FAMILY MEDICINE INPATIENT SERVICE

Policies and Guidelines

This handbook describes the policies and guidelines that govern the smooth operation of the Family Medicine Inpatient service . It contains information concerning admission criteria , scheduling of residents and faculty, education and supervision of residents.

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UPDATED 6/17/2019

***Please inform Dr. Karsten or Dr. Petersen if you find outdated information or links. Thank you.

FAMILY MEDICINE INPATIENT SERVICE
Algorithm for determining Family Medicine Admission

Please see the most recent algorithm on Info on Call.
https://infooncall/cs/groups/public/documents/webcontent/hcmc_p_080187.pdf

Info on Call→Departments→Family Medicine→Family Medicine Inpatient Service

FAMILY MEDICINE TEAM COMPOSITION AND COVERAGE RESPONSIBILITIES

FAMILY MEDICINE TEAM AND COVERAGE
The usual family medicine team consists of 4 senior residents, 4 G1s, 1 APP and attending faculty members. Typically one senior resident and one G1 cover 6 consecutive night shifts and then switch to days. The rest of the team divides their time between inpatient duties and outpatient clinic duties. There is APP coverage during the day every day of the week.

Resident day shifts are from 7am to 7:30pm and night shifts are from 7:30 pm to 7am. Day and night teams overlap for transitions of care.

Faculty shifts run 7 am – 6 pm/6 pm – 7 am on weekdays and 7 am-7 pm/7 pm-7 am on weekends. Half day faculty shifts run from 7 am – 12:30 pm Monday to Friday.

APP shift: 7 am – 6 pm

FMS Elective block: Resident will function as an admitting resident during the hours of 4:30pm-7:30pm, Monday- Friday. During the weekend, the resident will function as a member of the team and remain on service until their work is completed. This will vary based on the census on the service, complexity of patients, number of admissions and time of year.

Collegial Senior Collaboration:
Outline for shifts when two senior residents (G2/G2, G2/G3 and/or G3/G3) share night shifts. Please be mindful that there can and should be variations from this guideline. This allows for increased flexibility and adult learning. *Both seniors need to communicate agreement with the plans for the night. If they can not agree then the guidelines will be followed.*

Guest call, back up, and moonlighting will remain the same and the senior will fill in for the respective shift in which they are providing coverage

Guidelines:
1. Alternate management of the med/peds and maternity care pager every shift.

2. Maternity care side senior may take every 3rd Med/peds admissions dependent on the med/peds senior and the complexity of medical management of the admission(s) as well as the need to care for laboring patients. Laboring patients take precedence.
3. Should there arise a need for additional coverage of labor and delivery, med/peds senior will be called on to assist
4. If med/peds side senior would like to be present during deliveries they will communicate this to the resident managing labor and delivery.

Weekend coverage:
Senior resident and intern each on 12 hour shifts: 7am to 7:30 pm and 7:30 pm to 7am
APP shift: 7 am – 6 pm
FM Elective Resident: 7 am until work completed (see above)

Limit of Resident Workload:
It is the responsibility of the Program Director to ensure that the residency program does not place excessive reliance on the residents to provide for the service needs of the residency. The residency program is charged to ensure that a proper balance between patient care and education exists. One component of this is the program policy limiting the number of patients for whom residents provide ongoing care.

The Family Medicine Inpatient Service has a dynamic census and provides care for our clinic patients. Faculty physicians are ultimately responsible for all inpatient care and delegate responsibility to residents based on resident skills and patient needs. It is the goal of the Family Medicine Inpatient Service to maintain a sufficient number of patients to ensure adequate learning and growth for each resident.

On rare occasions the Family Medicine Inpatient Service census becomes high and raises concerns about Patient Safety. In response to this the following limits are placed on the workload of the residents:

- Each **G1** may care for **up to 7 patients** per day. The senior resident supervising the intern will care for an additional 4 patients independently of the G1's patients.
- Senior residents working without an intern will care for up to 8-10 patients per day depending on their experience and skill.
- The APP present on the service will care for up to 8 patients daily.
- The total patients on the service should be divided between the Adult Medicine/Peds service and the Maternity Care service, approximately ⅔ to ⅓ division, taking into consideration the acuity of the patients and the workforce available.
- Distribution of workload is a joint responsibility of the faculty and senior resident on the service and should take into account volume, complexity and acuity.
- In the event that there are still patients in excess of the above parameters then the Family Medicine Inpatient Service faculty will independently take care of patients and may call in the **Day Back-Up** at the discretion of the Faculty.

