

RESIDENT MANUAL

July 1, 2011 – June 30, 2012

Children's Hospital & Research Center Oakland

Pediatric Residency Program

INTRODUCTION

The current Resident Manual contains the terms and conditions of the written agreement between the Resident and the Children’s Hospital & Research Center Oakland Pediatric Residency Program. In accordance with the latest Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements and the current ACGME Pediatric Residency Review Committee’s “Program Requirements for Graduate Medical Education in Pediatrics”, this Resident Manual delineates the terms, conditions, & benefits of employment; institutional policies; & responsibilities of residents.

James S. Wright, M.D.
Director, Graduate Medical Education,
Director, Pediatric Residency Program

Pamela J. Simms-Mackey, M.D.
Associate Director, Graduate Medical Ed.
Associate Director, Residency Program

Michael E. Lang, M.D.
Associate Director, Residency Program
Medical Student Program Director

Chief Resident

Chief Resident

Chief Resident

Chief Resident

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1. INTRODUCTION TO CHILDREN'S HOSPITAL, THE PEDIATRIC RESIDENCY PROGRAM, THE RESEARCH CENTER (CHORI), & LIBRARY/ELECTRONIC DATABASES

Children's Hospital & Research Center Oakland officially opened its doors at its present site on September 16, 1914 as the Baby Hospital. From a humble beginning with 30 beds in the McElrath mansion and a clinic located in the carriage house, the Hospital has grown into a 190 bed nationally recognized tertiary care center, fully accredited by the Joint Commission. The 190 beds include a 47 bed Neonatal Unit, a 23 bed Critical Care Unit, an 18 bed Medical Rehabilitation Unit and a 12 bed Immunocompromised Patient Unit for Bone Marrow Transplant and Oncology patients. Children's has the only Pediatric Emergency Room and Pediatric Trauma Center in Northern California. The Medical Staff of over 700 includes over 160 hospital based physicians representing the major pediatric medical and surgical subspecialties.

Education is an important component of the Hospital's mission. Our Pediatric Training Program, which began in 1926, now includes 78 Pediatric Residents, 4 Chief Residents, and 10 Fellows in Pediatric Hematology-Oncology, Pediatric Infectious Disease, Pediatric Emergency Medicine, and Pediatric Pulmonology, as well as 10 UCSF Fellows in Pediatric Critical Care who receive half of their clinical training with us. Our Graduate Medical Education programs strive to provide organized educational experiences which promote the resident's professional, ethical and personal growth while ensuring safe and appropriate care for patients. The DIO, the Chair and Members of the GMEC, the Program Directors and their staff oversee the programs and assure compliance with ACGME Common, Specialty/Subspecialty-specific, and Institutional Requirements.

Our Pediatric Residency Program strives to provide the clinical experiences and to create the curriculum necessary to achieve the following educational goals:

Training our residents to become compassionate, appropriate and effective patient care providers for the whole child and family;

Ensuring that our residents build a solid foundation of medical knowledge and the ability to effectively apply knowledge of the biological, psychosocial, and epidemiological aspects of pediatric illness;

Promoting our residents' critical thinking abilities, including appraisal and assimilation of scientific literature, self-evaluation and life-long learning;

Developing our residents' communication skills with patients, their families, and other health care providers, and their ability to provide culturally competent medical care;

Imparting to our residents the highest sense of professionalism, responsibility, and ethical principles;

Providing residents with opportunities to learn how to be advocates for the health of children and families within our society;

Preparing residents to work effectively in various health care systems, by developing awareness of those systems, and to utilize resources, at times limited, to provide optimal care;

Training residents in an environment of respect and support, always recognizing that residency training, while challenging, need not be dehumanizing to be successful;

Providing our residents with training that will serve them well as either primary care physicians or in careers in pediatric subspecialties, research, advocacy, public or global health.

The continued excellence of our program reflects the commitment of Children's Hospital & Research Center Oakland to Graduate Medical Education. Sustaining educational programs of excellence is a cornerstone of the institution's mission to provide the highest quality of medical care to the children of Northern California.

Research at Children's

Children's Hospital & Research Center Oakland has a major commitment to research. Our 80,000 sq. ft. Research Institute (CHORI) has an annual research budget of over \$40 million dollars, and an environment that fosters collaboration and exchange of ideas among the two hundred basic and clinical researchers. Areas of research include hemoglobinopathies, stem cell biology, iron overload and iron metabolism, molecular genetics, cancer, cystic fibrosis and pulmonary diseases, lipid biochemistry, infectious diseases, vaccine development, immunology, diabetes, mass spectrometry and aging. Extensive information about the Centers of Excellence at CHORI and other research programs can be found at www.chori.org. CHORI scientists strive for fundamental advances in both the basic and applied biomedical sciences to save and improve the lives of both children and adults.

Library and Electronic Access to Medical Literature

All residents have 24 hours-per-day access to the Library of Children's Hospital & Research Center Oakland, located on the 4th floor of the hospital. The library houses a collection of textbooks, journals, videos, and electronic resources covering primarily pediatrics and its subspecialties. Approximately 400 journals are received, and there are over 4000 books and, counting the bound journals, about 13,000 volumes. Users have access to electronic databases and online journals in the rear of library, and from every computer terminal in the hospital. The library is staffed from 7:30 a.m. to 4:45 p.m. Monday through Friday. General circulation books may be checked out of the library for four weeks and can be renewed once (for four weeks) provided a hold has not been placed. Videotapes and bound journals can be checked out for one week. Reference books and unbound journal issues do not leave the library, but photocopies may be made from these collections.

