Yale NewHaven Health Bridgeport Hospital

GRADUATE MEDICAL EDUCATION
POLICIES AND PROCEDURES

Subject:	**Resident Clinical and Educational Work Hours in the Learning and Working Environment (Formerly Resident Duty Hours and On-Call Activities)**
Effective Date:	June 2017
Distribution:	Accredited and GMEC-approved programs

INTRODUCTION/POLICY:
Resident Clinical and Educational Work Hours in the Learning and Working Environment Clinical and educational work hours are defined as all clinical and academic activities related to the residency program; i.e., patient care (both inpatient and outpatient), administrative work related to patient care, the provision for transfer of patient care, time spent in-house during call activities, moonlighting (internal and external), clinical work done from home and scheduled academic activities such as conferences. Clinical and educational work hours do not include reading and preparation time spent away from the work site. Graduate medical education clinical and educational work hour standards incorporate the concept of graded and progressive resident responsibility leading to the unsupervised practice of medicine.

Clinical and Educational Work Hour Standards
Each ACGME- accredited training program is required to establish a formal written policy governing resident clinical and educational work hours consistent with institutional and program requirements. The policy at a minimum must document that the following institutional clinical and educational work hour standards are met. These standards reflect the need for programs to design schedules and clinical assignments to match residents' levels of training and competencies in order to improve education and patient safety. Individual program policies may have additional specialty specific clinical and educational work hour restrictions. All programs will distribute their program policy and procedures to resident and faculty.

- 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.

- EXCEPTION REQUESTS: Some Residency Review Committees may grant rotationspecific exceptions to the 80-hour limit for up to 10% or a maximum of 88 clinical and educational work hours per week based on a sound educational rationale. Any request for exception to the 80-hour limit must be reviewed and approved by the GMEC and DIO prior to submission to a program's RRC. 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.

- MANDATORY TIME FREE OF CLINICAL WORK AND EDUCATION

The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being.

Residents should have eight hours off between scheduled clinical work and education periods.

> There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements.

Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.

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. One day is defines as one continuous 24-hour period free from all clinical, educational, and administrative activities.

- MAXIMUM CLINICAL WORK AND EDUCATIONAL PERIOD LENGTH

Clinical and educational work periods for residents must not exceed 24 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 during this time.

- CLINICAL AND EDUCATIONAL WORK HOUR EXCEPTIONS

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:

To continue to provide care to a single severely ill or unstable patient;
Humanistic attention to the needs of a patient or family; or
To attend unique educational events.

These additional hours of care or education will be counted towards the 80-hour weekly limit.

- IN-HOUSE NIGHT FLOAT

Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. [The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]

- 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).

- AT-HOME CALL

Time spent on patient care activities by residents on at-home call must count towards 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.

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 weekly maximum; however, at-home call should not be associated with extensive returns to provide hospital service.

At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident and the program director must monitor the demand of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.

- MOONLIGHTING (INTERNAL AND EXTERNAL)

Please see Moonlighting Policy

Moonlighting is discouraged and must be approved in advance by the Program Director. Before seeking permission to moonlight, residents should closely review GME Policy on Moonlighting. Residents must not be required to engage in moonlighting and it 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. Residents should not participate in moonlighting if it will violate any provision within the GME policy that residents must have eight hours of time off from clinical work education before participating in moonlighting activities and before returning to duty after moonlighting.

If written approval for a moonlighting activity is received from the Program Director, the resident must enter in MedHub all time spent in Internal and External Moonlighting including any voluntary, compensated, medically-related work performed inside (not related with training requirements) or outside the institution where the resident is in training or at any of its related participating sites. These hours must be counted toward 80-hour maximum weekly limit.

PGY-1 residents are not permitted to moonlight. Residents on J-1 or J-2 visas cannot moonlight. Residents on an H-1B visa may not engage in any moonlighting activities unless compliance with legal requirements regarding sponsorship are met by the resident and sponsor/employer.

> Individual programs may have additional moonlighting restrictions and will distribute their program policy and procedures to residents and faculty.

Clinical and Educational Work Hour Oversight

Clinical and educational work hour compliance is a collective responsibility of GME and program leadership, faculty, and residents. Each program is required to use MedHub to log duty

hours and monitor compliance with institutional, common and specialty/subspecialty-specific program requirements.
Residents are expected to log duty hours concurrently. Unlocking of MedHub for retroactive logging (beyond two weeks) will only occur in rare circumstances, due to emergencies or system-related issues. Programs are expected to monitor duty hour logging compliance. Residents who regularly do not log duty hours concurrently jeopardize the programs ability to address scheduling and other issues that may result in violations. Programs must include this expectation in their formal written policy.

Program directors must monitor resident clinical and educational work hours and adjust resident schedules as needed to mitigate excessive service demands and/or fatigue and to prevent negative effects of clinical and educational work hours on learning and patient care. This includes monitoring the need for and ensuring the provision of back up support systems when patient care responsibilities are usually difficult or prolonged. Residents and faculty have a personal role and professional responsibility in the honest and accurate reporting of resident clinical and educational work hours.

Clinical and educational work hour reports will be reviewed by the GMEC and compliance issues addressed as needed.

Professionalism, Personal Responsibility, and Patient Safety
Residents and faculty members must be educated concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients. The program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment. The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.

The learning objectives of the program must be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; accomplished without excessive reliance on residents to fulfill non-physician obligations; and, ensure manageable patient care responsibilities. The program director in partnership with the sponsoring institution must provide a culture of professionalism that supports patient safety and personal responsibility. Residents and faculty members must demonstrate an understanding of their personal role in the following:

a) safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events;
b) provision of patient- and family-centered care;
c) assurance of their fitness for work;
d) management of their time before, during, and after clinical assignments;
e) recognition of impairment, including, illness from fatigue, and substance use, in themselves, their peers, and other members of the health care team
f) commitment to lifelong learning;
g) monitoring of their patient care performance improvement indicators; and,
h) accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data.

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.

Programs 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 institution, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns