CLINICAL EXPERIENCE AND EDUCATION POLICY

The Internal Medicine Residency Program fully endorses and adheres to the Accreditation Council for Graduate Medical Education (ACGME) Common Program Requirements (Section VI.F., effective July 1, 2017) and the UC Irvine Graduate Medical Education institutional Clinical Experience and Education Policy.

The internal medicine residency program, in partnership with the UC Irvine School of Medicine, is committed to an effective program structure that is designed to provide residents with optimal educational and clinical experiences, as well as a variety of strategies and opportunities to promote wellness.

Clinical Experience and Education hours

Clinical Experience and Education definition: All clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent on in-house call, and other scheduled activities, such as conferences. This term replaces the term "duty hours," "duty periods," and "duty."

Clinical Experiences and Education

1. Clinical experiences and educational endeavors must be limited to no more than eighty hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting.
2. Residents should have eight hours off between scheduled clinical work and education periods. There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the eighty-hour and the one-day-off-in-seven requirements.
3. Residents must have at least fourteen hours free of clinical work and education after twenty-four hours of in-house call.
4. Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative duties. At-home call cannot be assigned on these free days.
5. Adequate time for rest and personal activities must be provided. This should consist of a ten-hour time period provided between all daily duty periods and after in-house call.
6. Clinical and educational work periods for residents must not exceed twenty-four hours of continuous scheduled clinical assignments. Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care and/or resident education. Additional patient care responsibilities must not be assigned to a resident during this time.

Well-Being and Fatigue Mitigation

The training program is responsible for the following:

1. Education of all faculty members and residents to recognize the signs of fatigue and sleep

deprivation, and receive training on alertness management and fatigue mitigation processes.
2. Encouragement of residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning.
3. Assurance that both faculty and housestaff are aware of procedure to ensure continuity of patient care, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue, sickness or a family emergency.
4. Access to adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home. The UC Irvine Office of Graduate Medical Education provides safe, private sleep rooms to all residents, as well as a taxi reimbursement program.
5. Provision of educational opportunities, as well as reasonable opportunities for rest and personal well-being.

Maximum In-House On-Call Frequency

1. Residents must be scheduled for in-house call no more frequently than every fourth night (when averaged over a four-week period).

At-Home Call

1. 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.
2. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
3. 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.

Clinical Work Done from Home

1. Only the time residents devote to patient care activities, such as completing electronic health records and taking calls related to their patients, counts towards the eighty-hour maximum.
2. Reading done in preparation for the following day's cases, studying and research done from home do not count toward the eighty hours.

The internal medicine program and its institutions will not place excessive reliance on residents to meet the service needs of the participating training sites. To this end the program's policies with regard to work hours and all other educational and work environment issues will apply to all training sites.

As defined by the ACGME RRC for Internal Medicine, "PGY2 and PGY3 residents are considered to be in the final years of training" for purposes of defining supervision responsibilities.

Residents must not be routinely required to provide intravenous, phlebotomy, or messenger/transporter services. Inpatient support services must be available on a 24-hour basis to meet reasonable and expected demands, including intravenous services, phlebotomy services, messenger/transporter services and laboratory and radiological information retrieval systems that allow prompt access to all results.

Residents' service responsibilities must be limited to patients for whom the training program bears major diagnostic and therapeutic responsibility.

Residents will have no direct responsibility for non-teaching patients and will provide care for non-teaching patients only in the event of an emergency during which the resident is the only or best individual available to provide care.

Backup Policy

Adequate back up will be available at all times for house officers with patient care responsibilities. Back up will be regularly available and will comply with work hours requirements. Back up will be called whenever patient care caps are exceeded or whenever the burden of work would endanger patients or house officers.

It is the responsibility of the house officer to decide ultimately when further patients would impair the provision of safe and comprehensive patient care. Back up should be called at any time if patient care is affected. Furthermore, if the number of patients on any given team becomes too large for good patient care, the senior resident or attending on a team must report this to the Chief Resident who will evaluate the situation and make any necessary arrangements to stabilize the situation. The Chief Residents shall monitor this and shall be available to the house staff at all times for consultation and assistance.

