UNIVERSITY HOSPITALS CLEVELAND MEDICAL CENTER

DEPARTMENT OF ANESTHESIOLOGY & PERIOPERATIVE MEDICINE

ANESTHESIOLOGY RESIDENCY PROGRAM HANDBOOK 2018-2019

Revised:
11/7/18 NP
11/7/18 LG
3/28/19 LG

NOTICE

All residents in the Department of Anesthesiology are required to follow not only this Anesthesia Resident Manual, but also the University Hospitals Resident and Resident Manual, which can be found on the UH Community Digital Workplace. These policies are subject to frequent change and revisions, and all questions should be directed to the Program Directors and Chief Residents.

https://uhcommunity.uhhospitals.org/GraduateMedicalEducation/Uploaded%20Documents/UHCMC%20FINAL%20Resident%20Manual%202016.pdf#search=resident%20and%20Resident%20manual

Section 1: American Board of Anesthesiology Booklet of Information

The guidelines set forth by the ABA are online and all residents are required to know and abide by them.

The Booklet of Information (BOI) is designed to provide a comprehensive description of the requirements and policies pertaining to the ABA's certification and maintenance of certification processes. The ABA recommends that anyone planning to take an ABA examination read the BOI thoroughly prior to starting an application. All applicants for ABA examinations are asked to acknowledge via electronic signature that they have read a copy of the applicable BOI.

The ABA will publish its BOI online only in the "Publications" section of the ABA web site. The ABA BOI will be updated on an annual basis each February.

Please note: all current ABA fees are published on the ABA website in the **"Dates and Fees"** section.

ABA Website Link to Publications: http://www.theaba.org/Home/publications

ABA Booklet of Information: http://www.theaba.org/pdf/BOI.pdf

Section 2: ACGME Program Requirements for GME in Anesthesiology

https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/040_anesthesiology_2017-07-01.pdf

Residents are responsible for the content of the ACGME Program Requirements.

Contents

PROGRAM DESCRIPTION & AIMS

The anesthesiology residency at University Hospitals Cleveland Medical Center (UHCMC) is a four year training program covering all aspects of the practice of perioperative medicine. It also offers a combined five-year training program that prepares the resident for not only perioperative medicine but also the sub-specialty of critical care medicine. The Department of Anesthesiology and Perioperative Medicine is made up of over 50 physicians who medically direct every anesthetic within the University Hospital System. The department has faculty who are sub-specialty trained in regional pain control, cardiothoracic, critical care, obstetric, pediatric, perioperative medicine, and pain management.

The department boasts a wide variety of surgical and medical pathologies that provide an excellent case load for the residents. The cases take place not only in the operating room but increasingly in the out of operating room arenas. The department also has a very active medicine consult service and Center for Perioperative Medicine to provide pre-operative assessments to patients. The residents have dedicated weekly half day didactics. The residents leave with a comprehensive training in perioperative medicine with an emphasis on management and leadership.

Program Aims

1. Train residents to practice at the top of their license with early exposure to OR & advanced electives.
2. Provide Residents with the opportunity to match into their optimal Residency program at outstanding institutions.
3. Train residents who work in multidisciplinary teams to provide the upmost quality of care.
4. Train residents who go above the qualifications of maintaining board certification to become leaders in the anesthesia and perioperative medicine specialty.
5. Residents will be trained in a wide range of clinical subspecialties, caring for a diverse patient population, with increasing autonomy in clinical management and decision making. This is reinforced by regular simulation based educational sessions. Our residents graduate with the ability to do any case with any patient.

IMPORTANT DEPARTMENT AND HOSPITAL CONTACTS

Address: University Hospitals Cleveland Medical Center
Department of Anesthesiology and Perioperative Medicine
11100 Euclid Avenue
Cleveland, Ohio 44106

Phone: 216-844-7335

Dr. Marc Popovich	Department Chairman	Christine Adamovich	Residency Coordinator
Dr. Mada Helou	Residency Program Director	Ashley Love	Doctors Secretary
Dr. Nick Pesa	Residency Associate Program Director	Lisa Mullowney	Executive Secretary
Dr. Shelley Ohliger	Residency Associate Program Director	Kathy Deflorville	Lead Patient Access Scheduler
Dr. Joti Juneja Mucci	Critical Care Residency Director	Lauren Glosik	Education Coordinator
Dr. Peggy Seidman	Pediatrics Anesthesiology Residency Director	Holly Bennett	System Director
Dr. Melinda Lawrence	Pain Management Residency Director	Cindy Patrzyk	Administrator

Anesthesia Coordinator/Mather On-Call Attending:	30900	MOSC Coordinator:	30903
Assistant Coordinator/Mather On-Call Senior:	30901	MOSC Control Desk:	42613
PACU Resident/Mather On-Call Junior:	64120	MOSC PACU	42618
Anesthesia Control Desk:	52114	MOSC Pharmacy:	52065
OR Control Desk:	42260	MOSC Anesthesia Workroom:	52039
Mather OR Charge Nurse:	60128	Call into MOSC OR Anesthesia:	5006X
Mather Pharmacy:	42210	Call into MOSC OR Nursing:	6004X
Mather PACU:	42252		
Mather Preop:	42250	Mac House Attending:	66404
Mather OR Scheduling:	42236	Mac House Resident/Anesthetist:	64112
Blood Bank:	42800	Mac House Resident/Anesthetist:	64113
Mather Anesthesia Workroom:	52129	Mac House "Resident" Phone:	64119
Call into Mather OR Anesthesia:	523XX		
Call into Mather OR Nursing:	522XX	Out of OR Attending:	66405
Trauma Attending:	69205	CTICU Team Phone:	66410
Trauma Resident:	69207	SICU Team Phone:	66406
Trauma Anesthetist:	69206	ICU Night Attending:	48236

Prentiss Coordinator:	30902	Humphrey PACU:	73751
Prentiss Control Desk:	43506	Call into Humphrey OR Anesthesia:	738XX
Prentiss Pharmacy:	43474	Call into Humphrey OR Nursing:	737XX
Prentiss Preop/PACU:	43501		
Anesthesia Tech:	30907	Blocks Resident:	48291
Call into Prentiss OR Anesthesia:	7100X		
Call into Prentiss OR Nursing:	7363X		

Call Room Numbers:

Mather Attending	3306R	Mac Resident (outside)	2611
Mather Senior	3306N	Trauma Attending	3306S
Mather Junior	3306Q	Trauma Resident	3306P
Mac Attending	2026C	CTICU Resident	3306D
Mac Resident (inside):	2026D	SICU Resident	3306F

WORK RESPONSIBILITIES & EXPECTATIONS

All residents in the Department of Anesthesiology are required to follow not only this Anesthesia Resident Manual, but also the University Hospitals Resident and Resident Manual, which can be found on the UH Community Digital Workplace.

Typical resident work hours will vary from rotation to rotation. On average, the workday will take place from 06:00-17:00. Work hours will also vary depending on the volume of cases in the operating room, the availability of other frontliners, and other factors.

All residents scheduled to frontline a case in the operating room should be in the preoperative area in the morning by 06:45 in order to evaluate the patient. To achieve this, enough time should be allotted to adequately prepare the operating room before proceeding to the preoperative area.

On Wednesday morning, the department holds Wednesday Anesthesia Conference. The operating rooms do not start non-emergent cases before 08:15 in order to allow for this. All other first-start cases start at 07:15 for the rest of the week. On Wednesdays, an effort should be made to see patients scheduled for surgery before proceeding to WAC. This is not always possible, but aids in time management on the morning of conference. The goal for turnover between operating room cases is twenty minutes, and thirty minutes for cardiac, total joint, and neurosurgery cases. This will vary on the complexity of cases, acuity of patients, and other factors. Above all else, residents should remember that patient safety comes first.

When a resident is scheduled to work in MacDonald House, it is expected that he or she arrives to the front nursing station by 06:45 in order to relive the on-call team and to receive report on the patients on the floor. Report from the call team should ensure a smooth transition of patient care, and should end in time for the call team to leave by 07:00. On Wednesdays, extra time should be allotted so that all residents, both call team and day shift, can attend WAC. Residents should not take the first phone with them to WAC, and efforts should be made that residents can proceed to WAC without a phone if possible. Personal pagers should be worn at all times, however, so that the remaining staff in Mac House can reach the resident if needed.

While residents are in the operating room, reading is not permitted, including anesthesia books and journals, unless specifically granted permission by the attending for the case or if there is another anesthesia provider present to care for the patient. The focus of the resident should be on the patient at all times. Residents are to remain in the direct presence of the patient from the preoperative area until after report is given to the PACU or ICU staff, unless a break is given by an attending, another resident, or an anesthetist. No resident should ever leave the operating room and his or her patient without adequate transition of care to another anesthesia provider.

All residents will be issued personal pagers at the beginning of residency. Each resident is responsible for carrying his or her pager daily while at work. If a pager is forgotten, broken, or lost, it is the responsibility of the resident to alert the front desk and to supply a number by which he or she can be reached while at work. The resident will also then be responsible for proceeding to the Office of Telecommunications at the earliest possible time in order to secure a replacement pager. Residents should make every effort to keep the department alerted of current cell phone numbers, as well as emergency contacts.

Residents should make an effort to follow up on their patients from the previous day. This can include personally seeing the patient, discussing with the attending from the previous day, or other means of evaluating how the patient did post-operatively. Residents should also make an effort to see patients who are inpatient if scheduled for surgery the following day. This will facilitate evaluation of the patient before the day of surgery including assessment of access and airway and any anticipated difficulties, as well as giving the resident the opportunity to discuss the anesthesia plan with the patient prior to surgery as appropriate.

Before leaving work each day, all residents need to check in with the Coordinator/Assistant Coordinator or the on-call Mather attending. Exceptions to this rule include Chronic Pain, Acute Pain, Blocks, ICU, CPM, and OB. If the resident's case is cancelled, if the room finishes early, or if there is a break between cases in the day, the resident should check in with the front desk to see where he or she could be of assistance in the flow of cases for the day, including helping with breaks, lunches, etc.

Standby Assignment/Late Start Cases

If the resident is scheduled to be on standby or if the first case in his or her assigned room is not a first case start, then the resident should be in the hospital, in scrubs, and should report to the Control Desk by 06:45 to check in with the Coordinator/Assistance Coordinator. If on standby, helping in the preoperative area is appropriate, including assisting with IV placement, making IV fluid bags, assisting with transitions to the operating rooms, etc. Once cases are underway, the resident should check in with the desk to see where else assistance is needed, which may include evaluating any add-on patients for cases. Breaks should start around 08:30, and priority should be given to rooms with 1:3 attending to anesthetist staffing and rooms that have high turnover. All operating areas should be assessed for adequate breaks, including Mather, Prentiss, MOSC, Humphrey, and Out of OR. Lunches should then start around 11:00. The resident should first eat his or her own lunch in the event that an alternate assignment is then necessary, then help in breaking frontliners for lunch. Residents should again check in with the desk after ensuring that all rooms' frontliners have eaten lunch. Emergency rooms should also be set up as able. These rooms should be set up at the discretion of the Coordinator/AC or on-call attending. A cardiac room must always be set up. It is the responsibility of the cardiac junior resident to ensure that a cardiac room (usually MOR 18) is set up after finishing his or her cases for the day. If the cardiac junior is not available, then residents finishing cases early or available late duty residents should assist with setting up the designated cardiac room. The call team should not be left with the responsibility of setting up a cardiac room. Trauma rooms (MOR 1 and MOR 2) should also always be set up. This is the responsibility of the frontliner using these rooms to ensure that they are set back up after use. Trauma rooms must always be available for emergency cases. Breaks in the afternoon are also helpful for frontliners who will be staying late.

Lunch Policy

All residents must take their breaks and eat lunch on the hospital grounds when assigned to the operating rooms, without exceptions, in order to ensure that residents are available to return to their operating rooms in an emergency or to assist with or start emergency cases if needed. Residents may eat in the Anesthesia Resident Lounge or in the appropriate operating room lounges. During lunch, the resident should always be available to return to the operating room if needed, and the resident should make himself or herself available by pager by leaving the pager number in the operating room for the provider giving a break. If the resident's attending is the

one giving lunch, or if the patient in the operating room is unstable, the resident may not eat lunch in the Anesthesia Resident Lounge; he or she should instead eat in the appropriate operating room lounge.

GOALS & OBJECTIVES OF ROTATIONS

Goals and Objectives for every Anesthesiology rotation are posted on our Department website (our departmental google site). Access is protected by share only. Hard copies are also available in the office of the program coordinator.

Residents are required to review the goals and objectives of each rotation prior to the start of the rotation. You should continue to refer to the goals and objectives during the course of the rotation to identify your educational needs. Each goal and objective has a place to check-off items already learned and items that require additional reading.

Faculty should review the goals and objectives with the resident at the start of each rotation.

RESIDENT CALL

Anesthesia residents will take call according to junior and senior level ability, averaging three to six calls per month. This may differ depending on the availability of residents in the call pool, such as at the beginning of the academic year when junior residents being integrated to the call pool take fewer calls. CA1 residents will be acclimated to the operating rooms such that they will be ready to take junior OR call starting on July 1. Residents will generally be assigned one to three weekend calls per month, depending on rotation and seniority. Weekday calls are 16 hours in duration, with residents reporting to the Operating Room Control Desk or Mac House area by 14:45 to report for call and to receive an assignment. Weekday call residents will be relieved by 07:00 the following morning and will be post-call for the remainder of the day. Weekend calls are 24 hours, with residents reporting to the appropriate area by 07:15. Residents will be relieved by 07:30 the following morning.

There are two residents on general OR call daily, one junior and one senior level resident. There are two spots on Mac House obstetric anesthesia call daily, composed of any combination of residents having completed their junior rotation on OB, and anesthetists. There is one Trauma resident on call daily. The Trauma resident on his or her Trauma rotation will be scheduled for nights during the rotation, with alternating Thursday to Sunday 19:00-07:00 and Friday to Sunday 19:00-07:00 (Note: this weekend schedule may be altered if there are weekend holidays included in the rotation). When the on-service Trauma resident is not on call, there will be an afternoon trauma resident on call from 15:00-07:00, with the expectation of arrival at 14:45 to the OR Control Desk. There will be one OR attending (16:00-07:00), one Mac House attending (16:00-07:00), and one Trauma attending (07:00-19:00 and 19:00-07:00) on call each weekday, and on 24 hour call on the weekend for Mather OR and Mac House.

Residents are expected to work in collaboration with their Resident residents, anesthetists on call, and attendings in order to triage call requirements. This may necessitate residents leaving their assigned call areas to assist with urgent and emergent cases in other designated areas as deemed appropriate by the on-call staff.

While on call, the Junior Mather resident is responsible for carrying the Triples Code Pager and the phone 64120. If the resident is in the operating room, the Triples Code Pager may be held by another resident as deemed appropriate by the on-call attending. The Triples Code Pager will be held at all times. The Mather Junior resident is able to call the Mather Senior Resident, Mather attending, Trauma Resident, Trauma anesthetist, or Trauma attending in the event that there is anticipated difficulty during a code. It is the responsibility of the Junior Resident to ensure that adequate handoff of the Code Pager occurs in the morning following call, to either the on-coming junior resident on call on the weekend or the Assistant Coordinator during the weekday. The Code Pager should never be left unattended at anytime, anywhere, for any reason.

During call, the Mather Senior Resident will carry the 30901 phone, the Mather attending will carry the 30900 phone, the trauma resident will carry the 69207 phone, the trauma anesthetist will carry the 69206 phone, and the trauma attending will carry the 69205 phone. The trauma pager and the Code pager must be carried at all times by the anesthesia team.

While on call, the coordinator or on-call attending may assign preoperative evaluations to the on-call residents as necessary for anticipated or scheduled cases. This may include collecting

patient records and evaluating the patient for potential difficult airway or access or other concerns relating to the patient's anticipated case.

Call Request & Scheduling

Call requests are submitted to the Scheduling Chief Resident on a regular basis. Call requests can be submitted on the residency website under the Members Only section. Residents should submit call requests for all rotations, even if no specific requests exist. These submissions should also include whether the resident has scheduled or requested or waitlisted vacation, meeting days, or presentation days. Call requests will be granted as able and reasonable. Calls will be pro-rated based on vacation/meeting/presentation days granted.

The preliminary call schedule will be sent out by the Scheduling Chief Resident in advance of the rotation. It is the responsibility of the resident to review the preliminary schedule to look for errors or conflicts. With the creation of the preliminary schedule, late duty scheduling will be made available. Late duties are generally assigned based on the call schedule, with pre-call residents being assigned to late duty the day before their assigned calls. With dates that have additional late duty spots available and Saturdays during the rotation, a sign-up will be sent out by the Scheduling Chief to allow residents to sign up for additional late duties if able. Unfilled late duties will be assigned at the discretion of the Scheduling Chief. Any switches in late duties must occur to a resident at least at the same level of training in order to facilitate adequate number of senior residents for OR staffing during late duties.

There will be one resident assigned to backup call daily. This resident is designated based on affiliated rotations, including PACU, Blocks, and Acute Pain. Every effort should be utilized to minimize the use of the backup call system. As soon as a resident is aware that he or she is unable to fulfill his or her call, he or she should call the coordinator or on call attending, the program director/assistant program director, and the Chief Residents. If the backup resident takes call, he or she will receive the following day as a post-call day per ACGME regulations. There is no penalty for utilizing the backup call system; however, it is expected that residents only make use of this in the event of true emergencies, illness, etc. It is the expectation of the department that the distribution of calls be made to be even across all residents, with consideration of the backup call resident when needed as well.

Once the call schedule has been finalized, no changes will be made by the Scheduling Chief. All changes must be approved by Dr. Helou or Dr. Pesa, by the Coordinator or the On-call Mather attending, and notification given to the Scheduling Chief. If switches amongst residents are necessary, notification should be given to the aforementioned parties, as well as to Ms. Kathy Deflorville in the scheduling office if more than 24 hours in advance.

Home Call

During training, residents will periodically be assigned to Backup Call and Transplant Call during designated rotations. When the resident is on Backup Call, it is expected that the resident have his or her pager on him or her at all times, and that he or she is available to assume the duties of any of the on-call residents or ICU residents if a situation arises where the in-house resident is no longer able to fulfill his or her clinical duties. Similarly, when a resident is on Transplant Call, the resident is expected to be available for any Transplant operation that arises

while he or she is on call. In both situations, the resident would be expected to adhere to duty hour obligations, and to receive the appropriate post-call time.

While covering call for the Chronic Pain and Acute Pain services, residents are expected to carry with them the service pager. The resident is then expected to be available to return pages and to answer phone calls regarding patients on the respective services. As most interactions via phone call last approximately ten minutes, this is the time that is designated to each. The cumulative time spent on phone calls will then be added toward total duty hours logged by the resident. All duty hour obligations are thus applicable to time spent on clinical duties while on home call.

Call Rooms

Mather Call and Trauma Call rooms are located on the third floor of Mather in between the Men's and Women's locker rooms. The call rooms are unlocked, but they are not to be used by any staff during the daytime. It is prudent to check the call rooms upon starting one's call in order to ensure that they have been cleaned between shifts. If call rooms are found to not have been cleaned, Environmental Services should be contacted.

Mac House Call rooms are located on MacDonald 2. One call room is near the entrance to the Prentiss Operating Room PACU, and the other is inside the Mac House doorway along with the OB and Anesthesia Attending call rooms. Codes to both Mac House call rooms is 123456#. ICU Call rooms are in two separate locations. One ICU call room is in the Mather Call room area, and the other is located in the hallway outside of the ICU on the second floor ICU. While the ICU is being renovated, two ICU call rooms are available in the Mather 3rd floor area with the other call rooms.

LATE DUTY

Scheduled late duties in the operating room are from 17:30-21:30. These will typically fall the day before a 16-hour call. Other late duties will be signed up for or assigned for each rotation block, at the discretion of the Scheduling Chief Resident.

The block will be paid for the full four hours, even if the resident is relieved of clinical duties before 21:30. If performing clinical duties past 21:30, the resident may bill for an additional 2-hour block per each 2 hours after 21:30. Additional late duty hours submitted must be approved by the Program Directors. Emails detailing additional time requested should include the Scheduling Chief Resident, the Program Directors, and the attending on call during the late duty.

Residents who stay past 19:00 may request pay for an unscheduled late duty, except on the following rotations: Cardiac Junior, Neuro Junior, Vascular, as these rotations are expected to be longer in hours. There are no late duties on ICU rotations. Approval is required as with extended scheduled late duties. One resident each week will be assigned to Saturday late duty, from 07:00-15:00. Additional time may be requested beyond 15:00 if performing clinical duties as with weekdays.

Late duty hours are submitted via QGenda under the requests tab.

Trades

Late duties may be traded, but this must be done before 10:00 on the day of the assignment and the front desk must be made aware of the trade. Ideally, it would be done before the day of the trade and the coordinators and Ms. Kathy Deflorville should be emailed and updated. Trading may only be done between residents of equal training level and only 1 trade per day is permitted.

Late Duty Exceptions

- Per the Education Policy, residents at academic risk are not to do extra late duties.
- Residents are to remain compliant with ACGME duty hours, and late duties must not create violations of these rules.

RESIDENT CLINICAL WORK HOURS

Definition of Work Hours: Previously known as "duty hours," these are defined as all clinical and academic activities required for the residency program; i.e., patient care (direct patient care: both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care; time spend in-house during call activities, and scheduled activities such as required conferences. Clinical hours do not include reading and preparation time spent away from the duty site. Restrictions are based upon the ACGME Clinical Hour rules as found in the Common Program Requirements on the ACGME website: https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf

Policy: The Department of Anesthesiology will abide by the recommendations and required established guidelines established by the ACGME regarding resident duty hours and the University Hospitals GMEC.

Purpose: To ensure the residents have an adequate amount of time away from clinical duties in order to minimize fatigue, burnout, and provide for safe patient care.

Key elements of the current policy are posted below:

- There are no rotations that involve call any less than every fourth night.
- Duty hours must be limited to **80 hours per week, averaged over a four-week period**, inclusive of all in-house call activities.
- Residents must be provided with **1 day in 7 free** from all educational and clinical responsibilities, **averaged over a 4-week period,** inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
- One **single period of work** is not permitted to extend 24 hours of work plus 4 hours of limited activity (total of **28 hours**). The additional extended period of 4 hours may be used for attending noon conference, rounding, reporting on prior patients, rounding on patients already familiar to you from your current activity or elective, and events associated with your prior 24 hours of work.
- Adequate time for rest and personal activities must be provided. This should consist of a **8 hour time period provided between all daily duty** periods and after in-house call lasting less than 24 hours.
- Resident will have **14 hours free** of duty **after a 24-hour duty** period.
- Duty hours include the time spent on rotations away from University Hospitals that are part of your training and any **Moonlighting** activities. Program Director must approve the resident to participate in Moonlighting activities.
- Duty hours will be monitored by the Program Director and the PEC.

Monitoring of work hours: The program will ensure that the resident experience is not compromised by excessive reliance on residents to fulfill non-physician service obligations.

The Program director will monitor all submitted work hours submitted to MyEvaluations monthly and provide the PEC and GMEC updates.

The program will make every effort while preparing work and on- call schedules to ensure that residents do not exceed the maximum allowed work hours. However, it is also the duty of the resident to monitor his/her actual work hours during a rotation. In the event that a resident anticipates exceeding the work hour regulation, he/she must bring it to the attention of the Chief Resident and/or Program Director immediately, so necessary corrective steps can be taken prospectively.

It is essential that all residents arrive on-time for assigned duties to ensure duty hour compliance for all residents.

MOONLIGHTING

Residents are permitted to moonlight if:

- USMLE/COMLEX Step 3 passed
- Good standing with the program (not on remediation or learning plan)
- Program Directors must approve all moonlighting requests
- Moonlighting must not interfere with duty hours
- Outside moonlighting requests must complete a moonlighting form and submitted to Program Coordinator

Moonlighting on other services outside the Department of Anesthesiology is permitted, granted that the resident's priority is to the designated rotations and obligations. Moonlighting outside of the department is not permitted if it will interfere with duty hours, resident rotation obligations, or the general call pool or schedule for the rotation.

ICU Moonlighting

ICU Moonlighting is a voluntary privilege in the Department of Anesthesiology and Perioperative Medicine. ICU moonlighting scheduling and allocation is at the discretion of the ICU Residency Director, Dr. Mucci, and at the discretion of the Program Directors, Dr. Helou and Dr. Pesa. ICU moonlighting eligibility will be granted to seniors in the program. Residents must have completed at least four out of six required months in the ICU in order to be eligible to moonlight. Once instituted, the residents must pass ICU Boot Camp in order to be eligible to moonlight. Residents must pass both the AKT and the ITE at the 20%-ile in order to be eligible to moonlight. Moonlighting will be given to between two and four designated residents each month, depending on the Resident schedule in the ICU.

Residents designated to moonlight must be available for three of the four weekends during the month in order to be eligible. Moonlighting for the block will consist of three consecutive weekend nights and four consecutive weekday nights during two separate weeks. Preference in the ICU schedule will be given to on-service residents over those that are moonlighting. Priority and allocation of moonlighting will be determined by Dr. Mucci, with preference first given to ICU Residents, followed by ICU Residency track residents, and then to senior residents over junior residents.

There are rotations on which residents are not permitted to moonlight in the ICU in order to facilitate learning and staffing coverage for these rotations.

- **Acute Pain**—Senior must be available to facilitate Block resident's learning of regional anesthesia, as well as to carry the consult pager and be available for backup call as assigned.
- **Blocks**—Block resident is to be available for all blocks throughout the month and to learn regional anesthesia, as well as to be available for backup call as assigned.
- **ICU**—Residents in the ICU will not moonlight while in the unit in order to facilitate appropriate number of days off during the rotation.
- **Pediatrics**—Residents will not be permitted to moonlight while on Pediatrics in order to facilitate learning of pediatric anesthesia, assist with obtaining appropriate number and acuity of pediatric cases, and to help with adequate staffing of the Prentiss ORs.

- **Trauma**—During the trauma rotation, residents cover Trauma Call on the weekend nights and therefore would not be available to take the weekend component of the moonlighting schedule.
- **TEE/Liver—**During the month on TEE/Liver, it is the resident's job to facilitate in the cardiac junior's learning and to be available to learn echocardiography during this month. Residents must also be available for transplant call during this month and therefore will not be permitted to moonlight.
- **CPM**—During the rotation on CPM, residents will not be permitted to moonlight in order to be present all days during CPM and to participate in the CPM curriculum.

There are rotations during which senior residents will be eligible to moonlight in the ICU.

- OR rotations as appropriate
- Flex
- Research
- Perioperative Medicine Consults, senior rotation
- Medicine Consults, junior rotation
- OB Senior—not during the first week of the rotation while teaching OB junior.
- PACU—two weeks of PACU is required by the ACGME.
- OB Sr. and PACU will be given least priority for moonlighting.

The Hospital Policy on Moonlighting can be found in the Resident Manual on the GME intranet, at http://www.uhhospitals.org/cleveland/education/incoming-residents-and-Residents/next-steps .

FATIGUE MITIGATION and TRANSPORTATION

Policy: This policy is intended to ensure that the Department of Anesthesiology, its faculty and Residents will meet the standards of the ACGME common program requirements concerning fatigue mitigations.

At University Hospitals Cleveland Medical Center, the Department of Anesthesiology, in conjunction with Graduate Medical Education strives to promote physical wellness as a part of the Wellness Policy. Included in this is fatigue mitigation. To combat fatigue encountered by Residents following working hours, the following policy is in place.

This policy and procedure are designed to:

- Raise faculty and residents' awareness of the negative effects of sleep deprivation and fatigue on their ability to provide safe and effective patient care
- Provide faculty and residents with tools for recognizing when they are at risk
- Identify strategies for faculty and Residents to use that will minimize the effects of fatigue (in addition to getting more sleep)
- Help identify and manage impaired residents

Definition of Fatigue

Fatigue is a feeling of weariness, tiredness, or lack of energy. Fatigue can impair a physician's judgment, attention, and reaction time which can lead to medical errors, thus compromising patient safety. There are many signs and symptoms that would provide insight to one's impairment based on sleepiness. Clinical signs include:

- Moodiness
- Depression
- Irritability
- Apathy
- Impoverished speech
- Flattened affect
- Impaired memory
- Confusion
- Difficulty focusing on tasks
- Sedentary nodding off during conference or while driving
- Repeatedly checking work and medical errors

Responsibility of the Resident

- Adopt habits that will provide him/her with adequate sleep in order to perform the daily activities required by the program
- Strictly follow all duty hours requirements

Responsibility of the Faculty

- Faculty will be educated on the hazards of sleep deprivation and fatigue in the workplace and in the provision of care to patients
- Faculty members will be able to determine if residents are sleep deprived and will make the appropriate recommendations to the Resident that will correct this problem.

- The faculty will learn to accept the limitations on the role of the resident under the duty hour mandates and will not penalize the Resident as being lazy or disinterested when the Resident leaves a work assignment "on time'
- The faculty will be responsible to ensure continuity of care in the event a resident must be relieved of patient care duty secondary to fatigue and/or signs of sleep deprivation

Residents that feel fatigued following a long shift, overnight call, 24-hour call, late duty shift, challenging shift, etc. are encouraged to stay and sleep. Call rooms are provided by the hospital for residents.

Residents do have the option to use transportation to get home safely. They must use a reasonable form of transportation (Uber, Lyft, etc.). Reimbursement will be provided by the hospital only to and from home and the hospital. Receipt must be submitted within 30 days.

Education
Residents will receive annual education during schedule didactic time. If there is a need to educate a resident(s) more, than it will be decided on an as needed basis.

Faculty will receive annual education during a snippet presentation during Faculty meeting.

Available Call Rooms for Anesthesiology

Call Room Numbers:			
Mather Attending	3306R	Mac Resident (outside)	2611
Mather Senior	3306N	Trauma Attending	3306S
Mather Junior	3306Q	Trauma Resident	3306P
Mac Attending	2026C	CTICU Resident	3306D
Mac Resident (inside):	2026D	SICU Resident	3306F

PATIENT SAFETY

Residents are expected to report any patient safety issues or cases that happen during medical practice. The University Hospitals and the Anesthesiology Program require residents to any safety events or "near misses" through the PASS Reporting system.

PASS reports are used to report safety events or to report possible sources of error that could lead to safety events in the future. Good catches should also be entered as PASS reports. PASS reports are not meant to be used punitively. This is not equivalent to a "write up." They are interpreted in the spirit of our Just Culture. You can enter this report anonymously.

Below is the link to submit a PASS report and more information:
https://uhcommunity.uhhospitals.org/QualityCenter/Pages/PASSReports.aspx

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PASS Reports

Patient Advocacy & Shared Stories

Pass on information to the Patient Advocates and Risk Managers to improve Patient Satisfaction and Patient Safety

PASS reports are used to report safety events or to report possible sources of error that could lead to safety events in the future. Good catches should also be entered as PASS reports. PASS reports are not meant to be used punitively. This is not equivalent to a "write up." They are interpreted in the spirit of our Just Culture. You can enter this report anonymously.

Risk Management

Mission:
To ensure a safe, healthy and hazard free workplace for University Hospital's employees, patients and visitors in addition to reducing University Hospital's property exposures.
Vision:
To first identify the risks of injury to both people and property and then subsequently eliminate and/or minimize those risks through safety and loss control programs.
Current Initiatives:
Safety and Risk Control Services oversees . . .

2018 PASS Report Summary of Changes

Overall goals with the changes:

- Make entering a PASS report more intuitive
- Make entering a PASS report less time consuming

Disclaimer:

- The software program used does not allow some things to be changed
    - Examples: Which locations fall under which facility, the fact that outpatient encounters only show up in the system after billing is completed

Change 1: Location on the new Digital Workplace
With one click from the homepage (under "Clinical Resources") you can get to the PASS report webpage.

Change 2: Easier to understand PASS report webpage
You will only have to choose between your medical center location or physician office from the home page.
Choosing the PASS report category (anesthesia related vs. treatment/procedure related, etc) will be embedded within the PASS report form.

Change 3: Mandatory fields easily identifiable
All mandatory questions will be bolded and have an asterisk next to it, and there will be a reminder of this at the beginning of the form.

Change 4: More time to complete
The time out period will now be 40 minutes (instead of 20 minutes), and there will be a reminder of this at the beginning of the form.

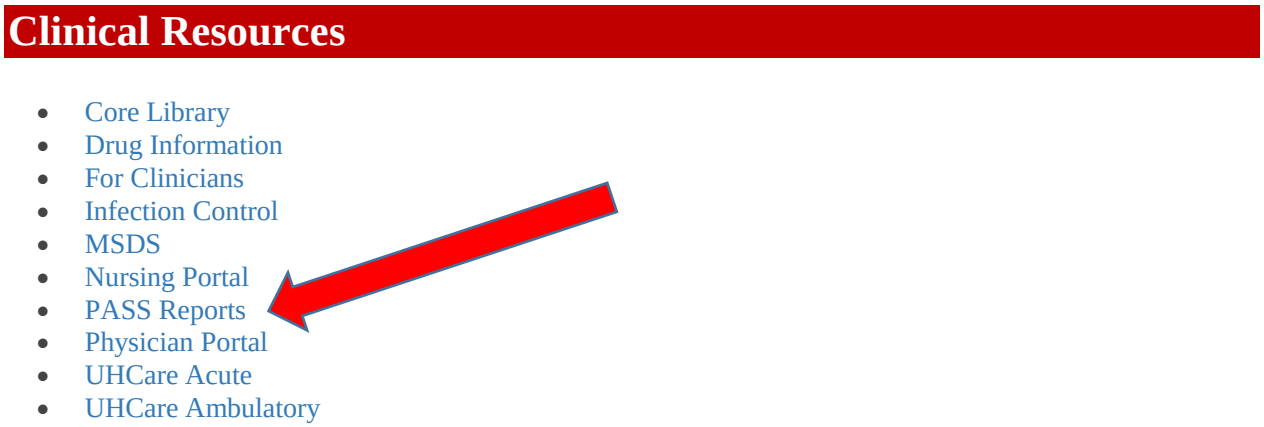
Change 5: Changing the order of questions to reflect high priority questions
After patient demographics, the first question will be to describe the event.
The text boxes to describe the event will be larger.

Change 6: Removed redundant and unnecessary questions
Some PASS subtypes had excess questions that on review and discussion with stakeholders were no longer necessary; where applicable these were removed.

Change 7: Instructions on how to search fields
There will be instructions on how to search for the department, employee, and location (which is not intuitive in this system, and cannot be changed).

Change 8: Confirmation that PASS report was submitted
After hitting submit, a new page will open up that verifies your PASS report was successfully submitted. This webpage will also tell you what will be done with the PASS report that you submitted, when to contact risk management, and whom to contact with questions.

On Intranet Home Page



SUPERVISION POLICY

Purpose
To promote an educational environment that fosters the acquisition of competence for independent practice while maintaining the highest standards of patient safety. To provide a basis for continued professional growth.

The program defines the level of supervision provided for each of the major learning activities.

Types of supervision:

- **Direct Supervision**

- **Indirect supervision:** with direct supervision immediately available – the supervising physicians is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.

The Anesthesiology resident will train under direct supervision or indirect supervision with direct supervision immediately available. The level of supervision will vary depending on the faculty and complexity of the patient and the documented competence of the resident.

Policy
All patient care is supervised by faculty members. Faculty and residents are required to inform patients of their specific roles, and that faculty are ultimately responsible for patient care. Teaching faculty are allowed to supervise a maximum of two operating rooms when educating residents.

Faculty – resident relationship:

- It is each faculty's responsibility to promote a non-threatening environment governed by mutual respect between faculty and trainee.
- The faculty is to teach, both by example and via direct & written feedback, the attributes of professionalism and effective interpersonal communication.
- The faculty is to provide medical knowledge in the pre-operative, operative and post-operative setting.
    - Pre-operatively, the faculty is expected to respond to the resident's page / text message. The faculty is to review the resident's anesthetic plan for the following day, and is to direct the resident's reading for the case. The attending is also expected to prompt the resident to attempt new anesthetic techniques.
    - Intra-operatively, the attending is to provide active coaching on clinical skills and procedures while incorporating cost conscious management principles. Residents in turn are required to call the attending when they need guidance or there is a change in the patient's condition.
    - Post-operatively, the faculty is expected to discuss case-specific routine post-operative care as well as inform the resident of any complications that happen to their patients in the post anesthesia care unit to enhance practice-based learning.
- In addition to providing verbal feedback throughout the day, it is the faculty's responsibility to fill out written evaluation forms at the end of the rotation.
- Finally, faculty are required to use the above to teach residents systems-based practice. Faculty should ensure that residents demonstrate a commitment to excellence in patient

care and to ethical practice, and that they regard patient needs above their own at all instances.

It is the Program Director's responsibility to monitor that teaching faculty are performing the abovementioned duties through both direct observation and through review of faculty and resident evaluations. It is also the Program Director's duty to review resident case logs and evaluate residents according to ACGME milestones to ensure adequate progression.

Progressive responsibilities for patient care by clinical year are as follows:

CBY: the vast majority of supervision is direct, with remaining instances under indirect supervision with direct supervision immediately available.

Residents provide direct patient care or consultative services in the following clinical areas:

- ENT
- Surgery
- Emergency Department
- Internal Medicine
- Intensive Care Unit
- Chronic Pain
- Operating Room – Orientation to Anesthesiology

Residents during this level are expected to be able to independently assess their patients, and in conjunction with the attending determine the existing pathologies and plan of care. They are expected to ensure the implementation of the plan set forth by the attending and to inform the attending of any obstacles to patient care that may arise.

CA-1: In the first third of their CA-1 year, residents are expected to fulfill their role as team members under direct supervision from staff / senior residents. They are assigned to simpler cases with healthy patients (Mostly ASA-1 and some ASA-2 patients), and they are expected to develop and execute their management plan under close supervision.

In the second two-thirds of their CA-1 year, residents are exposed gradually to various subspecialty rotations including Peds-Jr, Cards-Jr, OB-Jr, Neuro-Jr etc. Here, they are oriented by a senior resident and supervised by an attending.

CA-2: As CA-2's subspecialty experience is enhanced as residents rotate through Peds-sr, Cards-sr, OB-sr, Neuro-sr etc. Throughout this year, greater autonomy is expected as the residents start becoming the first point of contact for patient questions, with indirect supervision with direct supervision immediately available.

CA-3: All ACGME Case Logs must be completed early during this year. CA-3's are expected to assume a leadership role, coordinating the team and interacting with administrative staff. CA-3's are expected to independently assess patients & to develop and execute management plans while having indirect supervision with direct supervision immediately available. CA-3's care for the sickest patients, and in conjunction with the attending, help provide for the educational and supervisory needs of the junior residents. During

this year, residents should also become proficient at off-site Anesthesiology, e.g. MRI and interventional CT locations, EP, GI etc. Ca-3's also rotate to community sites including University Hospitals Regional Medical Center (Richmond and Bedford Campus), Westlake Surgery Center, Mentor Surgery Center and Suburban Surgery Center.

TRANSITIONS OF CARE

Purpose: To establish a protocol and standards within the University Hospitals-Cleveland Medical Center (UHCMC) Anesthesia Residency Program to ensure the quality and safety of patient care when transfer of responsibility for a patient or group of patients occurs during duty hour shift changes, during transfer from one level of acuity to another, and during other scheduled or unexpected circumstances.

Policy: An anesthesia team consisting of a faculty member and an anesthesia resident or CRNA or AA provides intraoperative anesthesia care at UHCMC. Transition of anesthesia care ("hand-off") to a different provider may become necessary at the end of the care giver's regular working shift, during the regular working hours for a short time to ensure adequate breaks, during transitions in level of care, including OR to PACU/ICU or ICU to general floor bed, or service change, including faculty/resident sign-out (ICU), inpatient consultation sign-out, and rotation changes for residents (Perioperative Medicine/ICU). This Policy formalizes and standardizes the process of any transition of care, which becomes necessary during the intraoperative and postoperative period. Patient confidentiality and privacy are ensured in accordance with HIPAA guidelines; this includes the appropriate disposal of any written material in HIPAA-compliant receptacles, and encryption of any electronic devices used during the handoff process. Oversight for establishing this Policy & Procedure is the responsibility of the Program Director.

Background: Adequate transfer of patient care is a crucial part of a safe medical practice. This policy defines a safe and standardized process to transfer accurate information about the patient including medical history, surgical procedure, current conditions and anticipated intraoperative course.

Procedures:

- Intraoperative and Perioperative transfer of care and other shift related transfers will follow a standardized checklist with standardized responsibilities.
    - The UHCMC Anesthesia Handover Checklist will be followed for transfer of patient care in the main OR and all satellite anesthetizing locations including obstetrical anesthesia.
    - The UHCMC Perioperative Checklist will be followed for transfer of patient care during Perioperative Medicine and ICU rotations.
- Handover procedures are performed whenever care or responsibilities are transferred between caregivers. This includes:
    - Any permanent transfers of care between faculty and/or between residents and AAs/CRNA's/NPs.
    - Intermittent transfers of care (e.g. as occurs for morning, lunch, and preoperative breaks)
    - Transition of care daily between the ICU day and night teams, in addition to monthly transitions from one block rotation to another, along with daily transitions for the perioperative day and night teams, in addition to monthly transitions from one block rotation to another.
- Handovers are performed face to face and at the bedside by going through the items on the Handover Checklist as well as going over and verifying all drawn up medications including controlled substances.

    - In addition to face to face verbal handover, there are paper and electronic documentation of the patient's anesthesia related care available to assist transition of care.
- A Handover will also occur at 7AM and 430PM & 7PM between incoming and departing anesthesia faculty managing the OR, Obstetrical Suites, Anesthesia Pain Service, Perioperative Medicine Service, and ICUs to ensure appropriate transfer of patient information and management duties.
    - This Handover will follow the UHCMC Anesthesia, OB, Acute Pain Service, Perioperative Medicine Service and ICU Handover Checklist.

Delineation of Responsible Providers

- The Anesthesia team caring for the patient is listed on Qgenda, iPro system and AcuteCare (EMR) and is available to all health care team members. This listing is updated in real time to reflect changes in coverage and identifies anesthesia trainees, CRNAs, and attending staff responsible for the care of the patient.

Transition of Care Tools

UHCMC Anesthesia Transition of Care Process

- The transition process should include, at a minimum, the following information in a standardized format. SBAR is an acceptable format (**S**ituation, **B**ackground, **A**ssessment, **R**ecommendations):
    - Identification of patient, including name, medical record number, and date of birth
    - Identification of attending physician of record and contact information
    - 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 the immediate future
    - Outstanding laboratories/studies – what needs follow up or review during shift
    - Changes in patient condition that may occur requiring interventions or contingency plans

UHCMC Anesthesia Case Handover Checklist

(to be performed for all anesthesia personnel changes)

Transition from OR to PACU will be accompanied by verbal handover and a paper document of the anesthesia record (template included below), along with an electronic record found in EMR.

Situation:

- Patients Name, Age, ASA, native language
- Allergies
- Procedure & current surgical status
- Surgical requests for anesthesia (e.g. relaxation, MAP)
- Patient position
- Anesthesia type

Background:

- Medical History
- Airway Management/Difficulties

- Regional anesthesia (placement? events?)

Assessment:

- Cardiovascular Status
- Pulmonary status & Vent settings
- Anesthetics given (Vapor/Opioids/Relaxants/Reversals)
- Other Medication given or due (Antibiotics/Antiemetics)
- IV / Arterial / Central lines (placement/usage events?)
- Fluid input and output
- Blood product availability
- Labs received/pending

Recommendations:

- Emergence and Disposition plan
- Extubation (Y/N)
- Reversal
- Pain medication
- PACU, ICU (informed? Transport arranged?)
- Reconcile medications and controlled substances
- Inform surgical and nursing staff of anesthesia personnel change

UHCMC Anesthesia Case Handover Checklist (CTICU specific)

In addition to the routine "Anesthesia Case Handover" (as documented above), additional information will be provided during transition of care for Cardiothoracic patients to CTICU staff, including a paper documentation and an electronic record of care found in EMR.

- Procedure
- Chest tubes
- Bypass time
- Cross Clamp time
- Pacer wires and settings
- Pre-op/post-op rhythm
- Access (central, arterial, swan, PIV)
- Airway (blade, view, size and depth of ETT)
- Ventilation issues
- OR ventilator settings
- Fluid Input and Output
- Synthetic clotting factors
- Infusions
- Specific medications dose and time (versed, fentanyl, rocuronium, antibiotics)
- Special concerns
- Post-op disposition

UHCMC Anesthesia OB Shift Handover Checklist

- Current ongoing or scheduled surgical procedures in OB
- Current laboring patients
- Current Epidurals/Continuous SpA
- Readiness of LD ORs

UHCMC Anesthesia Acute Pain Service Shift Handover Checklist

- Handoff checklist
  - Current pain patients
  - Current Procedure
  - Active Consults
  - Current Epidurals/Continuous catheters
  - Add-on cases
  - Pre-ops
  - Staffing

UHCMC Anesthesia Perioperative Medicine Shift Handover Checklist

Situation:

- Patients Name, Age, native language (if applicable)
- Identification of attending physician/primary care team
- Code Status
- Reason for Consult

Background:

- Medical History

Assessment:

- Overnight events, including changes in condition (acuity)
- Medications/interventions given
- Fluid input and output (if applicable)
- Labs/studies received/pending
- Consults requested/completed

Recommendations:

- Goals of care for the day
- Disposition plan

UHCMC Anesthesia ICU Shift Handover Checklist

Situation:

- Patients Name, Age, native language (if applicable)
- Identification of attending physician/surgeon
- Code Status
- Procedure

Background:

- Medical History, specifically reason for surgery
- Type of anesthesia employed (if applicable): GA, Regional, etc
- Airway Management/Difficulties

Assessment:

- Overnight events, including changes in condition (acuity)
- Neuro status
- Cardiovascular Status
- Pulmonary status & Vent settings
- Medications given
- Resuscitation (Crystalloids, Colloids, Products)

- IV / Arterial / Central lines (placement/usage events?)
- Fluid input and output (eg goals)
- Blood product availability
- Labs/studies received/pending
- Consults requested/completed

Recommendations:

- Goals of care for the day
- Disposition plan

ESCALATION OF CARE POLICY

The following policy provides examples of scenarios where a Resident must communicate with the attending physician responsible for a patient's care. This communication should occur whenever a Resident recognizes a problem threatening the safety of a patient, visitor or employee.

1. The following is a list of conditions that might require escalation. It is not totally inclusive of all conditions or situations that require escalation. Each situation must be evaluated independently.
    a. Unexpected change in a patient's medical condition
    b. Transfer of patient to a higher level of care
    c. Patient death
    d. Patient or family wishes to lodge a complaint
    e. Patient or family requests to speak to the attending physician
    f. Inappropriate or questionable medical or nursing practice (the attending is expected to assist the Resident with seeking appropriate resolution through the chain of command)
    g. Ethical or legal issues needing prompt resolution
    h. Equipment failure
    i. Threats/Workplace Violence

2. Anesthesiology specific escalation of care issues, provided below:
    - **Intraoperative:**
        - Change in hemodynamics greater or less than 20% baseline
        - Initiation vasopressors
        - Blood loss greater than 25% volume
        - Initiation blood transfusion
        - Surgical decision to increase acuity for post op (i.e. need for ICU care unanticipated)
        - Unexplained change in hemodynamics (i.e. increasing unexplained tachycardia)
        - Urine output under 0.25cc/k/h
        - Loss of IV access
        - Any time the trainee is uncomfortable caring for the patient without the physical presence of the attending

    - **PACU:**
        - Excessive obtundation
        - Excessive need for pain control
        - Airway compromise, increasing need for O2, ventilatory support (BVM, adjuvants etc), concern for re-intubation
        - Loss of IV access
        - Any time the trainee is uncomfortable caring for the patient without the physical presence of the attending

3. Critical care specific escalation of are issues, provided below:
    - New admission
    - Initiation of BAT (brain attack)
    - Death

- Change in code status
- CPR
- Adjusting settings on mechanical circulatory support (ECMO, VADs, impellas)
- Electrical Cardioversion
- Discharge decision
- Initiation of Dialysis
- Massive Transfusion
- Initiation of vasopressors
- Rapid titration of vasopressors
- Central line placement
- Intubation
- Initiation of anti-arrhythmic medications

4. It is the responsibility of all Residents to be knowledgeable about the escalation process and to implement it appropriately.

5. Implementation of the escalation process will not result in punitive action toward the initiating individual.

ROTATION SCHEDULE AND REQUESTS

The annual rotation schedule is posted on the resident website. Every effort will be made to keep this version of the schedule updated by the Chief Scheduling Resident.

- Residents are responsible for reviewing the posted schedule for any updates or errors.
- Vacation is limited to certain rotations and residents should be mindful of this when planning out their schedule if future obligations or conflicts are known.
- Priority is given to seniors for requests, and these are given on a first-come, first-serve basis.

Elective Month

All requests for an elective month preferences should be submitted to the Program Directors and to the Chief Residents as far in advance as possible in order to accommodate the requests.

- Only one resident per rotation block, for example, will be permitted to be on research.

CASE PROCEDURE LOGS

All cases done by residents are to be logged and reported to the ACGME. Even after the minimum requirements are met, all cases are to be continued to be logged for accurate records. The website for logging cases is https://www.acgme.org.

- Cases should be logged daily in order to accurately reflect resident activity. This is also important for program accreditation.
- Case logs will be evaluated on a biannual basis.
- Failure to log cases could result in an unsatisfactory result during the CCC resident review and semi-evaluation.
- Residents will be required to sign off on the case log report.
- Cases not logged will not count toward totals in residency.

Questions about cases and the logging system can be directed to the Program Director. Issues with logging cases should be addressed with the Program Director, Coordinator, or Administrator as soon as possible.

RESIDENT ADVANCEMENT AND PROMOTION POLICY

The Department of Anesthesiology ensures that each resident is treated fairly and held to the same and consistent reappointment process that meets all educational and contract guidelines of University Hospitals and the Department of Anesthesiology.

- Residents will be advanced to the next level of training based on satisfactory completion of all training requirements and satisfactory clinical competency based on the residents achieving satisfactory clinical competency evaluations (ABA clinical competency report and ACGME milestone report)
- Resident appointment will be for a 12-month period
- If a resident will not be promoted to the next level, written notification will be provided by the Program Director as soon as possible
- Exam pass results must be submitted to program before promotion granted and time of signature of employment contract
- If CCC members suggest to not allow the resident to graduate or promote, one of the following recommendation should be made to the Program Direct:
    - Keep resident at the current level of training for a specific period of time; re-evaluation will be needed to advance
    - Dismiss resident from the Residency
- The Program Director, along with the guidance or suggestions from the CCC, will have the final decision on promotion, remediation, and dismissal of residents.
- If the resident is not making adequate progress towards advancement to the next level of training, the CCC may choose to not renew the resident's contract. At least four months advance written notice will be provided to the residents, or as much written notice as possible.
- The resident has the right to appeal the action through the Due Process Policy.

Criteria for Advancement/Promotion of Residents

PGY-1 to CA-1

- Successful completion of all required PGYI year rotations in all six core competencies.
- Hospital compliance course requirements completed
- Must have taken USMLE/COMLEX Step 3
- Adequate progress on competencies and promotion by CCC

CA-1 to CA-2

- Successful completion of required CA-1 year rotations in all six core competencies
- Hospital compliance course requirements completed
- Maintenance of Case Logs
- Pass USMLE/COMLEX Step 3
- Must acquire permanent license
- Adequate progress on competencies and promotion by CCC

CA-2 to CA-3

- Successful completion of required CA-2 year rotations in all six core competencies
- Hospital compliance course requirements completed
- Maintenance of Case Logs
- Adequate progress on competencies and promotion by CCC

CA-3 to Graduation

- Successful completion of required CA-3 year rotations in all six core competencies
- Completion of ACGME minimum procedure requirements documented through ACGME Case Logs
- Completion of a scholarly activity project

DISMISSAL

If it is determined that a Resident's deficiency is of sufficient gravity to warrant dismissal, the Resident may be dismissed without first being offered an opportunity for remediation.

A. A Resident may be dismissed from the Residency Training Program for serious acts, which include but are not limited to the following:
   1. Serious acts of incompetence;
   2. Non-disability related impairment;
   3. Unprofessional behavior;
   4. Falsifying information; and
   5. Noncompliance with Hospital policies.

B. Immediate dismissal will occur if the Resident is listed as an excluded individual by any of the following:
   1. Material breach of the Resident's contract, any Policy set forth in this Manual, or any applicable policy of UHCMC or any UHHS affiliate or subsidiary at or for which Resident is providing services, expressly including, but not limited to any organizational integrity or compliance program or policy of any such entity;
   2. Conviction (including guilty plea or plea agreement) for a felony or the Resident's agreement to a consent decree or other judicial order or administrative settlement with respect to fraud or abuse or misconduct involving activities regulated by any governmental health care or accreditation agency;
   3. Failure to obtain or properly maintain any professional license or any privilege, membership or right to practice at UHCMC or any UHHS affiliate or subsidiary if such license, privilege or right is necessary for the Resident to fulfill duties assigned to Resident under his or her PSA, this Policy Manual or otherwise by his or her Program Director;
   4. Any suspension, revocation, restriction on or loss of any professional license or of any privilege, membership or right to practice at UHCMC or any UHHS affiliate or subsidiary (except for suspensions purely as a result of an administrative cause);
   5. Evidence of current alcohol, substance or drug abuse;
   6. Resident is the subject of an allegation of any of the following violations:
      a. Health care fraud or abuse;
      b. Financial fraud;
      c. Patient abuse;
      d. Violent crime, including domestic/child abuse;
      e. Theft or illegal use or possession of drugs;
      f. Sexual misconduct, sexual harassment or other forms of harassment or intimidation; or
      g. Any similar violations that are criminally or civilly proscribed.
   7. Resident has been consistently or materially disruptive, or consistently or materially fails to work cooperatively with UHCMC or other UHCMC Resident(s), whether or not such other Resident(s) are members of the Resident's assigned Department, or engages in conduct that brings, or threatens, discredit to the reputation of UHCMC or any of its Residents;
   8. Resident's failure or refusal to provide UHCMC with any information reasonably requested by UHCMC and necessary for UHCMC to evaluate whether Resident is in violation of Resident's PSA or this Policy Manual;

9. Resident becoming debarred, excluded, suspended or otherwise determined to be ineligible to participate in federal or state health care programs or in Federal procurement or non-procurement programs (collectively, "Ineligible"), or convicted of a criminal offense that could result in Resident becoming Ineligible; and
10. If applicable, Resident's failure to maintain a visa status that permits Resident to work for UHCMC.
    a. Department of Health and Human Services Office of Inspector General's "List of Excluded Individuals/Entities";
    b. General Services Administration "List of Parties Excluded from Federal Procurement and Non-Procurement Programs"; and c. Convicted of a crime related to the provision of health care items or services for which one may be excluded under 42 USC 1320a-7(a).

C. The Resident does not need to be on suspension or probation for dismissal to take place.

Non-renewal of Resident's Contract

A. If a Residency Program Director, Site Director or Department Chairman determines that a Resident is not meeting the standards of the program, he/she may make a recommendation for non-renewal of the Resident's contract.
B. The Program Director or Site Director must submit the recommendation for non-renewal in writing to the Director of GME and will include the basis on which the action is being taken. If the 29 DIO/Director of GME determines that there is sufficient reason not to renew the appointment, he/she will notify the Program Director, who will so inform the Resident in writing no later than four months prior to the end of the Resident's current contract. In accordance with applicable accreditation guidelines, if the primary reason(s) for non-renewal occur(s) within four months prior to the end of the contract, UHCMC will make every effort to ensure that the program provides the Resident as much written notice of the intent not to renew as circumstances will reasonably allow prior to the end of a Resident's appointment.

EDUCATION POLICY – Academic Risk and Remediation

ACADEMIC STANDING *(effective July 1, 2017)*

1. In order to remain in good academic standing, residents (not PGY-1) are expected to meet minimum performance requirements on the American Board of Anesthesiology (ABA) in-training exam (ITE), the The Anesthesia Knowledge Tests (AKT-6 and/or AKT-24), and the ABA BASIC exam taken at the end of the CA-1 year.

2. For the ITE:

a. The anesthesiology resident training program uses the annual in-training exam (ITE) scores as a metric for the knowledge competency at the CBY, CA1, CA2 and CA3 levels of training. There being a correlation between ITE scores and the likelihood of passing the written board examination of the ABA, it is the committee's desire that all residents in our training program perform above certain minimum standards on the ITE. These minimum levels are established by the CCC (Clinical Competence Committee) and approved by the Education Committee.

b. Presently, a failing score is considered below the 20th national percentile within a given training level and requires the aforementioned remediation plan. Scores from the 20th to 39th national percentile are considered passing with concerns. Scores at the 40th percentile and above are considered fully satisfactory.

i. A score of 36 is considered to be predictive of passing the ADVANCED exam taken after graduation

ii**.** In 2017, a failing ITE score was below 27 (CA-1), 33 (CA-2) or 33 (CA-3)

iii. In 2017, passing with concerns was 27- 30 (CA-1), 33-35 (CA-2) or 33-36 (CA-3)

c. Scores below the minimum acceptable percentile (20th national percentile) will be deemed a failure to meet our program's minimum standard for the knowledge competency and considered unsatisfactory. Failure to meet the minimum standards will have consequences which are outlined below.

i. Residents who do not meet these requirements will be given the status of **Academic Risk**

ii. A **remediation plan** will be formulated

iii. Consecutive failures may lead to **Official Academic Probation**

d. The score range above the minimal acceptable score but below fully satisfactory will be considered **passing with concerns**.

i. This group of residents will be required to formulate a learning plan in conjunction with their staff mentors.

1. The content and acceptability of the plan will be between the resident and the mentor.

2. An attestation form must be submitted back to the committee within two weeks of notification from the committee and contain the signature of the mentor indicating that the plan has been reviewed and discussed. No further action will be required for this group.

ii**.** If a resident is persistently in this score range, no formal escalation of remediation will occur, however both resident and staff mentor are encouraged to seek alternate forms of council to improve.

3. For the AKT (Anesthesia Knowledge Test)

a. Each class will be administered a test relevant to their level of training. As with the ITE, the examination scores will have associated with them similar minimally acceptable levels of performance for the knowledge competency with consequences. The AKT6 and AKT24 are part of the summative process and will be counted as exam failures. Since the AKT24 scores are not reported as a single percentile, rather as 7 specialty subcategories, the following has been adopted as a minimum passing score by the CCC and approved by the Education Committee. A passing score will consist of a 20^{th} percentile or better in at least 6 of 7 subcategories.

b. Failure to meet the minimum examination scores is considered a serious matter with adverse outcomes.

i. Residents who do not meet these requirements will be given the status of **Academic Risk**

ii. A **remediation plan** will be formulated

4. For the BASIC exam:

a. ABA Requirements:

i. A resident who fails the BASIC Examination for the first time may take the examination again at
the next opportunity.

ii. A resident who fails the BASIC Examination a second time will automatically receive an unsatisfactory for the Clinical Competence Committee reporting period during which the examination was taken.

iii. After a third failed attempt at the BASIC Examination, a resident will be required to complete six
months of additional training.

iv. After a fourth failed attempt a resident will be required to complete an additional 12 months of
residency training.

v. Continuation of residency training is at the discretion of the individual training program. A
resident cannot graduate from residency training without passing the BASIC Examination.

b. Program Requirements:

i. A resident who has failed the BASIC Examination shall be given the status of **Academic Risk** until they have passed the BASIC Examination.

1. A **remediation plan** will be formulated

ii. A resident will not advance beyond a CA-2 status without passing the ABA BASIC exam.

iii. Failure on the first attempt to pass the ABA BASIC will ***not*** result in an extension of training due to exam failure ***UNLESS*** the ITE exam was also previously failed

iv. Failure on the second attempt to pass the ABA BASIC will result in a 6 month extension of training.

v. Failure on the third attempt to pass the ABA BASIC will result in an additional 6 month extension of training.

vi. Failure on the fourth attempt to pass the ABA BASIC will result in termination from the residency program

5. Academic Risk:

a. All residents at Academic Risk will receive a Performance Action Alert, which is formal written notification (written counseling) of their unsatisfactory academic performance.

i. Written counseling remains sealed unless there is a subsequent exam failure or unsatisfactory performance determined at a CCC quarterly review.

b. All residents at Academic Risk will partake in a remediation plan (below)

c. All residents at Academic Risk will report to the hospital on their call day by 8:00 AM (or another pre-approved time, ex: 10 hours after last duty hour) for studying in the department library or another suitable location.

d. All residents at Academic Risk will need permission from the Program Director in order to sign up for
additional moonlighting (*e.g.*, extra late duties, Saturday duties, and paid ICU calls). This includes both inside the department and outside.

e. All residents at Academic Risk will relinquish ancillary professional responsibilities (e.g. committee work whether for internal or external organizations, officer positions for professional organizations, etc.)

f. Beginning with the graduating class of 2019, CA-2 residents who remain at Academic Risk will NOT be reimbursed for the cost of registration for the ADVANCED exam

e. Advancement from Academic risk to **Official Academic Probation**

i. Any resident who is at Academic Risk for >1 year.

ii. Two consecutive failures on any exam (ITE/AKT/staged board exam) after AKT6.

iii. Three failures at any time during the course of residency training after AKT6.

6. Remediation Plan

a. A formal plan formulated with and approved by the resident's staff mentor.

b. The plan must include a specific reading/study plan and schedule, a listing of perceived weaknesses and a method by which to measure improvement in knowledge.

i. assessment of improvement must be exclusive of the subsequent ITE/AKT/ staged exam.

c. Regular meetings with staff mentor (or Program Director, Education Director, etc.) are encouraged.

d. This plan must be submitted to the Clinical Competency Committee for approval within two weeks of the notification of a failing score from the committee.

i. Decision regarding the acceptability of the plan resides with the committee.

7. **Official Academic Probation**

a. A letter shall be included in the Resident's permanent file.

b. An unsatisfactory grade for Medical Knowledge will be reported to the ABA for that Clinical Competence Committee reporting period.

i. Residents may not graduate with a terminal unsatisfactory report to the ABA by their rules.

c. Residency training may be extended.

d. Dismissal from the training program or non-renewal of contract.

i. Two consecutive unsatisfactory reports to the ABA will automatically result in a 6 month extension of training by ABA rules.

8. The training program reserves the right to adjust the acceptable performance levels for both exams as they deem appropriate. Consequences of an unsatisfactory rating to the ABA can be found in the ABA policy booklet On-Line.

	Prior to PGY-1	PGY1 year	Clincal Orientation	CA-1 year (July/ Dec)	CA-1 year (Jan/ June)	CA-2 year (July/ Dec)	CA-2 year (Jan/ June)	CA-3 year (July/ Dec)	CA-3 year (Jan/ June)	After Graduation
USMLE1	PASS before 3rd year medical school									
USMLE2 (CS+CK) COMLEX	PASS prior to PGY1 start									
USMLE3		must PASS prior to start of CA-1year								
ABA Pt 1 A basic						July	January 2nd attempt if necessary	July 3rd attempt if necessary	January 4th attempt if necessary	
ITE$_{1,2,3,4}$		~ March			~ March		~ March		~ March	
AKT 1 pre			beginning of orientation							
AKT1 post			one month out from orientation							
AKT 6				October						
AKT 24								End of September		
ABA Pt 1 B advanced										After passing ABA Pt 1 A
ABA Pt 2 (Oral/OSCE)										After passing ABA Pt 1 B
	Footnotes:	Red - Hard Stop (Additionally, failure to pass the ABA Pt 1 A will result in Unsatisfactory report to the ABA until passed & maintenance of CA-2 status)								
		Orange - These exams are summative (will count as an exam failure if below the specified exam policy minimum in effect at time of administration)								
		Yellow - These exams are formative (will not count as an exam failure)								

Exam Performance	Trend	Consecutive Adverse Event #	Result
unsatisfactory and unsatisfactory	►►	2	Probation
unsatisfactory to satisfactory with concerns	▲	2	Academic Risk
satisfactory with concerns to unsatisfactory	▼	2	Academic Risk
satisfactory with concerns and satisfactory with concerns	►	2	Academic Risk
unsatisfactory	n/a	1	Academic Risk
satisfactory with concerns	n/a	1	Academic Risk
fully satisfactory	n/a	0	satisfactory

Graduation with Honors

1. The Program Evaluation Committee, at its discretion, will award a certificate of completion that includes a **WITH HONORS** designation to any resident who demonstrates excellence in academic performance, clinical performance and professionalism.

2. The committee will base its decision on the following guidelines:

a. Academic Performance: CA-3 residents scoring at least at the 75^{th} percentile on the CA-2 OR CA-3 ITE
(based on that year's scaled score norm table).

b. Clinical Performance / Professionalism: CA-3 residents nominated for honors by two current faculty.

c. Senior Talk: CA-3 residents who achieve a score of HONORS (>3.5) on their senior talk evaluations.

3. Residents who earn this designation will be recognized at the resident graduation ceremony, and it may be included on their CV.

Senior Talk

1. ACGME requirements mandate an academic project for CA-3 residents.
2. Each CA-3 resident shall make a 30-45 minute at the Wednesday Anesthesia Conference (WAC) on a subject or
   current interest, reviewing a particular area of anesthesia in depth.
3. This presentation shall be done under the direction and advice of a faculty advisor, who shall actively participate in assisting the resident in preparing for this formal presentation. Selection of topic and faculty mentor shall be approved by the WAC coordinator (Dr. Tripi). Residents must meet with the faculty mentor at least 1 week before the presentation to review the final draft of the presentation.
4. Faculty in attendance shall complete evaluations that rate the presentation based on the following three criteria, each with a score ranging from 1-4.
   - Demonstration of in-depth knowledge of the topic presented
   - Appropriate review of published literature
   - Smooth and well-organized presentation
5. A total evaluation score shall be calculated by averaging the score for all criteria across all attending evaluators.

CODES/TRIPLE PAGES

While on the PACU rotation and while on Mather Junior call, the resident will carry the Triple Pager/Code Pager. Cardiopulmonary Arrests in the hospital are announced by the operator. A triple Page overhead is stated announcing a "Code Blue," followed by the location, e.g. Lakeside 60 or Lerner Tower 8th floor. This will also come to the Code Pager in the form of a text page with the location of the code.

To proceed to the Code, take an Emergency Box from any of the Anesthesia Workrooms (red tackle box labeled "Emergency"). These Code Boxes contain supplies for intubation, including endotracheal tubes, blades and handles, oral airways, tube ties, and a medication box that might be needed during the Code. Taking a box to the Code is advised but not mandatory, as the Crash Cart on the floor should contain all supplies needed in an emergency. Keeping an LMA in the Code Box or on one's person during call is recommended as LMAs are a part of the Emergency Airway Algorithm, and will seldom be available on the floors. Upon arrival to the Code, the unit secretary or general activity will provide direction to the Code. Proceed to the head of the bed, make a proper introduction, and take over for the person managing the airway. Inspect the airway for debris, secretions, blood, dentures, etc. Establish the airway and ventilate with Ambu Bag and 100% oxygen. Ensure that the necessary things are made available and ready for intubation, including suction, laryngoscope, endotracheal tube, and extra assistance. Delegation is often necessary and can facilitate a smooth intubation and securement of the patient's airway. **DO NOT** give paralyzing agents (succinylcholine, rocuronium, etc.) to the patient without an attending present. Avoid induction agents (propofol, etomidate, etc.) if possible. After appropriate ventilation, intubate the patient and confirm placement with calorimetric color change at least five times, chest rise, bilateral breath sounds, and the absence of ventilation over the stomach. Secure the endotracheal tube with tube tie or tape. Discuss with the team running the code if anything of concern was noted in the airway, and ensure that a chest x-ray is ordered for placement. Offer assistance to the team for other necessary procedures if able, including peripheral IVs, central line placement, CPR, etc. Document the intubation as a "Non-OR Procedure Note," and be sure to include Code Intubate vs. Code Blue, indication for intubation and the state of the patient on arrival, emergent vs. urgent vs. elective, supplies and any medications used. Inform the Mather Call Attending or Coordinator of the intubation and assign the procedure note to him or her. If a problem is anticipated on arrival at a Code, call the attending immediately. During Code Blue or Code Intubate, remember that there are numerous anesthesiology colleagues (Mather Call Team, Trauma Call Team, ICU Team, Mac House Team) in the hospital at any one time--do not be afraid to call for help!

EVALUATIONS

Evaluations of Residents: Bi-weekly (every two weeks) evaluations will be completed on each Resident at the end of each rotation.

- Evaluations will be sent out to all supervising faculty of the specific rotation twice during the rotation (at 2 weeks and 4 weeks)
- The residents will receive each completed evaluation to review and sign-off
- The Program Director will receive and review each completed evaluation of the residents

Evaluations of Faculty: Residents must complete an evaluation of each supervising attending for each rotation.

- Evaluations will be sent out bi-weekly (every two weeks) during each rotation for the resident to evaluate each faculty that supervised them.
- Evaluations will be anonymous
- Faculty will have the opportunity to review all evaluations submitted

Evaluation of Rotation: Residents must complete an evaluation at the end of each completed clinical rotation.

- Evaluation will be sent out at the end of each 4-week rotation

Annual Evaluations of the Program: Program faculty and trainees must have the opportunity to evaluate the training program overall

- Evaluations of the program will be completed by both the residents and the faculty
- Evaluations will be sent out annually
- The evaluation results will be used:
    - to create the Annual Program Evaluation submitted to the GME
    - to evaluate and/or address items on the action plan and any ACGME citations at the time

Annual Evaluations of the Faculty: Program faculty must be evaluated annually, which must include annual written confidential evaluations by the residents

- Residents will have the opportunity to evaluate each of the core teaching faculty of the program annually
- Results will not be reviewed until after the residents have completed the program
- Evaluations will be fully anonymous

360 Evaluations: The program must use multiple evaluators to collect resident feedback and performance. A packet of evaluations will be given to a supervising faculty in the OR setting and the following list of people will complete an evaluation.

- Patient (or family member)
- Pre-op Nurse
- OR Nurse
- Post-op nurse or ICU staff
- Surgery team member (resident, faculty, or Resident)
- Anesthesia faculty

Semi-Annual Evaluations: residents will meet with the Program Director (or appointed faculty) semi-annually to review academic performance. The CCC milestone report will be reviewed along with the Semi-annual form completed. The following will be reviewed

- Test performance (including: AKT, ABA ITE, ABA Board, USLME/COMLEX Step 3)
- ACGME Case Logs
- Evaluation scores and comments
- Scholarly activity

Overall information and expectations:

- Evaluations are expected to be completed within 14 days of the completed rotation.
- Evaluations will be sent out through the MyEvaluations program
- Evaluations will be used in the CCC to determine ACGME milestones and competency

CLINICAL COMPETENCY COMMITTEE

The goal of the Clinical Competency Committee (CCC) is to provide broad input to the program director about each resident's performance in the Anesthesiology department. The CCC functions in an advisory role by meeting regularly to review all completed evaluations, director observation tools, case logs and QI activities. It also provides a consensus-based recommendation to the program director as to the standing of each trainee in the program and their suitability for promotion.

The Committee will provide performance-based assessments that respect the personal privacy of the residents in the program. The Committee will function objectively and in a manner that promotes the highest levels of professionalism and confidentiality. The program director has final responsibility for each trainee's evaluation and promotion decisions.

The CCC will have at least three members of the program faculty and meet at least every six months. They will also meet as often as needed to address resident performance issues as they arise, to provide input for the Program Director. Faculty members may include physicians and non-physicians from the Anesthesiology program or required rotations in other specialties who teach and evaluate the residents. Meeting minutes will also be taken.

The Clinical Competency Committee of Anesthesiology is composed of the following members:

Chair: Dane A.K. Coyne, M.D., Assistant Professor

The remaining members will comprise subcommittees, representing each educational year and expected rotation subgroups.

PGY-1

1. **Sub-Committee Chair:** Michael D. Altose, M.D., Section Head, Neuroanesthesia, Assistant Professor
2. Melinda M. Lawrence, M.D., Program Director, Anesthesiology Pain Medicine, Assistant Professor
3. Francis T. Lytle, M.D., Assistant Professor
4. Joti J. Mucci, M.D., Assistant Professor
5. Internal Medicine representative (Chief or faculty member)

CA-1

1. **Sub-Committee Chair:** Shelley J. Ohliger, M.D., Director, Pediatric Cardiac Anesthesiology, Assistant Professor
2. Soozan S. Abouhassan, M.D., Assistant Professor
3. Michael D. Altose, M.D., Assistant Professor
4. Faisal D. Arain, M.D., Assistant Professor
5. Lora B. Levin, M.D., Chief, Obstetrical Anesthesia, Assistant Professor
6. Nicole M. Luther, M.D., Clinical Instructor

CA-2

1. **Sub-Committee Chair:** Nicholas L. Pesa, M.D., Assistant Professor
2. Edwin G. Avery, M.D., Chief Anesthesia Officer, Harrington Heart and Vascular Institute, Professor
3. Xueqin Ding, M.D., Assistant Professor
4. David Dininny, M.D., Assistant Professor
5. Vasu Sidagam, M.D., Clinical Instructor

CA-3

1. **Sub-Committee Chair:** David A. Wallace, D.O., Assistant Professor
2. Soozan S. Abouhassan, M.D., Assistant Professor
3. Gregory K. Applegate, D.O., Assistant Professor
4. Raymond G. Graber, M.D., Chief, Orthopaedic Anesthesiology, Assistant Professor
5. Doris M. Leone, M.D., Assistant Professor
6. Nicholas L. Pesa, M.D., Assistant Professor
7. Andrew J. Plante M.D., Assistant Professor

The committee's responsibilities are to:

- Review all resident or clinical Resident evaluations semi-annually;
- Prepare and assure the reporting of Milestones evaluations of each resident or clinical Resident semi-annually to the ACGME (RRC);
- Advise the program director regarding resident or clinical Resident progress, including promotion, remediation, and dismissal;
- Prepare a report summarizing the Committee's recommendations and rationale for recommending any adverse action from each meeting; and
- Advise the Program Evaluation Committee about any evaluation issues identified during CCC meetings.

PROGRAM EVALUATION COMMITTEE

The Purpose of the Program Evaluation Committee (PEC) is to establish the composition and responsibilities of the Program Evaluation Committee, and to establish a formal, systematic process to annually evaluate the educational effectiveness of the Anesthesiology Residency Program curriculum, in accordance with the program evaluation and improvement requirements of the ACGME.

Policy

The Anesthesia Residency program established a Program Evaluation Committee to participate in the development of the program's curriculum and related learning activities. The PEC will annually evaluate the program to assess the effectiveness of the curriculum, and to identify actions needed to foster continued program improvement and correction of areas of non-compliance with ACGME standards.

Procedure

- The program director will appoint the program evaluation committee
- The PEC will have a minimum of three members, two program faculty and one trainee from the program.
- The Program Evaluation committee will participate in:
    - Planning, developing, implementing, and evaluating educational activities of the program
    - Review and make recommendations for revision of competency-based curriculum goals and objectives
    - Address areas of non-compliance with ACGME standards
    - Review the program annually using the following feedback instruments:
        - Anonymous monthly rotation surveys from residents
        - Anonymous annual program survey from residents and faculty
        - Direct feedback from residents and faculty
- Monitor and track each of the following:
    - Resident performance
    - Faculty development
    - Graduate performance including performance on certifying examination
    - Program quality
    - Progress in achieving goals set forth in previous year's action plan

Annual Program Evaluation

The program, through the PEC, will document a formal, systematic evaluation of the curriculum at least annually and will render a written Annual Program Evaluation (APE).

1. The annual program evaluation will be conducted on or about January of each year, unless rescheduled for other programmatic reasons.

2. Prior to the program review meeting the PEC Chair will:
    - identify an administrative coordinator to assist with organizing the data collection, review process, and report development
    - solicit written confidential evaluations from the entire faculty and resident body for consideration in the review (if not done previously in other forums)

3. At the time of the initial meeting, the Committee chair and members will consider:
    - achievement of action plan improvement initiatives identified during the last annual program evaluation
    - achievement of correction of citations and concerns from last ACGME program survey
    - residency program goals and objectives
    - faculty members' confidential written evaluations of the program
    - the residents' annual confidential written evaluations of the program and faculty
    - resident performance and outcome assessment, as evidenced by:
        - aggregate data from general competency assessments
        - in-training examination performance
        - case/procedure logs
    - graduate performance, including performance on the certification examination
    - faculty development/education needs and effectiveness of faculty development activities during the past year

4. Additional meetings may be scheduled, as needed, to continue to review data, discuss concerns and potential improvement opportunities, and to make recommendations. Written minutes will be taken of all meetings.

5. As a result of the information considered and subsequent discussion, the Committee will prepare a written plan of action to document initiatives to improve performance in one or more of these areas:
    - resident performance
    - faculty development
    - graduate performance
    - program quality
    - continued progress on the previous year's action plan

   The plan will delineate how those performance improvement initiatives will be measured and monitored.

6. The final report and action plan will be reviewed and approved by the program's teaching faculty, and documented in faculty meeting minutes. A report will be provided to the GMEC, and reviewed at a full meeting of the GMEC.

Members & Meetings

The PEC of the Anesthesiology Program will meet at least quarterly and as often as needed based on the curricular needs of the program. Faculty members may include physicians and non-physicians from the Anesthesiology PEC is composed of the following members:

Michael D. Altose, M.D., Ph.D.	Assistant Professor	Chair of Program Evaluation Committee
Mada Helou, M.D.	Assistant Professor	Program Director
Nicholas Pesa, M.D.	Clinical Instructor	Associate Program Director
Shelley Ohliger, M.D.	Assistant Professor	Associate Program Director
Peggy Seidman, M.D.	Professor	Program Director, Pediatric Anesthesiology Residency
Melinda Lawrence, M.D.	Assistant Professor	Program Director, Pain Residency
Joti Juneja Mucci, M.D.	Assistant Professor	Program Director, Critical Care Residency
Christina Stachur, M.D., MPH	Assistant Professor	Director, Medical Student rotators
Marc Popovich, M.D.	Professor	Department Chair
Ahmed Darwish, M.D.	Professor	Vice Chair, Education
Paul Tripi, M.D.	Professor	Vice Chair, Professional Affairs
Heather McFarland, D.O.	Associate Professor	Vice Chair, Clinical Operations
Dane Coyne, M.D.	Clinical Instructor	Chair of Clinical Competency Committee
James Reynolds, Ph.D.	Associate Professor	Research Faculty
David A. Wallace, M.D.	Assistant Professor	Core Faculty
Soozan Abouhassan, M.D.	Assistant Professor	Core Faculty
Emily Poynton, D.O.	Critical Care Resident	
Sivakanth Katta, M.D.	Chief Resident (PGY4)	
Daniel Diaczok, M.D.	Chief Resident (PGY4)	
Christine Abboud, D.O.	Chief Resident (PGY4)	
Erik Bergersen, M.D.	PGY4 Representative	
Jacqueline Sohn, D.O.	PGY2 Representative	
Lauren Glosik, C-TAGME	Academic Program Administrator	
Christine Adamovich	Resident Coordinator	

PROFESSIONALISM & RESIDENT EXPECTATION

All Anesthesiology residents are expected to act and look professional at all times, even outside of patient care. The purpose of this policy is to define the elements of professionalism and resident expectations.

Professional Conduct

- Dependability/Reliability/Responsibility/Punctuality
    - demonstrates awareness of own limitations, and identifies developmental needs and approaches for improvements
    - cares for self appropriately and presents self in a professional manner (i.e., demeanor, dress, hygiene)
    - recognizes and reports errors/poor behavior in peers
    - informs others when not available to fulfill responsibilities and secures replacement
    - takes responsibility for appropriate share of teamwork
    - arrives to lectures, clinics, meetings and appointments on time
    - accountable for deadlines; completes assignments and responsibilities on time
    - answers letters, pages, e-mail, and phone calls in a timely manner
- Personal Appearance
    - adheres to established dress codes (medical school and affiliated institutions)
    - wears attire generally accepted as professional by the patient populations served
    - maintains a neat and clean appearance acceptable to practice setting
- Honesty/Ethics/Confidentiality
    - demonstrates integrity (no lying, cheating or stealing)
    - forthcoming with information; does not withhold and/or use information for power
    - admits errors
    - adheres to professional and/or ethical standards (i.e., faculty, residents, Residents, and students conduct their affairs related to MATCH in an ethical and professional responsible manner and Program Directors and institutional officials honor conditions of their agreement with NRMP)
    - behaves with high morality
    - maintains and protects patient privacy and confidentiality (i.e., by knocking on the door before entering a patient room, appropriately draping a patient during an examination, not discussing patient information in public area including elevators and cafeteria, by keeping noised levels low, especially when patients are sleeping, and by the appropriate sharing of medical information with a patient and colleagues involved in the care of a patient)
- Orderliness/Cooperation/Critique
    - observant of order, authority or rule
    - willing to act jointly with others
    - accepts and responds to constructive criticism by appropriate modification of behavior
- Empathy, Sensitivity, Compassion, and Respect for Other People
    - considerate and appreciative of others' positions
    - sensitive to patients pain, emotional state or condition (i.e., disabilities, gender, ethnicity issues)

    - treats the patient as an individual, taking into account lifestyle, beliefs, personal idiosyncrasies, support system
    - communicates bad news with sincerity and compassion
    - deals with sickness, death, and dying in a professional manner with patient and family members
    - supports a balance in personal and professional activities for peers and subordinates
    - treats other people including patients and their families respectfully and without bias
- Communicates Skills/Collegiality/Language Use/Discretion
    - respects institutional staff and representatives
    - respects faculty during teaching session
    - communicates with discretion appropriate to circumstances
    - treats colleagues and co-workers and leaders in a respectful manner without bias (i.e., age, race, gender, ethnicity, sexual orientation, disability, religion, national origin or role in education)
    - mutual respect between teachers and learners (i.e., insightful rather than aggressive questioning; no belittlement; constructive feedback with opportunities for remediation)
    - communicates with appropriate terminology and vocabulary
    - communicates with appropriate gestures and mannerisms
    - commitment to maintaining appropriate relationships with patients, peers and subordinates (relationships between physicians and patients must be avoided)
- Documentation
    - Evaluations must be completed within 14 days of the received evaluations
    - Emails must be checked regularly and responded too if applicable
    - Scholarly activity must be submitted when requested or required

Evaluation of Professionalism
The Competency Committee will depend on the monthly faculty evaluations, 360 evaluations, and peer to peer observation to measure the above elements of professionalism

Identification Badges
Photo identification badges issued by University Hospitals are issued during Intern Orientation and are to be **worn at all times**. ID badges provide access to all areas of the hospital, including clinical work areas that require badges for entrance such as MacDonald House, Prentiss, and the OR areas. Badges can be used to purchase food from the cafeteria, and will confer an employee discount. Each year, residents also receive On-Call money which is available for use by swiping as well.

Radiation Badges
All residents will be given a radiation bade, or dosimeter, that should be worn when in the operating room. The purpose of this badge is to calculate the exposure to radiation. Dosimeters will be distributed and collected on a quarterly basis for evaluation. Lost badges will result in a fine of $20. Radiation exposure reports are available by contacting Ms. Lisa Mullowney. Residents are required to wear the dosimeter badges at all times when on duty and being exposed to x-ray, fluoroscopy, and other radiation-emitting devices.

Mailboxes
All residents have a mailbox in the Bolwell Anesthesia Offices, on the walls between the Classroom and the Library. These should be checked and emptied regularly.

Scrubs
Scrubs are hospital property and as such are not to be worn outside of work, including into and out of the hospital. In order to obtain scrubs, residents swipe their badges in the scrub machines located in the Mather OR locker rooms. Scrub jackets are available next to the scrub machines in each of the locker rooms. Scrub jackets are the only other allowable attire in the operating room. Undershirts, department jackets, and other attire is not permitted. White coats or scrub jackets should be worn to cover scrubs when outside of the operating room. As scrubs are hospital property, wearing them outside of the hospital has consequences. Repercussions for wearing scrubs outside of the hospital will include first time offense receives a warning, second time offense receives no pay for scheduled late duty, and third time offence receives additional unscheduled Saturday call. Scrubs outside the hospital—violations will have repercussions. It is permissible to wear non-OR scrubs to and from work.

White Coats
Each resident will be given three white coats issued by the Department of Anesthesiology. These coats are required for attire for different rotations throughout the academic year. Residents can have their white coats cleaned, free of charge, in the Uniform Room which is located in the sub-basement of Lakeside.

WELLNESS POLICY

Objective: To create a basis for wellness within the residency program, and to support the emotional, social, physical, and community wellness of residents within the Department of Anesthesiology.

- Emotional Health
    - Employee Assistance Program
        - Introduction to this hospital program during orientation
        - Scheduled optional and confidential initial visits for interns upon starting residency
            - Optional and confidential sessions
            - Department not alerted as to who attends and who does not
            - Will be instituted with the Class of 2021
        - Opportunities for EAP through self-referral or mandatory referral from a supervisor
            - To deal with issues that are affecting the resident
                - Stress debriefing, deaths, marital/family crises, etc.
        - UH EAP Work Life Website
            - Offers numerous resources and links for employees
- Social Health
    - Association of Residents and Residents
        - Holiday parties with other local hospitals
        - Social outings to meet and socialize with residents in other departments
        - Residents encouraged to join upon starting residency
    - Anesthesia Residents Social Committee
        - Representative from each class year serves in the role of chairperson for the committee
        - Plan outings within the department of Anesthesiology
        - Encourage camaraderie between residents, attendings, anesthetists, and ancillary healthcare staff
        - Includes events such as Annual Browns Tailgate, winery tours, Residency Graduation, happy hours, bowling events, etc.
- Physical Health
    - Encourage participation in hospital-sponsored physical activities
        - Earn wellness points with employee rewards
        - E.g. yoga sponsored by Department of Pediatrics Residency Program
        - E.g. Rejuvenation Tuesdays with updates on wellness happenings at UH
    - Tobacco-free policy
        - Residents sign no tobacco clause upon instituting employment
    - Yearly influenza vaccinations
        - Required and promoted by the hospital to work mask-free during flu season
        - Opportunities for all residents to receive influenza vaccine at no cost
    - Fatigue Mitigation

        - Residents encouraged to stay and sleep following call if needed
        - Cab vouchers from Protective Services for residents in order to safely travel home when experiencing fatigue if no call rooms are available
        - Yearly department conference on provider fatigue and safety in residency

- Community Health
    - Diversity programs
        - Promote the importance of diversity within the healthcare community
        - Encourage participation in hospital-sponsored opportunities
            - E.g. Diversity and Inclusion Breakfast Lecture sponsored by The Center for Clinical Excellence and Diversity Initiatives
        - Diversity Group
            - Includes faculty, residents, students
            - Assist with recruitment and events
            - Participates in outreach for medical students
            - Links to national resources
                - Student National Medical Association
                - Latino Medical Student Association
                - American Society of Anesthesiologists

- Lactation Room Availability
    - Residents who need to have designated time to pump, are excused following the University Hospitals policy
    - **Community Sites** – there is a designated room for breast pumping at most sites. If there is no room, hospital administration will make accommodations upon request.
    - **Main Campus** – there are multiple rooms designated for breast pumping at main campus. **All areas are available 24/7.**

Main Campus rooms available

- **RB&C –** The Rainbow Employee pumping room is RB&C 7309. Keys for 7309 will be found with the EMU Receptionist on HT7. (3 pumps available)
- **MacDonald –** 5th Floor room 5017 – keypad entry, # in drawer on Key holder or given on Lactation line 47975. (2 pumps available)
- **Mather Pavilion 3 –** Room 3160 just outside MICU—key is located at MICU Desk. (2 pumps available)
- **CTICU –** located just outside the CTICU (3rd floor of Mather)

The lactation room suggested for Anesthesiology Residents to use is located on the third floor of the CTICU.

EDUCATION LECTURES

The Department of Anesthesiology requires attendance at all didactics. While illness and vacation may prevent residents from attending lecture, Ms. Lauren Glosik should be notified if an absence is anticipated

Lecture Evaluations
Evaluations will be sent out automatically through MyEvaluations to anyone who attended WAC, Basic Curriculum, and Advanced curriculum lectures. These evaluations will be used in PEC when evaluating the program as well as annual faculty evaluations.

Basic Curriculum
The Basic Curriculum is designed to cover the content outlined by the ABA in preparation for the Basic Exam. The Basic Curriculum is to be attended by CA1s and interns who are on anesthesia service rotations. Lectures will take place in the morning on Wednesdays. Junior residents will be excused from clinical duties in the OR and other rotations while Basic Curriculum is taking place. Along with lectures, the morning academic half day is designed to contain simulations, journal discussions, oral board practice, and review time.

The ICU Boot Camp is a series of lectures designed to help prepare junior residents for their return to the ICU in a senior role. These lectures will be incorporated into the junior academic half day, with the goal of a review quiz following the curriculum in order to assess for preparedness in return to critical care rotations.

Learnly is an academic resource to which the junior residents will have access. CA1 residents are expected to use this tool to independently study for the Basic Exam on a regular basis throughout the academic year. Interns will be granted access to the introductory material via Learnly as well.

Advanced Curriculum
The Advanced Curriculum is designed to cover the content outlined by the ABA in preparation for the Advanced Exam. The Advanced Curriculum is to be attended by CA2s and CA3s. Lectures will take place in the afternoon on Wednesdays. Senior residents will be excused from clinical duties in the OR and from other rotations while Advanced Curriculum is taking place. Along with lectures, the morning academic half day is designed to contain simulations, journal discussions, oral board practice, and review time.

Senior residents will be granted access to TrueLearn as a board preparatory resource if they choose to participate for a reduced rate. CA2s will be able to access TrueLearn for the ITE, while CA3s will have access to both TrueLearn for the ITE as well as thereafter access to TrueLearn for the Advanced Exam.

Journal Club
Journal Club will be held on a monthly basis with the goal of reviewing relevant topics in anesthesia. Articles will be distributed for resident review prior to the scheduled date. Journal Club will be moderated by an attending and is open for attendance by all residents and attendings.

Critical Care Didactics
Critical Care Journal Club will be held during each rotation. Residents who are scheduled to be in the ICU on the day shift of Journal Club are expected to attend. All ICU Faculty and all other residents are also invited. Journal Club will consist of review of an article and topic with presentations by junior residents, with discussion to follow. ICU Didactics are also held on a regular basis with attendance expected from all residents present and on service.

Morbidity and Mortality Conference / Quality Assurance and Improvement
Morbidity and Mortality Conference will take place monthly as a part of the Wednesday Anesthesia Conference series. If there is a perioperative problem or anesthesia complication that occurs when involved in the care of a patient, a quality assurance form should be completed with a description of the event. This should be completed by the resident involved in the case, in conjunction with the attending involved. These cases will be reviewed by the Quality Assurance and Improvement Committee, and will be at the discretion of the committee if they are to be presented during WAC M&M. Presentation of the case should be done by the resident if present, and by the attending if the resident is not available. This allows for discussion about the case and for critical review of complications occurring in the department.

Attendance for Educational Lectures

1. Attendance at WAC is considered mandatory. All residents, regardless of rotation, are expected to attend. It should go without saying that you should allow yourself enough time in the morning to prepare for your cases so that you are not late. Any absences will need to be cleared with the PD or APD.
    a. Exceptions include residents that are on:
        - call that day
        - trauma rotation
        - PACU
        - vacation
        - Residents that are post-call or ICU are not required to attend but are highly encouraged to attend.

2. Attendance at educational half-day conferences is mandatory. Any absences will need to be cleared with the PD or APD.
    a. Exceptions include:
        - post-call
        - pre-call
        - vacation
        - Attendance is encouraged for residents in ICU
        - Chronic pain residents are mandated to come unless not on main campus

General Senior/Junior Resident Expectations

1. Pertaining to OR setup on days with interns, it is expected that the paired junior or senior communicate with the intern regarding OR knowledge and ability the evening before. It is highly encouraged for junior or senior residents to arrive at their normal time, i.e. the time you arrive to set up a room as if you're the only frontliner. It is the junior/senior resident's responsibility, in conjunction with the attendings, to acclimate our interns to the ORs.

2. On educational half days:
    a. Junior residents are expected to arrive at an appropriate time to set up the OR for a first case start and then attend WAC. If there is an intern assigned to the room that day, its encouraged to use that time to set up a room while teaching the intern proper setup/discuss the case plan with them. It is ultimately the junior's responsibility to have the room ready for the assigned cases – do not expect or rely on anyone else.

    b. Senior residents should also arrive at an appropriate time to make sure the OR is setup up to an appropriate standard and tailored to their personal preferences. As the senior resident, you are ultimately responsible for the room being ready to start on time. If there is an intern scheduled for the OR, the senior is encouraged to arrive earlier and facilitate/enhance case discussions between the Junior and Intern.

    c. Any issues should be directly discussed with one of the chief residents.

3. Please arrive on time for all your responsibilities, including but not limited to normal OR days, call shifts, WAC meeting, educational half-days, and ICU shifts. Everyone's time is valuable and arriving late indicates that your time is more valuable than others. Please be professional and respectful of others.

Repercussions

1. In order to encourage participation in educational activities, including WAC and educational half-days, we propose a series of escalating educational opportunities for individuals that are absent without proper approval.
    a. **First absence** will result in a warning.
    b. **Second absence** will result in an unpaid late duty.
    c. **Third offense** will result in an additional call.
    d. **Fourth offense** will result in an additional unpaid late duty and call as well as being assigned a "ABA keyword" to present as a lecture.

2. Pertaining to residents that are deemed consistently late to assigned responsibilities, they will be placed at the bottom of the resident relief list in order to encourage more educational opportunities.

3. Pertaining to residents that are consistently late to the ICU, these individuals will be placed at the bottom of the list for moonlight considerations and if ineligible for moonlighting, will not be able to leave before sign-out.

EDUCATIONAL STIPENDS

Each anesthesia resident will receive an annual educational stipend which can be used to purchase books, question banks, academic memberships, and other educational materials. The funds can also be used to pay for attendance to an educational meeting or conference. Allowed educational funds may change as needed. Balance of remaining funds are available upon request.

Residents will receive funds according to year of training:

- PGY1 $500
- CA1 $500
- CA2 $1,000
- CA3 $1,000

NOTE: If funds are not used by the end of the current academic year, they will be lost. Funds will not be rolled over.

ABA Exam: CA1 and CA3 residents will receive an extra $775 for the following:

- ABA Basic – CA1
- ABA Advanced – CA3

Conference Presentations:

- $500 (not to be deducted out of CME funds.) You must inform the secretaries prior to travel before being rewarded these funds.

REIMBURSEMENTS

- Reimbursements are entered on Fridays only before 2:00 pm. If receipts are given after 2:00 pm, they will be entered the following Friday.

- Must turn in expenses **30** days from purchase date, expenses turned in after this deadline will not be reimbursed.

- Receipts must be in an envelope with name printed clearly on the front. You will then place the envelope in the designated tray, located next to the radiation badges, labeled **Reimbursements**. Please do not place loose receipts on the desk of the secretaries as this will only cause confusion and delay reimbursements. Accounts Payable will no longer accept screenshots or pictures taken of receipts. Please do not send request via email.

- Once reimbursements are submitted, you will get an email confirmation that the expense has been submitted and you will need to approve the expense (Email responses generally do not work).

- Most common CME reimbursement requests are:
  - Textbooks, Ebooks
  - Membership dues
  - License renewal fees – **only Ohio license**
  - Medical applications

Stethoscopes only up to $200 – must be purchased through in-house vendors. See the secretaries for details.

- Non reimbursable items: laptops, Ipads, any computer hardware or software

- If making online purchases for approved items you must provide proof of payment. We will need email confirmations that have **total paid**, etc. Please print and follow above procedure.

- You must turn in detailed receipts from meals (original and itemized), if you don't turn in receipts **you will not be reimbursed.** Meals are only reimbursed when the conference does not provide one. Meal reimbursements are as follows with no exceptions:

  - $15 for breakfast
  - $25 for lunch
  - $25 for dinner

- Hotel reimbursements are a **maximum of $400 per day**. You are responsible for letting the secretaries know if rooms are split with another party prior to submitting reimbursements.

Trip Reimbursement

All receipts for reimbursement must be put in an envelope and placed on the desk next to the Radiation badges. The following rules are applicable as a part of the reimbursement policy.

Prior to submitting for reimbursement, residents must delegate access through iExpense. Follow the process below:

IExpense Info

1.) Log into Oracle:

2.) Enter your Username and Password

3.) Click on 'UHHS Internet Expenses' on the left side of the screen

4.) On the main expense screen, click on 'Access Authorizations' located on the top tab menu

5.) You are now at the delegation screen, under the Expenses Entry Delegations column, type in the last name of the secretary and manager submitting on your behalf, click on 'Save' located on the top right of the screen.

You will need to delegate Ashley Love, Lisa Mullowney, Cindy Patrzyk, and Holly Bennett

If you are still experiencing difficulty in adding delegators to iExpense. Please follow the directions below:

Log into Oracle

- Click on **Employee Direct Access**
- You should then see a section called: **GPS**
- Click on **GPS**
- In the search bar on the home screen, search for **Internet Expenses (iExpense) for Delegators**
- This course should pop up as the only class. Click on the yellow envelop on the right hand side to enroll in the class
- On the next screen, click the apply button
- You should be able to find this course now back on the **Oracle Home** screen.

Once you complete the online course, it will take 24-48 hours before the delegate option appears on your Oracle screen.

To approve expenses:

- Log into Oracle
- Select employee direct access
- Notifications
- Click on the reimbursement link

There will be an approve button on the top corner of the screen as well as at the bottom, click either of those buttons.

Trip Request

- If going to any meetings you must have a trip number prior to traveling or trips will not be reimbursed. This information must be submitted to the secretaries at least **2 weeks prior** to traveling. The sooner the better.

- You will email the completed **Trip Request Form**. Remember these are estimates.

Airfare will need to be purchased through Traveline. Once you receive your trip itinerary please forward over to the secretaries. This information is needed to update your CME funds. If you choose not to use Traveline and pay out-of-pocket, **you will not be reimbursed**.

Without your itinerary, you will not be reimbursed for any part of your trip.

Traveline: Corporate Travel
Monday thru Friday
8:00 am – 5:30 pm

Cleveland Local 440-602-8020 Toll Free 888-740-8747
Or email corporate@traveline.com

Important things to know:

- A trip number must be obtained prior to travel in order to qualify for reimbursement.
- Lavish or extravagant expenses will not be reimbursed.
- Expenses of spouses or significant others will not be reimbursed.
- All submitted receipts should be originals as able. All receipts should be itemized.
- Reimbursement for any mode of transportation will be limited to the cost of commercial fare for the resident. This includes airfare, railroad fare, bus fare, and boat fare. Use of one's personal vehicle for travel will be reimbursed at the rate allowed by the Internal Revenue Service. Flights must be booked through Direct Travel.
- Taxi fare will be reimbursed for travel to and from the airport and the conference meeting site.
- Incidental tips will be reimbursed within reason.
- Lodging: It is encouraged that lodging be obtained at the site of the meeting location. If this is not possible, rooms may be reserved at nearby hotels. Reimbursement will be at the rate of the meeting hotel rate, up to $400 per day.
- Registration fees for meetings and conferences will be reimbursed, provided that the meeting or conference is related to anesthesiology or medical education.
- Parking fees and tolls will be reimbursed if they are related to educational or teaching activities.

USMLE STEP III AND COMLEX LEVEL 3

The third part of the medical licensure boards is required for the residency. Residents need to complete this exam before the conclusion of the intern year. Residents should have passed this exam before advancement to the CA2 year. Without completion of this exam, residents are also not permitted to moonlight in the department.

VACATION POLICY

Each resident will be allowed twenty vacation days per year. If unused, five of these days can be carried over into the following academic year. Residents are also each allowed to use five meeting days and five presentation days per year. Vacation days should not be canceled within one week of the scheduled days without prior approval from the Program Directors; and Garrett Maguire (garrett.maguire@uhhospitals.org) should be alerted of all changes in vacations so that the vacation book may be updated. If a vacation request is "waitlisted," the resident should be prepared to use the vacation day as planned.

All vacation requests are all made through QGenda online.

There are currently 5 resident vacation spots per day available. The first residents filling those spots will be granted vacation as requested. Thereafter, residents will fall into the pool of general vacation requests with anesthetists on the waitlist and will be granted vacation as permitted by the overall number of people able to take vacation for that designated day. If the resident is waitlisted for requested vacation days, the resident SHOULD NOT make flight arrangements or other vacation arrangements that cannot be guaranteed.

Vacations that are requested more than 60 days in advance shall be granted automatically when requested in the system if spots are available. Any vacations requested within 60 days are subject to administrative approval by Program Directors. Vacation spots for Hot Weeks will be pre-booked in Qgenda for those winning the Hot Weeks.

- During the summer months, May through September, all vacation requests must be made for an entire week if made more than 60 days in advance.
- No more than two weeks can be taken at any one rotation.
- Single day requests will only be permitted if requested within 60 days. This rule is in place as summer months are generally highly requested times for vacation.

There are certain rotations during which vacation is not permitted:
Blocks
CPM
Chronic Pain
SICU/CTICU
Peds Jr Block 1 (first 4 week)

There are certain rotations during which vacation will be permitted for 1 week only:
Cardiac Jr Block
OB Jr Block
Peds Jr Block 2 (last 4 weeks)

Intern residents are permitted to take vacation during ENT, ED, Surgery, Medicine, Research, and the final two months of Anesthesia; no vacations will be permitted for interns during CTICU, SICU, Chronic Pain, and the first month of Anesthesia.

Absence Due to Illness

With the twenty allowed vacation days per day, there are no built in sick days. Calling in sick will result in the loss of a vacation day. If a resident anticipates not being able to work the following day due to illness, he or she should call the front desk the night prior and inform them of the anticipated absence. Otherwise, the resident should call as soon as he or she anticipates absence, with the latest acceptable call being by 06:15 on the morning of the absence. When a resident is sick when assigned to take call, the resident should also inform the backup call resident as soon as possible, as well as the on-call attending, the Program Directors, and the Chief Residents. If calling in sick for an ICU shift, the resident should inform the attending, the ICU Residents, and the Program Directors. Making up sick days for call and for ICU shifts is at the discretion of the Program Directors, Chief Residents, and the ICU attendings and Residents.

If circumstances arise where a resident needs to take an extended leave of absence during residency, the situation will be evaluated on a case by case basis with the Program Directors, Dr. Helou and Dr. Pesa, in conjunction with the Clinical Competency Committee. When an extended amount of time off is needed, the Department should be notified in writing. Residents will still be responsible for completing twelve months of training in the intern year and thirty-six months of anesthesia training in compliance with the ABA guidelines. All efforts will be made to ensure that the least amount of interruption in the resident's training occurs.

Graduate Medical Education should also be notified of the need for any extended leaves of absence. Per the GME Resident and Resident Manual, residents sustaining extended leaves of absence shall continue to be eligible for health benefits while taking unpaid leave.

Maternity/Paternity Leave

If a resident has the need to take maternity or paternity leave and he or she is eligible for FMLA, the resident must notify GME in writing and the policy of GME for residents and Residents will apply. Time taken for FMLA will result in extension of residency to comply with ABA and ACGME guidelines and to maintain ABA Board eligibility. This policy is further detailed in the Resident and Resident Manual, Section 7.4: Maternity/Paternity Leave, page 44 of the manual, which is available on the UH Community Digital Workplace.

https://uhcommunity.uhhospitals.org/GraduateMedicalEducation/Uploaded%20Documents/UHCMC%20FINAL%20Resident%20Manual%202016.pdf#search=resident%20and%20Resident%20manual

HOLIDAYS/HOT WEEKS

University Hospitals recognizes the following holidays:

New Year's Day
Memorial Day
Independence Day
Labor Day
Thanksgiving Day
Christmas Day

Only residents that are assigned holiday call for these days will be required to work on the day of the holiday. No elective OR cases will take place on these holidays. Days surrounding the holidays will be designated as part of the holiday call pool, but will be regular work days otherwise. The exception to this is if Independence Day, Christmas Day, or New Year's Day falls on a weekend, then the observed holiday will be on a designated weekday.

All residents will be required to work 2-3 holidays per year. Holiday requests will be distributed by the Scheduling Chief Resident at the beginning of each academic year. Residents must be on eligible rotations for call in order to fulfill holiday requests, and should therefore make their requests accordingly. Requests will be submitted as required, and thereafter the Holiday Call Schedule will be made and published.

The Department of Anesthesiology recognizes six hot weeks during the academic year which are highly requested weeks for vacation. Hot Weeks are as follows:

New Year's Week
American Society of Anesthesiologists Conference Week (October) → block vacations the week of ASA → no vacations during Thursday/Friday → block vacations Friday and Monday of ITE
Thanksgiving Week
Christmas Week

Vacations during the week of Thanksgiving, Christmas, and New Year's will only be granted if residents win the weeks in the Hot Week Call Pool. Requests to be considered for the Hot Week Call Pool will be submitted at the same time as holiday requests at the beginning of the academic year. Residents will be notified if they are selected randomly for a Hot Week for vacation. Once notified that a resident has been selected for a Hot Week, he or she has a limited time to verify that the week will be taken for vacation. Cancellation of the Hot Week closer to the time of the Hot Week can result in jeopardizing future eligibility for Hot Weeks. Other residents having requested the same Hot Week will then be eligible again for the pool for the Hot Week made available. Vacations during these weeks otherwise will be granted on a limited basis based on order of request in the department-wide scheduling request book.

The final two weeks of June are reserved for vacation for the CA3 class. This is to facilitate preparation for the Advanced Exam. Vacation during this time period will be given preferentially to the graduating class.

LIBRARIES

The **Department of Anesthesiology Library is located in the Bolwell Anesthesia Offices**. Computers in the library are available for use for residents when the library is not reserved. Lectures and other didactic activities will often take place in the Bolwell Library.

Mandy Neudecker (extension 41292) is the librarian for the Department of Anesthesiology. She is available to help with literature searches and to assist with scholarly research. Once yearly, she gives an update at WAC on instruction for accessing medical databases and the hospital and department's available resources.

The **Medical-Surgical Core Library** is located on the third floor of Lakeside in 3119. It is staffed Monday through Friday from 08:30-17:50; however, it is open to residents at all times. For access, press the buzzer to the left of the library door and it will contact Protective Services for you to identify yourself and be buzzed into the library. A copier is available for use in the library, free of charge.

The **Allen Medical Library** is one of the best medical libraries in the area. It is located on the corner of Euclid Avenue and Adelbert Avenue. Circulating volumes and journals are available there for house officers to borrow.

The **Health Center Library** is located on the first floor of Case Western Reserve University Medical School. CWRU also has two other libraries on campus, **Freiberger,** across from the Art Museum, and **Sears,** in the Case Quadrangle.

RESIDENTS' LOUNGE

The Anesthesia Resident Lounge is located in Bolwell 2073, across from the elevators. All anesthesia residents will be given a key to the lounge upon completion of orientation to the ORs. In the lounge there is a refrigerator, microwave, toaster oven, Keurig coffee machine, TV, hospital computers and laptops for use, couches, and a designated eating area. The cleanliness of this area is the responsibility of all residents. Environmental Services does not have access to this lounge, and access is only granted when requested in order to empty the garbage. This is a community space and should always be treated as such. Keys must be returned to Ms. Christine Adamovich prior to graduation.

Residents also have access to the Graduate Medical Education Residents' Lounge on the sixth floor of Lakeside. All members of the Association of Residents and Residents have access using their ID badges.

CONFERENCES & PRESENTATIONS

Meeting Days

Anesthesia residents may be able to attend scientific or clinical meetings at any time during residency if they are granted the time and are preapproved for attendance by Drs. Helou and Pesa. Residents will be granted five meeting days per year. In order to be eligible for attendance at a meeting, a trip number must be requested from Ms. Lisa Mullowney. Reimbursement for the trip can come from the resident education stipend, and will be dependent upon acquiring a trip number. Reimbursement allowances for travel, lodging, food, and other expenses will be delineated with the assigned trip number. Itemized receipts are required for reimbursement. Airfare will be reimbursed only if booked through Direct Travel. Chief Residents will receive an additional five meeting days.

Presentation Days

Aside from meeting days, residents will be granted presentation days in order to present at a scholarly meeting or conference. Presentation days are considered working days and should be treated as such. As working days, they do not count against the maximum allowable absence from the residency that the ABA sets. At the earliest anticipated time prior to the meeting, the resident should request these days in the scheduling book in order to accommodate the time off to be able to attend and present. Funds toward presentation will be granted in the amount of $500, and expenses will not be taken out of the educational stipend. Residents are highly encouraged to attend and participate in scientific meetings and conferences. All presentation days need to be approved by Drs. Helou and Pesa. Other departmental business travel may include invitation to speak at a conference, serve as a panel moderator, participate in an educational forum, serve as a regional or national standing committee member, or other functions that are in the best interest of the Department. Residents may also use both presentation days and meeting days for Residency and job interviews at the discretion of the Program Directors. Expenses for reimbursement will follow the same rules as for attendance at meetings and conferences. Prior approval is required.

Additionally, for presentation days:

- Printed documentation of acceptance to present must be provided to the department.
- One presented and one co-author will be eligible for reimbursement.
- Expenses will be reimbursed for actual presentation days, as well as one day before and after for travel.
- All other reimbursement rules apply, as stated below.
- Presentation days will be granted for 1 day of travel before the day of presentation, the day of, and 1 day after.

Midwest Anesthesia Residents' Conference

Attendance at the annual Midwest Anesthesia Residents' Conference is encouraged for all residents. The MARC falls in April or May of each year. Enough coverage is available for all departmental services for the weekend that all residents are able to attend. Any resident who chooses not to attend will be covering call or the ICU the weekend of the conference without exception. Residents who remain behind from the conference will also help to cover acute pain call. These calls will not count toward weekend call for the general call pool. There are two CA2s designated each year who will help to organize MARC presentations and submissions. These residents will be responsible for sending out emails with deadlines to submit both abstracts and PowerPoint presentations or posters. If residents do not meet the guidelines and deadlines, they are not guaranteed to be able to attend the MARC. Transportation for the conference is covered by the department: bus if driving distance, flight if farther away. All residents will typically leave at the same time, around 15:00 on Friday. Residents may NOT leave earlier unless special permission has been granted by the Program Directors in advance. Chief Residents may leave earlier if attending the Chief Resident meeting at the MARC. The hotel accommodations will also be covered by the department, with two people per room at the residents' own choosing. All trip reimbursement rules apply and must be submitted to Ms. Lisa Mullowney or to Ms. Holly Bennett within thirty days of return from the MARC. Attendance at the resident's own presentation is REQUIRED. Failure to attend one's own presentation will negate any reimbursement for the trip.

American Society of Anesthesiologists Annual Meeting

The Annual Meeting for the American Society of Anesthesiology falls in October of each year. Residents are highly encouraged to attend. The week of ASA is considered to be one of the Hot Weeks for vacation in order to accommodate attendance at the conference. Vacations requested for this week will fall under the Hot Week rules, and any other requested time off will be on a first-come, first-serve basis with the rest of the department. Residents should request meeting days or presentation days as soon as planning to attend ASA in order to facilitate acquiring the needed days to attend the meeting.

SUBSTANCE ABUSE

The Department of Anesthesiology follows the hospital Substance Abuse Policy 43 and Substance Abuse
Screening Policy 43B. In addition, there is a specific policy for the Department of Anesthesiology and Perioperative Medicine because of the uniqueness in anesthesiology that the individual that orders the controlled substances that are used in the practice of anesthesia is also the same individual that dispenses, administers, and accounts for the controlled substances. The actual policy states that the use, sale, manufacture, transfer, possession, or distribution of drugs or alcohol at University Hospitals Cleveland Medical Center or any of the University Hospitals Health system's facilities is prohibited by the Department of Anesthesiology and Perioperative Medicine at University Hospitals Cleveland Medical Center. Unauthorized use or misuses of over-the-counter medication, prescription drugs, or drug paraphernalia is included in the prohibition. Anesthesiologists, Residents, Anesthesia Assistants, Certified Registered Nurse Anesthetists, and Anesthesia Technicians are prohibited from reporting to the clinical area under the influence of drugs or alcohol. An Anesthesiologist, Resident, Anesthesia Assistant, Certified Registered Nurse Anesthetist, or Anesthesia Technician in violation of the policy will be subject to immediate disciplinary action up to and including termination, reporting to the state licensing board, and complaint to local law enforcement authorities. The Department of Anesthesiology and Perioperative Medicine at University Hospitals Cleveland Medical Center prohibits any Anesthesiologist, Resident, Anesthesia Assistant, Certified Registered Nurse Anesthetist, or Anesthesia Technician from being under the influence of drugs or alcohol while on University Hospital Cleveland Medical Center premises and all affiliated facilities. The Department of Anesthesiology and Perioperative Medicine will provide mandatory education on substance abuse and chemical dependency. The Department has a procedure for the identification of, intervention, referral for assessment and treatment, and monitoring reentry of an individual with a problem with substance abuse or chemical dependency. The department is responsible for identifying individuals with deteriorating clinical performance, behavioral changes, and excessive absenteeism but is not responsible for diagnosing the nature of the problem. With reasonable suspicion, the department will act to intervene and refer an Anesthesiologist, Resident, Anesthesia Assistant, Certified Registered Nurse Anesthetist, or Anesthesia Technician for assessment and treatment. Self-referral will be encouraged and the position of an Anesthesiologist, Resident, Anesthesia Assistant, Certified Registered Nurse Anesthetist, or Anesthesia Technician in the Department will not be jeopardized by a voluntary request for assistance with substance abuse and chemical dependency. The Department must be notified if the individual enters treatment. A leave of absence will be granted for the purpose of assessment, counseling, and/or treatment. The cost of assessment, treatment, and recovery programs is the sole responsibility of the individual Anesthesiologist, Resident, Anesthesia Assistant, Certified Registered Nurse Anesthetist, or Anesthesia Technician. Confidentiality is essential. No information regarding the participation of the Anesthesiologist, Resident, Anesthesia Assistant, Certified Registered Nurse Anesthetist, or Anesthesia Technician in drug testing, intervention, assessment, or treatment will be documented in the employee's file. A separate, confidential file will be maintained by the Department and will be available for review by the individual Anesthesiologist, Resident, Anesthesia Assistant, Certified Registered Nurse Anesthetist, or Anesthesia Technician at any time. The written consent of the Anesthesiologist, Resident, Anesthesia Assistant, Certified Registered Nurse Anesthetist, or Anesthesia Technician will be required for disclosure of any information related to his or her assessment, intervention, or treatment for substance abuse or chemical dependency. Violations of this policy constitute

professional misconduct and are subject to disciplinary action including suspension, termination, or conditional reentry following treatment. Anesthesiologists, Residents, Anesthesia Assistants, Certified Registered Nurse Anesthetists, and Anesthesia Technicians have the right to due process and may appeal any decision that adversely affects employment/practice status.

If a resident is impaired, he or she is referred to Employee Assistance Program for a confidential assessment and treatment referral. Our institution has an outpatient chemical dependency program and there are a number of inpatient chemical dependency treatment programs locally, one of which is for medical professionals. Once it is determined that a resident is impaired, he or she is encouraged to seek and receive treatment. Once he or she has successfully completed a substance abuse treatment program, he or she must then be reevaluated through the Employee Assistance and Corporate Health departments and deemed fit for duty to return back to work. Based on the recommendations of Employee Assistance, the recommendations of the chemical dependency treatment program,, and the nature of his or her impairment, a determination will be made is to if the resident will be allowed to reenter into the residency training program and be allowed to attempt completion. The decision for reentry into anesthesiology is made on a case-by-case basis. The recommendation made is similar to the Talbott Recovery Program reentry classification and falls into one of three categories based on criteria: Category I—certain return to anesthesiology immediately after treatment, Category II—possible return to anesthesiology (need to take one to two years off, then decide), or Category III—redirected into another specialty. There needs to be a compelling case if reentry is to be considered and a Reentry Contract with the resident is required before that option is considered.

BLOOD AND BODY FLUID EXPOSURE/NEEDLESTICK POLICY

Included below is the policy of University Hospitals Cleveland Medical Center for blood and body fluid exposure, including needlestick exposures, for employees. The policy is found on the UH Community Digital Workplace in the Policies Section.

IC-11 – Blood/Body Fluid Exposures in Employees Owner: Employee Health Revised: November 2016 Uncontrolled document – printed version only reliable for 24 hours

See Also:
IC – 7, Employee Health Service Infection Control Program
HR-67, Workers' Compensation Employee Incident Reporting

IC-11 – Blood/Body Fluid (BBF) Exposures in Employees Policy

1. UH provides initial and follow-up evaluation, counseling and treatment for employees1 experiencing a workplace exposure to Blood/Body Fluid (BBF)2 while on duty. Types of exposure are defined in Attachment A.

1.1. Evaluation includes screening and preventive intervention for hepatitis B and C and/or HIV-infected BBF based on the type and extent of exposure 3 following current Centers for Disease Control recommendations.

1.2. Source patients may be screened for the above bloodborne diseases. A mechanism is in place to facilitate source patient assessment and testing, coordinated by Employee Health Service (EHS.)

1.3. Current prophylaxis protocols 4 are available in EHS and the Infection Control Portal on the Intranet.

1.4. Final determination of the significance of the exposure is the responsibility of EHS. Infection Control may be consulted.

2. Employees at UH who sustain an exposure to BBF are to perform the following activities immediately after exposure. The initial management is:

2.1. Skin/needlestick: Wash exposed areas with soap and water or an antiseptic such as 70% alcohol or iodophor.

2.2. Eyes: Flush eyes with normal saline or water x 15 minutes.

2.3. Facial and oral mucous membranes: Wash face and/or rinse out mouth with water.

3. Notify supervisor and complete the First Report of Injury/Employee Incident Report (see policy HR-67, Workers' Compensation Employee Incident Reporting). This on-line incident report is completed and submitted to Disability Management Services.

4. Seek Evaluation of Exposure:

4.1. Evaluation, testing and medications are free of charge to employees who sustain a work place exposure to BBF.

4.2. If the wound is a deep laceration or significant puncture wound, staff must report to a UH Emergency Department or Urgent Care (ED/UC) regardless of time of occurrence.

4.3. If not a deep laceration, staff should present to designated area (EHS, ED/UC) to have injury/exposure evaluated as soon as possible after exposure.

4.4. Entity Hospitals: Follow entity-specific procedures. See Infection Control website on UH Intranet; follow to your respective entity.

4.5. UHCMC:

4.5.1. Days: Contact EHS (844-1602) or present to EHS 0730-1600.

4.5.2. Evenings, nights, weekends, holidays:

4.5.2.1. Report to the ED/UC triage nurse for initial evaluation and information.

4.5.2.2. Based on ED/UC evaluation, employee may be given postexposure prophylaxis medication if indicated. No employee blood work is routinely done in the ED, but a mechanism for source testing is in place, coordinated by ED/UC staff.

4.5.2.3. Employee to report to EHS for follow-up care the next business day.

4.6. UH Non Hospital-based employees:

4.6.1. Days: Contact EHS (844-1602) for guidance.

4.6.2. Evenings, nights, weekends, and holidays: Report to UH system hospital ED/UC for initial evaluation. Follow up with your company's protocol for exposures.

4.7. Employee Records:

4.7.1. Employee test results and consent forms are part of an exposure record separate from the employee's EHS record. All test results are sent to EHS and included in the employee's exposure record.

4.7.2. Employee exposure records are confidential and are not released without the employee's written permission.

[1] Employees: For the purposes of this policy, "employees" includes employees of UH and medical staff whose injuries occur while they are involved with the care of UH patients, volunteers and specific groups with whom Employee Health Services has contracts to provide postexposure services.

[2] Blood/body fluids (BBF): Amniotic fluid, bloody fluids, cerebrospinal fluid, pleural fluid, pericardial fluid, peritoneal fluid, semen, synovial fluid, and vaginal secretions..

[3] Exposure: Blood or body fluid splashes to the eyes, nose or mouth or on non-intact skin; needlestick or percutaneous exposure with a contaminated sharp object.

[4] Postexposure prophylaxis (PEP): Antiretroviral, or other medications, offered to exposed employee, within a specific time frame, after significant exposure.

ATTACHMENT A: Definition of Exposure--Bloodborne Pathogen Exposure Types

DETERMINATION IF HIV PROPYLAXIS IS NEEDED

A. HIV post exposure prophylaxis is recommended for HCW's exposed to source person with known HIV or for those whom there is a reasonable suspicion of HIV infection.

B. Exposures that may put HCW at risk for HIV infection are:

1. Percutaneous injury:
    a) Needlestick
    b) Cut with contaminated sharp object
2. Contact of mucous membrane or non-intact skin with blood, tissue or other body fluids that are potentially infectious.
    a) Non-intact skin is exposed skin that is:
        1. Chapped
        2. Abraded
        3. Afflicted with dermatitis
    b) Potentially infectious body fluids:
        1. Blood
        2. Semen
        3. Vaginal secretions
        4. CSF
        5. Synovial fluid
        6. Pleural fluid
        7. Peritoneal fluid
        8. Pericardial fluid
        9. Amniotic fluid
    c) Feces, nasal secretions, saliva, sputum, sweat, tears, urine and vomitus are NOT CONSIDERED potentially infectious UNLESS THEY ARE VISIBLY BLOODY.
3. Direct contact (without barrier protection) to concentrated HIV virus in a research laboratory
4. Human bites

Updated U.S.Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Post-Exposure Prophylaxis: Kuhar, et al 2013.

Electronically approved by Tom Zenty - President and CEO of UH November 2, 2016.
Electronically approved by William Lawrence Annable, MD - Chief Quality Officer and Director November 1, 2016.