HACKENSACK MERIDIAN HEALTH
OCEAN MEDICAL CENTER
GRADUATE MEDICAL EDUCATION
POLICIES AND PROCEDURES

Subject: **GENERAL RESPONSIBILITIES OF RESIDENTS AND FELLOWS**	**Policy Number:** **4.A**
Approved by GMEC: March 7, 2016	**Approved by MEC: June 7, 2018**

1. INTRODUCTION AND PURPOSE

The purpose is to provide guidelines to residents regarding their general responsibilities as a Ocean Medical Center (OMC) postgraduate trainee. Specific responsibilities are contained in departmental job descriptions and manuals.

2. SCOPE

This policy will apply to all of the postgraduate training programs at Hackensack Meridian Health (HMH) facilities.

3. APPLICABLE REGULATIONS AND GUIDELINES

ACGME Institutional Requirement IV.B

4. ATTACHMENTS

5. RESPONSIBILITY

6. DEFINITIONS

Resident refers to all interns, residents and subspecialty residents (fellows) engaged in post graduate education at Ocean Medical Center .They are also identified by their year of postgraduate training (e.g. PGY 1).

7. PROCESS OVERVIEW

A. Policy

OMC residents are expected to take advantage of the educational opportunities offered within the institution and provide medical treatment to the Medical Center's patients in a competent and caring manner. Moral, ethical and professional behavior is expected at all times.

To meet these responsibilities, residents are expected to:

1. Attend and actively participate in all didactic conferences and teaching rounds within the assigned department.

2. Render appropriate medical care to patients in a kind, caring manner under the supervision of the attending/consulting physician.

3. Attend assigned clinics.

4. Participate in the evaluation of the program, peers and teaching faculty as requested by the Program Director.

5. Participate in research projects and quality improvement activities of the Program or Affiliated Hospitals.

6. Document care and sign, date, and time patient charts and complete medical records in a timely manner.

7. Volunteer to serve as a member of various departmental and hospital committees.

8. Be on time for all assignments.

9. Respond in a timely manner.

10. Conduct themselves in an ethical and moral manner.

11. Maintain a professional appearance, comportment and conduct.

12. Assume progressive responsibilities as he/she gains experience.

13. Contribute to the overall success of the operation within the Department and Hospital.

14. Provide supervision and instruction to less senior residents and students.

15. Document completion of procedures and submit information on a timely basis to the Program Director's office.

16. Cooperate with nursing and support staff.

17. Attain proficiency in all (6) ACGME Competencies.

18. Perform "other duties" as required by your Department/Program Director.

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Subject: **RESIDENT INVOLVEMENT IN HOSPITAL AFFAIRS**	**Policy Number:** **4.B**
Approved by GMEC: March 7, 2016	**Approved by MEC: June 7, 2018**

1. INTRODUCTION AND PURPOSE

To provide guidelines which identify opportunities for residents participation in the hospital's affairs.

2. SCOPE

This policy will apply to all of the postgraduate training programs at Hackensack Meridian Health (HMH) facilities.

3. APPLICABLE REGULATIONS AND GUIDELINES

ACGME Institutional Requirements III.B.2., III.B.2.a), III.B.2.b)
Effective July 1, 2018

4. ATTACHMENTS

5. RESPONSIBILITY

Program Directors, Designated Institutional Official (DIO)

6. DEFINITIONS

Resident refers to all interns, residents and subspecialty residents (fellows) engaged in post graduate education at Ocean Medical Center. They are also identified by their year of postgraduate training (e.g. PGY 1).

7. PROCESS OVERVIEW

A. Policy

B. Procedure

8. RESPONSIBILITIES/REQUIREMENTS

OMC encourages residents to participate on hospital and departmental committees in an effort to continually upgrade the educational process and to enhance patient care.

Resident representatives to the committees are appointed by the Program Directors who may solicit volunteers, with the exception of membership on GMEC who are peer selected residents. Resident representatives are expected to attend all activities associated with committee membership. If the resident cannot attend, they must notify the committee they represent as well as their department.

