University of Utah
Division of Plastic Surgery
Resident Clinical Responsibilities, Teamwork and Transitions of Care

The call day shall run from 7:00 a.m. to 7:00 a.m.

Hand call is taken 50% by Plastic Surgery and 50% by the Orthopaedic service. However, if your service is called directly by a referring physician on the orthopedic "day," we will accept that patient at the Plastic Attendings discretion. All such calls should be referred to the Attending on call. Similarly, maxillofacial trauma is shared with ENT. Odd numbered days are ours, even for ENT days. Availability and affability are the keys to protecting our referral sources - please be prompt and courteous with all calls - never say "it's not my day."

WHOEVER receives a call for assistance of any kind should take the necessary details and accept responsibility to pass that information to the appropriate member of the Division for action; patients or referring physicians MUST not be told that they have contacted the wrong person and be left to find the "right" person.

There have been questions about patient/family calls from office staff to residents. When called/paged from office staff please respond and facilitate. If you are scrubbed in, ask if it can wait until between cases and then respond to the issue. If there is an urgent need, then the resident should ask the OR nurse to call the PA and the resident/nurse should ask the PA if they can help resolve the issue(s) with an appropriate plan. Any request to the PA should come directly from the resident (or OR nurse).

Patients who call for help following surgery should always be offered the opportunity to be seen, regardless of the time; pain, especially after extremity surgery, must never be treated without seeing the patient

Emergencies are to be seen within thirty minutes of notification.

Consultations are to be seen within three hours of notification.

If these criteria cannot be met, and no resident or staff substitute can be found, the Program Director or his deputy is to be informed;

Initial responsibility for all emergencies and for all consultations rests with the resident on call, who must communicate with the attending on call or with the attending requested by those referring the patient.

On the infrequent occasion when a hand emergency is being treated by us when the orthopedic service is taking hand call, the primary responsibility to work with the attending rests with the plastic surgery fellow on the hand service; if he/she is not available, with the fellow on call for plastic surgery.

The call schedule is prepared each month by the administrative chief resident in conjunction with the academic coordinator. In preparing that schedule, a running total is maintained, with

the intention of ensuring that each resident takes an equal number of days call in an academic year, regardless of time out for meetings and vacation. The Program Director is not inclined to get involved in disputes over resident call and strongly advises settlement of disputes by the residents themselves.

Beepers (in the "ON" mode!) are to be carried by residents at all times when not on approved vacation.

While it is intended to respect time off duty, our primary concern must be patient care, and one resident may have information essential to patients on his service.

The Division of Plastic and Reconstructive Surgery prohibits moonlighting.

This guideline is provided to faculty and residents in the Resident Orientation Handbook.

Transitions of Care

Each month the call schedule is available for review for residents, faculty and staff. This together with a weekly schedule of clinical and educational activities provides a framework to optimize transitions of care. Residents are encouraged to speak with the administrative chief residents and/or Attending physicians when they are at risk of exceeding the duty hour limits. Each patient care transition between residents is achieved through various means including secure electronic communication, in-person or via telephone with a brief review of each patient

<u>Resident Clinical and Education Work Hours</u>

Work hours are defined as time spent on all clinical and educational activities related to the residency or fellowship program. This includes patient care, administrative duties related to patient care, provision for transfer of patient care, time spent in-house during call activities, time spent on patient care activities while on at-home call, moonlighting activities, and scheduled educational activities such as conferences. Work hours do not include reading and preparation time spent away from the duty site.

A. Maximum Hours of Clinical and Educational Work per Week
    1. Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting.
B. Mandatory Time Free of Clinical Work and Education
    1. Programs must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being.
        a. Residents should have eight hours off between scheduled clinical work and educational periods. In certain circumstances, residents may 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.

2. Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.
3. Residents must be scheduled for a minimum of one day in seven free of clinical work and required education, when averaged over four weeks. At-home call cannot be assigned on these free days.

C. Maximum Clinical Work and Education Period Length

1. Clinical and education work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.
    a. 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.

D. Clinical and Educational Work Hour Exceptions

1. 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:
    a. To continue to provide care to a single severely ill or unstable patient.
    b. Humanistic attention to the needs of a patient or family, or
    c. To attend unique educational events.
2. These additional hours of care or education will be counted toward the 80-hour weekly limit.

E. Moonlighting

The Division of Plastic Surgery prohibits moonlighting.

F. In-House Night Float

The Division of Plastic Surgery does not have in-house night float. .

G. Maximum In-House On-Call Frequency

The Division of Plastic Surgery does not have in-house on- call

H. At-Home Call

1. Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks.
    a. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

2. 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 care must be included in the 80-hour maximum weekly limit.