)

VI.B.4. Residents and faculty members must demonstrate an understanding of their personal role in the:

VI.B.4.a) provision of patient- and family-centered care; (Outcome)

VI.B.4.b) safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; (Outcome)

VI.B.4.c) assurance of their fitness for work, including: (Outcome)

VI.B.4.c). (1) management of their time before, during, and after clinical assignments; and (Outcome)

VI.B.4.c). (2) recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team. (Outcome)

VI.B.4.d) commitment to lifelong learning; (Outcome)

VI.B.4.e) monitoring of their patient care performance improvement indicators; and (Outcome)

VI.B.4.f) accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data. (Outcome)

VI.B.5. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider. (Outcome)

VI.B.6. Each program in partnership with the Sponsoring Institution must provide a professional, respectful, and civil environment that is free from mistreatment, abuse, or coercion of students, residents, faculty, and staff. Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)

VI.C. Well-Being

VI.C.1. This responsibility must include:

VI.C.1.a) efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships; (Core)

VI.C.1.b) attention to scheduling, work intensity, and work compression that impacts resident well-being; (Core)

VI.C.1.c) evaluating workplace safety data and addressing the safety of residents and faculty members; (Core)

VI.C.1.d) policies and programs that encourage optimal resident and faculty member well-being; and (Core)

VI.C.1.d). (1) Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core)

VI.C.1.e) attention to resident and faculty member burnout, depression, and substance abuse. The program, in partnership with its Sponsoring Institution, must

educate faculty members and residents in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must: (Core)

VI.C.1.e). (1) encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence; (Core)

VI.C.1. e). (2) provide access to appropriate tools for self-screening; and (Core)

VI.C.1.e). (3) provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)

VI.C.2. There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. Each program must have policies and procedures in place that ensure coverage of patient care in the event that a resident may be unable to perform their patient care responsibilities. These policies must be implemented without fear of negative consequences for the resident who is unable to provide the clinical work. (Core). At a minimum the well-being policy must include:

1. Circumstances for which the resident may be unable to attend work and/or perform their patient care responsibilities
   a. Fatigue
   b. Illness
   c. Family emergencies
   d. Medical, mental health and dental appointments
   e. Others as agreed upon by the program director

2. Each program must include policies and procedures in place that ensure coverage of patient care in the event that a resident may be unable to perform their patient care responsibilities consistent with ACGME Common Program Requirement VI.C.2.

3. Well-being policies must be implemented and sustained without fear of negative consequences for the resident who is unable to provide the clinical work. (Core)

4. Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue. (Core)

VI.D. Fatigue Mitigation

VI.D.1. Each program must:

VI.D.1.a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation; (Core)

VI.D.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; and (Core)

VI.D.1.c) encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. (Detail)

VI.D.2. Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue. (Core)

VI.D.3. Each program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home. (Core)

VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care

VI.E.1. Clinical Responsibilities-The clinical responsibilities for each resident must be based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services. (Core) [Optimal clinical workload may be further specified by each Review Committee.]

VI.E.2. Teamwork-Residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty and larger health system. (Core) [Each Review Committee will define the elements that must be present in each specialty.]

VI.E.3. Transitions of Care (see DHS Policy #709)

VI.E.3.a) Each program must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)

VI.E.3.b) Each program, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. (Core)

VI.E.3.c) Each program must ensure that residents are competent in communicating with team members in the hand-over process. (Outcome)

VI.E.3.d) Each program and its clinical sites must maintain and communicate schedules of attending physicians and residents currently responsible for care. (Core)

VI.E.3.e) Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency. (Core)

VI.F. Clinical Experience and Education

VI.F.1. Maximum Hours of Clinical and Educational Work per Week-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. (Core)

VI.F.2. Mandatory Time Free of Clinical Work and Education

VI.F.2.a) Each 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. (Core)

VI.F.2.b) Residents should have eight hours off between scheduled clinical work and education periods. (Detail)

VI.F.2.b). (1) 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. (Detail)

VI.F.2.c) Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)

VI.F.2.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. (Core)

VI.F.3. Maximum Clinical Work and Education Period Length

VI.F.3.a) Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (Core)

VI.F.3. a). (1) 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. (Core)

VI.F.3. a). (1). (a) Additional patient care responsibilities must not be assigned to a resident during this time. (Core)

VI.F.4. Clinical and Educational Work Hour Exceptions

VI.F.4.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:

VI.F.4. a). (1) to continue to provide care to a single severely ill or unstable patient; (Detail)

VI.F.4. a). (2) humanistic attention to the needs of a patient or family; or (Detail)

VI.F.4.a). (3) to attend unique educational events. (Detail)

VI.F.4.b) These additional hours of care or education will be counted toward the 80-hour weekly limit. (Detail)

VI.F.4.c) A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.

VI.F.4.c). (1) In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the ACGME Manual of Policies and Procedures. (Core)

VI.F.4.c). (2) Prior to submitting the request to the Review Committee, the program director must obtain approval from the Sponsoring Institution's GMEC and DIO. (Core)

VI.F.5. Moonlighting

VI.F.5.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. (Core)

VI.F.5.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. (Core)

VI.F.5.c) PGY-1 residents are not permitted to moonlight. (Core)

VI.F.6. In-House Night Float-Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. (Core) [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 Review Committee.]

VI.F.7. Maximum In-House On-Call Frequency-Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). (Core)

VI.F.8. At-Home Call

VI.F.8.a) Time spent on patient care activities by residents on at-home call must count toward the 80-hour 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. (Core)

VI.F.8. a). (1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. (Core)

VI.F.8.b) 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 80-hour maximum weekly limit. (Detail)

RESPONSIBILITY

Administration
Director, Graduate Medical Education Committee
Graduate Medical Education Committee
Program Directors
Attending Staff
Residents

PROCEDURE DOCUMENTATION

Policies for Physicians in Residency Training Program at Los Angeles General Medical Center Program Policy and Procedures for Residents in Training

REFERENCES

ACGME Institutional Requirements
ACGME Common Program Requirements
ACGME Specialty and Subspecialty Program Requirements
ACGME Manual on Policies and Procedures
DHS Policy #310.2, "DHS Policy on Supervision of Residents"
Handbook of Policies for Physicians in Residency Training Program at LAC+USC Medical Center
Hand Off Communications Policy#709

REVISION DATES

July 01, 2003; October 20, 2008; February 11, 2014; October 10, 2017; August 26, 2023