Online Catalog of Holdings at Children's Hospital & Research Center Oakland

<http://207.67.203.47/C10068>

Internet Access to Databases

Databases for literature searching are accessed through the web based Ovid Technologies interface. The address for Ovid is:

<http://gateway.ovid.com>

userid: oakcho

password: divo1 (numeral 1)

Textural information as well as bibliographic information is available through MDConsult, which has about 40 textbooks, 50 full text journals, 600 clinical practice guidelines and 3000 patient education brochures. Residents may

access MDCONSULT from any computer terminal in the hospital at www.mdconsult.com .

In addition, they may access UPTODATE from any computer terminal in the hospital at www.utdol.com

Interlibrary Loan

The library can obtain copies of articles from journals, chapters from books, or the books themselves from other libraries. Borrowing is always attempted through free sources with whom the library has reciprocal agreements. If materials are not available free, your department may pay for them.

Personal Book Orders

Personal medical books can be ordered through the library. These orders are placed with our outside vendor. Requests should be given to library staff, who will check on the current price. You must pay in advance by check or exact cash.

Staff Reference Service

Mina Davenport, Librarian, can provide reference assistance to library users. She will help with search strategy and do MEDLINE and other database searches. Fill out a blue search request form and leave it at the circulation desk or call for an appointment to Mina Davenport at 510-428-3448 or x3448 mdavenport@mail.cho.org

Databases and Online Resources

Name	URL	ID	Password
<i>Bibliographic</i>			
MD Consult+	www.mdconsult.com	none	none
Ovid*	www.gateway.ovid.com	oakcho	divo1
Pubmed	desktop icon	none	none
<i>EBSCO</i>			
Psychlit	<i>search.epnet.com</i>	<i>oak</i>	<i>cho</i>
Psycharticles			
CINAHL			
Clinical Resources			
<i>UpToDate</i>			
	www.uptodateonline.com	<i>none</i>	<i>none</i>
GIDEON	www.web.gideononline.com	none	none
EBSCO	search.epnet.com	oak	cho
Cochrane			
Red Book	aappublications.org	none	

+remote access with your id and password , *remote access with this id and password
CINAHL and PsychArticles are available at <http://search.epnet.com> id:oak; pw:cho

TITLE	LOCATION
AAP Grand Rounds	http://www.aappublications.org
AAP News	http://www.aappublications.org
Academic medicine	Ovid
Acta orthopaedica + suppl	CINAHL
Acta orthopaedica Scandinavia	CINAHL
Acta oto-laryngologica	CINAHL
Acta paediatrica international – through 2009	http://www3.interscience.wiley.com/journal/117988202/home
Acta paediatrica international supplements – through 2009	http://www3.interscience.wiley.com/journal/117988202/home
American family physician	MDC
American heart journal	MDC
AJR: American journal of roentgenology id:oakcho pw:journal	http://www.ajronline.org/
American journal of bioethics	CINAHL
American journal of cardiology	MDC
American journal of clinical nutrition	www.ajcn.org
American journal of clinical pathology	http://ajcp.ascpjournals.org/content
American journal of emergency medicine	MDC
American journal of health behavior	CINAHL
American journal of health-system pharmacy	CINAHL
American journal of infection control	MDC
American journal of kidney diseases	MDC
American journal of medicine	MDC
American journal of obstetrics and gynecology	MDC
American journal of ophthalmology	MDC
American journal of orthopsychiatry	CINAHL
American journal of psychiatry	http://ajp.psychiatryonline.org/
American journal of public health	Psycharticles
American journal of respiratory and critical care medicine	http://ajrccm.atsjournals.org/
American journal of surgery	MDC
Anesthesia and analgesia	Ovid
Anesthesiology	MDC
Anesthesiology clinics	MDC
Annals of emergency medicine	MDC
Annals of family medicine	MDC
Annals of internal medicine	http://www.annals.org/
Annals of otology, rhinology & laryngology	CINAHL
AORN journal	MDC
Archives of dermatology	http://archderm.ama-assn.org
Archives of disease in childhood	Ovid
Archives of disease in childhood – fetal neonatal ed.	Ovid
Archives of facial plastic surgery	http://archfaci.ama-assn.org
Archives of general psychiatry	http://archpsych.ama-assn.org
Archives of internal medicine	http://archinte.ama-assn.org
Archives of neurology	http://archneur.ama-assn.org
Archives of ophthalmology	http://archophth.ama-assn.org
Archives of otolaryngology-head and neck surgery	http://archotol.ama-assn.org