DIDACTICS AND ROUNDS:

Family Medicine:

- **Teaching rounds**: Time of these reports are usually determined on a daily basis but should occur no later than 9:30 am
- **Interdisciplinary team /discharge rounds**: 9:00 am
- **Wednesday Core conference**: 12:30 pm-5:30 pm at Whittier clinic. All residents are expected to attend. Service is covered by FM faculty and APP during conference time.
- **Birth Center Safety rounds**: 8 am and 8 pm daily, Labor and Delivery conference room. A FM team member is required to attend.
- **Pediatric Safety rounds**: 8:45 am Monday to Friday.

Other didactics:

- **IM morning report**: 7:45 to 8:15 daily : Breakfast served
- **Pediatrics noon report** : Tuesday 12 noon

SICK/EMERGENCY CALL IN POLICY

A resident unable to attend to his/her call duties due to illness or an emergency (unscheduled absence) must:

- Contact the Family Medicine Residency Coordinator by telephone (612-873-8084). If unavailable a message with directions on who to contact will be left for the resident on the voicemail message. Follow these directions.
- During evening and weekends, the resident calling in must call the night back up call resident to alert them of the need to cover their work.
- Contact the faculty **and** senior resident on service to notify them of the change.

Residents will be noted to have been out sick for any shift missed. This applies to emergency leave as well. The residency coordinator will keep track of the shifts(s) missed.

Residents and FMS schedule conflicts: The residency program does not intentionally assign residents for FMS service coverage during vacations and other approved time away from the program. It is the resident's responsibility, however, to check their schedule for such conflicts. If such conflicts are found, it is the resident's responsibility to notify the coordinator and work to resolve the situation.

NIGHT BACK UP CALL

Night Backup covers the absence of residents on the inpatient service in the case of illness, emergencies or (on a case-by-case basis) other extenuating circumstances such as resident fatigue, concerns for patient safety or when clinical care needs exceed the residents' ability.

For weekend coverage, Night Backup may be used to help out with service if the senior resident and faculty feel that patient safety is an issue.

It is the responsibility of Senior Residents to look at the FM Inpatient schedule on AMION at the start of the block. This ensures that they are aware schedule variances due to vacations or academic leave.

Residents are scheduled for Night Backup call when on a non-call rotation, at the beginning of the academic year. If a resident is unable to take backup call due to a vacation or other commitment, the resident scheduled is responsible for finding a replacement and notifying the residency coordinator.

Only G2 and G3 residents are able to be on back up call. He/she is to be available 24 hours a day during the period he/she is serving as the back-up call resident. Please plan accordingly. Residents are to arrive at the hospital within one hour of notification.

Care of the Pediatric Patient

Procedure:

- Attend pediatric safety rounds every morning, 8:45 Monday through Friday.
    - Family medicine participants should introduce themselves as being from family medicine
    - Priority will be given to family medicine during safety rounds
- Complete daily "family centered bedside rounds" with the FM team and pediatric nurse caring for the patient. The pediatric nurse is willing to be pulled out of whatever other rounding she/he is doing, to accommodate the timing of the family medicine team.
- Do not do informal "curbside" consults of pediatric residents or faculty. Talk with your FM faculty or seniors about questions that you have, and if you are going to consult, make it a formal consult.

