Oklahoma State University
Medical Center

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		SUPERSEDES:	12/10/98, 10/11/01, 11/19/02, 6/23/04, 8/27/08, 4/21/10, 12/18/13, 3/18/15
POLICY TITLE:	**Do Not Resuscitate (DNR)**	REVIEW DATE:	September 2018
POLICY NUMBER:	**302-RI-105**	REVIEW RESPONSIBILITY:	Bioethics Committee Quality Council
DEPARTMENT:	Global	APPROVED BY:	Chief Executive Officer Chief of Staff Chief Nursing Officer
CATEGORY:	Patient Rights	SIGNATURE(S):	______________________ Chief Executive Officer ______________________ Chief of Staff ______________________ Chief Nursing Officer

PURPOSE

1. It is the policy of Oklahoma State University Medical Center (OSU Medical Center) that life support, including cardiopulmonary resuscitation (CPR), is to be administered to all patients **unless** there are clearly expressed patient choices or physician orders to the contrary.

    a. Decisions to withhold or provide resuscitation are best reached jointly between the physician and patient being subject to the same principles as any informed consent/informed refusal as well as the obligation to offer only clinically effective treatment.
    b. This policy is supported in the *Ethical and Religious Directives for Catholic Health Care Services*: "We have a duty to preserve life, but the duty to preserve life is not absolute, for patients may reject life-prolonging procedures that are insufficiently beneficial or excessively burdensome" (United States Conference of Catholic Bishops, 2009, Chapter Part Five, Introduction).

2. To ensure patient rights to personal treatment choices, all patients with an active Do Not Resuscitate (DNR) order will wear a purple wrist-band indicating their code status as DNR.

3. A DNR Order refers only to code status and does not reflect treatment decisions for other conditions. A DNR code status does not indicate less care or lower quality of care.

    a. Consenting to a Do-Not-Resuscitate order does not prevent the patient from receiving other health care such as the Heimlich maneuver or oxygen and other comfort care measures.
    b. All members of health care team are responsible for documenting discussions in which patient expresses their treatment choices.

SCOPE

This policy applies to all coworkers within OSU Medical Center including staff, managers, executives and physicians.

ACCOUNTABILITY

All medical staff and patient care providers will comply with this policy or make appropriate arrangements for another individual to manage the care of a patient with a DNR order.

DEFINITIONS

Attending Physician: A licensed physician who has primary responsibility for treatment or care of the person. If more than one physician shares that responsibility, any of those physicians may act as the attending physician under the provisions of the Oklahoma Do-Not-Resuscitate Act.

CPR (Cardiopulmonary Resuscitation): Full CPR involves chest compressions, intravenous access and drugs, defibrillation, and placement of advanced airways with ventilator assistance to restore or support cardiac or respiratory function in the event of a cardiac or respiratory arrest.

Clear and convincing evidence: Oral, written, or other acts of communication between the patient (with decision-making), and family members, health care providers, or others close to the patient with knowledge of the patient's personal desires.

DNR (Do-Not-Resuscitate) Order: Written physician order to suspend the otherwise automatic initiation of cardiopulmonary resuscitation (CPR).

Decision-Making Capacity: Medical determination of a patient's ability to make autonomous judgments in terms of ability to understand, evaluate, and communicate the nature of his/her illness.

Health Care Provider: Physician and non-physician providers of health care.

Incapacity: The inability, because of physical or mental impairment, to appreciate the nature and implications of a health care decision , to make an informed choice regarding the alternatives presented, and to communicate that choice in an unambiguous manner.

Representative: An attorney-in-fact for health care decisions acting in accordance with the *Uniform Durable Power of Attorney Act*, a health care proxy acting in accordance with the *Oklahoma Advance Directive Act*, or a guardian of the person appointed under the *Oklahoma Guardianship and Conservatorship Act.*

PROCEDURES

1. DNR decisions should be made by the patient with decision-making capacity or in discussion with the responsible physician. Resuscitation code status discussion should occur within the context of overall treatment goals based on the physician's knowledge and experience as well as the patient's own goals and values.

2. It is presumed that every person would consent to the administration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. Only when the health care provider has actual knowledge of the desire of the patient not to have cardiopulmonary resuscitation would this be withheld. Knowledge about the wishes of the patient may be through one of the following conditions:

    a. The person has notified his attending physician that he does not consent to the administration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. The notification of this desire has been entered in the patient's medical record.
    b. The parent or guardian of a minor child, after consultation with the minor child's attending physician, has notified the minor child's attending physician that the parent or guardian does not consent to the administration of cardiopulmonary resuscitation in the event of the minor child's cardiac or respiratory arrest, and that the minor child, if capable of doing so and possessing sufficient understanding and appreciation of the nature and consequences of the treatment decision despite the minor child's chronological age, has not objected to this decision of the parent or

guardian. The notification of this desire has been entered in the minor child's medical records.

c. A Do-Not-Resuscitate Consent Form in accordance with the provisions of the Oklahoma Do-Not-Resuscitate Act has been executed for that person.

d. An executed directive for health care or other document recognized by the Oklahoma Advance Directive Act, directing that life-sustaining treatment not be performed in the event of cardiac or respiratory arrest, is in effect for that person.

