



Wright State University  
Boonshoft School of Medicine  
Sponsoring Institutions

**Policies Governing  
Residency Duty Hours,  
Supervision, Care  
Transitions, and  
Professionalism**

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## Item 512: Patient Handoff Communication Policy

Adopted June 2013

### Purpose

To provide guidance on, and expectations for the development and implementation of a standardized process for handoff communication to ensure effective information transfer among providers during handoff with the overarching goal of minimizing the potential for medical errors. The primary objective of handoff communication is to provide accurate information about a patient's care, treatment, and services, current condition, and any recent or anticipated changes.

The Joint Commission requires all health care providers to "implement a standardized approach to handoff communications including an opportunity to ask and respond to questions" (2006 NPSG 2E). The Accreditation Council for Graduate Medical Education also requires that residency programs maintain formal educational programs in handoff and care transitions.

### Definitions

*Communication*: the process by which information is exchanged between individuals, groups, and organizations. In order to be effective, communication should be complete, clear, concise, and timely.

*Handoff* (as addressed in this policy): the process of transferring patient information and knowledge, along with authority and responsibility, from one clinician or team of clinicians to another clinician or team of clinicians during routine changes of duty assignment.

*Signout*: as defined by the Agency for Healthcare Research and Quality (AHRQ) is used to refer to the act of transmitting information about the patient.

*Transition of care*: Patient movement from one area or level of care to another (e.g. emergency department to inpatient admission, general medical floor to intensive care). Such transitions are addressed in other hospital and program policies.

### Policy

Patient care responsibilities are shared among many team members including, but not limited to, residents and fellows (hereafter referred to as "residents"). When a resident completes an assigned period of duty or prepares to leave the hospital/clinic to take care of other responsibilities, he/she is expected to "sign out" to the resident or attending assuming care for all assigned patients.

It is understood that specific handoff procedures will vary from one discipline to another and from one practice site to another. This policy outlines general principles and expectations for patient handoff, with the adoption of specific process and form to be determined by each program and site. Although no specific requirements are mandated, The Joint Commission provides guidelines for the development of the handoff process. Each program and site will develop its own standardized process and incorporate The Joint Commission guidelines to include the following:

1. Interactive communication between the giver and receiver of patient information, including an opportunity for the receiver to ask for clarification of any issues or items presented.

2. A system for providing updated information regarding each patient's condition, treatment, and anticipated needs during the coverage period.
3. A strategy to minimize interruptions during the handoff process.

It is expected that every program will develop the handoff process to include the following items:

1. To whom each resident will sign out and whether handoff includes transfer of an on-call phone or pager.  
Examples:
  - Intern to intern, senior to senior – handoff phone and code pager
  - Fellow to attending
  - Team to team
2. A location that will minimize interruptions
  - a. For many programs this will be a standard time and location for handoffs  
Examples:
    - 7:30 a.m. and 4:30 p.m. in the 6th floor conference room
    - Department conference room: all at 6:30 a.m., overnight at 11:30 a.m., short call at 5:30 p.m.
  - b. For other programs, a mutually agreed upon time and location that will minimize interruptions to the handoff process
3. Standardized handoff content (consider inclusion of a standard hard copy [see sample] or electronic "signout form" with discipline-specific details for each patient as written communication may assist the person conveying clinical information in organizing his/her thoughts and presenting important details, and provides the receiving party hard copy information for future reference). The most effective handoff of patient information includes both verbal and written components. Although the exact content may vary from one program to another most will likely include the following:
  - a. Demographic information: name, room number, date of birth, medical record number
  - b. Code status
  - c. Reason for admission and active problem list
  - d. Consultants currently involved in care
  - e. Current medications (if not readily available from Electronic Medical Record)
  - f. Allergies
  - g. Selected specific therapeutics: oxygen or ventilator settings, dietary restrictions, NPO status for imaging study
  - h. Expected action items (lab results, improvement in symptoms) and intended response. Examples:
    - If 9:00 p.m. Hgb < 7, transfuse one unit PRBC
    - If BP systolic consistently > 180, resume labetalol drip
    - If temperature > 101F, no need for additional cultures
  - i. Special family or communication issues. Examples:
    - Minor children – custody or guardian
    - Non-English speaking, available translator
  - j. Responsible attending physician, how to contact, and specific expectations for updates

If signout forms are used, they must be maintained in a confidential manner. Examples: specific document in the electronic medical record system, password protected document (Word, Excel, etc.) on a single computer workstation, handwritten hard copy passed directly from one resident to another.