Reminders:

- Upon admission, go to the Peds floor and introduce yourself to the nurse that is caring for the patient.
- Respond promptly to all pages from pediatrics, erring on the side of going to the peds floor to speak directly with the nurse.
- Use Info on Call: Department→Pediatric Inpatient→Pediatric Inpatient Portal https://infooncall/Departments/PediatricsInpatient/Portal/index.htm

Physician Standard Work for Discharges on the Family Medicine Inpatient Service

Maternity Care/Newborn Nursery

Day prior to Discharge

- Mom's discharge meds sent to pharmacy

Day of Discharge:

- 7:00 Sign-outs
- 8:00 Safety Rounds on L&D
- 8:15 Patient and Family Centered Rounding on G4
- Discharge Orders Written, patients discharged

Medicine/Pediatrics (G3, R5, Peds, CaRe, CMIC, RTU)

On Admission:

- Address the patient's living situation
- Assess the patient's need or desire to address the above
- Assess family support
- Communicate anticipated discharge needs to the Care Coordinator/Social Worker

Day prior to Discharge:

- Sign an "anticipated discharge" order detailing the conditions of discharge
- Put the patient's name on the whiteboard in O2-210
- Assess whether the patient has an adequate supply of regular medications or needs refills
- Determine any medication changes necessary for discharge

Day of Discharge:

- 7:00 Sign-outs
- 8:30 Round on anticipated discharges and complete discharge orders
- 8:45 Safety Rounds on Pediatrics
- 9:30 Pause to write discharge orders.
- Teaching Rounds with the residents to follow the completion of discharges
- Indicate on white board when discharge is completed

PRIMARY DELIVERIES ON FMS

The continuity resident must be notified when their continuity prenatal patient is admitted to the Labor and Delivery floor by the senior resident on the maternity care service. After notification, the resident must coordinate attendance and/or management of continuity prenatal patient with the faculty on duty.

The FMS faculty determines when the resident is needed in L&D and **will arrange with the resident coordinator for the resident to attend the delivery.**

Definitions

Continuity prenatal patient: a patient with whom the provider has an established outpatient relationship

Continuity resident: FM resident with established relationship with patient

Responsibilities:

Continuity resident will communicate with the inpatient attending and resident team.

FM attending will communicate with the program coordinator.

Program coordinator will contact the necessary clinic or rotation contacts to communicate the plan for resident attendance at the hospital.

Procedures:
While continuity patients are laboring, residents are expected to continue working in clinic or other rotation responsibility until the faculty determines that delivery is imminent and the resident is needed at the hospital. The FMS team will care for the patient in partnership with the continuity resident, and communicate progress with the continuity resident on an ongoing basis.

The FM Residency Coordinator will contact the continuity resident with approval or denial to attend the delivery.

If the resident is scheduled at **Whittier clinic**, the coordinator will also inform the Whittier preceptors and clinic charge nurse when the resident is approved to leave for HCMC. The remaining scheduled patients in clinic will be seen by other providers in clinic. Patients who have not yet arrived may be rescheduled as identified by the team nurse/session leader. Residents will return to clinic in a timely fashion after delivery to resume patient care.

Residents assigned to WHC Direct Care clinics may not always be able to leave these sessions to care for laboring patients.

Residents on other HCMC rotations are handled on a rotation based approach.

The following rotations **do not allow** for attendance at deliveries:

- Childrens
- Rural and Out of Country electives
- Hazelden week (Preventive Medicine)

The following rotations **may allow** for attendance at deliveries and will need to be arranged based on other immediate patient care needs:

- ED-adult and peds
- MICU

The following rotations are primarily outpatient and **will most likely be able** to accommodate continuity delivery attendance:

- Peds/Adolescent
- Amb Surg/Derm
- Preventive Medicine (except Hazelden week)
- Sports Medicine
- Geriatrics
- Electives
- Practice Readiness
- Ambulatory Peds

Gynecology
Surgical Subspecialties
Medical Subspecialties
Orthopedics
Population Health

The same process as outlined above should be followed. Residents need to have clear permission to attend to their patient on labor and delivery, before leaving their clinical responsibilities.

SIGN-OUTS and **TRANSITION OF CARE POLICY**

Purpose: To describe a formal process for transition of care from one team to another. This promotes health information exchange between teams about patients to improve patient safety and decrease errors

Rationale: Sign-outs are a common cause of errors in medicine, thus a standardized approach can help decrease some of these errors. Minimizing the number of transitions is also important to facilitate both continuity of care and patient safety.