2. When a patient lacks decision-making capacity, and has previously executed an Advance Directive or is under guardianship, the DNR decision shall be reached consensually by the legally recognized representative or guardian of the patient and the attending physician.

    a. Advance Directives, as well as the patient's previously stated wishes, require interpretation and need to be incorporated into a treatment plan that includes specific orders.
    An incapacitated person's representative has notified the incapacitated person's attending physician that the representative, based on the known wishes of the incapacitated person, does not consent to the administration of cardiopulmonary resuscitation in the event of the incapacitated person's cardiac or respiratory arrest. The notification of this desire has been entered in the patient's medical records.

3. For patients who have not appointed a representative, the physician may initiate a DNR order on either condition being met:

    a. An attending physician of an incapacitated person without a representative knows by clear and convincing evidence that the incapacitated person, when competent, decided on the basis of information sufficient to constitute informed consent that the person would not have consented to the administration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. The Attending Physician completes the Certification of Physician section of the Oklahoma Do-Not-Resuscitate Physician Certification & Order Form. **OR**
    b. If the attending physician believes that beginning or continuing the administration of cardiopulmonary resuscitation, in reasonable medical judgment, would not prevent the imminent death of the patient. The Attending Physician completes the Certification of Physician section of the Oklahoma Do-Not-Resuscitate Physician Certification & Order Form.
        i. In such circumstances, the ethic of medicine directs the physician to inform the patient or surrogate of the DNR order and the basis for its implementation.
        ii. There may be situations where limited resuscitative measures are appropriate. In order to identify what these designations are, the following are the options that a physician may order:
            (1) Full Code
            (2) Intubation Only (allows for intubation—respiratory intervention)
            (3) Do Not Intubate (DNI) (allows for treating arrhythmias, administering medications—cardiac intervention)
            (4) Do Not Resuscitate (DNR)

4. If a consensual decision regarding a DNR cannot be reached in any of the foregoing circumstances, the attending physician, caregiver, or family member shall consult with Biothics.

    a. In the event that a physician does not feel that decisions made are consistent with his/her ethical beliefs, the physician may withdraw from the case after arranging alternative coverage.

5. Once the DNR decision has been made, the order must be entered into the electronic health record by the responsible physician.

    a. Physician shall document code status discussion and appropriateness of the decision in the progress notes.
    b. Copies of any supporting documentation, i.e. Oklahoma DNR Consent Form, Advance Directive including Durable Power of Attorney for Health Care Decisions (DPOA), guardianship papers, etc.,

shall be placed in the medical record.

c. If an Oklahoma DNR Consent Form was placed in the medical record, a copy of the form will be given to the patient upon discharge. A patient's DNR status shall be communicated prior to transferring the patient to another facility or service. Documentation of the patient's wishes regarding CPR shall be sent to the receiving facility or service prior to patient's discharge from the hospital.

6. A verbal order for DNR is not acceptable. Once the DNR order has been recorded in the patient's medical record, the nurse shall place a purple wrist-band on patient's wrist to indicate DNR status.

7. Policies that lead either to the automatic enforcement of all DNR orders or to automatic cancellation of such orders during procedures requiring anesthesia may not sufficiently address a patient's right to self-determination.

   a. An institutional policy of automatic cancellation of the DNR status in cases where a surgical procedure is to be carried out removes the patient from appropriate participation in decision making. Automatic enforcement without discussion and clarification may lead to inappropriate perioperative and anesthetic management.
   b. The best approach is a policy of "required reconsideration" of previous advance directives and DNR orders. The patient and the physicians who will be responsible for the patient's care should discuss the new risks and the approach to potential life-threatening problems during the perioperative period. The results of such discussions should be documented in the record.
   c. The operative and anesthetic permit shall indicate that the patient or the duly authorized patient's representative has had the opportunity to discuss and reconsider any advance directive. If the DNR order is suspended during the procedure requiring anesthesia, the suspension must be documented in the medical record and the purple wrist-band removed from the patient. Once the perioperative period is over [to be explicitly defined], the DNR order must be re-ordered, documented in the medical record, and the purple wrist-band placed back on the patient's wrist.

8. There is a presumption that the DNR code status of patients being transferred from an outside facility or the DNR status of a prior admission at OSU Medical Center will be continued. This shall be confirmed by the physician with the patient or authorized surrogate and entered into the medical record.

9. Patients with an Oklahoma DNR Consent Form shall have their choices honored within the hospital unless otherwise directed by the patient or patient's surrogate decision-maker. The attending physician must enter this order into the medical record.

