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ACADEMIC

Department of Pediatrics Mission Statement

With our KU partners, our mission is to optimize the health and well-being of children and their families through excellence in patient care, education and research.

Pediatric Residency Program Aims

Our aim is to prepare competent general pediatricians for the next phases of their careers, including readiness for the certifying examination as well as practice or fellowship training, in a learning environment moving towards integration with Children’s Mercy.

Clinical training focuses on resident educational needs over clinical service needs. Our interprofessional teams emphasize safe, evidence based, compassionate care for a diverse patient population including underserved and immigrant populations. Residents are involved with direct patient care as well as quality improvement activities and institutional CLER committees focused on improving patient care as well as the resident experience.

Education focuses on the learning styles of residents preparing them to both learn and teach.

Pediatrics Education Division Mission Statement

The mission of the Education Division is to provide a culture of learning to facilitate the journey of becoming competent clinicians maintaining high standards of professional behavior and dedication to life-long learning

Program Goals

Pediatricians are responsible for promoting health and treating disease and injuries in infants, children and teenagers. To do so means not only caring for the child but also for parents and families and often for entire communities as well.

Our residents will be trained to provide family-centered care that is evidence based and compassionate. They will learn to identify problems that may cause ill health in children and to determine treatment plans to alleviate these problems by using their skills and those of colleagues. Included in caring for children are the following skills and attitudes our Program expects all residents and faculty members to uphold:

- Dedication to putting the patient first
- Possession of a life-long desire to learn and improve
- Continuous use of quality improvement
- Communication skills that enhance the patient-physician relationship
- Willingness to advocate for patients in an increasingly complex medical system
- Desire to carry out the professional responsibilities of a pediatrician

The curriculum of the Department of Pediatrics Residency Program is designed to assist physicians in acquiring the knowledge, skills, attitudes, and clinical judgment necessary to meet these responsibilities. Residents show progress towards meeting these goals by demonstrating continuous improvement on the in-training exam offered by the American Board of Pediatrics. Successful completion of the Pediatrics Board Examination is a goal for each resident. A wide variety of educational and clinical experiences will be available during training to help you accomplish this goal.
Throughout residency, you will learn the non-testable skills- how to work together, how to teach, how to communicate with patients and other health care professionals, how to critically look at a problem and work to solve it, and how to develop the professionalism expected of physicians. You will have opportunities to learn about advocacy, ethics and the business side of medicine. Additionally, based on your future career plans be they fellowship, academic medicine or private practice, there is flexibility in both the clinical and educational programs to allow individualization of your training in order to prepare you for your practice beyond residency. Such experiences are vitally important if our graduates are to meet the ever-changing demands of pediatric practice.

Together with your fellow residents, students and faculty, work hard, enjoy what you do and never forget that you make a difference in the lives of children. On behalf of the entire staff of the Pediatric Medical Education Center, welcome!

**Compact between Resident Physicians and their Teachers**

The Program has adopted the AAMC (Association of American Medical Colleges) compact between Resident Physicians and their Teachers. The Compact is a declaration of the fundamental principles of graduate medical education (GME) and the major commitments of both residents and faculty to the educational process; to each other and to the patients they serve. The Compact’s purpose is to provide institutional GME sponsors, Program Directors and residents with a model statement that will foster more open communication, clarify expectations and re-energize the commitment to the primary educational mission of training tomorrow’s doctors.

Additional information about the Compact can be found at the AAMC website, [www.aamc.org/residentcompact](http://www.aamc.org/residentcompact)

**Commitments of Teaching Faculty**

- As role models for our residents, we will maintain the highest standards of care, respect the needs and expectations of patients, and embrace the contributions of all members of the healthcare team.
- We pledge our utmost effort to ensure that all components of the educational program for resident physicians are of high quality, including our own contributions as teachers.
- In fulfilling our responsibility to nurture both the intellectual and the personal development of residents, we commit to fostering academic excellence, exemplary professionalism, cultural sensitivity, and a commitment to maintaining competence through life-long learning.
- We will demonstrate respect for all residents as individuals, without regard to gender, race, national origin, religion, disability or sexual orientation; and we will cultivate a culture of tolerance among the entire staff.
- We will do our utmost to ensure that resident physicians have opportunities to participate in patient care activities of sufficient variety and with sufficient frequency to achieve the competencies required by their chosen discipline. We also will do our utmost to ensure that residents are not assigned excessive clinical responsibilities and are not overburdened with services of little or no educational value.
- We will provide resident physicians with opportunities to exercise graded, progressive responsibility for the care of patients, so that they can learn how to practice their specialty and recognize when, and under what circumstances, they should seek assistance from colleagues. We will do our utmost to prepare residents to function effectively as members of healthcare teams.
- In fulfilling the essential responsibility we have to our patients, we will ensure that residents receive appropriate supervision for all of the care they provide during their training.
- We will evaluate each resident’s performance on a regular basis, provide appropriate verbal and written feedback, and document achievement of the competencies required to meet all educational objectives.
- We will ensure that resident physicians have opportunities to partake in required conferences, seminars and other non-patient care learning experiences and that they have sufficient time to pursue the independent, self-directed learning essential for acquiring the knowledge, skills, attitudes, and behaviors required for practice.
- We will nurture and support residents in their role as teachers of other residents and of medical students.
Commitments of Residents

- We acknowledge our fundamental obligation as physicians—to place our patients’ welfare uppermost; quality health care and patient safety will always be our prime objectives.
- We pledge our utmost effort to acquire the knowledge, clinical skills, attitudes and behaviors required to fulfill all objectives of the educational program and to achieve the competencies deemed appropriate for our chosen discipline.
- We embrace the professional values of honesty, compassion, integrity, and dependability.
- We will adhere to the highest standards of the medical profession and pledge to conduct ourselves accordingly in all of our interactions. We will demonstrate respect for all patients and members of the health care team without regard to gender, race, national origin, religion, economic status, disability or sexual orientation.
- As physicians in training, we learn most from being involved in the direct care of patients and from the guidance of faculty and other members of the healthcare team. We understand the need for faculty to supervise all of our interactions with patients.
- We accept our obligation to secure direct assistance from faculty or appropriately experienced residents whenever we are confronted with high-risk situations or with clinical decisions that exceed our confidence or skill to handle alone.
- We welcome candid and constructive feedback from faculty and all others who observe our performance, recognizing that objective assessments are indispensable guides to improving our skills as physicians.
- We also will provide candid and constructive feedback on the performance of our fellow residents, of students, and of faculty, recognizing our life-long obligation as physicians to participate in peer evaluation and quality improvement.
- We recognize the rapid pace of change in medical knowledge and the consequent need to prepare ourselves to maintain our expertise and competency throughout our professional lifetimes.
- In fulfilling our own obligations as professionals, we pledge to assist both medical students and fellow residents in meeting their professional obligations by serving as their teachers and role models.

Resident Code of Professional and Personal Conduct

The University of Kansas School of Medicine has undertaken a "Professionalism Initiative," conceived to raise awareness of professionalism within the KU medical community as a whole, from the first day of medical school, throughout one's career in the health sciences. The Professionalism Initiative guidelines for professional attitudes and behaviors for all medical professionals, regardless of position or seniority in the medical community, are incorporated into the Resident Code of Professional and Personal Conduct.

Additional information on Professionalism can be found in the Pediatric Residency Policies and Procedures Manual. Additional information on the Professionalism Initiative under Resident Code of Professional and Personal Conduct can be found in the University of Kansas Graduate Medical Education Policy and Procedure Manual.

http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html

Evaluation

The Department of Pediatrics and the Pediatric Residency Program support the Evaluation policies which can be found in the University of Kansas Graduate Medical Education Policy and Procedure Manual.

http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html
Remediation, Probation and Corrective Actions, Suspension and Termination

Unsatisfactory performance based on the resident evaluation, poor academic performance, inappropriate or unprofessional behavior, or other deviations from acceptable performance as judged by teaching staff and/or Program Director, will result in corrective action as necessary to maintain the quality of patient care (safety, call coverage), the quality of the Program (ITE scores, conference attendance), the steady operation of the institution (medical records, duty hours) and the well-being of the resident. Corrective action usually begins with attending, Chief or Program Director discussing a deficiency with the resident involved. The Program Director has the authority to administer an appropriate disciplinary action including the following: Warning Status, Probation (short or long term), Suspension, Non-Renewal of Contract, Termination or other discipline as determined by the Program Director.

Except in instances where patient care is threatened or there has been other serious professional misconduct, the Program Director will inform the Chair of the Department and the GME office of any anticipated disciplinary action beyond Warning Status. Formal procedures for Probation, Suspension, Termination and Non-Renewal of Contract are outlined in the Institutional GME Policies and Procedures manual.

Should a resident be found to be deficient in any of the competencies and not meeting advancement or promotion specifics, the resident will usually be placed on Warning Status (usually 1-3 months) unless the deficiency is severe enough to warrant Probation or Suspension without Warning Status.

At the initiation of a remediation period, the resident will meet with the Program Director, the Associate Director, or their designee wherein:

1) expectations and deficiencies will be stated  
2) specific knowledge, skills or behaviors that must be demonstrated will be outlined  
3) other behaviors that the individual can do to improve will be explored and planned  
4) responsibilities may be altered for a period of time  
5) portions of the Program may be required to be repeated  
6) an attempt will be made to determine if there are outside factors, which may explain why a problem has developed.  
7) professional or personal counseling with an educational specialist, psychologist or psychiatrist may also be recommended

This meeting will be documented. The outline of the Warning Status/Probation/Suspension will be given to the resident for his/her agreement of the meeting content, and a final copy will go into the resident's personnel file. A copy will also be sent to the resident’s advisor if appropriate. The resident may ask for another resident to be present at this meeting to serve as a resident advocate.

Should the resident continue to be deficient despite appropriate counseling, professional assessment and input (if indicated), and faculty efforts, a period of Probation (usually 3 months) is indicated. A written letter of probation will state:

1) deficiencies that the individual has been counseled for and that sufficient improvement has not been made,  
2) that because of this the individual is being put on probation,  
3) time of probation,  
4) expectations during this period,  
5) what will be done to assist the individual in meeting these expectations,  
6) mechanism(s) will be to determine improvement and  
7) consequences or options are to be if expectations are not met.
The deficient resident will receive this letter, a copy will go into his/her personnel file and a copy will be submitted to the KU GME office. Reporting of remediation actions depends on when in residency remediation occurs. Warning Status is a Program level remediation and although it may be reported to the Institutional GME office, it is not reported to boards or on licensing or verification requests. Periods of probation may be reported to the American Board of Pediatrics and verification and licensing requests.

A resident put on probation who has successfully accomplished remediation in the probationary period but who has received intermittent low satisfactory or isolated unsatisfactory marks during the academic year (and particularly following a probationary period), may be asked to repeat the year. This is particularly so, if the Residency Committee feels the resident can receive no better than a marginal grade on the American Board of Pediatrics assessment and/or if the Department will in all likelihood be unable to certify that the resident can sit for the board examination should the resident's performance trend continue. Although marginal evaluations at certain points in training in the area of medical knowledge and patient care may not negatively affect the resident’s ability to sit for the board exam at the end of training, any marginal evaluation in the area of professionalism may result in the resident not being permitted to sit for the pediatric certifying examination.

The probationary period is intended to emphasize to the resident the importance of satisfactorily meeting the residency training requirements and expectations of the Department including prompt seeking of assessment, counseling, or assistance, should there be any possibility of personal problems, learning disability, or outside factors that may be contributory to the resident's performance. The Program Director with assistance from faculty with first-hand knowledge of the resident’s areas of sub-competent performance is responsible for the definition of expected remediation, establishment of a defined time in which this must be accomplished, alerting his/her attending faculty during this period of probation to the importance of helping the resident with defined problems and for an honest evaluation of the resident’s performance.

Residents on probation must achieve a satisfactory evaluation from their attending faculties on assigned clinical service rotations during their probationary period. Probationary actions will only be shared with those needing to know, and normally will not be disclosed to other residents or students. Should the resident fail the above probationary period, then at the discretion of the Program Director a letter extending the probation may be issued, or a letter dismissing the resident from the Program on a designated date will be issued, assuming that dismissal was a consequence of probationary failure as stated above. Accompanying this letter must be a statement of the resident's right of appeal.

The remediation and probationary policies of the Program are in line with the policies of the University of Kansas School of Medicine.