Archives of pathology & laboratory medicine	CINAHL
Archives of pediatrics and adolescent medicine	http://archpedi.ama-assn.org
Archives of surgery	http://archsurg.ama-assn.org
Behavioral medicine	Psycharticles
Bioethics	CINAHL
Bioterrorism watch	CINAHL
Blood	http://bloodjournal.hematologylibrary.org/
Bone marrow transplantation	http://www.nature.com/bmt/index.html
British journal of haematology – 1998 through 2008	http://www3.interscience.wiley.com/journal/118517380/home
British journal of psychiatry	http://bjp.rcpsych.org/
British medical journal	
–limited access	http://www/bmj.com
2010	Ovid
Bulletin of the World Health Organization	CINAHL
Canadian journal of anesthesia	http://www.springerlink.com/content/121278/
Canadian medical association journal	MDC
Cancer	
	http://www3.interscience.wiley.com/journal/28741/home
Cardiology clinics	MDC
Chest	MDC
Child development - through 2009	http://www3.interscience.wiley.com/journal/117957161/home
Child development perspectives	http://www3.interscience.wiley.com/journal/118492257/home
Child welfare	CINAHL
Children's healthcare	CINAHL
Circulation	Ovid
Cleft palate – craniofacial journal	http://cpci.allenpress.com/cpcjonline/?request=index-html
Clinical cornerstone	MDC
Clinical genetics – through 2008	http://www3.interscience.wiley.com/journal/117984292/home
Clinical infectious diseases	http://journals.uchicago.edu/cid
Clinical laboratory science	CINAHL
Clinical pediatric emergency medicine	MDC
Clinical pediatrics	Ovid
Clinics in chest medicine	MDC
Clinics in geriatric medicine	MDC
Clinics in laboratory medicine	MDC
Clinics in liver disease	MDC
Clinics in perinatology	MDC
Clinics in sports medicine	MDC
Contemporary pediatrics	CINAHL
Critical care clinics	MDC
Critical care medicine	MDC
Current opinion in pediatrics	Ovid
Dermatologic clinics	MDC
Developmental medicine and child neurology + supplements – through 2009	http://www3.interscience.wiley.com/journal/118482279/home
Diabetes care	http://care.diabetesjournals.org/

Disease-a-month	MDC
Emergency medicine clinics	MDC
Emerging infectious diseases	http://www.cdc.gov
Endocrinology and metabolism clinics	MDC
European journal of pediatrics	http://www.springerlink.com/content/100415/
Families, systems, health	Psycharticles
Family planning perspectives	CINAHL
Family practice management	MDC
Gastroenterology clinics	MDC
Gastrointestinal endoscopy	MDC
General hospital psychiatry	MDC
Hastings Center Report	CINAHL
Health psychology	Psycharticles
Hematology/oncology clinics	MDC
Immunology and allergy clinics	MDC
Infectious disease clinics	MDC
International family planning perspectives	CINAHL
International journal of play therapy	Psycharticles
Issues in comprehensive pediatric nursing	http://informahealthcare.com/loi/cpn
Issues in law and medicine	CINAHL
JOGNN - through 2009	
	http://www3.interscience.wiley.com/journal/118495258/home
Journal for healthcare quality	
	http://www3.interscience.wiley.com/journal/122585946/group/home/home.html
Journal of abnormal child psychology	http://www.springerlink.com/content/104756/
Journal of abnormal psychology	Psycharticles
Journal of allergy and clinical immunology	MDC
Journal of applied psychology	Psycharticles
Journal of autism and developmental disabilities	CINAHL
Journal of bone and joint surgery – American	http://www.ejbis.org/
Journal of bone and joint surgery – British	http://www.jbjs.org.uk/
Journal of child neurology	http://jcn.sagepub.com
Journal of child psychology and psychiatry - through 2009	
	http://www3.interscience.wiley.com/journal/117960395/home
Journal of clinical anesthesia	MDC
Journal of clinical endocrinology & metabolism	MDC
Journal of clinical pharmacy & therapeutics	CINAHL
Journal of clinical oncology	http://jco.ascopubs.org
Journal of consulting and clinical psychology	Psycharticles
Journal of counseling psychology	Psycharticles
Journal of developmental and behavioral pediatrics	Ovid
Journal of family practice	http://www.jfponline.com/
Journal of family psychology	Psycharticles
Journal of infectious diseases	http://journals.uchicago.edu/jid
Journal of law, medicine & ethics	CINAHL
Journal of learning disabilities	http://ldx.sagepub.com
Journal of legal medicine	CINAHL
Journal of maternal-fetal and neonatal medicine	http://informahealthcare.com/loi/jmf
Journal of men's health	MDC
Journal of mental health	CINAHL
Journal of negative results in biomedicine	Pubmed