Signout forms must never be:

1. Sent by unencrypted email, even through a hospital system
2. Left in a publicly accessible mailbox or other “drop area”
3. Copied for or sent to unauthorized users
4. Disposed of in non-confidential trash receptacles

Every program is expected to monitor the handoff process. Faculty should seek feedback from residents to make changes that will enhance the ability to cross-cover residents to deliver care as intended by the primary team. Residents should share ideas that will improve the quality of information delivered so covering residents can more easily adjust therapy based on changes in patient condition. The handoff processes should be revised as needed for ongoing improvement in the quality and safety of patient care.

## Item 208: Fatigue, Supervision, Duty Hours

Revised May 2011

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### Introduction

Graduate medical education programs should produce competent physicians capable of independent practice. PGY-1 residents will be regularly and directly supervised by experienced physicians, including by more senior residents and faculty. Senior residents should have well-developed patient care skills and should require only periodic, indirect supervision. Residents must assume progressive responsibility for patient care and recognize their limits, seeking consultation from attendings and supervisors in a timely fashion.

### Resident Fatigue

In residency training, impaired performance means missed opportunities for learning and, at worst, hazards to patients.

a. Fatigued residents typically have difficulty with:

- Appreciating a complex situation while avoiding distraction
- Keeping track of the current situation and updating strategies

- Thinking laterally and being innovative
- Assessing risk and/or anticipating consequences
- Maintaining interest in outcome
- Controlling mood and avoiding inappropriate behavior

b. Signs of fatigue include:

- Involuntary nodding off or waves of sleepiness
- Problem of focusing
- Lethargy
- Irritability or mood lability
- Poor coordination
- Difficulty with short-term recall
- Tardiness or absences at work

c. High risk times for fatigue-related symptoms are:

- Midnight to 6:00 a.m.
- Early hours of day shifts
- First night shift or call night after a break
- Change of service
- First two to three hours of a shift or end of a shift
- Beginning of residency or new to night call

d. Methods to limit fatigue-related problems include:

- Following the 80-hour limit of the total number of hours worked.
- Establishing a workload that allows for as little variation in work schedules as is feasible. Rapid or frequent shifts from day to night work are known to increase the risk of fatigue.
- Creating individualized schedules to accommodate idiosyncratic energy cycles.
- Encouraging residents to consult their primary care physicians if daytime fatigue seems out of proportion to the workload. Sleep studies may be warranted.
- Obtaining diagnosis and treatment to determine if fatigue is depression or other psychiatric syndrome.

## Supervision

Residents must develop the knowledge, skills, and attitudes to deliver patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. A supervisor must continuously assess the skills of residents, the amount of independence to be granted, and the level of supervision required. This supervisory level must assure the provision of safe patient care, maintain expected professional standards, and encourage the pursuit of orderly intellectual and professional growth.

### *Individualized Learning Priorities*

At the onset of each rotation, supervisors should assess the professional experience of their residents including areas of strength and weakness. This evaluation can start with the review of written evaluations of previous performance and

continue through discussion with the resident as well as close observation of early performance in all phases of patient care. Each educational rotation should be individualized and emphasize areas where residents need more attention to achieve ideal patient-care skills. The supervisor and the resident should jointly formulate those learning objectives. The supervisor should also recognize individual differences among residents, such as special areas of interest, and compensate for them. Residents should know the goals and objectives they are expected to achieve during the rotation.

#### *The Supervisor's Role*

The supervisor should motivate residents toward independent learning, self-reliance, and intellectual competence, as well as cultivate curiosity, critical thinking, and mature understanding. Residents need assistance in evaluating, integrating, and correlating clinical information. They must solve problems at the highest taxonomic levels. Supervisors should articulate the thought processes used in problem solving so that residents can develop their individual analysis and synthesis processes. The supervisor should help residents learn with clear instruction that correlates with their levels of understanding.

The supervisor should be readily available to guide and support residents with patient responsibilities and must recognize that the faculty and residents have collective responsibility for patient safety and welfare. When approached by residents about patient care problems, the supervisor should be helpful and considerate. The supervisor should actively encourage questions, opinions, and comments. Learning is enhanced by reasonable flexibility and the willingness to allow discussion of alternative ideas of management suggested by residents. The supervisor should discuss patient care problems with residents to stimulate profound thought. New psychomotor skills should be demonstrated first by the supervisor and then performed by residents under observation until the residents attain proficiency.

The supervisor should recognize the resident's concurrent personal, ethical, and social development. Residents need to develop an individual system of productive self-assessment and self-confidence. These attributes can be facilitated by an observant, thoughtful, and dedicated supervisor. The supervisor must monitor for signs of resident fatigue and intervene to assure safe patient care and learning.

