

The New ACGME Common Program Requirements: The Impact on Clinical Faculty

New Common Program Requirements (CPRs)

- Recently the ACGME has implemented far reaching changes in the Common Program Requirements which govern all residency programs
- For the first time these CPRs mandate significant changes in the way faculty interact with and are responsible for the program activities

Areas of Change Affecting Faculty Include

- Far more than just duty hours. Require institution to educate faculty in:
 - Learning Environment
 - Professionalism
 - Proper supervision
 - Transitions of care / communication
 - Fatigue: facts, mitigation and alertness management
 - Duty hours

Learning Environment

Faculty must demonstrate an understanding and acceptance of their personal role in the following:

- **Assurance of the safety and welfare of patients entrusted to their care**
 - modeling behaviors that show the well being of the patient is paramount
 - explain to the learners why they are making certain decisions
 - showing how they monitor and coordinate the care of other consultants including the use of unwarranted diagnostic or therapeutic tests or procedures.
- **Provision of patient and family centered care**
 - demonstration of the highest professional behaviors
 - maintaining patient confidentiality especially in public places,
 - not displaying arrogance in dealing with students and patients,
 - being conscientious in dealing with patients (not taking shortcuts, returning calls, etc)
 - being altruistic, pointing out conflicts of interest to learners and how to avoid them and other examples.
- **Assurance of their fitness for duty as described in and accordance with the LSUHSC Fitness for Duty Policy**

Faculty must demonstrate an understanding and acceptance of their personal role in the following:

- **Management of the time before, during, and after clinical assignments**
 - reinforcing healthy lifestyles including sleep hygiene.
- **Recognition of impairment, including illness and fatigue, in them and in their peers**
- **Attention to lifelong learning**
 - faculty complete LSUHSC on-line compliance modules.
- **Monitoring of patient care performance improvement indicators**

Faculty must demonstrate an understanding and acceptance of their personal role in the following:

- **Honest and accurate reporting of duty hours, patient outcomes, and clinical experience data –**
 - Faculty must reinforce the importance of accurate and timely reporting of duty hours is part of the resident's contract and failure to do so is grounds for disciplinary action up to and including termination.
 - They must reinforce that case logs and clinical data reporting are an important part of program accreditation as is their ability to take certification tests as compliance moves towards maintenance of certification.
- **Faculty members must demonstrate responsiveness to patient needs that supersedes self-interest –**
 - Physicians accomplish this by recognizing 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.

Professionalism

The Elements of Professionalism required of physicians are:

- **Altruism** – the best interests of the patient over your own
- **Accountability** – to patients , society and the profession
- **Excellence** – consciously exceeding expectations
- **Duty** – being available, accepting inconvenience and risks when meeting the needs of the patient. Advocacy of patients interest and volunteering time and effort to the profession and society.
- **Honor and Integrity** –
 - being fair, being truthful, keeping one's word
 - meeting commitments, being straightforward
 - recognizing conflicts of interest and avoidance of relationships that allow personal gain to supersede the best interest of the patient

Challenges to the Elements of Professionalism

- **Abuse of Power** –
 - Interactions with patients and colleagues
 - Bias and sexual harassment
 - Breach of confidentiality
- **Arrogance**
- **Greed** - physicians must continually ask themselves whether their actions are guided by the best interests of their patients or their own financial interests .
- **Misrepresentation** - consists of lying and fraud
- **Impairment**
- **Lack of Conscientiousness** -
 - “failure to fulfill responsibilities”
 - a physician who does the minimum
- **Conflicts of Interest**

Supervision

Expected components of supervision

- Assessing the skill level of the resident by direct observation.
 - Faculty members should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.
- Documenting the supervision which should generally include but not be limited to:
 - progress notes in the chart written by or signed by the faculty
 - addendum to resident's notes where needed
 - counter-signature of notes by faculty
 - a medical record entry indicating the name of the supervisory faculty.
- Giving frequent formative feedback and formal summative written feedback that is competency based and includes evaluation of both professionalism and effectiveness of transitions.

Expected components of supervision

- Each patient must have an identifiable, appropriately-credentialed and privileged attending physician who is ultimately responsible for that patient's care.
- This information should be available to residents, faculty members, and patients.
- Residents and faculty members should inform patients of their respective roles in each patient's care.

Transitions

Transitions / Hand Offs

- Transitions of care create the most risk for medical errors.
- In recognition of this, we have created a transitions policy that includes:
 - A minimum format for effective transitions must be witnessed and attested to by faculty.
 - Provision of a complete and accurate rotational schedule in New Innovations.
 - Presence of a back up call schedule for cases where a resident can't complete work.
 - The ability of residents to freely and without fear of retribution report their inability to carry out their clinical duties due to fatigue or other reasons.

New Guidelines

- All programs must ensure and monitor effective hand-over processes
- Programs must ensure residents are competent in the hand-over process
- Program 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

Education of Residents on Effective Transitions

- Most common cause of sentinel event is miscommunication
- Should be face to face
- Should be written and verbal communication
 - Each program should adopt specialty specific components to hand offs
 - Demographics, Diagnoses, Current problem list, medications, pertinent labs, etc.