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Subject: **LEGIBILITY OF MEDICAL RECORD DOCUMENTATION**	**Policy Number:** 4.C
Approved by GMEC: March 7, 2016	**Approved by MEC: June 7, 2018**

Reference: HMH Legibility of Medical Record Documentation PolicyStat ID: 3354032

Attachments:

Policy on Legibility of Medical Record Documentation

Hackensack Meridian *Health*

Origination Date:	*01/2006*
Last Approved:	*11/2015*
Last Revised:	*11/2015*
Next Review:	*11/2018*
Owner:	*Deeba Siddiqui: VP PATIENT SAFETY HMH*
Policy Area:	*Patient Safety*
Applies To:	
Applicability:	*Legacy Meridian Health Group*

Legibility of Medical Record Documentation

Purpose:

To provide a process for the identification and reporting of illegible medical record documentation.

To improve the effectiveness of communication between health care providers by requiring legible medical record documentation.

Scope:

All staff of Meridian Health.

Policy:

DEFINITION: Illegible - Very difficult to read as determined by two (2) licensed/certified health care professionals due to the entry being poorly written or printed.

It is the policy of Meridian Health to ensure that all medical record documentation is legible. Handwritten medical record documentation that is difficult to read jeopardizes patient safety. Illegible handwriting is a serious source of communication error as it can lead to medication and/or treatment errors and at the very least, can delay patient care and result in inefficient operations. The intent of this policy is to identify and correct chronic behavior rather than occasional occurrences.

Procedure:

1. Legibility concerns may be identified by physicians, nurses, pharmacists, and other healthcare professionals that rely on the medical record for patient care information, including Health Information Management and Case Management staff.
2. All examples of illegible team member medical record documentation will be forwarded to the manager of the respective department, as well as the site Human Resources Department for tracking and trending.

   When three (3) or more occurrences of illegible documentation are received for an individual, within a twelve (12) month rolling period, the site Human Resources Department staff member will advise the manager to follow the Human Resources *Guidelines for Cooperation and Discipline* policy, #MHS-HR-01-2601, as it pertains to "Failure to Perform to a Satisfactory Degree", and issue a Level 1 Infraction.
3. All examples of illegible physician/Licensed Independent Practitioner (LIP) medical record documentation will be forwarded to the Outcomes Management/Quality Department or designee of their respective

facility for tracking and trending. Whenever such documentation is received the Outcomes Management/ Quality Department or designated department will forward this to the physician/LIP involved.

When three (3) or more occurrences of physician/LIP illegible documentation are received within a twelve (12) month rolling period, the Outcomes Management/Quality or designated department staff will forward this to the appropriate Medical Staff Department Chair/Director or designee for follow-up action.

Special Notes / Appendix

References:

1. The Joint Commission "Comprehensive Accreditation Manual for Hospitals
2. Center for Medicare & Medicaid (CMS), "Conditions of Participation for Hospitals"

Pre-PolicyStat Number: MHS-ADMIN-01-1063

All revision dates: 11/2015, 03/2014, 01/2011, 05/2007, 01/2006

Attachments:

No Attachments

Applicability

Bayshore Medical Center, Hackensack Meridian Health Inc. , Jersey Shore University Medical Center, Legacy Meridian Health, Ocean Medical Center, Raritan Bay Medical Center - Old Bridge Division, Raritan Bay Medical Center - Perth Amboy Division, Riverview Medical Center, Southern Ocean Medical Center

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Subject: **Supervision and Accountability**	**Policy Number:** **4.D**
Revised and Approved GMEC: March 7, 2016	**Approved MEC: June 7, 2018**

1. INTRODUCTION AND PURPOSE

To establish an institutional supervision and accountability policy to ensure all residency/fellowship training programs provide increasing amounts of responsibility with appropriate supervision for all residents.

2. SCOPE

This policy will apply to all of the postgraduate training programs at Ocean Medical Center and participating sites.