#### *Evaluation of Performance and Feedback*

Resident performance evaluation and provision of feedback should be continuous processes. The supervisor should use fairness, patience, and tact, always treating residents with respect. The supervisor should observe while residents perform procedures, interact with them during rounds and conferences, evaluate them in all aspects of patient care, and then provide them with constructive critique and helpful suggestions. All supervision must be done in a tactful and confidential manner. Written evaluations should be precise and honest and include detailed descriptions of actual observed performance. Performance evaluations should be discussed with and acknowledged by residents and communicated only to appropriate administrators of the program.

#### **Duty Hours**

Recognizing the relationship between resident duty hours, quality patient care, and quality education, programs must follow these requirements in regard to duty hours for residents and fellows.

### *Maximum Hours of Work per Week*

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting. When residents are on call at home and are called into the hospital, the time then spent in the hospital must also be counted towards the weekly hour limit.

1. In emergency room assignments, residents should be scheduled to work a maximum of 12 hours to be followed immediately by 12 hours off duty.

### *Duty Hour Exception*

The Graduate Medical Education Committee (GMEC) must review and endorse any program's exception request before the request is submitted to the program's RRC. The GMEC will only consider requests for duty hour exceptions when the program can clearly show that the exception is necessary for educational reasons. Only programs accredited in good standing, i.e., without a warning or a proposed or confirmed adverse action, may request that an exception be considered.

The program director must submit a written request for GMEC review. The program's responsibility is to make a clear showing that the exception is necessary for educational reasons. The proposal must include the following documentation:

1. **Patient Safety:** Information must be submitted that describes how the program will monitor, evaluate, and ensure patient safety with extended resident work hours.
2. **Educational Rationale:** The request must be based on a sound educational rationale, which should be described in relation to the program's stated goals and objectives for the particular assignments, rotations, and level(s) of training for which the increase is requested. Blanket exceptions for the entire educational program should be considered the exception, not the rule.
3. **Moonlighting Policy:** Specific information regarding the program's moonlighting policies for the periods in question must be included.
4. **Call Schedules:** Specific information regarding the resident call schedules during the times specified for the exception must be provided.
5. **Faculty Monitoring:** Evidence of faculty development activities regarding the effects of resident fatigue and sleep deprivation must be appended.
6. **Program improvement:** Evidence of improvement related to citations from the last program review, either internal or by the RRC, must be included.

If approved by the GMEC, the GMEC chair and the designate institutional official (DIO) will sign a letter documenting GMEC endorsement. The GMEC endorsement letter and a copy of this policy must be included in the RRC proposal.

### *Moonlighting*

Residents are not required to perform patient care activities outside of the educational program ("moonlighting"). Any moonlighting that occurs within the residency program and/or its primary clinical site(s), i.e., internal moonlighting, must be counted toward the 80-hour maximum weekly hour limit. Moonlighting by residents must be approved by the program director, in compliance with Policy 210 Patient Care Activities Outside of the Educational Program ("Moonlighting") and the guidelines of the program and only if the activities do not adversely affect patient care and the resident's educational program. PGY-1 residents are not permitted to moonlight.



*Mandatory Time Free of Duty*

Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

*Maximum Duty Period Length*

Duty periods of PGY-1 residents must not exceed 16 hours in durations.

Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities.

Residents may be allowed to remain on-site in order for effective transitions for patient safety and resident education. This period of time must be no longer than an additional four hours.

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

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 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:

- Appropriately hand over the care of all other patients to the team responsible for the patients' continuing care; and
- Document the reasons for remaining to care for the patient in questions and submit that documentation in every circumstance to the program director.

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

*Minimum Time Off between Scheduled Duty Periods*

PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.

Intermediate-level residents [as defined by the review committee] should have 10 hours free of duty, and must have eight hours, between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.

Residents in the final years of education [as defined by the review committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. 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 [as defined by the review committee] 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. The program director must monitor these circumstances of return-to-hospital activities.

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

PGY-2 residents and above must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period).

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*At-Home Call*

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 weeks.

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

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."

*Transitions of Care*

Each program should have a documented process in place for ensuring the effectiveness of transition of patient care.

*Monitoring of Duty Hours*

Each program must have written policies and procedures consistent with the ACGME Requirements for resident duty hours and the working environment. Monitoring of duty hours is required, at sufficient frequency to ensure compliance with the Common Program Requirements regarding duty hours, as well as individual program requirements.

Each program is required to submit to the DIO a written report for the past year and upcoming plans for the next year. The program's annual report must include data obtained through the program's duty hour compliance efforts, areas of potential non-compliance, and plans for addressing any problems identified, including needed resources.