Chief Resident Elective
Internal Medicine Residency Program at University of Kansas Medical Center
Mandatory experience for graduating PGY-3 residents selected as Chief Residents for the upcoming academic year

Director: Leigh M. Eck, M.D., Program Director
Duration: 1-3 weeks based on block schedule arrangement
Supervision: Program Leadership Team – Program Director and Associate Program Directors
Facility: University of Kansas Medical Center

Required Didactics:
1. Core and Case Conferences - Monday, Tuesday, Wednesday, Thursday, and Friday at 12:00 PM
   1. Location Varies Daily
2. Grand Rounds – Wednesday at 8:00 AM
   • Clendening Auditorium
3. Patient Safety Conference – Quarterly - Aug, Nov, Feb, May at 12:00 PM
   • Clendening Auditorium
4. Clinicopathologic Conference – Quarterly - Aug, Nov, Feb, May at 12:00 PM
   • Clendening Auditorium

Educational Purpose:
Rising chief residents are required to spend a month in the spring of their final year of training on an administrative elective. This rotation is designed to prepare the rising chief resident to assume the higher level of responsibility and autonomy inherent in the chief position. Emphasized competencies include systems-based practice, centered upon graduate medical education and residency program, medical knowledge (via intensive board preparation), and interpersonal skills and communication (via assumption of leadership and teaching roles in the residency program).

Educational Methods:
Rising chief residents are mentored by the Program Director and other program leaders, and participate in weekly program leadership meetings. In addition, the residents will attend the national APDIM Chief Residents’ Conference, held in April. The residents are also expected to regularly attend case and core conferences, and to commit to intensive independent study in preparation for the ABIM certification examination.

Clinical experience during the rotation is limited to the resident's continuity clinic sessions for one half-day per week. As trainees nearing assumption of the role of attending physician after graduation, rising chief residents are expected to function nearly independently in their continuity clinics.

The rising chiefs will meet regularly with the outgoing chiefs, and will also conduct a housestaff meeting to obtain feedback from the residents regarding ideas for the upcoming academic year. Other responsibilities include review and revision of the housestaff manual, joint development of programmatic goals for the upcoming academic year, and completion of the resident rotation schedule.

Recommended educational resources for this rotation include the following:
- MKSAP and MedStudy Board Review Materials - available in the Chief Resident Office
- RRC Program Requirements, http://www.acgme.org/acWebsite/RRC_140/140_prIndex.asp
- APDIM Chief Residents’ Manual

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Patient Care
1. PGY-3 Level Performance in the Continuity Clinic (Please see ABIM Milestone Based Ambulatory Curriculum)

Medical Knowledge
1. PGY-3 Level Performance in the Continuity Clinic (Please see ABIM Milestone Based Ambulatory Curriculum)
2. Prepare for successful performance on ABIM Board Examination
3. Prepare scheduled teaching sessions for 3rd year medical students and residents

Practice Based Learning and Improvement
1. Identify, analyze and learn from errors in patient care through planning of Patient Safety Conferences and Clinicopathological Conferences
2. Establish goals for the upcoming chief resident year, including recruiting, academic development and programmatic initiatives
3. Participate in Teaching Conferences
   1. Core and Case Conferences - Monday, Tuesday, Wednesday, Thursday, and Friday at 12:00 PM
      • Location Varies Daily
   2. Grand Rounds – Wednesday at 8:00 AM
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   3. Patient Safety Conference – Quarterly - Aug, Nov, Feb, May at 12:00 PM
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Interpersonal and Communication Skills
1. Develop the leadership Skills required for interaction with resident, both one-on-one and in the context of conferences and housestaff meetings

Professionalism
1. Role model professional behavior for student and resident learners

Systems-Based Practice
1. Develop an understanding of the complex systems of administration of residency programs
2. Develop understanding of the accreditation process for residency programs including RRC Program Requirements
GMEC Resident Supervision

A. Supervision of Residents

- Each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by each Review Committee) who is responsible and accountable for that patient’s care.
- This information must be available to residents, faculty members, other members of the health care team, and patients.
  - Inpatient: Patient information sheet included in the admission packet and listed on the “white board” in each patient room
  - Outpatient: Provided during introduction verbally by residents and/or faculty
- Residents and faculty members must inform patients of their respective roles in each patient’s care when providing direct patient care.
- The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.

B. Methods of Supervision

- Supervision may be exercised through a variety of methods.
- For many aspects of patient care, the supervising physician may be a more advanced resident or fellow.
- Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member, fellow or senior resident physician, and either on site or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident delivered care with feedback.
- The program must demonstrate that the appropriate level of supervision in in place for all residents is based on each resident’s level of training and ability, as well as patient complexity and acuity.
- Supervision may be exercised through a variety of methods, as appropriate to the situation.
- The Review Committee may specify which activities require different levels of supervision.