3. APPLICABLE REGULATIONS AND GUIDELINES

- ACGME Institutional Requirements III.B.4; effective July 1, 2015
- ACGME Common Program Requirements VI.A; effective July 1, 2017
- CODA Requirements of the ADA
- Council on Podiatric Medical Education (CPME)
- American Society of Health–System Pharmacists (ASHP) Regulations on Accreditation of Pharmacy Residents

4. ATTACHMENTS

None

5. RESPONSIBILITY

Program Directors, Associate Program Directors, Core Faculty, Attending Physicians and the Designated Institutional Official (DIO) and Associate Designated Institutional Official (A-DIO).

6. DEFINITIONS

"Residents" refers to all interns, residents and subspecialty residents (fellows) engaged in post graduate education at Ocean Medical Center (OMC). They are also identified by their year of postgraduate training (e.g. PGY-1). Senior resident refers to all fellows and residents in their final year of training.

7. RESPONSIBILITIES/REQUIREMENTS

Policy

"Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care." (VI.A.2.a)

Every resident is assigned to a designated service. On-call schedules and rotation schedules are developed on a monthly basis to provide residents with a variety of service and patient experiences. Back up is available at all times through more senior residents and faculty and attending physicians.

Each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by applicable Review Committee) who is ultimately responsible and accountable for that patient's care. VI.A.2.a).(1)

1. This information must be available to residents, faculty members, and patients. VI.A.2.a).(1).(a)
2. Residents and faculty members must inform patients of their respective roles in each patient's care. VI.A.2.a).(1).(b)
3. The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.

Supervision may be exercised through a variety of methods. 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, fellow or senior resident physician, either on site, or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident delivered care with feedback. VI.A.2.b)

OMC's GME programs must demonstrate that the appropriate level of supervision is in place for all residents based on each resident's 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. VI.A.2.b).(1)

Levels of Supervision VI.A.2.c)

To promote oversight of resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:

1. Direct Supervision: the supervising physician is physically present with the resident and patient. VI.A.2.b).(1)

2. Indirect Supervision: 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, but and is immediately available to provide Direct Supervision. I.A.2.c.(2).(a)

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

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

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. VI.A.2.d

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

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

3. Senior residents or fellows should serve in a supervisory role of 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. VI.A.2.d).(3)

4. Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member. VI.A.2.e)

5. Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence. 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.] VI.A.2.e).(1)a

6. Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility. VI.A.2.f)

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Subject: COMPLIANCE WITH MAGGIE'S LAW	Policy Number: 4.E
Approved by GMEC: March 7, 2016	Approved by MEC: June 7, 2018

1. INTRODUCTION AND PURPOSE

To establish guidelines for resident adherence to "Maggie's Law", which refers to N.J.S.A. 2C:11-5: "Death by vehicular homicide". The statute provides:

A. Criminal homicide constitutes vehicular homicide when it is caused by driving a vehicle or vessel recklessly. (For the purposes of this section, driving a vehicle or vessel while knowingly fatigued shall constitute recklessness. 'Fatigued' as used in this section means having been without sleep for a period in excess of 24 consecutive hours.) "Proof that the defendant fell asleep while driving or was driving after having been without sleep for a period in excess of 24 consecutive hours may give rise to an inference that the defendant was driving recklessly."

B. "Vehicular homicide is a crime of the second degree."

2. SCOPE

This applies to all faculty and postgraduate medical education programs and individual residents.

3. APPLICABLE REGULATIONS AND GUIDELINES

GME Policy 3.D – Fatigue Prevention, Identification and Management

4. DEFINITIONS

Resident refers to all interns, residents and subspecialty residents (fellows) engaged in post graduate education at Ocean Medical Center. They are also identified by their year of postgraduate training (e.g. PGY 1).

5. PROCESS OVERVIEW

Residents and Program Directors should be aware of the potential problems that may result from driving a vehicle after having been without sleep for a period in excess of 24 consecutive hours.

A. Residents who have been without sleep for a period in excess of 24 consecutive hours must, before driving, take one or more of the following actions.
   1. sleep for a period of time sufficient to feel rested before driving
   2. arrange to be driven to their home/ place of residence, alternative site
   3. take public transportation to their home/ place of residence, alternative site.