Procedure:
To optimize patient safety, the number of transitions/sign outs should, when practical occur no more than **two times daily** on the Family Medicine Inpatient Service. This frequency minimizes the number of transitions of care for patient safety and balances appropriate rest for residents and promotes compliance with duty hours.

While on the inpatient service, residents are required to perform patient care transitions (sign-outs) using the standard written and verbal formats for transitions of care.

Utilizing the dot phrase: "fmsignout"

These transitions/sign-outs occur at 7 am and 7:30 pm daily. Sign-outs are supervised by faculty.

Responsibilities during Sign-outs:
The primary resident caring for the patient is responsible for reviewing and updating the information on the written sign-outs.
The senior resident is responsible for oversight of the intern's written and verbal sign-outs
Faculty is present at sign-out sessions and will give feedback to residents as appropriate

Sign-outs will:
- begin at the designated time
- happen in quiet and controlled environment to limit distractions
- be concise without any unnecessary or editorialized information
- have clear roles and responsibilities of all participants. In general, G1s wil give sign-outs with senior residents listening and clarifying as needed.

- have the sickest patients specifically identified.
- have information discussed in a consistent order using the agreed upon template
- not be delayed due to missing team members. It is the team members responsibility to arrive on time for sign outs.

Evaluation of the Sign-Out Process:
This process is evaluated by faculty and monitored by the Program Director. Residents are evaluated at a mid-point during the block and receive feedback about performance.

HCMC POST CALL FATIGUE AND CAB VOUCHER POLICY

See policy manual and Info on Call:
Departments→Graduate Medical Education→GME Policies→Fatigue Mitigation Policy

https://infooncall/cs/idcplg?IdcService=GET_FILE&Rendition=Web&RevisionSelectionMethod=Latest&dDocName=HCMC_P_039808&noSaveAs=1

Appendices

A. General Supervision Policy

Purpose: To ensure appropriate supervision for all HCMC Family Medicine residents that is consistent with proper patient care and the educational needs of the residents.

Policy: Residents must be supervised by faculty in such a way that the residents assume progressively increasing responsibility according to their level of education, ability and experience. On-call schedules for teaching staff must be structured to ensure that supervision is readily available to residents on duty. Faculty and residents are educated to recognize the signs of fatigue and will prevent and counteract the potential negative effects. The Program Director will ensure, direct, and document adequate supervision of residents at all times. Residents will be provided with rapid, reliable systems for communication with supervising faculty

1. All residents must be supervised by a qualified attending physician. The supervising physician (or his/her qualified designee with oversight from the faculty physician member) must be in the hospital providing direct supervision or indirect supervision with immediate availability to all PGY-1 residents. For PGY-2 and PGY-3 residents, supervising physicians may be in the hospital or immediately available by telephone and within 20 minutes of the hospital.

2. All residents must consult with the supervising physician regarding the assessment and treatment of a patient's illness. Treatment plans must be in accordance with the attending physician's recommendations.

3. All residents, regardless of level of training, must communicate directly with the attending family physician in any clinical circumstance which constitutes a major change in an inpatient clinical status or any situation which requires more complex medical decision making. Examples of these situations include but are not limited to:

    - Acute deterioration of an inpatient's cardiac, pulmonary, or neurologic status
    - Change in an inpatient's status requiring transfer to the intensive care unit
    - Change in an inpatient code status
    - Complex medical decision making for hospitalized patients
    - Admission of any patient in active labor
    - Acute deterioration of an active labor patient's electronic fetal heart rate tracing

4. All supervision must be documented in the resident rotation schedules and in the attending physician on-call schedules. In addition, the electronic medical record will accurately reflect both the admitting and the current attending faculty physician.

5. Residents must be supervised in such a way that they are able to assume progressively increasing responsibility according to their level of education, ability, and experience. The level of responsibility accorded to each resident must be determined by the teaching

staff.

6. The Department must have resident rotation schedules available at all times to provide to all interested parties.

7. Residents must precept all outpatient encounters. For the first six months, all PGY-1s are required to precept all patients during the visit. The preceptor is required to meet and assess the patient to ensure that safe and competent patient care has occurred. At the end of the first six months, PGY1 residents are assessed for their ability to move from direct to indirect supervision before they are allowed to discharge patients without a face to face meeting with the faculty preceptor.

8. Residents transferring into our program as a PGY-2 must precept their patients prior to completing the patient encounter for the first two months. This does not necessitate meeting the patient face to face, unless requested by the resident or deemed worthwhile by the preceptor.

9. All office and hospital procedures must be performed with direct supervision from attending physician faculty.

10. All supervision must be documented in the resident rotation schedules and by attending physician on-call schedules. Each department will have available at all times such schedules and will provide such to all interested parties.

B. Policy on Trigger Protocols for Urgent Attending Physician Notification

Attending notification guidelines, known as "trigger protocols", identify specific criteria that should trigger a phone call by a resident to an attending physician to inform the attending of a change in patient condition. Expected communication practices when there is a critical change in the patient's condition are that the attending will be notified, ***within 1 hour*** following evaluation. These include:

Inpatient / General

1. Request for admission to hospital/outside facility requesting transfer
2. Transfer to ICU or higher level of care
3. Unanticipated intubation or ventilatory support
4. Development of new significant cardiac changes (e.g. CODE, serious arrhythmia, PE, hemodynamic instability)
5. Development of new significant neurological changes (e.g. CVA, seizure, new onset of paralysis, acute decline in level of consciousness)
6. Medication or treatment errors requiring clinical intervention (e.g. invasive procedure(s), increased monitoring, new medications)
7. Patient, family, or clinical staff request for attending notification
8. Unable to contact patient or unsure of management of critical lab result, or patients from community clinics or nursing home patients while on call
9. Unanticipated change in CODE status
10. Death
11. Signing out against medical advice (AMA)
12. Suicide attempt

Obstetrics

13. New triage or admission (call immediately for preeclampsia or preterm labor)
14. Notification of need for OB consult
15. Fetal tachycardia, category II or III fetal heart rate tracing
16. Patient in active labor
17. Significant adverse changes to vitals (hyper/hypotension, T>100.4, unexpected or unexplained tachycardia)
18. Pre-eclamptic changes (e.g. hyperreflexic, visual changes, increased BP, HELLP)
19. Arrest of dilatation after onset of active labor for ≥ 2 hours

NOTE: This protocol is designed to ensure communication, but ***should not preclude*** communication for any issue short of the above criteria. Any member of the team should feel comfortable to contact the attending of record at any time for questions of clinical management.

Inability to reach the attending should NOT impede needed or emergent clinical care.*

C. Supervision Procedure for Labor and Delivery

All Family Medicine faculty physicians are qualified in obstetrics. Family Medicine faculty provide on-site supervision of family medicine obstetric patients for all deliveries. In addition, Family Medicine faculty physicians provide on-site supervision when patients are in active labor, medically complicated or in any way unstable.

At all times there is an obstetrician and a senior resident in an ACGME obstetrics residency on-site for emergency consultations, and to provide c-section or emergency procedures outside the scope of Family Medicine. A resident may request an attending at any time and is never refused. Any significant change in a patient's condition must be reported immediately to the attending physician.

D. Lines of Responsibility for Residents and Attending Physicians on the Family Medicine Inpatient Service

Attending Physician

Supervision of all orders, procedures and treatment plans
Daily examinations of each patient on service
Reviewing and co-signing the daily note written on each patient on service
Completion of resident evaluations
Monitoring of resident's academic action plans
Supervision of APPs

Senior Residents

Review all admissions
Assignment of daily activities of the PGY1 residents, APP and medical students
See all OB triage patients
Review of PGY1 daily assessment and plan
Negotiation with attending for final therapeutic plan

Daily examinations of each patient
Supervision of PGY1. Review of all laboratory and radiology results
Written and verbal sign-out to on-call team each day
Communication via EPIC mail with patient's primary care physician as needed
Promote teamwork among residents
Review sign-out report for accuracy
Supervision and education of medical student when on service