Journal of nervous and mental disease	Ovid
Journal of neurosurgery	http://thejns.org
Journal of neurosurgery – pediatrics	http://thejns.org
Journal of neurosurgery – spine	http://thejns.org
Journal of nuclear medicine	http://jnm.snmjournals.org/
Journal of occupational and environmental medicine	MDC
Journal of occupational rehabilitation	CINAHL
Journal of paediatrics and child health – through 2008	http://www3.interscience.wiley.com/journal/117968610/home
Journal of pediatric and adolescent gynecology	MDC
Journal of pediatric gastroenterology and nutrition	MDC
Journal of pediatric health care	MDC
Journal of pediatric hematology/oncology	Ovid
Journal of pediatric nursing	MDC
Journal of pediatric oncology nursing	http://jpo.sagepub.com/
Journal of pediatric rehabilitation	http://www.iospress.nl/loadtop/load.php?isbn=18745393
Journal of pediatrics	MDC and http://www.sciencedirect.com/science/journal/00223476
Journal of perianesthesia nursing	MDC
Journal of perinatology	http://www.nature.com/jp/index.html
Journal of the American Academy of Child and Adolescent Psychiatry	MDC
Journal of the American Academy of Dermatology	MDC
Journal of the American Academy of Surgeons	MDC
JAMA	http://jama.ama-assn.org
Journal of the American Society of Echocardiography	MDC
Journal thoracic & cardiovascular surgery	Ovid
Journal of trauma, injury, infection and critical care	Ovid
Journal of women's health	CINAHL
Journal of women's health & gender-based medicine	CINAHL
Lancet ID:chrco PW:journals	http://thelancet.com
Lancet Infectious Disease	MDC
Lancet Neurology	MDC
Lancet Oncology	MDC
Leukemia	http://www.nature.com/leu/index.html
Mayo Clinic Proceedings	http://www.mayoclinicproceedings.com/
Medical Clinics	MDC
Medical Education	CINAHL
Medical Letter	http://www.medletter.com/
[includes Treatment Guidelines]	
Medicine & Science in sports & exercise	Ovid
Mental health in family medicine	CINAHL
MMWR	http://www.cdc.gov
MMWR Surveillance Summaries	http://www.cdc.gov
MMWR Recommendations and Reports	http://www.cdc.gov
Nature	http://www.nature.com/nature/index.html
Neonatal network	http://neonatalnetwork.metapress.com
Neoreviews	http://www.aappublications.org
Neurologic clinics	MDC
Neurology	MDC

Neuropsychology	Psycharticles
Neurosurgery	Ovid
NEJM	http://content.nejm.org
Nutrition review	http://www3.interscience.wiley.com/journal/118902515/home
Obstetrics and gynecology	Ovid
Obstetrics and gynecology clinics	MDC
Operative techniques in general surgery	MDC
Ophthalmology clinics	MDC
Orthopedics clinics	MDC
Otolaryngologic clinics	MDC
Pacing & clinical electrophysiology	CINAHL
Pediatric and developmental pathology	http://www.pedpath.org/
Pediatric cardiology	http://www.springerlink.com/content/100366/
Pediatric clinics	MDC
Pediatric critical care medicine	MDC
Pediatric dermatology	http://www3.interscience.wiley.com/journal/118504902/home
Pediatric emergency care	Ovid
Pediatric hematology and oncology	http://informahealthcare.com/loi/pho
Pediatric infectious disease journal	Ovid
Pediatric neurology	MDC
Pediatric radiology	http://www.springerlink.com/content/100483/
Pediatric research	Ovid
Pediatric surgery international	http://www.springerlink.com/content/101176/
Pediatrics	http://www.aappublications.org
Pediatrics in review	http://www.aappublications.org
Perspectives on sexual and reproductive health	http://www3.interscience.wiley.com/journal/117981744/home
PET clinics	MDC
Pharmacotherapy	http://www.pharmacotherapy.org
PLOS biology	Pubmed
PLOS clinical trials	Pubmed
PLOS computational biology	Pubmed
PLOS genetics	Pubmed
PLOS medicine	Pubmed
PLOS neglected tropical diseases	Pubmed
PLOS ONE	Pubmed
PLOS pathogens	Pubmed
Primary care; clinics in office practice	MDC
Psychiatric clinics	MDC
Psychological assessment	Psycharticles
Radiologic clinics	MDC
Radiology	http://radiology.rsna.org/
Rheumatic disease clinics	MDC
Scandinavian journal of public health	CINAHL
Science	http://www.sciencemag.org/magazine.dtl
Sleep medicine clinics	MDC
Surgical clinics	MDC
Thorax	Ovid
Topics in language disorders	Ovid
Ultrasound clinics	MDC
Urologic clinics	MDC

2. TERMS, CONDITIONS, & BENEFITS OF EMPLOYMENT; & INSTITUTIONAL POLICIES

A. Resident Recruitment and Selection:

Only applicants with one of the following qualifications are eligible for appointment to ACGME-accredited programs sponsored by CHRCO:

1. Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).
2. Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).
3. Graduates of medical schools outside the United States and Canada who meet one of the following qualifications:
 - Have received a currently valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment or,
 - Have a full and unrestricted license to practice medicine in the U.S. licensing jurisdiction in which they are training.
4. Graduates of medical schools outside the United States who have completed a Fifth Pathway program provided by an LCME-accredited medical school.

Selection:

1. Eligible applicants are selected on the basis of their preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity. The program may not discriminate with regard to sex, race, age, religion, color, national origin, disability, sexual orientation, or veteran status.
2. The Pediatric Residency Program participates in NMRP, offering all First Year positions through it. Only applicants who meet the appointment qualifications delineated by the ACGME above are eligible for consideration.
3. The Intern Selection Committee is composed of faculty, residents, and program directors who carefully weigh the criteria suggested by the ACGME (academic credentials, aptitude, communication skills, personal qualities, preparedness) and adhere strictly to the institution's policy against discrimination. At the Intern Selection Committee Meeting in February, Committee Faculty, Resident Members, along with the Residency Program Directors, thoroughly review and discuss all eligible applicants to the Residency, and generate a Rank List for the NRMP Match.