*Adapted from Stony Brook University Medical Center- Disruptive Resident Behavior Policy;* http://www.stonybrookmedicalcenter.org/gme/policy/disruptivebehavior/

Additional information on the Remediation and Probation and Corrective Actions: Suspension, Termination and Non-Renewal of Contract can be found in the *University of Kansas Graduate Medical Education Policy and Procedure Manual.* http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html
Resident with Disruptive Behavior Policy

I. Policy
It is the policy of the University of Kansas Pediatrics Residency Program that all residents conduct themselves in a professional and cooperative manner, and shall not engage in disruptive behavior such as but not limited to the following:

- Conduct that interferes with the provision of safe, effective, and efficient patient care
- Conduct that interrupts hospital or clinic operations
- Conduct that interrupts the administration of the program, department or institution
- Abusive behavior including sexual harassment
- Retaliating or threatening reprisal for reporting disruptive behavior
- Using vulgar, profane or abusive language unbecoming of a medical professional
- Behavior that is intimidating, belittling or implies incompetence
- Refusal (purposefully or non-purposefully) to comply with resident schedules
- Persistent or uncorrected, unacceptable performance on measures of medical knowledge including but not limited to the yearly In-Service Training examination
- Failure to progress academically or to develop the clinical skills necessary for progressive autonomy in training
- Dishonesty in any form.

Residents are expected to:

- Accept and incorporate feedback in a non-resistant and non-defensive manner
- Address dissatisfaction through appropriate means
- Cooperate and communicate with all faculty, other health professionals, and staff
- Be truthful in all written and verbal communication

Residents identified as demonstrating disruptive behavior are at risk for the following actions: warning, probation, suspension or dismissal.

II. Purpose
To ensure that every resident conducts him/herself in a professional, cooperative and appropriate manner and to encourage the prompt identification and resolution of alleged disruptive behavior by all involved or affected persons through informal, collaborative efforts at counseling and remediation.

This policy provides a formal process for the further investigation and resolution of disruptive resident behavior that has not been appropriately modified by prior efforts.

Finally, this policy provides guidelines for the appropriate discipline of residents who have failed to appropriately modify their behavior after the informal efforts and formal processes described in this policy have been applied.

III. Process
The degree to which a resident’s behavior disrupts the educational, clinical, and/or administrative functioning of the residency, department, or university will determine the level of intervention.

Upon receipt of a written or oral report of alleged disruptive behavior by a resident, a Program Director will initiate an informal investigation as he/she deems appropriate to identify or rule out the existence of disruptive behavior.
During the investigation, a Program Director will meet with the resident to review the alleged behavior and the requirements of this policy. Other faculty or residents may be present at the meeting who the Program Director or resident feel as necessary to explain the alleged disruptive behavior. At the completion of the investigation, the Program Director will make a determination as to whether the resident engaged in disruptive behavior.

- If determined that the resident has not engaged in disruptive behavior, he/she will advise the resident that no additional action is required.
- If determined that the resident has engaged in disruptive behavior an intervention will be enacted based on the severity and level of disruption of the behavior.

Any of the following are available to the program to facilitate the resident’s modification of the behavior. The interventions do not necessarily progress from PIP through Probation and any may be used for a first or subsequent intervention.

1. **Performance Improvement Plan (PIP): Faculty level of concern** not reportable to licensing or credentialing agencies
   - Advisors: Associate Program Director (s)

   A PIP is a formal process to help residents improve performance and/or modify behavior. It is a focused, written action strategy specifically designed to address the areas of concern and provides clearly defined expectations for the behavior to be changed with metrics and outcome statements. The PIP is an opportunity for the program to provide focused support to a resident to overcome an area of concern. A PIP can be requested by a resident to proactively address areas of concern.

   The APDs work with the faculty and resident to develop a remediation plan with an established timeline and outcomes. All PIPs will be reviewed by the Program Director. The PIP will be reviewed with the resident to counsel the resident concerning compliance with the PIP and to assist the resident in identifying methods for structuring professional and working relationships and resolving problems without disruptive behavior.

   Upon completion of the PIP requirements the APDs will make a recommendation to the Program Director regarding next steps. The recommendation may include successful completion of the requirements with no further intervention required, additional PIP activities, Warning Status, Probation, or submission to the Academic and Professionalism Committee. The Program Director makes final determination of next steps.

   Noncompliance with any portion of the PIP will be brought to the attention of the Program Director. Residents found noncompliant with a PIP may be forwarded to the Academic and Professionalism Committee.

2. **Warning Status: Program level of concern** may be reported to licensing/credentialing agencies
   - Advisors: Program Director (oversight)
   - Associate Program Director (s)

   Residents who do not demonstrate progressive responsibility of clinical performance, who behave in an unacceptable fashion as outlined within this policy or who demonstrate a pattern of behavior that has not been remediated through other means may be placed on Warning Status.

   The formal, written, Warning Status action plan will be developed by the APDs in partnership with involved faculty members and the Program Director. The Warning Status will be reviewed with the resident to counsel the trainee concerning compliance with the Warning Status and assist the resident in identifying methods for structuring professional and working relationships and resolving problems without disruptive behavior.

   Written documentation of this status change may be forwarded to the Graduate Medical Education (GME) office and a copy will be placed in the resident's file for documentation purposes.
Upon completion of the Warning Status requirements the APDs will make a recommendation to the Program Director regarding next steps. The recommendation may include successful completion of the requirements with no further intervention required, continued Warning Status, Probation, or submission to the Academic and Professionalism Committee. The Program Director makes final determination of next steps.

Noncompliance with any portion of the warning status will be brought to the attention of the Program Director. Residents found noncompliant with Warning Status may be forwarded to the Academic and Professionalism Committee.

3. **Immediate referral to the Academic and Professionalism Committee**

Residents demonstrating repeated disruptive behaviors or egregious disruptive behaviors may, at the discretion of the Program Director, be forwarded directly to the Academic and Professionalism Committee.

The Program Director will determine the members of each A&P Committee. The committee will be led by a senior member of the Department of Pediatrics usually the Vice Chair of Education or Vice Chair of Clinical Affairs. The two to four other faculty members including an Associate Program Director and a member of the behavioral sciences will be chosen based on the disruptive behavior being addressed. The resident may ask for a peer to also be part of the committee.

The committee will meet to investigate the alleged disruptive behaviors including meeting with the resident to further assist the resident in identifying methods for structuring professional and working relationships and resolving problems without disruptive behavior. It is the intent of this policy to allow the committee latitude to develop any plan for resolution that is deemed appropriate with the goal of rehabilitating the resident.

The A&P Committee will make recommendations to the Program Director who makes final determination of next steps.

4. **Probation: GME level of concern** that will be reported to licensing/credentialing agencies

   Advisors: Program Director (oversight)
              Associate Program Director(s)

The reasons for the probation must be fully discussed between the Program Director, APDs, and the resident. Appropriate documentation will be provided to the resident that includes,

- the term of the probationary status
- explicitly stated reason for the probationary status
- resources to be provided by the program
- clearly identified expectations for performance for the probationary status to be lifted
- clearly identified consequences of noncompliance and/or not fulfilling the required expectations

A record of the probation will be submitted to the Graduate Medical Education (GME) office and placed in the resident’s training file. Probation is reported to licensing and credentialing agencies.

Noncompliance with any portion of the probation will be cause for dismissal or nonrenewal of the resident’s contract.
5. Termination/Dismissal: *GME level of concern* that will be reported to licensing/credentialing agencies

Indications for dismissal are the same as for probation, except that the Program Director and Chairman deem the offense to be sufficiently egregious to warrant immediate dismissal from the program.

Academic Dismissal: Residents may be dismissed from the program in situations where the resident has been unable to meet the performance standard established by the program, and documented feedback and remediation efforts have been unsuccessful.

Non-Academic Dismissal: Residents may be dismissed by the Program Director, with approval of the Chair for gross breaches of professionalism, dishonesty, behavior that jeopardized patient safety, or other egregious behaviors.

*Adopted by Pediatric Residency Committee July 2010; Amended May 2014, Reapproved July 2016, Amended July 2017*

**Professionalism Call**

**Clinical Professionalism Call**

This call will be assigned when a resident is noncompliant with a clinical expectation. Examples include but are not limited to: reporting for call, answering calls when on home call, failing to follow protocol for sick days and arriving late for continuity clinic, urgent care or any assigned clinical responsibility.

This call will consist of either an in-house or home call depending on the circumstances. The reason for the extra call is to “pay back” the program for covering the resident clinically.

Clinical Professionalism call will be assigned by the Chief with the approval of the Program Director. Repeated clinical professionalism calls fall under the Resident with Disruptive Behavior Policy.

**Administrative and Educational Professionalism Call**

This call will be assigned when a resident is noncompliant with an administrative or educational task. Examples include but are not limited to: Clinical Experience and Educational Time entry, PREP questions, and Core attendance expectations.

This call will be served in the PMEC typically from 7:00am-8:00am or 5:00pm-6:00pm with one of the Program Directors. The reason for the extended work day is to provide supervised time for the resident to complete required administrative or educational tasks.

Administrative and Educational Professionalism Call will be assigned by the Program Director after consultation with Program Coordinator, Associate Program Director (s) or Chief. Repeated administrative and educational professionalism calls fall under the Resident with Disruptive Behavior and will be handled as per that policy.

*Adopted by Pediatric Residency Committee May 2012; Reapproved May 2014, Reapproved July 2016*
Other Resident Well-Being Policies
Resident Assistance & Access to Counseling, Residents with Disabilities, and Lactation Support Guidelines

An online screening for eating disorders, alcohol disorders, anxiety disorders and depression is available to all KU residents. This is a free screening and taken anonymously. The screening is provided so that you may find out in just a few minutes whether or not professional consultation would be helpful to you.
http://www.mentalhealthscreening.org/screening/KUMC

Additional information for Resident Well-Being Policies including those for Resident Assistance and Access to Counseling, Residents with Disabilities and Lactation Support Guidelines can be found in the University of Kansas Graduate Medical Education Policy and Procedure Manual.
http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html

Disaster Policy

The Department of Pediatrics and the Pediatric Residency Program follows the Disaster Policy as set forth by the institution.

A “disaster” is an event or set of events causing significant alteration to the residency experience at one or more residency programs. These are generally considered to impact an entire community or region of an extended period of time. A local extreme emergent situation differs from a disaster in that these situations are localized to the sponsoring institution, a participating institution or other clinical setting. Either situation may cause disruption to resident assignments, educational infrastructure and/or clinical operations with may affect the Institution’s or Program’s ability to conduct resident education in substantial compliance with ACGME standards.

Additional information for the Disaster Policy can be found in the University of Kansas Graduate Medical Education Policy and Procedure Manual.
http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html

Equal Opportunity and Harassment Policy

The Department of Pediatrics and the Pediatric Residency Program follows the Equal Opportunity and Harassment Policy as set forth by the institution.

Additional information for Equal Opportunity and Harassment Policy can be found in the University of Kansas Graduate Medical Education Policy and Procedure Manual.
http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html

Risk Management Policy

The Department of Pediatrics and the Pediatric Residency Program follow the Institutional policies regarding Risk Management.

When an Attorney calls for Faculty or Resident (usually MD or DO or PhD), the protocol is to contact:
Amy Sokol, Risk Manager, Legal Counsel at 8-7283 or email amysokol@ku.edu. Ms. Sokol will get in touch with KU Hospital risk management as needed.

Additional information for Risk Management can be found in the Pediatrics Residency Handbook and University of Kansas Graduate Medical Education Policy and Procedure Manual.
http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html
Impaired Physician and Substance Abuse Policy

The Department of Pediatrics and the Pediatric Residency Program follows the Institutional policies regarding impaired residents and residents with substance abuse.

Additional information specifically related to the Prevention of Illegal Drug and Alcohol Use, Impaired Physician and Substance Abuse Policy and Alcohol, Drugs and Tobacco under Resident Code of Professional and Personal Conduct, can be found in the University of Kansas Graduate Medical Education Policy and Procedure Manual. http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html

Resident, Faculty and Program Evaluations

The Department of Pediatrics and the Pediatric Residency Program procedures regarding the specification of satisfactory performance including expectations and responsibilities and duties are outlined in the Pediatric Residency Handbook. Examples of evaluations including Resident Evaluations, Faculty Evaluations, Program Evaluations and other 360 evaluation examples are provided in the Pediatric Forms on Blackboard.

Additional information regarding Evaluation can be found in the University of Kansas Graduate Medical Education Policy and Procedure Manual. http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html

Breakfast and Lunch Policy

Light breakfast is provided for Morning Teaching Conference. The Residency Coordinator will prepare the cart for MTC with food and coffee by 7:15am. The residents scheduled to present MTC is responsible for picking up the cart in the PMEC and taking to MTC. They are then responsible for bringing the cart back to the PMEC after MTC is over.