B. The responsibility of Ocean Medical Center is to ensure that a place conducive to sleep is available to residents at the end of any shift of 24 or more consecutive hours.

C. The Program Director shall inform all residents of the potential impact of sleep deprivation and fatigue on performance and the provisions of Maggie's Law. The Program Director must also ensure that any site at which residents work 24 hours or more has a space available that is conducive to sleep.

D. Oversight:

   1. The Office of Academic Affairs will oversee this process and ensure that the Program Directors comply with this policy.

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Subject:	Policy Number:
TRANSITION OF CARE	4.F.
Approved by GMEC: March 7, 2016	Approved by MEC: June 7, 2018

1. INTRODUCTION AND PURPOSE

The purpose of this policy is to define a safe process to convey important information about a patient's care when transferring care responsibility from one resident to another.

2. SCOPE

This policy will apply to all of the postgraduate training programs at Meridian Hospitals Corporation (MHC) facilities.

3. APPLICABLE REGULATIONS AND GUIDELINES

ACGME Institutional Requirements VI.E.3., VI.E.3.a), VI.E.3.b), VI.E.3.c), VI.E.3.d), VI.E.3.e)
Office of Academic Affairs Resident's Manual

4. ATTACHMENTS

None

5. RESPONSIBILITY

Program Directors, Designated Institutional Official (DIO)

6. DEFINITIONS

Resident refers to all residents, including subspecialty residents (fellows) engaged in post graduate education at Ocean Medical Center (OMC). Residents are also identified by their year of postgraduate training (e.g. PGY 1).

7. PROCESS OVERVIEW

A. Policy
B. Procedure

8. RESPONSIBILITIES/REQUIREMENTS

A. Policy:

1. Requirements

i. Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure.
ii. Programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.
iii. Programs must ensure that residents are competent in communicating with team members in the hand-over process.
iv. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care.

2. Hand-over Guidelines

i. Hand-overs must follow a standardized approach and include the opportunity to ask and respond to questions.
ii. A hand-over is a verbal and/or written communication which to facilitate continuity of care. A "hand-over" or "report" occurs each time any of the following situations exists for an inpatient, emergency room patient, clinic patient, observation patient, or any other patient:
iii. Move to a new unit
iv. Transport to or from a different area of the hospital for care (e.g. diagnostic/treatment area)
v. Assignment to a different physician temporarily (e.g. overnight/weekend/vacation coverage) or longer (e.g. rotation change)
vi. Discharge to another institution or facility
vii. Each of the situations above requires a structured hand-over with appropriate communication.

3. Characteristics of a High-Quality Hand-over

i. Hand-overs are interactive communications allowing the opportunity for questioning between the giver and receiver of patient information.
ii. Hand-overs include up-to-date information regarding the patient's care, treatment and services, condition, and any recent or anticipated changes.
iii. Interruptions during hand-overs should be limited in order to minimize the possibility that information would fail to be conveyed or would be forgotten.
iv. Hand-overs require a process for verification of the received information, including repeat-back or read-back, as appropriate.

B. Procedure:

i. Hand-over procedures will be conducted in conjunction with (not be limited to) the following physician events:
    a. Shift changes
    b. Meal breaks
    c. Rest breaks
    d. Changes in on-call status
    e. When contacting another physician when there is a change in the patient's condition
    f. Transfer of patient from one care setting to another
ii. Hand-over procedures and information transfer forms and guidelines for physicians are developed and implemented by each service according to the needs of that service. The hand-over forms or guidelines may be in either paper or electronic format, and must include unambiguous and factually correct clinical information agreed upon by physicians on that service, as being integral to the provision of safe and effective patient care for that patient population.
iii. Each service will develop and implement a hand-over process that is in keeping with the shift or rotation change practices of its physicians and that facilitates the smooth transfer of information from physician to physician.
iv. Each service hand-over process must include an opportunity for the on-coming physician to ask pertinent questions and request information from the reporting physician.
v. Each hand-over process must be conducted discreetly and free of interruptions to ensure a proper transfer.
vi. Within each service, hand-overs will be conducted in a consistent manner, using a standardized hand-over form or structured guideline.
vii. Each residency program will develop an evaluative process which includes both peer-peer and supervisor-trainee monitoring.
viii. Hand-overs, whether verbal or written, should include, at minimum, specific information listed below (as applicable):
    a. Patient name, location, age/date of birth
    b. Patient diagnosis/problems, impression
    c. Important prior medical history
    d. DNR status and advance directives
    e. Identified allergies
    f. Medications, fluids, diet
    g. Important current laboratory results, vital signs, cultures
    h. Past and planned significant procedures
    i. Specific protocols/resources/treatments in place (DVT/GI prophylaxis, insulin, anticoagulation, restraint use, etc.)
    j. Plan for the next 24+ hours
    k. Pending tests and studies which require follow up
    l. Important items planned between now and discharge
ix. A receiving physician shall: a) Thoroughly review a completed hand-over form or receive a verbal hand-over and take notes, b) Resolve any unclear issues with the transferring physician prior to acceptance of a patient
x. In addition, the SBAR should be used to deliver or receive the information:

a. **Situation**: What is the problem?
b. **Background**: Pertinent information to problem at hand
c. **Assessment**: Clinical staff's assessment
d. **Recommendation**: What do you want done and/or think needs to be done?

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Subject: **MEDICAL RECORD DOCUMENTATION**	**Policy Number:** 4.G
Approved by GMEC: March 7, 2016	**Approved by MEC: June 7, 2018**

1. INTRODUCTION AND PURPOSE

Completion of medical records is both a professional and contractual obligation. Hospital and Medical Staff policies require all physicians, residents, fellows and medical staff, to complete all medical records in an accurate and timely fashion. Completion of medical records is an expectation that must be met in order to satisfactorily achieve proficiency in Professionalism and other core competencies as defined by the Accreditation Council for Graduate Medical Education.

2. SCOPE

Members of the resident staff are required to complete medical records within two weeks of the time such records are made available to the resident by the Medical Records Department. Failure of timely chart completion will result in placement of offenders on the medical record delinquent list.

3. APPLICABLE REGULATIONS AND GUIDELINES

ACGME Institutional Requirement IV.C, IV.C.1., IV.C.1.a), IV.C.1.b) Effective July 1, 2018
Office of Academic Affairs Resident Manual

4. ATTACHMENTS

None

5. RESPONSIBILITY

Program Directors, Designated Institutional Official (DIO)

6. DEFINITIONS

Resident refers to all interns, residents and subspecialty residents (fellows) engaged in post graduate education at Ocean Medical Center. They are also identified by their year of postgraduate training (e.g. PGY 1).

8. RESPONSIBILITIES/REQUIREMENTS

OMC residents are expected to take advantage of the educational opportunities offered within the institution and provide medical treatment to the Medical Center's patients in a competent and caring manner. Moral, ethical and professional behavior is expected at all times.

All House Staff are required to complete medical records in a timely manner. If a delinquency does occur, at two weeks after the records are made available, the Resident will receive a warning letter. A copy of this letter will be placed in the Resident's file but will be removed if the medical records are completed within four weeks from the time of availability of the records (i.e. within two weeks from the date of the warning letter).

At three weeks after the records are available, the Resident will receive a second letter. This letter will: a) warn the Resident that he/she will receive a permanent letter in one more week if the records are not completed, and b) mandate that the Resident attend the next Graduate Medical Education Committee (GMEC) meeting to explain why his/her medical records cannot be completed in a timely manner.

At four weeks after the records are available, the Resident will receive a letter informing him/her of probationary status as a Resident; a permanent copy of this letter will be entered into the Resident's file describing the Resident's deficiency in the core competency of Professionalism and will be reportable in future communications.

Bona fide vacation or illness may constitute an excuse subject to the approval of the GMEC.