4. In the event that the program finds it necessary to recruit and appoint one or more residents at other than a first-year position, the following is required.
 - To determine the appropriate level of training for a resident who is transferring from another ACGME-accredited program, the Program Director must receive written verification of the previous educational experiences in that program and evaluations of the transferring resident prior to accepting that resident into the program.
 - If an applicant is under contract to another training program, the Program Director shall contact the individual's current Program Director prior to formally offering the position to request release of the applicant from their contract. If such release is not forthcoming, no position shall be offered to that individual.

B. Appointment

Residents accepted into the Pediatric Residency Program will be provided a length of training sufficient to meet the American Board of Pediatric requirements for certification in pediatrics, unless their performance proves unsatisfactory. Likewise, residents accepting a position in the pediatric training program are expected to stay in the program until completion. The training program has no obligation to allow continuation from year to year of a resident who has not performed in a satisfactory fashion.

Post Graduate Level 1 (PL-1) Appointments

All PL-1 positions shall normally be offered through the NRMP. Following receipt of the Match List, an individual written letter of appointment/contract, accompanied by a copy of the current Resident Manual shall be sent to all new PL-1 residents. This letter/contract shall include the current salary scale for PL-1 appointments and refer to the terms, conditions, & benefits of employment; & institutional policies at Children's Hospital & Research Center Oakland, which are delineated in this Manual. This letter of appointment/contract should be signed and returned to the Medical Education Office at least one month prior to the start of the academic year. Deferment of appointment following the match is not allowed. Prior to commencing the year, the PL-1 must provide evidence of successful completion of medical school (diploma or letter).

C. Reappointment

Post Graduate Level 2 and 3 (PL-2 and PL-3) Reappointment

All residents are required to give formal notice of their intention to continue in the program at least six months prior to the start of the next

academic year. All residents who elect to continue their residency training, as long as their performance has not been judged unsatisfactory, shall receive an individual written letter of appointment/contract accompanied by a copy of the current Resident Manual. This letter/contract shall include the current salary scale for PL-2 or PL-3 appointment and refer to the terms, conditions, & benefits of employment; & institutional policies at Children's Hospital & Research Center Oakland, which are delineated in this Manual. This letter of appointment/contract should be signed and returned to the Medical Education Office six months prior to the start of the academic year.

Section 3: PL1 s and new transfers shall be notified in writing no later than March 1 if the Hospital does not intend to review their agreement for the following academic year. PL2s shall be notified in writing no later than December 15 if the Hospital does not intend to renew their agreement for the following academic year. However, if the primary reason(s) for the non-renewal occurs later than the respective notification deadlines set forth above, the Hospital shall provide the House Officer with as much written notice of the intent not to renew as the circumstances will reasonably allow, prior to the end of the House Officer's agreement

Section 4: Recommendations of non-renewal shall be in writing and shall set forth the reasons for such non-renewal. House Officers shall have the right to appeal recommendations for non-renewals under the discipline procedure set forth in this agreement. Issues concerning non-renewal shall not be subject to the grievance and arbitration procedure set forth in this agreement.

D. Financial Support

1. Salaries

The following is the salary for the 2011-12 academic year.

PL-1 \$50,592.51 PL-2 \$54,667.22 PL-3 \$59,151.12

The individual letter of appointment/contract provided to each resident contains the current salary appropriate to the PGY level.

Effective the first day of the pay period closest to July 1, the Hospital will increase the salaries based on the Resident's assigned PL level.

Children's Hospital & Research Center Oakland pays its employees on a biweekly basis; there are 26 pay periods in a calendar year. Paychecks are available in the Medical Education Office every other Friday after 11:30 a.m.

2. Relocation Bonus

PL1 s and incoming transfers shall receive a gross relocation bonus of \$2,400.00 within two (2) weeks following their start date.

3. Education Expenses

Residents shall be reimbursed for approved medical education expenses

up to the following annual amounts:

PL 1	\$500
PL 2	\$550
PL 3	\$600

Original receipts and/or cancelled checks are necessary for reimbursement and should be submitted to the Medical Education Office. All monies must be spent by the end of each academic year and cannot be carried over to the next year.

Approved medical education expenses include pediatric conference expenses (registration fee, travel costs, lodging, per diem meal allowances, etc.), medical textbooks, medical journals, diagnostic kits, medical equipment and medically related software expenses. Medical license renewal costs are eligible for reimbursement if incurred during the PL-3 year.

Costs associated with non-medical foreign language courses and expenses related to electives away from Children's Hospital and Research Center at Oakland are specifically not reimbursable. If in doubt, contact the Director of Medical Education prior to incurring the expense.

Miscellaneous

The Hospital shall pay for PALS and NALS certification courses during the PL-1 year only and for a PALS recertification course prior to December 1 of the PL-3 year. The Hospital will pay for the House Officer's American Academy of Pediatrics membership annually. The Hospital will pay for the House Officer's California Medical License and DEA fee during the PL-2 year only. The Hospital will pay one USMLE Step III examination fee for any resident who takes the exam prior to December 1 of their PL-1 year.

E. Resident Responsibilities

1. Required Examinations and Training Courses

Pediatric Advanced Life Support (PALS)

All residents accepted into the residency program are required to acquire PALS certification prior to beginning clinical duties and are expected to maintain certification throughout their period of residency training. The Hospital shall pay for PALS and NRP certification courses during the PL-1 year only and for a PALS recertification course prior to December 1 of the PL3 year only.