At noon conferences when lunch is provided by the department or program, food is provided for all attendees, not exclusively residents, so early arrival is encouraged to guarantee a meal. When food is not provided by the department for noon conferences, residents are expected to pick up lunch prior to arriving at conference from either the main cafeteria or other resident and fellow meal locations.

In alignment with the University’s Vendor Policy, pharmaceutical representatives are not permitted to provide meals.

It is the responsibility of ALL residents to clean up after themselves. An assigned cleaning schedule will be posted if meal clean up becomes a problem. If rooms are not cleaned after conferences food will not be allowed at any conference.

Cleaning includes ALL of the following:

- All remaining food is disposed of properly.
  - Trash it, bring it to the floor for the on-call team or bring it to the clinic conference rooms
- Utensils are washed
- Dirty plates, empty soda cans and dirty napkins are thrown away
- All chairs are straightened and paper trash is picked up
- Computer and projector are turned off
Conference Attendance Policy

All residents are responsible for ensuring they sign-in for each conference.

Core Conference at KU: Residents are required to attend 75% of the Core Conferences per block rotation with the following exceptions: Night Service and CMH rotations as well as rotations outside of Kansas City. Residents should review recorded conferences for educational purposes but make up attendance will not be tracked.

For all other rotations, because conferences are recorded and available on Blackboard, the 75% attendance is not adjusted for missed conferences due to valuable clinical experiences (such as opportunities for procedural experience, rare clinical experiences, community assignments), vacation, post call, CME or other time away from KU. If you have rotational conflicts such as patient care issues or administrative barriers that routinely result in missing more than 25% of required conferences, those absences should be discussed with the Chief or a Program Director so as to mitigate non-educational clinical distractions from Core.

PGY Level Didactic Conference at CMH: Residents are expected to attend 100% of PGY Level Didactic Conferences at CMH (1 Friday afternoon per month.) unless doing so would violate duty hour restrictions. Clinical schedules at KU will be made to allow residents to attend this conference on all rotations. Residents will not be scheduled for days off on these Fridays. In the case of excused absences such as vacation or sick leave, the resident is expected to review recorded conferences that were missed.

Morning Teaching Conference: All inpatient and SDS residents are expected to attend MTC at 7:30am (Mon, Tues, Wed, and Fri) with the following exceptions: NICU. All other residents on the KU campus are strongly encouraged to attend. Attendance will be reviewed and residents found absent from MTC will be expected to report their whereabouts at the time of the missed MTC.

All Other KU Conferences: Attendance at all other teaching conferences is strongly encouraged and each resident is expected to attend at least 50% of other conferences including Professor’s Rounds, Grand Rounds, and Wednesday Noon Conferences quarterly.

Attendance will be monitored by sign in sheet or QR reader as well as by random attendance audits during conferences. Conferences viewed from satellite locations should be reported to the Residency Coordinator for inclusion in attended conferences. It is the responsibility of the resident to inform the Residency Coordinator of missed conferences for reasons beyond what has been described above. Resident attendance will be reviewed by the Clinical Competency Committees.

Residents are expected to promptly return to scheduled rotations after all didactic sessions.

_Adopted by Pediatric Residency Committee July 2010; Amended May 2013; Amended May 2014, Amended June 2015; Amended July 2016, Amended July 2017_
CLINICAL

Supervision of Residents

In accordance with the GME Handbook, the Faculty of the Department of Pediatrics will “provide an organized educational program with guidance and supervision of the resident that facilitates professional and personal growth while ensuring safe and appropriate patient care. A resident will be expected to assume progressively greater responsibility through the course of a residency, consistent with individual growth in clinical experience, knowledge and skill. The University of Kansas School of Medicine gives residents significant but appropriately, well-supervised latitude in the management of all patients and provides a comprehensive experience in their specialty area in order for them to become independent and knowledgeable clinicians with a commitment to the life-long learning process that is critical for maintaining professional growth and competency.”

Schedules listing the attending physician for Inpatient Pediatrics, Full Term Nursery and outpatient acute care clinics are prepared monthly by the Chief and distributed to the appropriate residents. Schedules for the NICU and PICU attending physicians are posted on those units and distributed by their respective administrative offices. If there are any concerns regarding faculty supervisory coverage, residents can also contact the page operator who has a daily schedule of all faculty assignments as well.

Additional information on the Supervision Policy can be found in the Pediatric Residency Handbook and University of Kansas Graduate Medical Education Policy and Procedure Manual.
http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html

The Pediatric Residency’s Supervision of Resident Policy is in line with the Institutional policy regarding supervision of residents. Every patient seen by a resident is seen under the supervision of a staff physician who assumes complete responsibility for those patients for whom they are the attending physician. The staff physician is also responsible for education of the residents. Attending supervision may be direct or indirect. Indirect supervision occurs when the responsible staff is aware of the patient and is available to assist or provide direct supervision if needed but is not physically present. In these situations, a senior resident may provide direct supervision of a more junior resident. Supervision is always available from more senior residents and attending physicians. Residents should always obtain help in any clinical situation in which they are inexperienced or uncomfortable. In all instances, the level of resident supervision must ensure the highest quality, safety and effectiveness of patient care. The level of supervision must be appropriate for individual resident’s progressive responsibility as determined by the residents’ level of education, competence and experience.

Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care of the individual patient; assuring the development of the skills, knowledge and attitudes in the resident to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth. For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty who give value, context and meaning to those interactions. As residents gain experience and demonstrate growth in their ability to care for patients they assume roles that permit them to exercise those skills with greater independence including graded and progressive responsibility.

Residents in the Pediatrics Residency Program practice only under the supervision of attending physicians who are licensed and credentialed by our participating institutions including the KU Children’s Center and affiliate clinics, University of Kansas Hospital, and Children’s Mercy Hospital in Kansas City, Missouri. All patients cared for by resident physicians will have an identifiable supervising faculty member or other approved licensed independent practitioner who assumes ultimate responsibility for the actions of the resident to whom portions of care will be delegated based on the needs of the patient and the skills of the residents. A patient’s responsible supervising attending physician or licensed practitioner should be identified to residents, faculty members and patients. Residents and faculty should inform patients of their respective roles in each patient’s care.
Program Director and Attending Physicians

While the Program Director and faculty assign to each resident the privilege to assign progressive responsibility, authority, conditional independence and supervisory roles in patient care based on specific criteria, the attending physician has the ultimate responsibility for all medical decisions regarding his/her patients including those made by senior residents, junior residents and medical students under their supervision. The attending physician may determine additional service specific levels of supervision and teaching required for each trainee based on the resident’s level of training, experience and competence. Faculty members are expected to devote sufficient time to fulfill their supervisory and teaching responsibilities. This includes supervision assignments of sufficient duration, both block and longitudinal assignments, to assess the knowledge and skills of each resident in order to delegate to him/her to appropriate level of patient care authority and responsibility.

The Role of the Attending:
- To have ultimate responsibility for all medical decisions regarding his/her patients
- To be responsible for providing supervision of all care provided by residents including the handoff process between resident care teams
- To develop a plan for the medical management of each patient in conjunction with the residents and consulting services
- To be responsible for the implementation of diagnostic and therapeutic plans as well as their documentation in the medical record.
  - Inpatient: The attending will document their involvement and agreement with the resident’s plan with a note written within 24 hours of admission that demonstrates that the attending took a history and performed an exam needed for care and decision making in the case.
  - Outpatient: The attending will document their involvement and agreement with the resident’s plan with a note at the time the patient is seen. The note should be in line with the Medicare Primary Care Clinic Exemption rules.
- To respond promptly and professionally to any question or concern from residents no matter what time of day or day of the week
- To encourage residents to seek guidance at any time the resident needs help in the care of patients
- To be readily available to provide supervision and consultation at all times, or to have a clearly designated covering physician at any time for the level of supervision required by each resident at each training level on each clinical service
  - For all inpatient services: During daytime hours, supervising attendings are expected to be able to be physically present with residents and patients (Direct Supervision) as well as physically within the confines of the site of patient care and immediately available to provide direct supervision. (Indirect Supervision with direct supervision immediately available) After hours and on weekends, supervising attendings must be available for a telephone/pager consult at any time and able to come promptly to the hospital or clinic to provide on-site supervision and consultation to the resident. (Indirect Supervision with direct supervision available)
  - For all outpatient services: Supervising attending are expected to be readily available including physical presence at the site of patient care with either immediate availability to provide direct supervision (continuity clinics, same day sick/acute care clinic, specialty clinics) or immediately available via phone and available to provide direct supervision (specialty consults.)

Contacting Supervising Faculty
- Faculty will communicate with the resident expectations for when to be contacted in the care of the patient. While communication with the attending should be frequent and ongoing, the timeliness of communication will vary with the severity and urgency of the patient. At minimum, significant changes, events or circumstances in the patient’s condition must be communicated to the supervising attending.
Supervisory Senior Residents

Supervisory residents will provide care as part of a team led by an attending physician. Given that independent development of progressive treatment and management plans is important for senior residents, the attending accepts responsibility for all decisions made by the senior. Senior residents will also serve in the supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the resident.

The Role of the Supervisory Resident:

- To supervise the juniors, subI’s and medical student in the care all patients
- To make the patient’s parent or legal guardian aware of the name of the attending and his/her role as the responsible caregiver for the child as well as their role as resident in the patient’s care
- To document in the medical record the accepting attending for each patient
- To develop a diagnostic and therapeutic plan for each patient under the supervision of the attending physician and to ensure that the plan is carried out
- To write a note at the time of each admission or when a patient’s condition changes that demonstrates the senior’s involvement in the plan for the patient and that includes a history and exam findings that are needed for care and decision making in the case
- To manage the team as a whole and facilitate the interactions between the attending, team, consultants, nurses, and other members of the health care team
- To communicate clearly, effectively and promptly with the attending from admission through discharge
- To be available for any urgent or emergent situations that arise in the care of patients
- To be immediately available to actively participate in the treatment and management of the juniors’ patients
- To know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence for each individual clinical assignment

Junior Residents

The junior and the supervising resident will provide care as a team. Given that independent development of treatment and management plans is important for juniors, the supervising resident accepts responsibility for all decisions made by the junior.

The Role of the Junior Resident:

- The junior shall not accept responsibility for care of any patient until their supervising resident and attending have been notified and accept responsibility for the patient
- To keep the supervising resident immediately informed and in agreement with all management plans
- To know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence for each individual clinical assignment
- If a junior resident is not comfortable with the decisions of the supervising resident, the senior resident is not immediately available because of another patient care responsibility or if the junior has further questions, the junior will call the attending physician

Classification of Supervision

- Direct Supervision: the supervising physician is physically present with the resident and patient
- Indirect Supervision with Direct Supervision Immediately Available: the supervising physician is physically within the hospital or other site of patient care and is immediate available to provide Direct Supervision
- Indirect Supervision with Direct Supervision Available: the supervising physician is not physically present within the hospital or other site of patient care but is immediately available my 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
Examples of significant changes requiring faculty involvement: admission, transfer to and from ICU, need for intubation or other ventilator support, DNR or other end of life decision, cardiac arrest, changes in hemodynamic status requiring intervention fluid or inotropic support, neurological changes, medication errors requiring clinical intervention, clinical problem requiring an invasive procedure, care of medically complex patient, or any incident that compromises patient safety.

General Pediatrics Inpatient Admission Communication: It is expected that the call team call the attending at minimum between 9pm-10pm nightly to follow up any admissions previously discussed and to review the overnight care plans. The Night Service Senior or Post-Call Senior is expected to call the attending between 6am-6:30am to discuss any admissions not previously discussed and other overnight care questions so as to facilitate ongoing patient care between morning check out at 6:30am and rounds at 9:00am. (Oversight Supervision) In addition, all admissions should also be discussed with the general pediatrics attending in as reasonable a time from the admission as patient care necessitates.

Hematology-Oncology, PICU and NICU Admission Communication: All admissions are to be discussed with the attending at the time of admission. (Indirect Supervision with direct supervision available)

*Adopted by Pediatric Residency Committee, July 2008; Reapproved July 2010, July 2011; Reapproved May 2014, Reapproved July 2016*

**Role of the Caregiver**

It is important that patients know who is taking care of them. This includes introducing yourself to the patient and patient’s family and explaining your role on the team.

On the inpatient pediatric units (Pediatric Floor, PICU and Full Term Nursery), a member of the team will provide a Caregiver Sheet for the patients and their families listing the attending and residents on each team including pictures.

Additional information on the Role of the Caregiver can be found in the *Pediatric Residency Handbook* and the *University of Kansas Graduate Medical Education Policy and Procedure Manual.*


**Optimal Clinical Workload**

The Program Director must make an assessment of the clinical learning environment with input from the faculty and residents to determine optimal clinical workloads.