Admissions and Admissions Cap Policy

For the purposes of the admissions cap, an admission or unit transfer is counted under the cap if the resident has physically taken responsibility for the patient. Anticipated ED admissions, transfer patients who have not yet arrived at the facility, clinic patients waiting for beds, admissions from home not yet at the hospital do **not** count towards the admissions cap until they arrive and become the responsibility of the admitting resident.

On inpatient rotations or during night float:

A first-year resident must not be responsible for more than five new patients per admitting day. (The first 2 unit transfers to a ward team do not constitute a "new" admission.)

a. A first-year resident must not be assigned more than eight new patient admissions in a 48-hour period.

b. The second- or third-year resident must not be responsible for admitting more than a total of 10 new patients per admitting day or more than 16 new patients in a 48-hour period, which includes the first-year resident's patients being supervised, plus 2 or more ICU transfer patients.

Ongoing Care

UCI IM residency general medicine ward teams will be capped at 18 patients with the option to flex to 20 total patients in extreme circumstances as defined by the program directors or chief residents.

a. A first-year resident must not be responsible for the ongoing care of more than 10 patients and generally not more than 8 patients.

b. When supervising one first-year resident, the second- or third-year resident must not be responsible for the ongoing care or more than 14 patients

c. When supervising more than one first-year residenta second- or third-year resident must not be responsible for the ongoing care of more than 20 patients.

d. A first-year resident rotating in an intensive care unit must not, general, be responsible for the ongoing care of more than 6 patients.

Duty Hours

When averaged over any unique rotation or assignment, duty hours must not exceed 80 hours per week. Duty hours include all activities related to the residency program including patient care, education, medical records completion, required research during the body of the residency (but not additional research years outside of the ACGME requirement or research conducted on personal time as a personal activity) and administration, but do not include reading and preparation time spent away from the duty sites.

When averaged over any specific rotation or assignment of any duration, residents must have at least one day (full 24 continuous hours) out of 7 free of patient care duties. This includes being free from back up responsibilities and from responding to pages.

1. Duty periods of PGY1 residents must not exceed 16 hours in duration.

2. Duty periods of PGY2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital.

3. Residents are encouraged to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.

4. It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.

5. Senior residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

In unusual circumstances, senior residents (not interns), 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 of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

Under those circumstances, the resident must:

i. Appropriately hand over the care of all other patients to the team responsible for their continuing care; and,

ii. Document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

iii. The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

6. PGY1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.

7. Residents in the final years of education (PGY 2-3) must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

   a. This preparation must occur within the context of the 80- hour, maximum duty period length, and one-day-off-in seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

   b. Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.

8. Residents must not be scheduled for more than six consecutive nights of night float.

    a. 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 GMEC governing the SOM's residency programs and will be applied to SOM's residents appointed to those residencies.

9. PGY2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

10. Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour 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 duty, when averaged over four week.

    a. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

11. Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period".

12. Adequate time for rest and personal activities will be provided between duty periods. This should generally be a minimum of ten hours off from responsibilities and no less than eight hours off in any case.

13. Emergency Medicine shifts must not exceed 12 hours per shift.

14. Emergency medicine assignments must be separated by at least 12 hours of non-patient care duties.

15. Residents taking at-home call must be provided one 24-hour period in 7 averaged over 4 weeks completely free of educational and clinical responsibilities.

16. Moonlighting must be counted toward the 80-hour limit (See the Policy on Resident Moonlighting.) All moonlighting, in house or external must be counted in the Duty Hours limits.

17. Interns (PGY1 residents) must not work longer than 16 continuous hours and must leave the hospital after 16 hours without further time for transition, completion of work or handoffs. Interns cannot take call from home although

they can take back-up call from home. Interns must not provide unsupervised care, either in-house or from home.

18. Senior residents (PGY2 or PGY3) must not work longer than 24 continuous hours with 4 additional hours allowable for hand-offs and transition, but not for the admission of new patients or ongoing patient care activities. Senior residents can take at home call, but must receive one day out of seven free from call. Senior residents may return to the hospital after less than 8 hours off between duty periods. This activity must be monitored by the program director.

19. Residents must attend a minimum of 130 continuity clinics over the 36 months of training. Residents must not attend continuity clinic after 24 hours on continuous in-house duty.

20. During ambulatory assignments and in continuity clinic, when averaged over the course of a year, a first-year resident's patient load must be 3-5 patients per half-day session, a second and third-year residents 4-6 patients.