Neonatal Resuscitation Program (NRP)

All residents are required to obtain NRP certification during the PL-1 year and are expected to maintain certification throughout their period of residency training. The Hospital shall pay for NRP certification courses during the PL-1 year only.

In-Training Examination

All residents are required, except while on vacation or on approved absence from the hospital, to take the annual In-Training Examination, on the dates assigned by The American Board of Pediatrics.

USMLE

The Chief Resident shall ensure that interns are free from other clinical duties during the examination and that no intern is on call the night prior to or between examination days. The Hospital will pay one USMLE Step III examination fee for any resident who takes the exam prior to December 1 of their PL-1 year.

2. Licensure

According to State law, no PL-3 resident may be allowed to practice medicine without a valid California Medical License.

Because issuance of a California Medical License may take up to nine months from the date of application, residents should apply for a California Medical License and Drug Enforcement Agency (DEA) number as early as possible during their PL-2 year, but **no later than September 1st**.

Children's Hospital & Research Center Oakland will pay the initial California Medical Licensure and DEA fee for all residents continuing in the program who submit completed applications to the Medical Education Office prior to September 1st of their PL-2 year. The Medical Education Office will then directly forward these applications to the appropriate agencies.

All residents shall furnish a copy of their California Medical License and DEA number to the Medical Education Office as soon as possible following issuance, **but no later than March 1st of their PL-2 year**.

Failure to submit an application for licensure by December 1st or to obtain a valid California Medical License and DEA number by March 1st may result in disciplinary action including non-renewal of contract for the PL-3 year. Any PL-2 who has not obtained a California Medical License cannot be assigned a PL-3 track.

3. Employee Health

All residents shall have tuberculosis testing and N95 Mask Fit Testing performed by Employee Health Service upon employment and annually thereafter. If a resident is known to be PPD positive, then a chest x-ray is required to exclude active tuberculosis (may be performed up to one year prior to employment). All newly hired residents must undergo a physical examination as soon as possible following employment. In addition, all newly hired residents should bring evidence of immunity (serologic) or previous immunization to the following diseases: varicella, measles, rubella, and hepatitis B. If a resident is neither immunized nor immune to these diseases, Children's Hospital & Research Center Oakland will provide serologic testing and immunization at no charge to the resident. All job-related injuries or needle-stick accidents must be reported immediately to Employee Health. Details of the general CHRCO policy on employee health is available in the Medical Education Office.

4. Dress Code

Residents are expected to dress in an appropriately professional manner in accordance with the general **Children's Hospital & Research Center Oakland dress code policy**. Specifically, denim jeans and shorts are not permitted. Residents are discouraged from wearing scrub suits except while on overnight call or in the Emergency Department, Intensive Care Nursery or Pediatric Intensive Care Unit.

Security/ID Name Badges are provided to all residents and must be worn and visible while on duty.

5. Medical Record Documentation

Accurate and timely medical record documentation is an important part of each resident's patient care responsibilities. The chart is a major route of communication for the team members and it is often the primary source of information used retrospectively for quality assurance and legal considerations. It is important to write legibly or type clearly in Meditech or on any preprinted form or word document to be placed in the Medical Record. All entries in the medical record must be dated and signed. With your signature, print your name and your title, i.e. MD, PL-1 (or Resident – First Year), MD, PL-2, (or Resident – Second Year).

History & Physical (H & P)

Patients admitted to Children's Hospital & Research Center Oakland must have an admission H & P completed by the primary house officer assigned to the patient and co-signed by the senior supervising resident and the patient's attending.

The history and physical must include the following:

1. Source of the history
2. Chief complaint.
3. History of present illness, including assessment of emotional, behavioral, and social status.
4. Past history (to include birth history, illnesses, injuries, surgery, transfusions, allergies, immunizations, development/education.
5. Family history.
6. Social history, including exposure to tobacco smoke or other environmental hazards.
7. Review of Systems
8. Physical exam.
9. Laboratory and radiology results.
10. Diagnostic Impression.
11. Treatment/Care Plan.
12. Documentation of discussion with the family regarding their involvement in the treatment and care of the patient.

This history and physical must be performed and recorded in the medical record within 24 hours of admission, or within 30 days prior to elective surgery. The H&P is not to be removed or used by the resident on rounds or for other purposes. If necessary, a photocopy of the H&P can be made for these reasons.

All H & P's completed by a PL-1 or 4th year medical student must be accompanied by a note and co-signature from the senior supervising resident and attending. In general, this note may be brief, but in the case of the 4th year medical students, the supervising resident note must include at a minimum a summary of the patient's presenting features, pertinent physical examination findings, laboratory and radiology results and the assessment and plan for the patient's hospitalization.

H & P 's completed by third year medical students are not to be placed in the medical record.

Progress Notes

Progress notes serve to document the patient's course in the hospital and the chronology in which treatment was delivered, and should reflect any changes in the condition and results of treatment. They should also reflect periodic review for longer hospitalizations, or as a patient's condition warrants.

They should be written in a standard **Subjective, Objective, Assessment, Plan (SOAP)** format.

Progress notes must be written by the resident at least once daily.

They should emphasize the resident's assessment and proposed plan, and not merely record the previous 24- hour activities. They should include language that the patients status and the plan have been reviewed with the Attending Physician.

Progress notes written by fourth year medical students require a supervising resident's co-signature. Those written by PL-1's do not require a co-signature.

Abbreviations

Abbreviations may be written in the medical record if they meet hospital requirements and Medical Staff rules and regulations.

1. Abbreviations should be clear, concise and understandable in the context being used.
2. Abbreviations appearing on the "Unacceptable Abbreviations" list cannot be used in the medical record.
3. Medication names cannot be abbreviated in the physician orders.

4. Abbreviations cannot be used when documenting the patient's diagnoses and procedures on the Discharge Abstract/Summary.

UNACCEPTABLE ABBREVIATION LIST

DO NOT WRITE THESE ABBREVIATIONS IN PATIENT MEDICAL RECORDS

ABBREVIATION	INTENDED MEANING	PREFERRED TERM
AD	right ear	Write out right ear, left ear, each ear or both ears
AS	left ear	
AU	each/both ears	
MS MSO4 MgSO4		Write out morphine sulfate or magnesium sulfate
TIW or tiw	three times a week	Write three times a week or 3X per week
q.d. or QD every day	every day	Write out daily or
q.o.d. or QOD	every other day	Write out every other day
ABBREVIATION	INTENDED MEANING	PREFERRED TERM
U or u	unit	Write out unit
IU Unit	international unit	Write out International
Trailing zero (.X mg)	X mg	Never write a zero by itself after a decimal point (X mg)
No leading zero (.X mg)	0.X mg	Always use a zero before a decimal point (0.X mg)
ug	microgram	Write out microgram
cc milliliters	cubic meter	Write out ml or

Discharge Procedures and Abstract (DCA)

Discharge needs should be anticipated and arranged as soon as possible following admission. Case management is available to assist in discharge planning. Discharges should occur without delay once a patient is identified as appropriate for home based care. Discharges should be done in the morning before rounds if possible. The electronic discharge abstract, the DCA, should be completely filled out by the intern or resident prior to discharge. Abbreviations are not allowed on the discharge abstract.

Medical Records Completion

Residents are required to complete their medical records in a timely fashion, but in no event later than fourteen (14) days after a patient's discharge. Medical records not completed within fourteen (14) days of discharge are declared delinquent. Within seven (7) days of notification of a delinquent medical record, the Resident must visit Medical Records and complete the available delinquent charts.

(a) Suspension for Failure to Complete Records:

A Resident who fails to visit Medical Records to complete all available delinquent charts within seven (7) days of the delinquent record notification shall be suspended from clinical duties and reassigned full-time to the Medical Records Department until the Resident completes all available delinquent charts. Each day on suspension shall count only as a single day regardless of the number of delinquent charts that have not been completed within the prescribed time frame. Residents who accumulate more than fifty (50) days on suspension during their residency will have a letter placed in their file documenting their suspension and the reasons therefore. Periods of suspension under this provision, depending on length, may require the Resident to extend his/her period of training to meet the Residency Review Committee requirements for Board Certification. An extended period of training pursuant to this section shall not exceed the period of suspension, unless necessitated by Board Certification requirements.

(b) Participation in the Program Reviewed for Failure to Complete Medical Records:

Residents who accumulate ninety (90) days on suspension during their residency shall have their continued participation in the program reviewed.

6. Orders

See details of Order Writing in Medical Staff Rules and Regulations on CHONET [http://192.168.1.59/inetdocs/mso.rulesregs/MS Rules and Regulations 2010.pdf](http://192.168.1.59/inetdocs/mso.rulesregs/MS_Rules_and_Regulations_2010.pdf)
Section 10 – Orders, page 64

All orders are to be written using the computer based Order Entry System. Training will begin at orientation and be reinforced during the first day of your rotation. Instructions are also available in the Meditech Library under "Meditech Information/Instruction". Practitioners must be logged into the computer with their own log-in and password. Orders entered using the order entry system must be validated by having the

prescriber's name mnemonic match, so that the "ordered by" and "entered by" names are the same as the ordering practitioner.

Verbal orders are to be given only when failure to do so would be detrimental to patient care. They must be transmitted only to a Registered Nurse (RN) or Respiratory Care Practitioner (RCP). The verbal order will be transcribed onto the order sheet by the RN or RCP who accepts it. The Verbal Order must be repeated back to the practitioner to insure accuracy. All verbal orders must be dated and signed as soon as possible and always within 48 hours by the ordering physician.

7. Informed Consent

See details of Patient Consent in Medical Staff Rules and Regulations on CHONET [http://192.168.1.59/inetdocs/mso.rulesregs/MS Rules and Regulations 2010.pdf](http://192.168.1.59/inetdocs/mso.rulesregs/MS_Rules_and_Regulations_2010.pdf) Section 6: Patient Consent to Treatment, page 47

Medical and surgical procedures can only be performed after informed consent has been obtained from the parents, legal guardian, or with judicial authorization. It also helps to explain procedures to older children and adolescents and seek their consent. However, only an emancipated minor may sign a consent form.

Documentation of the consent process should be written into the chart either in the Progress Note or incorporated into the History and Physical Examination. Documentation should include from whom the consent was obtained, relationship to the patient, type of procedure, "risks and benefits discussed", "alternatives to the procedure presented", and "consent to proceed granted". Consents are valid for 30 days from the date of the signature on the consent form.