Minimum patient loads should usually be five on the general inpatient unit, and four in PICU and NICU. However, there may be situations in which lower patient loads may be acceptable. The Programs will justify lower patient loads with evidence such as severity of illness indicators or other factors.

Maximum patient loads should be determined based on the patient, resident and attending factors of capacity, expertise and availability of supervision.
2017 ACGME Requirements-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 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 ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision established by the ACGME.

**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.
RRC APPROVED LICENSED INDEPENDENT PRACTITIONER SUPERVISOR 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)

Physician assistants, nurse practitioners, psychologists, physical and occupational therapists, speech and language pathologists, dieticians/nutritionists, counselors, and audiologists are just some of the providers who see their own patients and may serve as teachers and/or supervisors for residents as appropriate in ambulatory (i.e. school-based health centers, child development clinics) and inpatient (i.e. NICU) settings. Some states may have regulatory rules that won’t allow LIPs to supervise residents. (Pediatric FAQ 8/2015)

PR VI.A.2.a).(1).(b) Inform each patient of their respective roles in patient care, when providing direct patient care.

Residents and faculty members must inform each patient of their respective roles in that patient’s care when providing direct patient care.

See Role of the Caregiver in the Pediatric Residency Policies Manual.

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)

PGY-I residents must always be supervised either directly or indirectly with direct supervision immediately available.

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. The program director must evaluate each resident’s abilities based on specific criteria. PR VI.A,2.d).(1,2,3)

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 should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each.

RARE CIRCUMSTANANCES WHEN RESIDENTS may elect to stay or return to the clinical site PR VI.F.4.a)

The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.

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.

Residents should not have more than six consecutive nights of night shifts. (Pediatric FAQ 8/2015)

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- timing of admission communication is dependent of acuity of patient
2. Transfer of patient to a higher level of care such as floor to PICU or nursery to NICU
3. Clinical deterioration, especially if unexpected including Rapid Response or Code Blue
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

See PGY level charts and Resident Supervision Policy in the Pediatric Residency Policies Manual.
<table>
<thead>
<tr>
<th>LEVEL of SUPERVISION</th>
<th>PGY 1 ACTIVITIES/PROCEDURES (as defined by RRC* &amp; Program)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DIRECT</td>
<td>Procedures: All procedures until signed off as competent to perform Independently. Procedures residents must be able to perform: bag-mask ventilation, neonatal endotracheal intubation, peripheral IV placement, venipuncture, umbilical catheter placement, lumbar puncture, bladder catheterization, GYN exam, wound care and simple laceration repair, incision and drainage of abscess, giving immunizations, developmental screening, procedural sedation, pain management, temporary splinting of simple injuries, simple removal of foreign body Procedures residents must understand and may perform: circumcision, arterial line placement, arterial puncture, chest tube placement, endotracheal intubation of a non-neonate, thoracentesis Rotations: PGY-1 residents must be supervised either directly or indirectly with direct supervision immediately available on every clinical rotation or service. Supervision can be by a more senior resident.</td>
</tr>
<tr>
<td>INDIRECT A (with direct supervision immediately available)</td>
<td>Procedures: Once signed off as competent, any of the above listed procedures. Rotations: PGY-1 residents must always be supervised either directly or indirectly with direct supervision immediately available. Supervision can be by a more senior resident. Common Circumstances: admissions, care of complex patient, ICU/higher level of care transfer, rapid responses, code blues or other pediatric emergency activations, DNR or other end of life decision</td>
</tr>
<tr>
<td>INDIRECT B (with direct supervision available-as determined by program specific RRC guidelines PR V1.D.5.a),(1))</td>
<td>PGY-1 residents must always be supervised either directly or indirectly with direct supervision immediately available.</td>
</tr>
<tr>
<td>LEVEL of SUPERVISION</td>
<td>INTERMEDIATE LEVEL RESIDENTS ACTIVITIES/PROCEDURES (as defined by RRC* &amp; Program)</td>
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<tr>
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</tr>
<tr>
<td>DIRECT</td>
<td>Procedures: Any procedure not previously signed off as competent at the end of the PGY 1 year.</td>
</tr>
</tbody>
</table>
| INDIRECT A (with direct supervision immediately available) | Procedures: Umbilical catheterizations, neonatal intubations, conscious sedation  
Rotations: NICU, CMH –ED, CMH- PICU |
| INDIRECT B (with direct supervision available) | Rotations: Continuity Clinic, Outpatient Subspecialty Clinics, PICU-KU, Term Nursery, Inpatient Pediatrics, Call  
Common Circumstances: admissions, care of complex patient, ICU/higher level of care transfer, rapid responses, code blues or other pediatric emergency activations, DNR or other end of life decision |
| OVERSIGHT (with direct supervision available) | Rotations: Community Medicine- community sites (observational only, no direct patient care,) Home Call (Mommy Call) |

<table>
<thead>
<tr>
<th>LEVEL of SUPERVISION</th>
<th>RESIDENTS IN FINAL YEARS OF TRAINING ACTIVITIES/PROCEDURES (as defined by RRC* &amp; Program)</th>
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Rotations: NICU, ED-CMH, PICU-CMH |
| INDIRECT B (with direct supervision available) | Rotations: Continuity Clinic, Outpatient Subspecialty Clinics, ED, PICU-KU, Term Nursery, Inpatient Pediatrics, Call,  
Common Circumstances: admissions, care of complex patient, ICU/higher level of care transfer, rapid responses, code blues or other pediatric emergency activations, DNR or other end of life decision |
| OVERSIGHT (with direct supervision available) | Rotations: Home Call (Mommy Call) |
ACGME Common Program Requirements Section VI in Effect 7/2017

Background and Intent: The revised requirements are intended to provide greater flexibility within an established framework, allowing programs and residents more discretion to structure clinical education in a way that best supports the above principles of professional development. With this increased flexibility comes the responsibility for programs and residents to adhere to the 80-hour maximum weekly limit (unless a rotation-specific exception is granted by a Review Committee), and to utilize flexibility in a manner that optimizes patient safety, resident education, and resident well-being. The requirements are intended to support the development of a sense of professionalism by encouraging residents to make decisions based on patient needs and their own well-being, without fear of jeopardizing their program’s accreditation status. In addition, the proposed requirements eliminate the burdensome documentation requirement for residents to justify clinical and educational work hour variations.

Patient Safety and Quality Improvement

All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Graduate medical education must prepare residents to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by residents who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.

Residents must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Residents will receive training on Patient Safety and Quality Improvement through completion of various training modules through the Institute for Healthcare Improvement Open School Online Courses. Graduating residents will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

It is necessary for residents and faculty members to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.

Well-Being

In the current health care environment, residents and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician. Self-care is an important component of professionalism; it is also a skill that must be learned and nurtured in the context of other aspects of residency training. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as they do to evaluate other aspects of resident competence.

Transitions of Care

Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. Programs must ensure that residents are competent in communicating with team members in the hand-over process. Programs and clinical sites must maintain and communicate schedules of attending physicians and residents currently responsible for care. Each program must ensure continuity of patient care, consistent with the program’s policies and procedures referenced in VLC.2, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency.

Additional information on these policies can be found in the University of Kansas Graduate Medical Education Policy and Procedure Manual as they become available.
http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html
Designation of Educational Unit Time

Residents should be scheduled for 32 half days of activity per educational unit and must be scheduled for 30 half days of activity per educational unit (15 work days). On specialty and outpatient rotations time will be designated to clinical, consult, and educational activities.

Clinical activities – any half day with scheduled clinical activities such as scheduled outpatient clinics, outreach clinics, and procedures

Consult activities – any half day with the potential for clinical activity
During this time, the resident is required to be on campus and available to the attending within 10 minutes of a page. If there are no consults, the resident may engage in other educational activities. The resident is expected to check-in with the attending at the beginning of each half day.

Educational activities- any half day with scheduled educational activities
These half days are provided to allow completion of required rotational educational activities such as structured reading, projects, pre and post-tests, case conference preparation and presentation, etc. Each of these activities is expected to have an assessment method, i.e. if the activity is to read an article, the assessment method can be a discussion of the article with the attending. If the required rotational educational activities are completed, this time should be used for required program educational activities such as board review.

The priority during this time is the education and as such, these activities may be performed at home, however, the potential for clinical activities is present. Therefore, during this time, the resident must be available to the attending within 1 hour of a page. The resident is required to check in with the attending at the beginning of each half day. Based on the attending’s judgment the resident may be asked to return to campus for clinical activities.

It is during this time that the resident may be scheduled for Jeopardy Call. If the resident is unavailable when paged for consult or jeopardy call a sick/vacation day will be charged.

Conferences- all conference that are required by the rotation (noon conference, MTC, etc.) should also appear on the residents’ schedule including days designated for educational or independent activities

Independent activities- half days with no scheduled clinical, consult or educational activities
This time is above the minimum 30 half day requirements of an educational unit. This time may or may not be available on various rotations. It is during this time that the resident may be allowed to do participate in additional continuity clinic experience (general or specialty) or research activities.

If the resident is using this time for one of these activities instead of educational activity, the attending and the chief must be notified. Continuity clinic is protected time. Research may be protected time however if a rotational clinical activity arises, the resident will be paged with the opportunity to participate. If they choose the clinical activity, the resident must be available to the attending within 1 hour of a page.

The resident is required to check in with the attending at the beginning of each half day. Based on the attending physician’s judgment the resident may be asked to return to campus for clinical activities. It is during this time that the resident may be scheduled for Jeopardy Call.

Effective July 1, 2014 all educational units must include a minimum of 30 half days of scheduled activity.

Rotations when the resident does not have vacation time
The resident is available for 40 ½ day weekday sessions
The resident may have four ½ days scheduled for educational activities
The resident may have four ½ days scheduled for independent activities
All other ½ days will be scheduled for clinical or consult activities
Any holiday time, post call days or other time off rotation will be subtracted from independent activity time first, then from educational activity time
Rotations when the resident has vacation time
   The resident is available for 30½ day weekday sessions
   The resident may have three ½ days scheduled for educational activities
   No independent activity time will be allowed
   Any additional holiday time, post call days or other time off rotation in the month will need to be made up with additional ½ day weekend consult or educational activities

Rotations when the faculty member has vacation time
   If a faculty member (of a single faculty member division) is out (vacation, sick, or CME) the program will be made aware at least 60 days prior (in the case of a planned absence.)
   For short absences, educational or independent activities may be scheduled to the maximum time outlined.
   Faculty absences up to 4 days may be handled this way unless the resident has any other time off rotation.
   Longer, week-long absences will be handled on a case-by-case basis

Rotations when the resident and the faculty member have vacation
   This vacation time should coincide if at all possible
   If the vacation times do not coincide, an alternate rotation may be assigned

Adopted by Pediatric Residency Committee, May 2013, amended May 2014, Reapproved July 2016

Completion of Rotation Requirements

Rotational requirements are educational and clinical activities that complement the clinical service component of each rotation. Rotational requirements assist the evaluating faculty in determining the level of competency in areas such as technical skills, compassion, use evidence-based medicine in clinical decision making, and level of medical knowledge. Rotational requirements are to be completed during the rotation. When rotational requirements are not done in a timely manner, evaluations of the resident’s performance are delayed.

Expectation for Rotation Requirement Completion: The expectation is that all rotation requirements will be due by 8am on the Monday following the final day of the rotation (senior switch day). The program coordinator will send an email notice to any resident with outstanding requirements allowing until 8am Wednesday morning for completion. The program coordinator will send the names of residents with outstanding requirements to the Chief by noon on Wednesday at which time the Chief will decide which of the following will occur.

Educational Professionalism Call for Outstanding Rotation Requirements: Residents will be paged to arrange an educational professionalism call with a Program Director or the chief to be carried out that week. Educational professionalism call will be served at 7am or 5pm in order to complete requirements. Multiple educational professionalism calls may be served if the time to complete the rotational requirements is greater than one hour.

If the resident’s current rotation prohibits serving the educational professionalism call as above, the resident will be pulled from their rotation to complete requirements. In these cases, the attending will be notified of the required professionalism call by the program. The attending will determine when during the week the resident will serve the professionalism call so as to be the least disruptive to the clinical service. The period away for the professionalism call will be for a maximum of 4 hours. In this circumstance, the need to serve the educational professionalism call causes a disruption in a clinical service resulting in the assignment of a clinical professionalism call as well.

Special Circumstance Extension of Rotation Requirement Completion: If after discussion with the resident the Chief determines that an extension for rotation requirement completion is appropriate, the agreed upon completion date will be sent to the Program Coordinator. Failure to complete requirements by the new deadline will result in a professionalism call as above.

The names of any resident who has not completed rotation requirements as outlined above will be forwarded to the Program Director. Failure to meet these expectations is considered disruptive behavior and the Resident with Disruptive Behavior Policy may be applied.
Excused Extensions for Rotation Requirement Completion: If unable to complete rotational requirements by the above deadlines, residents may email the Chief before 8am Monday morning requesting an extension. The email should include a reason for the request and a planned date for submission of the rotation requirements to be no later than noon on that Friday. Requests due to not managing time within the given rotation will rarely be excused. Extensions are typically until the next Monday following switch day.

In the circumstance when the resident is physically unable to complete requirements the week they are due such as rotating to an out of town rotation or being on vacation, the resident will be expected to complete the activities in the above manner the first Monday they are available.

Adopted by Pediatric Education Committee, May 2014; reapproved July 2016

Answering Service Guidelines- Nighttime and Daytime

Nighttime Page Operators’ Procedure for Contacting Those on First Call

1. Contact the resident on Home Call by pager unless requested to do otherwise. The parent will be instructed to expect a call back within 20 minutes and to call the answering service back if they have not heard back.
2. If the patient calls back after 20 minutes and has not been contacted by the resident, then page the resident again with notation in the text message that this is the second page and that they need to call the operator back. The resident will notify the answering service that the second page was received before calling the parent back.
3. If no response in 10 minutes after the second page then the Senior Resident On-Call for Pediatrics (917-3333 pager) will be paged. A notation that the resident should contact the page operator that they did receive the call will be included on the page.
4. If unable to contact the senior resident on call, the backup faculty member will be paged with the message.
5. If a patient requires a translator, this will be indicated in the text page from the operator. The resident will call the operator back in order for the operator to set up the three-way call. The operator should wait for the resident to call back before getting the translator on the line but sometimes the page will be that the translator is holding.

Residents’ procedure for Triaging Phone Calls

1. When a patient calls the answering service, they should be asked to identify their provider.
2. All patients should be triaged to the resident on back-up call who will take calls from 5:00 p.m. to 9:00 p.m. Monday through Friday and from 8:00 a.m. to 12:00 p.m. on Saturdays, Sundays and holidays. After that the calls will go to the senior resident on call for the floor, 9:00 p.m.-8:00 a.m. Monday through Friday and 12:00 p.m.-8:00 a.m. Saturdays, Sundays and holidays
3. General Pediatrics faculty members are back up for the resident calls for questions and help and should be called if the resident does not respond to a page. If for any reason the backup resident is called into the hospital to work, the page operator and the faculty member should be notified that the faculty member will be taking the phone calls.
4. After 9:00 p.m., the senior resident on call for the floor, beeper 917-3333, will take all the calls for all the patients until 8:00 a.m. when the clinic opens or the weekend/holiday call hours start. Faculty backup during this time period is the General Attending on the floor.
5. If a patient calls early in the morning for an appointment, please direct them to call their providers office at either the satellite location or the main location after 8:00am to obtain an appointment.
6. The page operators must be notified of any changes to the Home Call schedule made after the final monthly call schedule has been distributed. It is the residents’ responsibility to notify the page operator. The page operators’ number is 588-6368. You may be directed to call another number on your pager but this is the number to give parents to call.
7. All calls on KU MOB and KU PV patients will be documented in O2. If a faculty member is identified as the PCP, the telephone encounters should be routed to that provider for review. If a resident is identified at the PCP or KU Pediatrics is identified as the PCP, those telephone encounters should be routed to the Chief for review. Cards should be submitted to the Chief within 24 hours of the call.

**IF THE OPERATORS OR RESIDENTS EXPERIENCE ANY DIFFICULTIES WITH THE RESIDENTS OR STAFF PLEASE CONTACT PROGRAM DIRECTOR.**

**Daytime Call Answering Guidelines**

All daytime phone calls will be routed through the main clinic scheduling number. The nature of the call will be ascertained and one of the following will occur:

- If the phone call is regarding a prescription refill, the patient will be instructed to contact their pharmacy for a refill fax request to be sent to 913-588-6338 (General Pediatrics Office)
- If the phone call is to schedule an appointment, a scheduler will schedule the appointment
- If the phone call is for general advice, the call will be transferred to the triage nurse
- If the patient wishes to speak directly with the resident, a telephone encounter will be sent to the resident in O2 that includes the patient’s name, the care giver’s name, a brief description of the nature of the call, and a contact phone number. Residents are expected to respond to telephone messages in their In-Box within 24 hours Monday-Friday and within 48 hours Saturday-Sunday.
- If the caller chooses to wait to receive a return call from the resident, the family will be told the following: “Due to the nature of the resident’s schedules, it may be up to 24 hours before you receive a return call. If you do not receive a return phone call within 24 hours, please call 913-588-6917.”

With this protocol for daytime phone calls, it is imperative that residents check their O2 Inbox daily.

**Changes to schedule:** Residents are responsible for notifying the Chief of any changes so that those can be noted in the On-Call system. If changes are last minute, call the page operator that night to make the changes AND notify the Chief of the change.

**Failure to answer pages:** Failure to answer pages from the operator for home calls for any reason (pager not working, did not check most recent schedule, etc.) are subject to Professionalism Call and possibly the Resident with Disruptive Behavior Policy.
Dress Code

The University of Kansas Hospital projects an image of professionalism in our community. The grooming and
dress of our employees conveys a message of respect, credibility, and quality of service. In a Hospital setting,
appearance and cleanliness are extremely important in meeting the standards for infection control and safety.
Employees have the opportunity to create a positive impression by consistently presenting themselves as models
of cleanliness, modesty and conservative good taste.

The following standards should be practiced consistently:

Grooming Standards

- Practice daily oral hygiene
- Bathe daily and use effective deodorant
- Heavily scented toiletries should be avoided
- Make-up should be conservative and in good taste
- Hair styles as well as mustaches and beards should be clean, neatly groomed, and moderate
- Use of jewelry should be minimal and conservative
- Fingernails should be clean, well-groomed and of a reasonable length. Due to infection control issues,
  employees who are providing direct patient care may not wear artificial fingernails or extenders and must
  keep fingernails trimmed to ¼ inch above each finger in keeping with APIC standards. **This policy may
  apply to other positions in the Hospital as determined by the Vice President of the department.

** According to the Association for Professionals in Infection Control (APIC) artificial nails or extenders have
been found to harbor pathogenic organisms and have been implicated in the transmission of organisms to patients.

Clothing Standards

- All garments must be fresh and clean
- Uniforms: as designated by respective department or specialty units
- Shoe soles should be non-marking and without metal caps
- Socks or hose must be worn
- Appropriate undergarments must be worn
- Unacceptable Clothing
  - Athletic shoes and t-shirts are generally not acceptable except as designated specifically by
    department uniform code
  - Tight fitting or revealing garments
  - Blue jeans, sweat clothing, shorts, halter-tops, leggings, mini-skirts
  - Items of clothing imprinted with advertising or objectionable language

Additional Infection Control Standards for Neonatal Intensive Care Unit

- Do not come into the unit if you have any signs or symptoms of illness.
- Remove all jewelry below the elbows.
- Remove all jackets prior to entering a patient room. (Hooks are provided outside of patient rooms).
- If you have long sleeves on, they must be rolled up above the elbows.
- Do a thorough wash up to the elbows upon entering the unit or patient room.
- Hand gel MUST be used each time you enter and leave a patient room and immediately prior to touching a
  patient.
- Exam gloves must be worn with all patient contact.

Additional information for Dress can be found under Resident Code of Professional and Personal Conduct in the
University of Kansas Graduate Medical Education Policy and Procedure Manual.
http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html

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ADMINISTRATIVE

Resident Eligibility, Selection and Appointment and Information for Applicants with Required Selected Applicant Questionnaire

The Department of Pediatrics and the Pediatric Residency Program’s criteria for resident eligibility, transfer, application, selection and appointment is in accordance with the policies for such set forth by the Institution.

The program only accepts applications through Electronic Residency Application Service (ERAS). The program also participated in the National Residency Matching Program (NRMP) and all positions will be submitted through NRMP. If quota is not matched, the program will participate in the Supplemental On-Line Application Process (SOAP.)

Application Process: The program’s application process is outlined on our website.

Selection Criteria: Invitations for interviews are extended to selected candidates by the program on the basis of residency program-related criteria. Candidates are chosen on the basis of their medical training, general achievements, and personal qualities such as their preparedness, ability, aptitude, academic credentials, communication skills and personal qualities such as motivation and integrity. The Program will not discriminate with regard to sex, race, age, religion, color, national origin, disability or any other applicable legally protected status. During the interview, you will generally meet the department Chairman, Program Director, members of the selection committee, other faculty, and residents in order to assess the personal qualities that are required of a successful resident. Residents will give you a tour of our facilities and offer you plenty of opportunities to have your questions answered.

Information for Applicants and Required for Selected Applicant Questionnaire: If matched to a position with the University of Kansas, you will be asked to answer the Applicant Questionnaire. The questions are also part of the Kansas license application.

Additional information on Eligibility, Transfer, Application, Selection and Appointment of Residents, Information for Applicants and Required for Selected Applicant Questionnaire, and Appointment Review can be found in the University of Kansas Graduate Medical Education Policy and Procedure Manual.
http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html

The Resident Agreement

The Department of Pediatrics and the Pediatric Residency Program follows all procedures related to Resident Agreements as outlined in The Resident Agreement and Severance of the Resident Agreement in the University of Kansas Graduate Medical Education Policy and Procedure Manual.
http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html
Resident Standing, Promotion, Program Completion and Credentials on Certificate

The Department of Pediatrics and the Pediatric Residency Program procedures outlining resident responsibilities and criteria for advancement are outlined in the *Pediatric Residency Handbook*.

Resident and fellow certificates may include the awardees’ previous degree earned with the name (John Doe, Ph.D.; Sally Jones, M.D.). The previous degree must match the official degree earned and shall not be converted to equivalent degrees. For foreign medical institutions, the official degree conferred is verified by searching the Foundation for Advancement of International Medical Education and Research database. This database is endorsed by the Educational Commission for Foreign Medical Graduates.

Additional information regarding *Resident Standing, Promotion and Program Completion* can be found in the *University of Kansas Graduate Medical Education Policy and Procedure Manual.*

http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html

Work Environment Statement

The Department of Pediatrics and the Pediatric Residency Program is committed to providing a work environment that promotes the safety, health, well-being and educational success of every resident and follows the policies the policies for such set forth by the Institution regarding the work environment.

*The Resident Agreement: Rights and Responsibilities* can be found in the *University of Kansas Graduate Medical Education Policy and Procedure Manual.*

http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html

Ombudsman Guidelines for Residents

The Ombudsman is an academic faculty member in good standing without alignment or administrative connection to either program leadership or School of Medicine/GME Leadership. The Ombudsman will serve as a sounding board/resource to residents with questions or concerns about their program, faculty, or school of medicine. Residents may access the Ombudsman by email ombudsmanabebe@kumc.edu or ombudsmanhoward@kumc.edu.

*Ombudsman Guidelines for Residents* can be found in the *University of Kansas Graduate Medical Education Policy and Procedure Manual.*


**Licensing and Step 3 Policy**

All residents are required to apply for a temporary license to practice medicine in Kansas prior to beginning practice at the University of Kansas Medical Center. In order to get licensed by July 1st, new residents will be expected to submit all necessary paperwork by the deadlines set by the PMEC. Failure to do so may result in your license not being issued by July 1st. If such a delay is the fault of the resident, the resident may be required to use vacation and sick time for the off work between July 1st and the day they become licensed. Residents upon receipt of license have full legal authority to authenticate death certificates. Your license, both temporary and permanent will be kept in your portfolio in the residency office.

**Licensure and Step 3:** The temporary license is not sufficient licensure to practice outside of residency sponsored rotations in Kansas and Missouri such as PGY 3 locum tenens and out-of-state rotations. Residents must have passed USMLE Step 3/COMLEX Step 3 in order to obtain a permanent license.

Reimbursement for timely completion of Step 3 is a residency benefit. The details for reimbursement are as follows:

1. **Goal:** All PGY 1 residents should sit for Step 3 by December 30th of the PGY 1 year. Residents must sit for Step 3 before June 30th.
2. Residents sitting for Step 3 between Match Day and starting residency on July 1st may submit their Step 3 registration for reimbursement.
3. Registration fees for Step 3 will be paid by the program if registration is completed before September 30th of the PGY 1 year.
4. Registration fees for Step 3 will not be paid by the program if registration is completed after October 1st of the PGY 1 year. In these situations, the Program Director may determine that reimbursement is appropriate for extenuating circumstances.

The Institution requires all residents to sit for Step 3 before promotion to the PGY3 year and to pass Step 3 before the certificate for residency completion be issued, however program requirements may be more stringent. Therefore the Pediatric Program requirements are the following:

1. Residents should sit for Step 3 prior to February 28th of the PGY1 year or promotion to the PGY 2 year may be at risk.
2. Residents must make every effort to pass Step 3 prior to promotion to the PGY2 level. If the resident has not passed Step 3 by the end of the PGY 1 year, a portion of the PGY 2 educational funds will be restricted for Step 3 purposes (board review course, study materials, etc.) The educational funds may NOT be used for re-registration fees.
   a. If Step 3 is not passed prior to June 30th of the PGY 1 year, half of the PGY 2 educational funds must be used for Step 3 purposes only.
   b. If Step 3 is not passed prior to December of the PGY 2 year, the remaining PGY 2 educational funds must be used for Step 3 purposes only and any remaining funds after Step 3 reimbursements will be forfeited.
   c. In the case of extenuating circumstances, the Program Director may determine that the educational funds not be subject to this policy.
3. For this policy, the date of passing will be the date the test was taken, not the date the score was received by the resident or the program. If the test was taken on June 30th of the PGY 1 year, the PGY 2 educational funds will be frozen until the score is reported however if the test was passed, the resident will still receive 100% of the educational funds.
4. Residents must have received a passing score on Step 3 by February 28th of the PGY 2 year or risk nonrenewal of contract or non-promotion to the PGY 3 year.

A permanent license is not required for residency training unless you wish to participate in locum tenens in your senior years. A permanent license is required before sitting for certification examination.

*Adopted by Pediatric Residency Committee July 2010, Reapproved June 2011, Amended May 2014, Reapproved July 2016*
Missouri Contiguous License

All residents are required to apply for a contiguous license to practice medicine in Missouri when doing required and elective rotations to Children’s Mercy Hospital. In order to get licensed by July 15th new residents will be expected to submit all necessary paperwork by the deadlines set by the PMEC. Failure to so may result in your license not being issued by July 15th. If such a delay is the fault of the resident, the resident may be required to use vacation and sick time for the days not worked between July 15th and the day they become licensed. Your license will be kept in your portfolio in the residency office. All fees are paid for by the program as well as your renewals each year.

BNDD

All residents are required to apply for a Missouri BNDD. Missouri states that any person who is responsible for prescribing, dispensing, or stocking controlled substances must have a registration. Residents must apply online; all fees are paid for by the program as well as renewals each year.

American Board of Pediatrics Certifying Examination

There are two ACGME requirements pertaining to certifying examinations.

V.C.2.c).(1)  At least 80% of those who completed the program in the preceding five years should have taken the certifying examination. (Outcome)

V.C.2.c).(2)  At least 70% of a program’s graduates from the preceding five years how are taking the certifying examination for the first time should have passed. (Outcome)

The goal of the program is to support board preparation over the 36 months of residency training through formal and informal didactics, clinical teaching, educational support, educational mentorship, and focused board review preparation at the program, class and individual levels.

Access to Resident Files Policy

A wide variety of information is stored in our Resident Portfolios. There are two sections of the Resident Portfolio: the public section with contracts, employment forms, certification cards, anything that is public in nature and a peer-review/confidential section with everything else including but not limited to evaluations, critical incidents, procedures, ERAS applications, etc.

Resident portfolios are kept in the Residency Offices so that they are easily accessible by the Program leadership which includes the residency coordinators, the Program Directors and department chair. More senior residents have a good deal of their portfolios in paper form stored in labeled notebooks. More recent evaluations are stored electronically. Junior residents will have most of their information stored electronically. Residents, like patients, have a right to confidential information.

Resident files are divided into two distinct sections, a public file and a peer-reviewed, confidential file. For internal use, the full file is accessible as described below. For external use, only the public file is available for review.

- **Public (Manila) File:** Certifications, Licensing, HR/GME Forms, Application / Diploma
- **Peer-Reviewed, Confidential (Red) File:** Evaluations, Presentations / Projects, Director Correspondence, Letters of Recommendation, Correspondence
Any viewing of portfolio information must be done in the Residency Office. Copying of portfolio information by anyone other than the resident will not be allowed without the permission of the Program Director.

Residents
- Residents may access their file in the presence of the coordinator or Program Director. Files are not to leave the residency office. Residents may receive a copy of materials in their resident file.

Resident Advisors
- Resident advisors will have access to their advisee’s quarterly reviews and monthly evaluations.
- At the Residency Coordinator’s discretion, advisors may view other material in their advisee’s portfolio.
- If the Residency Coordinator is not comfortable allowing the resident advisor access to the requested material, a written request should be made to the Program Directors by either the Resident Advisor or the Residency Coordinator. The request should explain what material is being requested and for what purpose. Granting of requests to view the additional portfolio information is at the discretion of the Program Director.

Clinical Competency Committee Members
- Residency committee members will have access to all assigned residents’ evaluations.
- At the discretion of the Residency Coordinators, members of the residency committee may view other material in the residents’ portfolios.
- If the Residency Coordinator is not comfortable allowing the residency committee member access to the requested material, a written request should be made to the Program Directors by either the Residency Committee Member or the Residency Coordinator. The request should explain what material is being requested and for what purpose. Granting of requests to view the additional portfolio information is at the discretion of the Program Directors.

Other Faculty
- At the discretion of the Residency Coordinators, other faculty members may have access to individual residents’ quarterly review summaries.
- If the Residency Coordinator is not comfortable allowing the faculty member access to the requested material, a written request should be made to the Program Directors by either the faculty member or the Residency Coordinator. The request should explain what material is being requested and for what purpose. Granting of requests to view the portfolio information is at the discretion of the Program Directors.

All requests for additional access to resident portfolios, both to the Residency Coordinator and to the Program Directors, will be tracked for each resident. Again, like patients, our residents deserve the courtesy of knowing when their personal information is being accessed and for what purposes.

*Adopted by Pediatric Residency Committee, July 2005; Revised September 2005; Reapproved July 2010; Reapproved May 2013; Reapproved May 2014, Reapproved July 2016*

Additional information on Resident and Fellow Files under Resident Code of Professional and Personal Conduct can be found in the University of Kansas Graduate Medical Education Policy and Procedure Manual.
Pediatric Clinical Competency Committee

Membership
- The CCC year of service will run July-June
- In order to develop broad expertise in competency-based milestone assessment, the CCC will be composed of the following:
  - Program Leadership faculty members will include the Program Director, Associate/Assistant Program Director, the Chief and the Chair of the Department (for PGY 3 CCC)
  - Level Specific faculty members are expected to participate in the CCC for at least 3 years. One faculty member per year will rotate off the CCC. For each resident level, this group will include a general pediatrician and a critical care physician or subspecialist.
  - Resident Class Specific faculty members are expected to participate in the CCC for 3 years or a time period following an assigned class of residents. For each resident class, this group will include a general pediatrician, a subspecialist and a non-physician.
- To start in 2013, Resident Level Specialists will have 1-3 year term lengths. Class Level Specialists will move from CCC to CCC with their class so will also have 1-3 year term lengths. Moving forward, new members of the CCC will all have 3 year term lengths. After 3 year term on CCC, faculty members will have at least one year off of the CCC. This structure mirrors the rotating nature of the KU SOM committees.
- Given the sensitive nature of the resident review process, all members of the CCC will be expected to maintain the highest standards of confidentiality as part of participation on the CCC

Semiannual Resident Evaluation Process
- The CCC will meet on a semi-annual basis in December and in June to review all aspects of resident performance including educational, clinical and professional development.
- The non-leadership members of the CCC will each review and prepare for presentation 1-2 residents for a total of 3 resident reviews per year.
  - Preparation for resident presentation will include review of all evaluations by all evaluators available for that resident including but not limited to: ITE Reports, Faculty Evaluation of the Resident, Peer Evaluations, Nursing/Allied Health Evaluations, Medical Student Evaluations, Patient Evaluations, Continuity Clinic Evaluations, Conference Evaluations, Self-Evaluations and any applicable Program Director correspondence.
  - A packet containing all evaluations will be prepared by the Residency Coordinator at least 72 hours before the CCC meeting. A form for a structured review of all evaluations will be created for use as a template for resident presentation. It is anticipated that a thorough review of all resident evaluations with preparation for presentation may take 2 hours of faculty time per resident.
- At the CCC meeting, each resident will be discussed. Based on the experiences of other programs with CCCs, it is anticipated that the CCC meetings for 2013-2014 may take up to 1 hour per resident, ~8 hours per class for our program. It is anticipated that this time will decrease significantly over time as the process is honed. Faculty members are expected to be available for the entire review session.
- Dates for the CCC meetings will be determined at least 4 months in advance as faculty attendance is mandatory for all assigned CCC meetings.

Milestone Evaluation Reporting to the ACGME
- The CCC will complete the ACGME required Milestone reporting during the resident evaluation review.
  - When there is clear agreement regarding milestone assignment, the milestones will be reported as recommended by the presenting faculty member.
  - When there is not clear agreement on milestone assignment, the CCC will come to a consensus on the milestone level to be reported.
- The final reporting of each milestone will be approved by the CCC prior to submission to the ACGME.
- The Program Director will complete the milestone reporting on WebADS.
Advising on Resident Progress: Promotion, Program Completion, Remediation and Dismissal

- The CCC is responsible for making recommendations to the program director for resident progress, including remediation, dismissal, promotion and graduation.

- If concerns arise regarding resident performance during the CCC meetings, the CCC will make recommendations regarding any form of remediation to the Program Director. The program leadership will be responsible for developing individual remediation plans based on these recommendations.

- The PGY 1 CCC will be responsible for determining what milestone level achievement will be required for residents in the KU Pediatrics Residency Program to be promoted to the supervisory level. These standards will be reviewed on a yearly basis or more often in light of recommendations from national organizations studying these standards.
  
  - Given that high stakes decisions such as promotion may not be possible after only 5 months of residency training, an additional meeting of the PGY 1 CCC will be held in mid-February in order to make determinations regarding promotion to the supervisory level prior to the March 1st deadline for all decisions regarding non-promotion. This meeting is expected to be significantly shorter, 1-2 hours, with the PD presenting all residents.

- The PGY 3 CCC will be responsible for determining what milestone level achievement will be required for residents in the KU Pediatrics Residency Program for successful completion of residency. These standards will be reviewed on a yearly basis or more often in light of recommendations from national organizations studying these standards.

Meetings and Time Commitment

- Each CCC will meet twice a year, in December and again in June. The PGY 1 CCC may also meet in mid-February. Ad hoc meetings of any of the CCC may be scheduled by the Program Director if needed.

- For each CCC meeting (December and June), faculty members will be allowed to close 1 faculty clinic that week as compensation for the time needed for CCC participation.

Pediatric Evaluation Committee

Membership

- The PEC year of service runs September to August.

- The full PEC will meet 6 times in the year. Faculty attendance at all full PEC meetings is strongly encouraged. Dates for all PEC activities will be scheduled by early June providing 3 months to be able to make clinic adjustments to allow attendance at the first full PEC meeting.

- The PEC will be composed of the faculty and resident representation from the following groups:
  
  - Program Leadership will include the Program Director, Associate/Assistant Program Director, Chief (current and rising), and Chair of the Department and Vice Chair for Education
  
  - Faculty membership will consist of all educational liaisons and residency directors
  
  - Resident membership will include three peer selected members from each class.

Oversight of All Significant Activities of the Residency Program Including Evaluation and Tracking Protocols

- The PEC’s primary goal is the administration and maintenance of an educational program that produces competent pediatricians capable of practicing independently without supervision at the end of training.

- The PEC will actively participate in the planning, developing, implementing, tracking and evaluating all significant activities of the residency program including but not limited to: Annual Program Evaluation (APE- see below,) Recruitment, ITE Performance/Specialized Intensive Pediatric Review (SIPR)/Core, Match Analysis, ACGME Faculty and Resident Survey Reporting, Faculty and Resident Scholarly Activity Oversight as well as Pediatric Residency Policies and Procedures.

- The PEC will oversee the development and execution of policies and procedures consistent with the institutional and ACGME requirements including those related to resident Clinical Experience and Education and working environment.
Development of Competency-Based Goals and Objectives and Resident Evaluations of Rotations/Assignments

- Individual members of the PEC (faculty and residents) will be invited to be active participants in specialty appropriate Curriculum Meetings throughout the year. All rotation/clinical experiences will be reviewed once a year. Part of the review includes development and revision of competency-based goals and objectives and milestone-based assessments based on resident evaluations of rotations and assignments as well as other supporting curriculum documents.
- Curriculum Meetings are open to all faculty members and residents.
- Brief updates of individual Curriculum Meetings will be presented to the full PEC.

Development of Written Annual Program Evaluation (APE) and Action Plans

- The APE is a University of Kansas GMEC process due annually in September. This is a comprehensive review of the program based on evaluations of the program by faculty, residents and others.
- As part of the APOA, the PEC will review the previous year’s goals in the areas of Program Quality, Resident Performance, Graduate Performance, and Faculty Development and set goals in these areas for the upcoming year.
  - Program Quality includes development of action plans to correct areas of non-compliance with ACGME standards or areas of concern from the Faculty and Resident Evaluations of the Program
  - Action plans, written by the Program Director, are reviewed by the PEC prior to GMEC submission.
  - Program leadership is responsible for tracking each action plan and informing the PEC of progress toward goals during regularly scheduled PEC meetings.

Meetings and Time Commitment

- Full PEC meetings
  - September: Review APE and Recruitment Planning
  - November: Review ITE and Board Prep
  - April: Match Results and Certifying Examination Results Review
  - May: Review of ACGME Resident and Faculty Surveys
  - June: Review of Annual Resident and Faculty Program Reviews
  - July: APE Review
- Curriculum Reviews: Educational Liaisons, rotational faculty and staff, Program Leadership and Residents)
  - February-May: Each curriculum review will focus on 2-4 rotations per session
  - Items to be reviewed at each meeting include: 12 months of Resident Evaluations of Rotations, Goals and Objectives, Rotational Expectations, ABP Content Specifications, Board Performance Data and other educational, clinical and scholarly resources as found on BlackBoard
Clinical Experience and Education (formerly Resident Duty Hours)

The policy was adopted from the following Common Program Requirement effective July 1, 2003, amended based on the Revised Common Program Requirements effective July 1, 2011 and amended based on the Revised Common Program Requirements effective July 1, 2017. The Pediatric RRC may impose stricter Clinical Experience and Education restrictions.

Additional information on Clinical Experience and Education (formerly Resident Duty Hours) and Call Schedules can be found in the Pediatric Residency Handbook and University of Kansas Graduate Medical Education Policy and Procedure Manual.

http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html

High Quality Education and Safe and Effective Patient Care

- Didactic and clinical education must have priority in the allotment of residents' time and energies.
- On-call schedules for teaching staff must be structured to provide resident supervision and faculty support/consultation is readily available to residents on duty.
- Duty hour assignments in teaching settings must recognize that faculty and residents collectively have responsibility for the safety and welfare of the patient.
- Faculty and residents must be educated to recognize the signs of fatigue and to apply preventive and operational countermeasures. The Program Director and faculty must monitor residents for the effects of sleep loss and fatigue, and to respond in instances when fatigue may be detrimental to resident performance and well-being.
- Programs must provide residents appropriate backup support when patient care responsibilities are especially difficult and prolonged, and if unexpected needs create resident fatigue sufficient to jeopardize patient care during or following on-call periods.
- Faculty and residents have a professional responsibility to appear for duty fit and ready to work

Resident Clinical Experience and Education

Clinical Experience and Education are defined as all clinical and academic activities related to the residency Program (patient care, administrative duties related to patient care, provision of transfer of care, time spent in-house on call, scheduled academic activities such as conferences, activities required by accreditation standards such as membership on hospital committee, as well as activities that are accepted practice in residency programs such as participation in interviewing residency candidates. Clinical Experience and Education does not include reading and academic preparation time such as time spent away from the patient care unit preparing for presentations.

The resident is expected to be rested and alert during Clinical Experience and Education time, and the resident and resident’s attending medical staff are collectively responsible for determining whether the resident is able to safely and effectively perform his/her duties.

Maximum Hours of Clinical and Educational Work per Week

- Residents must be limited to no more than 80 hours per week, averaged over four weeks.
- Hours are inclusive of all in house clinical and educational activities, works done from home and all moonlighting.
  - Types of work from home that must be counted include using an electronic health record and taking calls from home. Reading done in preparation for the following day’s cases, studying, and research done from home, do not count toward the 80 hours.
  - Resident’s decisions to leave the hospital before their clinical work had been completed and to finish that work later from home should be made in consultation with the resident’s supervisor.
  - In such circumstances, residents should be mindful of their professional responsibility to complete work in a timely manner and to maintain patient confidentiality.
Mandatory Time Free of Clinical Work and Education
- Residents must have at least one full (24 hour) day out of seven free of clinical work and required education, averaged over four weeks. Home call cannot be assigned on these free days.
- Residents should have 8 hours off between scheduled clinical work and education periods.
  - There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one day off in seven requirements.
- Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.

Maximum Clinical Work and Education Period Length
- Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.
- Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education.
  - Additional patient care responsibilities must not be assigned to a resident during this time.

Clinical and Educational Work Hour Exceptions
- 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,
  - Humanistic attention to the needs of a patient or family; or,
  - To attend unique educational events
- These additional hours of care or education will be counted toward the 80-hour weekly limit.
- Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.

In-House Night Float
- Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements.
- Residents must not be assigned in-house call more often than every third night, averaged over four weeks.
- Residents assigned to night service must not be scheduled for more than 6 consecutive nights.

Home Call
- Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit.
- Frequency of at-home call is not subject to the every third night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks.
- At-home call must not be so frequent or taxing as to preclude rest and reasonable personal time.
- Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be include in the 80-hour maximum weekly.

Averaging
- Averaging must occur by rotation. This avoids heavy and light assignments being combined to achieve compliance.

Approved by Pediatric Residency Committee November 2008; Reapproved July 2010; Amended July 2011; Reapproved May 2012; Reapproved May 2014, Reapproved July 2016, Amended July 2017
Clinical Experience and Education Time Entry: Reporting, Monitoring and Accountability Policy

Reporting of Clinical Experience and Education

Program Expectation: Residents are expected to enter all Clinical Experience and Education time worked by noon on Monday for the preceding week. A two-week cycle for reporting hours is not sufficient for rapid response to duty hour issues.

GME Expectations: Clinical Experience and Education time must be submitted by residents by the 10th of the following month, preferably weekly. The Program is notified of potential violations as Clinical Experience and Education are submitted in order to correct schedules as needed. Program Directors must review violations by the 15th of the following months.

Benefits
- Compliance with GME requirements for billing purposes
- Early identification of potential violations that CAN be fixed during a block rotation

Monitoring of Clinical Experience and Education

- Compliance will be checked Monday afternoon.
- Any resident who has not entered time will be emailed to complete their time entry.
- Time will again be checked first thing Tuesday morning.
- Failure to enter time at this point will result in a Violation.

Process for Program Notification of Clinical Experience and Education Violations
Notices these violations are automatically generated by the system and emailed to the Program Director and Program Coordinator. The email includes the resident provided explanation for the violation. If the violation is for hours > 24 hours but < 28 hours and the explanation was administrative duties related to patient care, education or provision of transfer of patient care, the violation is noted in the Clinical Experience and Education Violations Report.

Violations of > 24 hours for reasons other than the above, violations > 28 hours as well as hours per week and shift break violations are true violations and the Clinical Experience and Education violation policy is enacted.

Accountability of Accurate Reporting of Clinical Experience and Education Worked

Expectation: Residents are expected to follow all ACGME Duty Hour regulations. Residents are also expected to be honest in reporting hour violations so that personal and systematic changes can be made to assure Program wide compliance with Clinical Experience and Education requirements.

Benefits
- Compliance with ACGME Duty Hour regulations
- Programmatic culture change to view Clinical Experience and Education as a professionalism issue
Enforcement of Time Policies

1st Hours Violation (in a given academic year)
- Meeting with Chief
- Notice sent to Senior Resident, and Attending (if applicable)
- Discussion of how to fix system or personal barriers to compliance

2nd Hours Violation (in a given academic year)
- Meeting with Program Director
- Notice sent to Senior Resident, Attending and Advisor (if applicable)
- Notice of violation will be placed in Resident File- such behavior may be reported on future verifications and letters of recommendation
- Administrative Professionalism Call will be assigned to allow resident time to document work hours.

3rd Hours Violation (in a given academic year)
- Meeting with Academic and Professionalism Committee with possible Probationary Status for Unprofessionalism

Approved by Pediatric Residency Committee November 13, 2008; Reapproved July 2010; Reapproved May 2011; Reapproved May 2013; Reapproved May 2014, Reapproved July 2016, Amended July 2017

Clinical Experience and Education Violations Report and Exceptions Report Policies

Clinical Experience and Education Violations Report

Violations although not desired occur on occasion and may be permitted in special circumstances with appropriate documentation. Both Violation Reports and Exceptions Reports will be generated and maintained by the program.

Reports demonstrating compliance with and noting specific violations are required by the ACGME. To that end, the program will generate a monthly, no less than quarterly, Clinical Experience and Education Violation Report. This report will include:

- Resident, date of violation, rotation of violation
- Violation and explanation for violation as provided by the resident
- Signature of resident signature of residency coordinator
- Forward to Program Director

Program Administrator Responsibilities

- Run monthly, no less frequently than quarterly, Violation Reports
- Correct false positive violations
- Page residents with violations to complete their section of the Violation Report or to document “unusual circumstances”

Resident Responsibilities

- Understand all Clinical Experiences and Education expectations
- Respond to emails to correct false positive violations
- Respond to pages to complete Exceptions Report within 48 hours
- Provide explanations for violations and sign Exceptions Report
- Provide documentation for any unusual circumstances related, when on their own initiative, the resident remains beyond their scheduled period of duty to continue to provide care to a single patient
- Failure attend to hours violations within 48 hours will result in matter being forwarded to the Program Director
**Program Director Responsibilities**

- Document review of systemic causes of violations with residents and faculty as appropriate. Lead programmatic change to address any violations arising from system issues.
- Review each episode of unusual circumstance related additional duty resulting in duty periods beyond 28 hours.

**Clinical Experience and Education Exceptions Report**

**Exceptions Permitted by Pediatric Review Committee and the KU Pediatrics Residency Program**

- In unusual circumstances, PGY 2 and PGY 3 residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring or humanistic attention to the needs of a patient or family.
- Under those circumstances, the resident must:
  - Appropriately hand over the care of all other patients and document the reasons for remaining to care for the patient in question and submit that documentation to the Program Director.
  - Each submission for additional service will be reviewed by the Program Director and tracked both individually and program wide.

**Institutional Clinical Experience and Education Monitoring**

Clinical Experiences and Education is also monitored at an institutional level. Monthly duty hour reports for all residencies and fellowships are review by the GMEC-Executive Committee and then the GMEC. Programs with excessive duty hour violations are more carefully monitored with GMEC Duty Hour Action Plans. These intensive monitoring plans are reviewed by the GMEC.

*Approved by Pediatric Residency Committee June 9, 2011, Reapproved July 2016, Amended July 2017*

**Fatigue Guidelines: Transportation, Swing and Call Rooms, Fatigue Mitigation File**

Symptoms of fatigue and/or stress are normal and expected to occur periodically with the resident population, just as it would with other professional settings. Not unexpectedly, residents may on occasion, experience some effects of inadequate sleep and/or stress.

*Physicians are to appear for duty appropriately rested and fit to provide the services required by their patients.* If you are fatigued and unable to perform your patient care duties, please contact your supervisor (i.e., Chief, faculty supervisor, Program Director, Chair and/or GME Office/DIO). Please inform your supervisor of your situation so that they can arrange for alternate coverage to ensure continuity of patient care.

*Call Rooms:* Pediatric call rooms should be utilized for fatigued residents/fellows for rest and/or power napping. If a pediatric call room is not available, you may use the swing call room (HH Room 2901, code 2660*)

*Fatigue Transportation:* If adequate rest facilities are not available, then you may use the voucher fatigue transportation service. Vouchers for transportation will be available 24/7 in the PMEC for easy access afterhours. For each event, two vouchers will be needed (one for home and then one for back to work the following morning.)
Protocol for Voucher Use

- The Vouchers should be filled in by the resident/fellow and the transportation service driver (designated as KUMC Resident Program Transportation voucher). Please print your name, Department and home address on the voucher.
- When you are ready to leave, please call 10/10 Taxi Service (913-647-0010) and tell them you are using the KUMC Resident Program Transportation voucher and your destination. They will pick you up at the Main Entrance of the hospital. The transportation service is allowed only to pick you up from the KUH Hospital Main Entrance and drop you off at your home address, without any interval stops. This also applies for the return trip from your home to back to the hospital main entrance the next morning.
- The transportation service will collect each voucher white copy and submit to the GME Office. It is important that you return the YELLOW copy of the voucher to your Program Director.
- The resident is responsible for discussing the event and fatigue issue with their Program Leadership the following day. This must be documented by the program leadership in the “Fatigue Mitigation File”.

Fatigue Mitigation File: This file should contain documentation for discussions by the program leadership pertaining to reasons behind fatigue preventing ability to perform patient care duties or necessitating use of transportation service including the date of the incident, rotation, fatigue situation circumstances and actions to mitigate the fatigue. The purpose of this file is to track both individual and program-wide episodes of fatigue and additional duty in order to mitigate future recurrences.

Additional information on the Resident Fatigue and Stress, GMEC Fatigue (Transportation/Swing Room) Guidelines can be found in the University of Kansas Graduate Medical Education Policy and Procedure Manual.
http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html
Moonlighting and Locum Tenens Policy

Moonlighting

The Pediatrics Residency Program does not permit any moonlighting activities. Unapproved employment outside of the University of Kansas Medical Center may result in suspension from the training Program.

Locum Tenens

Residents must obtain prior written approval by the Program Director, Chairman of the Department, and the Executive Dean of the School of Medicine before engaging in any extra-Institutional locums. Once a resident has obtained a full, unrestricted permanent license, he/she may participate in locums opportunities depending on their academic status in the Program. Most locum tenens opportunities are sponsored through the institution’s Office of Rural Health.

As of July 1, 2012, the Kansas Locum Tenens program requires all residents and fellows to purchase their malpractice insurance for temporary coverage and provide a notice of basic coverage form. Rural Health will provide assistance with the process as needed. Residents and fellows will be given an additional $200 for each episode of locums coverage for the purpose of reimbursement for insurance. New forms are in the works and will be effective at this time as well.

Many of these opportunities involve weekend coverage and days away from rotations are minimal. However, if you will not be present for any part of your scheduled rotation including travel time to and from the locums, that time should be counted as locum time. Residents have 5 days of locum tenens time a year. As with educational days above, if locum time is used during a particular rotation, the resident may not be allowed to take other time off during the rotation. The 2011 Common Requirements require that moonlighting time be counted in the 80-hr week requirement. The Institution position is that locum tenens qualifies as external moonlighting and as such, locum tenens clinical activities, regardless of leave time taken, are subject to the 80-hr weekly maximum. Additional restrictions on locum tenens may also apply. Residents whose performance on the In-Training- Examination is indicative of successful passage of the pediatric board exam will be permitted to participate in locum tenens.

Additional information on the Moonlighting, Locum Tenens, and Extra-Institutional Practice can be found in the University of Kansas Graduate Medical Education Policy and Procedure Manual. http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html

Approved by Pediatric Residency Committee July 2010, Reapproved June 2011, Reapproved July 2016
Vendor Relations Policy

The Department of Pediatrics and the Pediatric Residency Program follow the Institutional policy that went into effect May 2008. Highlights of the policy that affect residents are as follows:

I. Gifts and Meals
   A. Personal gifts, regardless of value, from vendor representatives to all KUMC Personnel are prohibited, including, but not limited to loans, economic opportunities, meals, tickets or vouchers for entertainment events, pens, notepads or cash. It is strongly advised that no form of personal gift from a vendor be accepted under any circumstances.
   B. KUMC personnel must consciously and actively divorce clinical care decisions and research activities from any perceived or actual benefits expected from any company. The overriding principle at KUMC is that healthcare providers represent their patients’ best interests and not those of vendors. It is not acceptable for patient care decisions to be influenced by the possibility of personal financial gain.
   C. KUMC personnel cannot accept gifts or compensation for prescribing or changing a patient's prescription. KUMC personnel cannot accept gifts or compensation for listening to a presentation by a representative.
   D. KUMC personnel cannot accept compensation, including the defraying of costs, for attending a CME event or other activity or conference (that is, if the individual is not speaking or otherwise actively participating or presenting at the event).
   E. Representatives cannot use KUMC personnel or resources to distribute information about vendor-sponsored events. This includes KUMC e-mail, mailings, e-page or other mass notification methods. Departmental and division offices, including residency and fellowship Programs, will not circulate announcements of vendor-sponsored events or provide e-mail lists or address lists of KUMC personnel, physicians or house staff.

II. Promotional Items and Drug Samples
   A. KUMC personnel will not accept or distribute items (e.g. pens, note pads, and similar "reminder" items). Promotion of drug or medical device products may not be for uses not reflected in United States Food and Drug Administration (FDA) approved product labeling. Under no circumstances can promotional items be used in patient care areas.
   B. Proper discretion will be utilized to assure the distribution of drug samples is for the benefit of the patient, not for product promotion.

Additional information on the State Ethics Policy and KUMC Vendor Relations Policy under Resident Code of Professional and Personal Conduct can be found in the University of Kansas Graduate Medical Education Policy and Procedure Manual.
http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html

Role of the Resident on a Hospital or University Committee
The Department of Pediatrics and the Pediatric Residency Program support the Role of the Resident on a Hospital or University Committee which can be found in the University of Kansas Graduate Medical Education Policy and Procedure Manual.
http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html
Grievances and Appeal and Fair Hearings

Should a resident in the Department of Pediatrics have a grievance or be dissatisfied with any aspect of the Program, he/she is encouraged to initially discuss the issue with his/her attending, advisor or the Chief. If this is felt by the resident to be inappropriate or the issue is not satisfactorily resolved, timely discussion with the Program Director or the Chairman is highly recommended. The Institutional GME office is yet an additional avenue for grievances. A resident may have another resident attend these discussions with them to serve as a resident advocate.

Documentation of the issues and a statement of dissatisfaction by the aggrieved resident may be helpful, and is also encouraged, particularly when making an appeal to a Departmental committee or Board of Appeal. A resident may request to appear before Residency Committee (composed of faculty representatives, the Chief, and residents from each level). It should be understood that this committee is an advisory to the Department, the Chairman and the Program Director, and Committee recommendations or decisions only become policy or take effect with the Chairman's or Program Director's assent. Academic, promotional, competency, attitude, behavioral, and impairment issues or grievance would normally be concerns of the Residency Committee. The Chair of this committee is the Residency Director. The Program follows the grievance process as outlined in the Institutional GME manual.

Additional information on Grievances and Appeal and Fair Hearing can be found in the University of Kansas Graduate Medical Education Policy and Procedure Manual. http://www.kumc.edu/school-of-medicine/gme/policies-and-procedures.html

Social Media Policy

I. PURPOSE:

The Program supports Kansas Board of Regents’ support of the “responsible use of existing and emerging communication technologies, including social media, to serve the teaching, research and public service missions of the state universities. These communications technologies are powerful tools for advancing state university mission, but at the same time pose risks of substantial harm to personal reputations and to the efficient operation of the higher education system.”

These guidelines apply to pediatric residents who identify themselves with the KU Department of Pediatrics, the KU Pediatric Residency Program and/or use their KU email address in social media platforms such as but not limited to professional society blogs, wikis, LinkedIn, Facebook, YouTube, MySpace, Twitter, etc. for deliberate professional engagement or casual conversation. These guidelines apply to private and password-protected social media platforms as well as to open social platforms. As per the Board of Regent’ policy, this policy “does not include email sent to a known and finite number of individuals, or non-social sharing or networking platforms such as Listserv and group or team collaboration worksites.”

II. SCOPE:

2.1 In general, KU Pediatric Residency Program views internet social networking sites positively. The Program respects the right of residents to use them as media of self-expression. However, social media can also be abused by individuals who enter information on it and/or by those who access and read it with a result that the residency program or its affiliates could be viewed negatively or be subject to other adverse consequences.

2.2 “Friending” by program leadership and administration: Personal boundaries need to be respected and potential conflict of interest minimized. The Program Director will not send/accept friend requests of residents until the resident has completed training. Other residency leaders will send/accept friend requests at their discretion.

2.3 The PMEC administration may periodically audit resident’s social media sites to ensure compliance.
III. POLICY GUIDELINES:

3.1. Residents must be respectful in all social media communications. Residents should not use obscenities, profanity, or vulgar language, nor may they engage in harassing, intimidating or threatening behavior online. Residents must not use social media to disparage the KU faculty, program, other residents, or other affiliates of KU. Behaviors that are prohibited include, but are not limited to:
   a) Comments that are derogatory regarding race, sex, religion, color, age, disability, or any other protected status
   b) Any sexually suggestive, humiliating, or demeaning comments
   c) Threats or bullying comments (directly to an individual or indirectly to one individual regarding a third party)

3.2. Residents should only use their work email for work-related forums (e.g. following a professional organization, like MSM, on Facebook). Otherwise, use personal email for personal communication.

3.3. It is highly recommended that residents not allow patients (former or current) to be added to personal friends list as this may compromise patient privacy and confidentiality as well as overstep appropriate physician-patient boundaries. It is always acceptable to refuse inappropriate “friend” requests.

3.4. Residents may not comment through social media in any manner that conveys an impression that he or she is acting as a representative or spokesperson for KU or the Pediatric Residency Program including both personal activity and/or professional activity that is not part of official KU communication where the resident identifies him- or herself as a KU Pediatric Resident, either through a bio, comments, or by using a KU email address.

3.5. The following disclaimer should be added in any forms of social media whenever you identify yourself as part of KU or the Pediatric Residency Program while not officially acting on behalf of the medical center: *The views and opinions expressed here are not necessarily those of any component of the University of Kansas and they may not be used for advertising or product endorsement purposes.*
   Example: If you list KU School of Medicine as your employer on your Facebook info tab, you must add the disclaimer on the tab as well.

3.6. Residents must follow the KU guidelines in regard to: Compliance (HIPAA and the protection of patient information) and Conflict of Interest Policy

3.7. Residents must follow general civil behavior guidelines with respect to: Copyrights and Disclosures

3.8. Residents must not use social media to discuss engaging in conduct that is prohibited by other policies, including but not limited to: the improper or illegal use of drugs or alcohol

3.9. Residents must not post pictures or videos of faculty, program staff, other residents, patients, or any affiliates on a website or other social media venue without first obtaining permission from the person or entity whose picture or video is being used.

3.10. Residents should be aware that pictures, videos, and comments posted on social media sites are often available for viewing by third parties and could be considered detrimental to KU, the Pediatric Residency Program, or our affiliates. Therefore, in addition to the other requirements of this policy, residents must review their privacy settings on the various social media sites they use, and make any adjustment to those settings or edit the content of those sites in order to be in full compliance with this policy.

3.11. The use of KU name, logo, or any copyrighted material of our organization is not allowed without prior written permission of KU.

3.12. If someone from the media or press contacts you about posts made in online forums that relate to KU in any way, notify one of the Program Directors before responding.

3.13. Violation of any part of the social media policy is inappropriate and may result in disciplinary action, up to and including termination of employment.

In addition to the above Department Social Media Policy, residents in the program will abide by the policies and procedures governing the University of Kansas Medical Center’s Social Media Policy. Additional information on Social Media can be found in the KU Policy Library.

http://policy.ku.edu/KUMC/information-technology/social-media

Approved by Pediatric Residency Committee July 2014, Amended July 2016
Tips on Social Networking from KU Medical Center

1. Represent yourself professionally
As a student at the University of Kansas Medical Center, you are considered a professional and should represent yourself as such at all times. This will help you, as students, prepare to practice and maintain professional and ethical standards after you graduate. Your online profiles should also represent you in a professional light.

2. Be aware of your online identity
Just because you are careful about what you put on your personal pages does not mean other people are. Embarrassing or compromising pictures can very easily appear on a friend’s page and get “tagged” to yours. Have conversations with your friends about what is appropriate to post and why.

3. Once it is out there, it is out there
Caching means that if you post something on a site, even just for a day or two, it will remain in cyberspace forever. Caching is a great thing when you have lost something you need on the internet. However, it can also come back to haunt you when those embarrassing pictures you took down three years ago show up in your file at a job interview. You do have the ability to contact search engines, like Google, who cache large amounts of information and request that they remove the content. However, you should consider the growing number of search engines and that your request may take some time to process. Give careful thought to the content you are placing on your social networking page. It may be advisable not to put it out there in the first place.

4. The Internet is not a private place
The internet is a great place to market yourself, whether you intend to or not. Most social networking sites are public, meaning anyone can join, create a profile, look at your profile and even become your “friend”. But while you are out there posting pictures of last weekend’s festivities with your friends, remember that they are probably not the only ones looking at your profile.

By now we have all heard stories from around the country about men and women who have had negative consequences as a result of their Facebook or Twitter content. Do not be the next person to get fired, lose an interview, or be arrested for things that were seen or read on your social media pages.

5. Use your privacy settings
All social networking sites have privacy settings, most of which range from none to paranoid! These are put in place to protect you, your information and your online identity, so be thoughtful about your settings and use them.