C. Levels of Supervision Defined

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

Direct Supervision:
- The supervising physician is physically present with the resident and patient.

Indirect Supervision A (with direct supervision immediately available):
- The supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.

Indirect Supervision B (with direct supervision available):
- The supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.
**Oversight:**
- The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

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

<table>
<thead>
<tr>
<th>Per Program Specific RRC Requirements</th>
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<tr>
<td><strong>RRC APPROVED LICENSED INDEPENDENT PRACTITIONER SUPERVISOR</strong> and this information must be available to the residents, faculty members, other members of the health care team and patients. (PR VI.A.2.a (1))</td>
<td></td>
</tr>
<tr>
<td>Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care.</td>
<td></td>
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<tr>
<td>Information regarding licensure for attending physicians is available via a publicly available database: <a href="http://docfinder.docboard.org/ks/df/kssearch.htm">http://docfinder.docboard.org/ks/df/kssearch.htm</a></td>
<td></td>
</tr>
<tr>
<td>Licensure data on resident physicians is kept up to date in the University of Kansas Health System GME Office.</td>
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<tr>
<td>VI.A.2.a). (1). Inform each patient of their respective roles in patient care, when providing direct patient care.</td>
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</table>
| This information must be available to residents, faculty members, other members of the health care team, and patients.  
  - Inpatient: Patient information sheet included in the admission packet and listed on the “white board” in each patient room. Provided during introduction verbally by residents and/or faculty.  
  - Outpatient: Communicated to patient at time of appointing scheduling. Provided during introduction verbally by residents and/or faculty. |  |
| PGY – 1 residents must be supervised either directly or indirectly with direct supervision immediately available. Conditions and the achieved competencies under which a PGY -1 resident progresses to be supervised indirectly with direct supervision available: (PR VI.A.2.e.(1).(a)) |  |
| Guidelines for circumstances and events in which residents must communicate with their supervising faculty member are delineated in the Housestaff Manual and in the rotational goals and objectives. PGY-1 residents are supervised, either directly or indirectly with direct supervision immediately available on site, by PGY-2 or PGY-3 residents or staff members on all rotations, including night float, at all training sites. During daytime inpatient, consult, and outpatient rotations, supervision is direct and occurs by an attending physician as well as a senior resident. On night float rotation at KU Hospital, a senior resident and a hospitalist faculty attending are present on location to immediately provide direct supervision. On night float rotation at Kansas City VA Hospital, a senior resident is present on location to immediately provide direct supervision and a faculty attending is available by pager and is available to provide Direct Supervision. Residents are not responsible for nighttime coverage at the Leavenworth VA Hospital. |  |
| The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the Program Director and faculty members. (PR VI.A.2.d, (1,2,3)) |  |
| The program has adapted the American Board of Internal Medicine’s Milestones of Competency to delineate our overall and rotational goals and objectives. Our evaluation system provides data on the ACGME reporting milestones. This data along with review of |  |

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the resident’s portfolio of work allows the Program Director and faculty members to make
determinations on a resident’s ability to gain progressive authority and responsibility.

The program director must evaluate each resident’s abilities based on specific criteria,
guided by the Milestones.

Faculty members functioning as supervising physicians must delegate portions of
care to residents based on the needs of the patient and the skills of each resident.

Senior residents or fellows serve in a supervisory role to junior residents in
recognition of their progress toward independence, based on the needs of each
patient and the skills of the individual resident or fellow.

RARE CIRCUMSTANCES WHEN RESIDENTS may elect to stay or return to the clinical site
:( PR VI.F)

In rare circumstances, after handing off all other responsibilities, a resident, on their own
initiative, may elect to remain or return to the clinical site in the following circumstances:
  to continue to provide care to a single severely ill or unstable patient;
  to attend to humanistic attention to the needs of a patient or family; or,
  to attend unique educational events.

The program monitors circumstances in which residents stay beyond scheduled periods of
duty through the institutional work hours monitoring system in MedHub. The program
leadership reviews the resident work hours report weekly, and residents are instructed to
enter a comment in their work hours report indicating the reason for their work hours
violation. In addition, the chief residents contact all residents with reported work hours
violations to inquire about the cause and impact of the violation. This data is reviewed and
discussed during weekly program leadership meeting, and trends are carefully sought and
addressed.

DEFINED MAXIMUM NUMBER OF CONSECUTIVE WEEKS OF NIGHT FLOAT AND MAXIMUM
NUMBER OF MONTHS PER YEAR OF IN-HOUSE NIGHT FLOAT (PR VI.F. 6.)

Maximum Frequency of In-House Night Float
Residents must not be scheduled for more than six consecutive nights of night float.
VI.G.7. Maximum In-House On-Call Frequency
PGY-2 residents and above must be scheduled for in-house call no more frequently than
every-third-night (when averaged over a four week period).
VI.G.7.a) Internal Medicine residency programs must not average in-house call over a four-
week period.
All call for the program occurs on a night float schedule except for Sunday night intern call
on inpatient services, which is a 16-hour shift performed on a rotation about once to twice
per month per intern.

Program-specific guidelines for circumstances and events in which residents must
communicate with appropriate supervising faculty (PR VI.A.2.e)

1. Admission to Hospital
2. Transfer of patient to a higher level of care
3. Clinical deterioration, especially if unexpected
4. End-of-life decisions
5. Change in code status
6. Red Events
7. Change in plan of care, unplanned emergent surgery or planned procedure that
does not occur
| 8. Procedural complication |
| 9. Unexpected patient death |

**Title:** Red Event Definition  
**Date:** 12/21/2016

**Departments who must adopt:**  
The University of Kansas Health System (TUKH)

**Operators who must adopt:**  
All TUKH employees

**NOTE:** THIS IS A CONTROLLED DOCUMENT THAT SUPPORTS A SPECIFIC PROCESS

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**RED EVENTS - DEATH AND SERIOUS INJURY AND/OR NEAR MISS**

- Serious blood transfusion reaction
- Contaminated drug, device or biologic
- Equipment related injury
- Falls resulting in major injury
- Fire, flame, smoke or heat during patient care
- Electric shock or burn during patient care
- Infection: Patient to patient and or visitor exposure
- Maternal/Perinatal  
  - Unexpected perinatal death
  - Unexpected infant death
  - Unexpected maternal death or serious disability
- Medication error with serious injury and/or death
- Elopement of patient lacking capacity, danger to self or others, or involuntarily admitted
- Radiation overdose
- Restraint or bedrail use causing death or serious injury
- Seriousiatrogenic injury
- Unexpected deaths in ambulatory settings (excluding Emergency Department)

- Procedural and perioperative events  
  - Procedure performed on wrong body part or wrong patient
  - Wrong procedure performed
  - Unexpected intraoperative/postoperative death
  - Death during elective surgery or procedure
  - Unintentionally retained foreign object
  - Wrong donor sperm or egg
- Security:  
  - Disruptive behavior that causes harm or injury to patient or impedes patient care
  - Sexual assault or rape of a patient, visitor or employee
  - Infant discharged to the wrong family
  - Impersonation of a health care professional
  - Patient abduction
- Suicide/Homicide of patient, employee, visitor on health system premises campus
- Any defect that has the potential to cause harm across the health system

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**Process Owner:** Assistant Director of Quality / Magnet / Research  
**Approved by:** Quality Risk Committee  
**Version:** 1.0-12/21/16

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# PGY 1

<table>
<thead>
<tr>
<th>LEVEL of SUPERVISION</th>
<th>ACTIVITIES /PROCEDURES (as defined by RRC &amp; Program)</th>
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</table>
| **DIRECT**           | Abdominal paracentesis  
Advanced cardiac life support  
Arterial line placement (until at least one has been performed)  
Arthrocentesis  
Central venous line placement  
Venous blood draw (until at least one has been performed)  
Arterial blood draw (until at least one has been performed)  
Incision and drainage of an abscess  
Lumbar puncture  
Nasogastric intubation (until at least one has been performed)  
Pap smear and endocervical culture (until at least one has been performed)  
Peripheral line placement (until at least one has been performed)  
Pulmonary artery catheter placement  
Thoracentesis |
| **INDIRECT A (with direct supervision immediately available)** | Electrocardiogram interpretation |
| **INDIRECT B (with direct supervision available-as determined by program specific RRC guidelines PR VI.D.5.a).(1))** | N/A |

## All OTHER RESIDENTS

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<tr>
<td><strong>DIRECT</strong></td>
<td>Pulmonary artery catheter placement</td>
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| **INDIRECT A (with direct supervision immediately available)** | Each of the procedures below can be performed with Indirect supervision with direct supervision immediately available provided that the requirements above have been met during the PGY-1 year; if not, then direct supervision must continue to occur until the required number have been performed.*  
Abdominal paracentesis  
Advanced cardiac life support  
Arterial line placement  
Arthrocentesis  
Central venous line placement  
Venous blood draw  
Arterial blood draw  
Incision and drainage of an abscess  
Lumbar puncture  
Nasogastric intubation  
Pap smear and endocervical culture  
Peripheral line placement  
Thoracentesis  
Electrocardiogram interpretation |
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<th>INDIRECT B (with direct supervision available)</th>
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<tr>
<td>OVERSIGHT (with direct supervision available)</td>
<td>N/A</td>
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GMEC-EC APPROVAL 5/27/11
GMEC APPROVAL 6/6/11, 06/05/17
Modified 6/20/11, May 2, 2017

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