REFERENCES

O.S. §63 3131.1 to 3131.14
CMS Interpretive Guidelines for Advance Directive; §482.13(b)(3)
Healthcare Facilities Accreditation Program (HFAP) 2015; Advance Directives 15.01.12
Oklahoma Nondiscrimination in Treatment Act; November 1, 2013

Related Forms: Oklahoma Do-Not-Resuscitate Physician Certification & Order; Oklahoma Do-Not-Resuscitate Consent Form; DNR Compliance Form

Oklahoma State University Center for Health Sciences
College of Osteopathic Medicine

Policy on Duty Hours

Standard

IV.J. Duty Hours: The Sponsoring Institution must maintain a duty hour policy that ensures effective oversight of institutional and program-level compliance with ACGME duty hour standards. (Core)

IV.J.1. Moonlighting: The Sponsoring Institution must maintain a policy on moonlighting that includes the following:

IV.J.1.a) residents/fellows must not be required to engage in moonlighting; (Core)

IV.J.1.b) residents/fellows must have written permission from their program director to moonlight; (Core)

IV.J.1.c) an ACGME-accredited program will monitor the effect of moonlighting activities on a resident's/fellow's performance in the program, including that adverse effects may lead to withdrawal of permission to moonlight; and, (Core)

IV.J.1.d) the Sponsoring Institution or individual ACGME-accredited programs may prohibit moonlighting by residents/fellows. (Core)

Policy: The duty hours policy of OSU CHS will mirror those specified in the ACGME Common Program Requirements:

VI.G. Resident Duty Hours

VI.G.1. 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. (Core)

VI.G.1.a) Duty Hour Exceptions. A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale. (Detail)

VI.G.1.a).(1) In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures. (Detail)

VI.G.1.a).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO. (Detail)

VI.G.2. Moonlighting

VI.G.2.a) Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program. (Core)

VI.G.2.b) Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit. (Core)

VI.G.2.c) PGY-1 residents are not permitted to moonlight. (Core)

VI.G.3. 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 (Core)

VI.G.4.Maximum Duty Period Length

VI.G.4.a)Duty periods of PGY-1 residents must not exceed 16 hours in duration. (Core)

VI.G.4.b)Duty periods of PGY-2 residents and above maybe scheduled to a maximum of 24 hours of continuous duty in the hospital. (Core)

VI.G.4.b).(1)Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested. (Detail)

VI.G.4.b).(2)It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours. (Core)

VI.G.4.b).(3)Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty. (Core)

VI.G.4.b).(4)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. (Detail)

VI.G.4.b).(4).(a)Under those circumstances, the resident must:

VI.G.4.b).(4).(a).(i)appropriately hand over the care of all other patients to the team responsible for their continuing care; and, (Detail)

VI.G.4.b).(4).(a).(ii)document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director. (Detail)

VI.G.4.b).(4).(b)The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty. (Detail)

VI.G.5. Minimum Time Off between Scheduled Duty Periods

VI.G.5.a) PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods. (Core)

VI.G.5.b) 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. (Core)

VI.G.5.c) 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. (Outcome)

VI.G.5.c).(1) 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. (Detail)

VI.G.5.c).(1).(a) Circumstances of 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. (Detail)

VI.G.6. Maximum Frequency of In-House Night Float. Residents must not be scheduled for more than six consecutive nights of night float. (Core)
[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.]

VI.G.7. 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). (Core)

VI.G.8. At-Home Call

VI.G.8.a) 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. (Core)

VI.G.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. (Core)

VI.G.8.b) 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". (Detail)

Policy: Specialty-specific definitions and policies (please note these policies coincide and further define the referenced items above). Source: *Duty Hours in the Learning and Working Environment* ©2015

A. Anesthesiology.

VI.G.1.a) The Review Committee for Anesthesiology will not consider requests for exceptions to the 80-hour limit to the residents' work week.
VI.G.5.b) An intermediate-level resident is in the second, third, or fourth year of the four year of anesthesiology residency, and has neither achieved the goals and objectives of all core rotations nor fulfilled all minimum case requirements. (Core)
VI.G.5.c) A resident in the final years of education has achieved the goals and objectives of all core rotations and fulfilled all minimum case requirements. (Core)
VI.G.5.c).(1).(b) The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. (Detail)
VI.G.5.c).(1).(c) Residents in the final years of education may extend the eight-hour duty-free period when called upon to provide continuity of clinical care that is of critical importance to a patient and that provides unique educational value to the resident. (Detail)
VI.G.5.c).(1).(d) Exceptions to the eight-hour duty-free period must be determined in consultation with the supervising faculty member and reported to the program director. (Core)

B. Diagnostic Radiology

VI.G.1.a) The Review Committee for Diagnostic Radiology will not consider requests for exceptions to the 80-hour limit to the residents' work week.
VI.G.5.b) R1, R2, and R3 residents are considered to be at the intermediate level.
VI.G.5.c) R4 residents are considered to be in the final years of education.

C. Interventional Radiology

VI.G.1.a) The Review Committee will not consider requests for exceptions to the 80-hour limit to the residents' work week.
VI.G.5.b) PGY-2, PGY-3, and PGY-4 residents are considered to be at the intermediate level.
VI.G.5.c) PGY-5, PGY-6 and PGY-7 residents are considered to be in the final years of education.

D. Emergency Medicine

VI.E.1. When emergency medicine residents are on emergency medicine rotations, the following standards apply: (Core)
VI.E.1.a) While on duty in the emergency department, residents may not work longer than 12 continuous scheduled hours. (Core)
VI.E.1.a).(1) There must be at least an equivalent period of continuous time off between scheduled work period. (Core)
VI.E.1.b) A resident should not work more than 60 scheduled hours per week seeing patients in the emergency department, and no more than 72 duty hours per week. (Core)
VI.E.1.b).(1) Duty hours comprise all clinical duty time and conferences, whether spent within or outside the residency program, including all on-call hours.

VI.E.1.c) Emergency medicine residents must have one day (24-hour period) free per each seven-day period. This cannot be averaged over a four-week period. (Core)
VI.F.1. Interprofessional teams must be used to ensure effective and efficient communication for appropriate patient care for emergency medicine department admissions, transfers, and discharges. (Core)
VI.G.1.a) The Review Committee for Emergency Medicine will not consider requests for exceptions to the 80-hour limit to the residents' work week.
VI.G.5.b) PGY-2 residents are considered to be at the intermediate-level.
VI.G.5.c) Residents who are PGY-3 or beyond are considered to be in the final years of education.
VI.G.5.c).(1).(b) The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.

E. Family Medicine

VI.E.1. The program director must have the authority and responsibility to set appropriate clinical responsibilities (i.e., patient caps) for each resident based on that resident's PGY level, patient safety, resident education, severity and complexity of patient illness/condition, and available support services. (Core)
VI.G.1.a) The Review Committee for Family Medicine will not consider requests for exceptions to the 80-hour limit to the residents' work week.
VI.G.5.b) PGY-2 residents are considered to be at the intermediate-level.
VI.G.5.c) PGY-3 residents are considered to be in the final years of education.
VI.G.5.c).(1).(b) The Review Committee defines such circumstances, applicable to all residents, as: required continuity of care for a severely ill or unstable patient, or a complex patient, or a maternity care continuity delivery patient with whom the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. (Detail)
VI.G.6.a) Night float experiences must not exceed 50 percent of a resident's inpatient experiences. (Core)

F. Internal Medicine

VI.G.1.a) The Review Committee for Internal Medicine will not consider requests for exceptions to the 80-hour limit to the residents' work week.
VI.G.5.b) No residents will be designated as being at the intermediate level.
VI.G.5.c) PGY-2 and PGY-3 residents are considered to be in the final years of education.
VI.G.5.c).(1).(b) In unusual circumstances, residents may remain beyond their scheduled period of duty or return after their scheduled period of duty to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity of care for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of the patient or family. Such episodes should be rare, must be of the residents' own initiative, and need not initiate a new 'off-duty period' nor require a change in the scheduled 'off-duty period.' (Detail)
VI.G.5.c).(1).(c) Under such circumstances, the resident must appropriately hand over care of all other patients to the team responsible for their continuing care, and document the reasons for remaining or returning to care for the patient in question and submit that documentation to the program director. (Detail)

VI.G.5.c).(1).(d) The program director must review each submission of additional service and track both individual residents' and program-wide episodes of additional duty. (Detail)
VI.G.7.a) Internal Medicine residency programs must not average in-house call over a four-week period. (Core)

G. Cardiovascular Disease; Gastroenterology; Medical Oncology; Nephrology

VI.G.1.a) The Review Committee for Internal Medicine will not consider requests for exceptions to the 80-hour limit to the fellows' work week.
VI.G.5.b) Internal medicine subspecialty fellows are considered to be in the final years of education.
VI.G.5.c) Internal medicine subspecialty fellows are considered to be in the final years of education.
VI.G.5.c).(1).(b) In unusual circumstances, fellows may remain beyond their scheduled period of duty or return after their scheduled period of duty to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity of care for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of the patient or family. Such episodes should be rare, must be of the fellows' own initiative, and need not initiate a new 'off-duty period' nor require a change in the scheduled 'off-duty period.' (Detail)
VI.G.5.c).(1).(c) Under such circumstances, the fellow must appropriately hand over care of all other patients to the team responsible for their continuing care, and document the reasons for remaining or returning to care for the patient in question and submit that documentation to the program director. (Detail)
VI.G.5.c).(1).(d) The program director must review each submission of additional service and track both individual fellows' and program-wide episodes of additional duty. (Detail)
VI.G.7.a) Internal Medicine fellowships must not average in-house call over a four-week period. (Core)

H. Interventional Cardiology

VI.G.1.a) The Review Committee for Internal Medicine will not consider requests for exceptions to the 80-hour limit to the fellows' work week.
VI.G.5.a) Internal medicine subspecialty fellows are considered to be in the final years of education.
VI.G.5.a).(1).(b) In unusual circumstances, fellows may remain beyond their scheduled period of duty or return after their scheduled period of duty to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity of care for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of the patient or family. Such episodes should be rare, must be of the fellows' own initiative, and need not initiate a new 'off-duty period' nor require a change in the scheduled 'off-duty period.' (Detail)
VI.G.5.a).(1).(c) Under such circumstances, the fellow must appropriately hand over care of all other patients to the team responsible for their continuing care, and document the reasons for remaining or returning to care for the patient in question and submit that documentation to the program director. (Detail)
VI.G.5.a).(1).(d) The program director must review each submission of additional service and track both individual fellows' and program-wide episodes of additional duty. (Detail)
VI.G.7.a) Internal Medicine fellowships must not average in-house call over a four-week period. (Core)

I. Obstetrics and Gynecology

VI.G.1.a) However, the Review Committee for Obstetrics and Gynecology does not allow requests for exceptions to the 80-hour per week limitation on resident duty hours.VI.G.5.b) PGY-2 residents are considered to be at the intermediate level.
VI.G.5.c) PGY-3 and PGY-4 residents are considered to be in the final years of education.
VI.G.5.c).(1).(b) The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.

J. Ophthalmology

VI.E.1. The program director must establish guidelines for the assignment of residents' clinical responsibilities by PGY-level, including clinic volume, on-call frequency, and backup requirements, as well as appropriate role in surgical procedures. (Core)
VI.E.2. The guidelines should include key clinical and surgical procedures appropriate for each PGY-level, along with the level of supervision required. (Core)
VI.E.3. Residents must be provided instruction in recognizing situations in which they are overly fatigued or overburdened with duties, communicating the need for assistance when these situations occur, and recognizing the variation in workload necessary with varying experience and competency of fellow residents. (Core)
VI.F.1. Programs must provide a team-oriented learning environment for patient care which incorporates both outpatient and inpatient exposure. The team may include faculty members and residents in ophthalmology, referring and consulting physicians, laboratory and administrative staff, medical students, nurses, optometrists, orthoptists, pharmacists, and technicians, among others. (Detail)
VI.F.1.a) Education in effective communication among team members must be provided. (Detail)

VI.G.1.a) The Review Committee for Ophthalmology will not consider requests for exceptions to the 80-hour limit to the residents' work week.
VI.G.5.b) PGY-2 and PGY-3 residents are considered to be at the intermediate level. (Detail)

VI.G.5.c) PGY-4 residents are considered to be in the final years of education.
VI.G.5.c).(1).(b) The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.

K. Orthopaedic Surgery

VI.D.1. A licensed independent practitioner may include non-physician faculty working in conjunction with the orthopaedic surgery department. (Detail)
VI.G.1.a) The Review Committee will not consider requests for exceptions to the 80-hour limit to the fellows' work week.
VI.G.5.b) PGY-2 and PGY-3 residents are considered to be at the intermediate level.
VI.G.5.c) PGY-4 and PGY-5 residents and fellows (PGY-6 and above) are considered to be in the final years of education.
VI.G.5.c).(1).(b) The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom

the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.
VI.G.6.a) Night float may not exceed three months per year. (Detail)

L. Otolaryngology

VI.D.5.a).(2) Each program must define those physician tasks for which PGY-1 residents may be supervised indirectly with direct supervision available, and must define "direct supervision" in the context of the individual program. (Core)
VI.D.5.a).(3) Each program must define those physician tasks for which PGY-1 residents must be supervised directly until they have demonstrated competence as defined by the program director, and must maintain records of such demonstrations of competence. (Core)

VI.E.1. The workload associated with optimal clinical care of surgical patients is a continuum from the moment of admission to the point of discharge. (Detail)
VI.E.2. During the residency education process, surgical teams should be made up of attending surgeons, residents at various PGY levels, medical students (when appropriate), and other health care providers. (Detail)
VI.E.3. The work of the caregiver team should be assigned to team members based on each resident's level of education, experience, and competence. (Detail)
VI.F.1. Effective surgical practices entail the involvement of members with a mix of complementary skills and attributes (physicians, nurses, and other staff members). Success requires both an unwavering mutual respect for those skills and contributions, and a shared commitment to the process of patient care. (Detail)
VI.F.2. Residents must collaborate with fellow surgical residents, and especially with faculty members, other physicians outside of their specialty, and non-traditional health care providers, to best formulate treatment plans for an increasingly diverse patient population. (Detail)
VI.F.3. Residents must assume personal responsibility to complete all tasks to which they are assigned (or which they voluntarily assume) in a timely fashion. These tasks must be completed in the hours assigned, or, if that is not possible, residents must learn and utilize the established methods for handing off remaining tasks to another member of the resident team so that patient care is not compromised. (Detail)
VI.F.4. Lines of authority should be defined by programs, and all residents must have a working knowledge of these expected reporting relationships to maximize quality care and patient safety. (Detail)
VI.G.1.a) The Review Committee for Otolaryngology will not consider requests for exceptions to the 80-hour limit to the residents' work week.
VI.G.5.b) PGY-2 and PGY-3 residents are considered to be at the intermediate level.
VI.G.5.c) PGY-4 and PGY-5 residents are considered to be in the final years of education.
VI.G.5.c).(1).(b) The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. (Detail)
VI.G.6.a) Night float rotations cannot exceed two consecutive months in duration, and residents can have no more than three months of night float assignments per year. (Core)
VI.G.6.b) There must be at least two months between each night float rotation. (Core)

M. Pediatrics

VI.D.5.a).(1).(a) PGY-1 residents must always be supervised either directly or indirectly with direct supervision immediately available. (Detail)
VI.E.1. The program director must have the authority and responsibility to set appropriate clinical responsibilities for each resident based on the PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services. (Core)
VI.E.2. Residents must be responsible for an appropriate patient load. Insufficient patient experiences do not meet educational needs; an excessive patient load suggests an inappropriate reliance on residents for service obligations, which may jeopardize the educational experience. (Core)
VI.G.1.a) The Review Committee for Pediatrics will not consider requests for exceptions to the 80 hour limit to residents' work week.
VI.G.5.b) PGY-2 residents are considered to be at the intermediate level.
VI.G.5.c) PGY-3 residents are considered to be in the final years of education.
VI.G.5.c).(1).(b) The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.
VI.G.6.a) Night experiences should be of educational value. (Core)
VI.G.6.a).(1) In order to accomplish this, night assignments should have formal goals, objectives, and a specific evaluation component. (Detail)

N. Surgery

VI.D.5.a).(1).(a) The program must define those physician tasks for which PGY-1 residents may be supervised indirectly, with direct supervision available, and must define "direct supervision" in the context of the program. (Detail)
VI.D.5.a).(1).(b) The program must define those physician tasks for which PGY-1 residents must be supervised directly until they have demonstrated competence as defined by the program director, and must maintain records of such demonstrations of competence. (Detail)
VI.D.5.a).(1).(c) The program should use the template of definitions provided in the FAQ or a variation of the template to develop these definitions. (Detail)
VI.E.1. The workload associated with optimal clinical care of surgical patients is a continuum from the moment of admission to the point of discharge. (Detail)
VI.E.2. During the residency education process, surgical teams should be made up of attending surgeons, residents at various PG levels, medical students (when appropriate), and other health care providers. (Detail)
VI.E.3. The work of the caregiver team should be assigned to team members based on each resident's level of education, experience, and competence. (Detail)
VI.F.1. Effective surgical practices entail the involvement of members with a mix of complementary skills and attributes (physicians, nurses, and other staff). Success requires both an unwavering mutual respect for those skills and contributions, and a shared commitment to the process of patient care. (Detail)
VI.F.2. Residents must collaborate with fellow surgical residents, and especially with faculty, other physicians outside of their specialty, and non-traditional health care providers, to best formulate treatment plans for an increasingly diverse patient population. (Detail)

VI.F.3. Residents must assume personal responsibility to complete all tasks to which they are assigned (or which they voluntarily assume) in a timely fashion. These tasks must be completed in the hours assigned, or, if that is not possible, residents must learn and utilize the established methods for handing off remaining tasks to another member of the resident team so that patient care is not compromised. (Detail)
VI.F.4. Lines of authority should be defined by programs, and all residents must have a working knowledge of these expected reporting relationships to maximize quality care and patient safety. (Detail)
VI.G.1.a) The Review Committee for General Surgery will not consider requests for exceptions to the 80-hour limit to the residents' work week.
VI.G.5.b) PGY-2 and PGY-3 residents are considered to be at the intermediate level.
VI.G.5.c) Residents at the PGY-4 level and beyond are considered to be in the final years of education.
VI.G.5.c).(1).(b) The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.
VI.G.6.a) Night float rotations must not exceed two months in duration, four months of night float per PGY level, and 15 months for the entire program. (Core)

Oklahoma State University Medical Center
Moonlighting Policy

"Moonlighting" refers to a service performed by a resident in the capacity of an independent physician, completely outside the scope of his/her residency-training program. For insurance purposes, "external moonlighting" refers to moonlighting at a non–OSU Medical Center facility. Moonlighting hours must be counted toward the 80-hour duty hour limit.

Residents are not required to engage in moonlighting.

Residents are prohibited moonlighting UNLESS they have the written approval of the Program Director or his/her designee, and the Director of Medical Education. The requirements necessary for such approval are set forth below under "Moonlighting".

Residents must have insurance coverage for moonlighting.

In addition to the requirements below, the Chair or his/her designee's decision to approve or deny a resident's request to moonlight will depend on a number of factors including, but not limited to, interference with the resident's responsibilities in the training program and the individual circumstances of the resident.

MOONLIGHTING REQUIREMENTS:

1. The Resident must submit a written request for approval to moonlight by completing the "Moonlighting Form" form obtained either from the Program Director, Program Coordinator or from Appendix D in this House Staff Manual.
2. In order to be considered for moonlighting, the resident must meet the following requirements:
    a. Residents must agree to obtain professional liability insurance coverage for the resident's moonlighting services and that the resident has received privileges. <u>If the facility does not provide insurance coverage, residents must obtain their own professional liability insurance, for no less than limits of $1mm per claim and $3mm in the annual aggregate, and provide proof of such insurance to the Director of Medical Education before moonlighting begins</u>.
    b. Residents must be fully licensed to practice medicine in the state where the moonlighting will occur.
    c. Residents must not wear identifiers as trainees in OSU Medical Center residency-training programs.
    d. Moonlighting counts toward the 80-hour limit set by the ACGME and AOA. The Program Directors are expected and required to assess the resident's progress in the program and ask the resident to stop moonlighting if performance does not reach an expected level. The resident must be aware of these expected levels of academic and clinical performance before beginning the moonlighting experience.

e. Residents must assure the Program Director in writing that the total hours in residency training and the moonlighting commitment DO NOT EXCEED the limits set by the ACGME and AOA. Fabrication of the duty hour information could result in termination from the training program. Resident must also:

- Have approval from the Program Director;
- Provide proof of professional liability insurance;
- Fill out Request to Moonlight form;
- Have approval from the Director of Medical Education.

f. In meeting ACGME duty hour guidelines, resident/fellow must have their Moonlighting facility send/fax a copy of the Resident/Fellow's hours monthly to Graduate Medical Education at (918) 599-5949. No exceptions.

Oklahoma State University Medical Center
Resident/Fellow Moonlighting Request

Date: ____________________

Resident/Fellow ____

PGY Year _______

As a resident/fellow in the ____________________________ training program, I am requesting formal approval for the following moonlighting activities.

I understand that the hospital's medical liability policy does not cover these activities and I have attached a copy of my malpractice insurance certificate that endorses my moonlighting activities.

I understand that my moonlighting activity hours are inclusive of the 80 hour per week maximum work limit and will be reported in my duty hours through New Innovations. I understand that my moonlighting privileges may be revoked if it is deemed by the program director that these activities interfere with my residency/fellowship duties or responsibilities.

Moonlighting Location

Name of Site: ____________________________________

Address: ____________________________________

City, State, Zip: ____________________________________

Phone: ____________________________________

Type: __ Clinic __ ER __Hospital __Other ____________________
Specify

Average Hrs/Month: ____________________

Start Date: ____________________

____
Please print name legibly

____
Resident Signature

____
Program Director Signature

____
Director of Medical Education Signature

Oklahoma State University Center for Health Sciences
Resident Work Environment Policy

SCOPE

This policy applies to all Residents and Fellows at OSU Medical Center

PURPOSE

The Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements requires policies regarding the resident work environment. Specific to this policy, OSU Medical Center must provide appropriate support services to minimize the work of residents extraneous to the educational programs.

DEFINITION

- Residents on duty in the hospital must be provided adequate and appropriate food services and sleeping quarters.
- All Residents (specialty and sub-specialty) are expected to dress in appropriate professional attire when engaged in any Residency activity.
- OSU Medical Center will ensure that patient care is supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of residents. Residents must have access to supervising faculty. Faculty schedules will be structured to provide Residents with appropriate supervision and consultation.
- OSU Medical Center provides counseling and other support services to meet each Resident's unique needs. Any resident in need of services should contact their Program Director and the Office of the Designated Institutional Official to set up an appointment with the Employee Assistance Program (1 800 221 3976)
- Patient support services including an intravenous team, phlebotomy services, laboratory services, and transportation services must be provided in a manner appropriate to, and consistent with, educational objectives and patient care.
- An effective laboratory and radiologic information retrieval system must be in place to provide for appropriate conduct of the educational programs as well as timely, high quality patient care.
- A medical records system that documents the course of each patent's illness and care must be available at all times and must be adequate to support patient care, the educational needs of residents, quality assurance activities, and provide a resource for scholarly activity.
- Appropriate security and personal safety measures must be provided to residents in all locations including but not limited to parking facilities, on-call quarters, hospital and institutional grounds, and related clinical facilities.
- Educational materials to support patient care in the working environment (e.g. computer with internet access, biomedical library materials, etc.) must be available at all times.

- OSU Medical Center insures that each program defines, in accordance with its Program Requirements, the specific knowledge, skills, attitudes and educational experiences required for residents to demonstrate attainment of the ACGME Six General Competencies:

  a. Patient care that is compassionate, appropriate and effective for the treatment of health problems and the promotion of health;

  b. Medical knowledge about established and evolving biomedical, clinical and cognate (e.g. epidemiological, social and behavioral) sciences and the application of this knowledge to patient care;

  c. Practice-based learning and improvement that involves investigations and evaluations of their own patient care, appraised and assimilation of scientific evidence and improvements in patient care;

  d. Interpersonal and written communication skills that result in effective information exchange and "teaming" with patients, their families and other health professionals;

  e. Professionalism as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to a diverse patient population;

  f. Systems-based practice as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system for health care and the ability to effectively call on system resources to provide care that is of optimal value.

TRANSITIONS OF CARE AT OSU MEDICAL CENTER

I. Purpose:

To establish protocol and standards within Oklahoma State University Medical Center residency and fellowship programs to ensure the quality and safety of patient care when transfer of responsibility occurs during duty hour shift changes and other scheduled or unexpected circumstances.

II. Definition:

A handoff is defined as the communication of information to support the transfer of care and responsibility for a patient/group of patients from one provider to another. Transitions of care are necessary in the hospital setting. The transition/hand-off process is an interactive communication process of passing specific, essential patient information from one caregiver to another. Transition of care occurs regularly under the following conditions:

1. Change in level of patient care, including inpatient admission from an outpatient procedure or diagnostic area or ER and transfer to or from a critical care unit.
2. Temporary transfer of care to other healthcare professionals within procedure or diagnostic areas
3. Discharge, including discharge to home or another facility such as skilled nursing care
4. Change in provider or service change, including change of shift for nurses, resident sign-out, and rotation changes for residents.

III. Policy:

Individual programs must design schedules and clinical assignments to maximize the learning experience for residents as well as to ensure quality care and patient safety, and adhere to general institutional policies concerning transitions of patient care. All training programs must design call and shift schedules to minimize transitions in patient care. Schedule overlaps should include time to allow for face-to face handoffs to ensure availability of information and an opportunity to clarify issues. The following areas should be adhered to:

- Residents will not exceed the 80-hour per week duty limit averaged over 4 weeks with transitions of care
- Faculty are scheduled and available for appropriate supervision levels according to the requirements for the scheduled residents.
- All parties involved in a particular program and/or transition process have access to one another's schedules and contact information. All call schedules are available on the New Innovations, The Medical Staff Office as well as the hospital operator.
- Patients are not inconvenienced or endangered in any way by frequent transitions in their care.
- All parties directly involved in the patient's care before, during, and after the transition

have opportunity for communication, consultation, and clarification of information.

IV. Procedure:

The transition/hand-off process should involve face-to-face interaction with both verbal and written/computerized communication, with opportunity for the receiver of the information to ask questions or clarify specific issues. The hand-off process may be conducted by telephone conversation if for some reason face to face communication cannot be given secondary to extenuating circumstatnces. The transition process should include, at a minimum, the following information in a standardized format that is universal across all services:

- Identification of patient, including name, medical record number, and date of birth
- Identification of admitting/primary/supervising physician
- Diagnosis and current status/condition (level of acuity) of patient
- Recent events, including changes in condition or treatment, current medication status, recent lab tests, allergies, anticipated procedures and actions to be taken
- Outstanding tasks – what needs to be completed in immediate future
- Outstanding laboratories/studies – what needs follow up during shift
- Changes in patient condition that may occur requiring interventions or contingency plans

Each residency program must develop components ancillary to the institutional transition of care policy that integrate specifics from their specialty field. Programs are required to develop scheduling and transition/hand-off procedures to ensure that:

Each program must include the transition of care process in its curriculum.

Residents must demonstrate competency in performance of this task. There are numerous mechanisms through which a program might elect to determine the competency of trainees in handoff skills and communication. These include:

- Direct observation of a handoff session by a supervisory level clinician by a peer or by a more senior trainee
- Evaluation of written handoff materials by clinician or by a peer or by a more senior trainee
- Assessment of handoff quality in terms of ability to predict overnight events

Programs must develop and utilize a method of monitoring the transition of care process and update as necessary. Monitoring of handoffs by the program to ensure:

- There is a standardized process in place that is routinely followed
- There consistent opportunity for questions
- The necessary materials are available to support the handoff (including, for instance, written sign-out materials, access to electronic clinical information)
- A setting free of interruptions is consistently available, for handoff processes that include face-to-face communication
- Patient confidentiality and privacy are ensured in accordance with HIPAA guidelines