Fatigue / Fatigue Mitigation and Alertness Management

Facts About Fatigue

(modified from American Academy of Sleep Medicine resources)

- Resident sleepiness levels that can approximate those seen in sleep apnea and even narcolepsy
- Sleep and wakefulness are highly regulated by the homeostatic process
 - drives the length and depth of sleep and the circadian rhythm which influence timing and duration of daily sleep/wake cycles.
- Most people need 8 hours of sleep a night. Significant cognitive declines occur with one night of missed sleep.

More Facts

- Sleep deficits continue until they are made up
 - it usually takes 2 nights to make them up.
- Tasks dependent on high and/or sustained levels of vigilance those of longer duration, and those requiring newly learned procedural skills are particularly vulnerable to short term sleep loss.
- In sleep deprived residents their own patients, nursing staff, co-workers, family all become the “enemy” because they are between them and sleep.
 - “Behavioral problems” can be an unrecognized side effect. Feelings of isolation, depression, vulnerability, motivation, life satisfaction etc are well known feelings that resolve with adequate sleep.

More Facts

- After about 16 hours performance deteriorates.
 - self perception of sleepiness consistently underrates the degree of sleepiness. Sleepy residents do not recognize they are sleepy. You can fall asleep briefly (“micro-sleeps”) and in studies residents did not perceive themselves to be asleep almost half the time they had fallen asleep. Residents were wrong 76% of the time when they reported staying awake.
- Sleeping less than 7 hours per day can lead to sleep deficit.
- Chronic sleep restriction to 6 hours or less leads to performance deficits similar to that seen following total sleep deprivation.

Alertness Management

- Prophylactic naps prior to call improve alertness during call
- 15 minute naps q 2-3 hours on call significantly ameliorate performance decrements especially between 2 and 9 am
- Naps take the edge off but do not replace sleep

Driving and Drowsiness

- There is a clear link between driving drowsy and car crashes
 - sleeping 5 hours or less increases crashes 4.5 times
 - fatigue related crashes more likely to cause injury or death than other common causes
- Warning signs
 - Trouble focusing on the road
 - Difficulty keeping your eyes open
 - Nodding
 - yawning repeatedly
 - drifting from your lane or missing signs / exits
 - not remembering driving the last few miles
 - closing your eyes at stoplights
- Mitigating falling asleep while driving
 - don't drive drowsy – take taxi other transportation
 - 20 minute nap and caffeine before going home
 - pull off the road and take nap if any above signs

Sleep Strategies for Residents – Pre-Call

- Avoid starting Call with a SLEEP DEFICIT - GET 7-9 ° of sleep
- Avoid Heavy Meals within 3° of sleep
- Avoid Stimulants to keep you up
- Avoid ETOH to help you sleep
- Avoid Heavy Exercise 3° before sleep

Sleep Strategies for Residents – On-Call

- Tell Chief/PD/Faculty, if too sleepy to work!
- Nap whenever you can (> 30 min or < 2 hours)
- BEST Circadian Window 2PM-5PM & 2AM- 5AM
- AVOID Heavy Meal
- Strategic Consumption of Coffee (t ½ 3-7 hours)
- Know your own alertness/Sleep Pattern!

Sleep Strategies for Residents – Post-Call

- Lowest Alertness 6AM –11AM after being up all night
- Full Recovery from Sleep Deficit takes 2 nights
- Take 20 min. nap or Cup Coffee 30 min before driving

Duty Hours

Duty Hours

- To block a petition filed by AMSA and others to have the OSHA take over duty hour enforcement which would eventually lead to a takeover of all graduate medical education.
- The ACGME adopted new duty hour standards
 - They are quite serious about their absolute enforcement.
- Which will also include unannounced institutional visits .
- Therefore faculty must know the duty hours rules and help enforce them.

Current ACGME Duty Hour Limits 2011

	2011 Rules
Maximum hours of work per week	80 hours, averaged over 4 weeks
Maximum Duty Period Length	<ul style="list-style-type: none">• PGY-2 and above: 24 hrs (admitting patients for up to 24 hrs, plus 4-hr for transition and educational activities); No new patients after 24 hours• PGY-1 : 16 hrs
Maximum in-hospital on-call frequency	Every third night, averaged over a 4 week period

	2011 Rules
Minimum time off between scheduled duty periods	<ul style="list-style-type: none">• Should have 10 hrs; must have 8 hrs• Must have 14 hours after 24 hours of call
Maximum frequency of in-hospital night float	<ul style="list-style-type: none">• 6 consecutive nights
Mandatory time off duty	<ul style="list-style-type: none">• 1 day (24 hours) off per week, averaged over 4 weeks
Moonlighting	<ul style="list-style-type: none">• Internal and external moonlighting is counted against 80-hour weekly limit• PGY-1 are not permitted to moonlight

Time Off between 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.
- Circumstances or 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.

At Home Call

- Count towards the 80-hour maximum weekly hour limit...only time spent in hospital
- Not subject to the every-third night limitation
- 1 day in 7 free of duty, when averaged over four weeks.
- 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”.
- *Must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.*

Any Questions?

- For LSUHSC-NO residency programs, please contact the Office Of Graduate Medical Education at 568-4006.