PGY1
Initial assessment of new patient admissions
Daily progress note on each primary patient
Daily examination of each primary patient
Writes all orders on primary patients
Written and verbal sign outs of patients to the on-call team
Communicating with senior resident about patients plan of care
Mentoring medical students when co managing patients

Advanced Practice Providers
Initial assessment of new patient admissions
Daily progress note/discharge summary on each primary patient
Daily examination of each primary patient
Writes orders on primary patients
Written and verbal sign outs of patients to the on-call team
Discuss treatment plans with faculty

E. Levels of Supervision for residents

To ensure oversight of resident supervision and graded authority and responsibility, the HCMC Family Medicine Training program uses the following classification of supervision:

Tier 1
Direct Supervision – the supervising physician is physically present with the resident and patient.

Tier 2
Indirect Supervision:
a) With direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
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.

Tier 3
Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident, is assigned by the program director and faculty members.

First year trainees entering the residency program are assigned to Tier 1 supervision in the first 6 months of training. At the end of 6 months, PGY1s are assessed by the residency faculty using the program's Developmental Milestones to ascertain promotion to Tier 2a supervision.

At the end of the PGY1 year, residents take a Supervisor's Examination. Successful passage of this examination results in promotion to determine their suitability to move to Tier 2b supervision and promotion to the second year of post graduate training.

F. FACULTY RESPONSIBILITY AND ACCOUNTABILITY ON THE INPATIENT SERVICE

Attendance

Faculty supervision in house 24/7
Half day faculty leaves at 12:30 (weekdays)
Full day faculty leave at 6pm on weekdays, 7pm on weekends.
Faculty to Faculty sign-outs should be done to satisfy the oncoming faculty
Attend Safety Rounds at 8:00 am and 8:00 pm on L&D 7 days a week (or ensure FM representation)
Attend Pediatric Safety Rounds at 8:45 Mon – Fri for Pediatric patients on FMS
On-call faculty will attend morning and evening sign-outs. Faculty should remain quiet and allow for resident to resident sign outs.

Feedback:

Attend, contribute and support Feedback Fridays
Support teamwork amongst residents
Write weekly evaluations on Google Docs

Teaching:

1. **When on call**
    a. Residents must notify the on call faculty of new admissions at the time of their admission – be pleasant when woken up.
    b. Write/addend notes on all admissions that you staff (if you hear the presentation then write a note)
    c. On call faculty are expected to supervise and assist the resident in providing full care for admitted patients. Therefore, thoughtful decisions about antibiotic selection, diet orders, tests and consults should be made at the time of the patient admission.
    d. Faculty are expected to examine all triage patients on L&D before their discharge from the unit and document/addend the notes for this visit in EPIC
    e. Faculty are expected to supervise and document procedures done on laboring patients on L&D
2. **Responsibilities for faculty on the FM Inpatient service**
    a. Be a role model for a caring and competent Family physician
    b. Confer with senior resident about workload distribution
    c. Make every effort to maximize the educational experience for the residents
    d. Evaluate patients, review and addend the resident's or intern's note

e. Attend Feedback Friday at 12:15 pm--does not supercede giving individual feedback to residents when appropriate
f. Attend Birth Center Patient Safety rounds at 8:00 am and 8:00 pm
g. Attend Discharge Planning Rounds at 9:00 am

3. Workload sharing

a. The HCMC Family Medicine residency program supports shared patient burden between faculty and residents.
b. Do direct patient care as necessary
c. Help residents to organize the workload

4. Other expectations

Wednesday conferences

a. On Wednesday afternoons, patient care is managed by the Family Medicine faculty and APP.
b. Faculty are required to see patients, write notes and orders, request consults and do admission and discharge work for patients
c. Collaboration between FM Inpatient faculty is encouraged to facilitate seamless care for patients on the service.

G. DUTY HOURS:
(per the ACGME Common Program Requirements VI. The Learning and Working Environment . VI.F. Clinical Experience and Education; effective: July 1, 2019)

https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf
For details.

The ACGME duty hours apply to the FM Inpatient service as in all other areas where residents are trained.