After discussion of the procedure with the parents or guardian and documenting this in the chart, an order needs to be written that an "Authorization for Consent to Surgery or Special Diagnostic or Therapeutic Procedures" form be prepared and signed by the parents or guardian. Hospital personnel will obtain the signature but any additional questions or concerns will be referred back to the Attending Physician.

Whenever there is a reasonable possibility that the patient will require blood transfusion, the patient, parent or guardian must be given a copy of the Gann Act, have explained to them the benefits versus risks of the transfusion, and then sign a transfusion consent. If possible, the consent should be obtained far enough in advance to allow for the option of designated donor blood. For more details about the Transfusion Protocol look in the Meditech Library in the "Laboratory" Cabinet under "Transfusion Protocol".

8. Procedure Competencies

Attaining proficiency in clinical and technical procedures is an important goal of residency training. Documentation of procedure competencies during residency is required by the RRC guidelines and can be used to support the resident's application for clinical privileges in the future. A core group of procedures, emphasizing those

procedural skills appropriate for a general pediatrician, have been identified as a requirement for graduation from the residency program.

These mandatory procedural skills consist of the following:

1. Basic and advanced life support
2. Endotracheal intubation
3. Placement of intraosseous lines (demonstration in a skills lab or PALS course is sufficient)
4. Placement of intravenous lines
5. Arterial puncture
6. Venipuncture
7. Umbilical artery and vein catheterization
8. Lumbar puncture
9. Bladder catheterization
10. Gynecologic evaluation of prepubertal and postpubertal females
11. Wound care and suturing of lacerations
12. Subcutaneous, intradermal, and intramuscular injections
13. Developmental screening test
14. Procedural sedation
15. Pain management
16. Reduction and splinting of simple dislocations/fractures

Also, residents must maintain certification in pediatric advanced life support (PALS) and neonatal resuscitation program (NRP) during their residency training.

In addition to the required procedures above, residents are strongly encouraged to become proficient in the following procedures by the end of their residency training:

1. Circumcision
2. Tympanometry and audiometry interpretation
3. Vision screening
4. Hearing screening
5. Simple removal of foreign bodies (e.g., from ears or nose)
6. Inhalation medications
7. Incision and drainage of superficial abscesses
8. Chest tube placement
9. Thoracentesis

The procedure competency system in use at Children's Hospital & Research Center Oakland includes both an initial supervision and certification of a successful procedure attempt as well as documentation of all subsequent successful procedures performed. Supervision and documentation of skills must be by faculty or residents with documented competency in the procedures.

The initial certification of proficiency is documented on an "Initial Certification of Procedure Competency" form following successful performance of a specific procedure. This form should be completely filled out including patient's name, age, diagnosis, date of procedure, indication for procedure and supervisor's name. In addition, the supervisor and the resident performing that procedure must sign the form. This form should be turned into the Medical Education Office, to be logged into the hospital wide database and then placed in the resident file. All subsequent procedures should be documented either in the **ACGME Procedure Log** or the **My Evaluations Procedure Log** with the

type of procedure, date of procedure and age of patient. The resident is encouraged to maintain as complete a list as possible of all procedures performed during their residency training.

This chart shows the rotations where each procedure is mostly likely to be needed.

Required Procedure	Rotations likely to do procedure	PL-1	PL-2	PL-3
Arterial Puncture	PICU	XX		XX
PALS	Orientation	XX		
Bladder Catherization	ED Annex, ED	XX	XX	XX
Developmental Screen (ASQ)	CAP, Cont. Clinic	XX	XX	XX
Endotracheal intubation	NICU, PICU, Alta Bates, Anesthesia	XX	XX	XX
Gyn exam prepubertal female	CAP, Cont. Clinic	XX	XX	XX
Gyn exam postpubertal female	Adolescent, ED, Cont. Clinic	XX	XX	XX
Intravenous Line Placement	Wards, ED	XX	XX	XX
Lumbar Puncture	ED, Wards	XX	XX	XX
Pain Management	Heme/Onc (Red/Aqua)	XX	XX	XX
Placement of IO	Covered in PALS/Transport	XX	XX	XX
Procedural Sedation	End of intern year	XX		
Reduction/Splinting	ED	XX	XX	XX
SQ, ID, and IM injections	CAP (shot room day)	XX		
Transport Ride Along	End of intern year	XX		
UAC/UVC placement	Alta Bates, NICU	XX	XX	XX
Venipuncture	ED, CAP (lab day), Wards, Anesthesia	XX	XX	XX
Wound Care suturing of lacs	ED	XX	XX	XX
Recommended Procedures				
Chest Tube Placement	PICU, NICU/AB, Transport	XX	XX	XX
Circumcision	Newborn (Kaiser)	XX		
Hearing Screen	CAP (day with MA)	XX		
I & D of superficial abscess	ED, ED Annex	XX	XX	XX
Inhalational Medications	CAP (day with MA)	XX		
Simple Removal of FB	ED, ED Annex	XX	XX	XX
Thoracentesis	PICU	XX		XX
Audiometry Interpretation	CAP (day with MA)	XX		
Vision Screening	CAP (day with MA)	XX		
Spirometry Interpretation	Asthma clinic, CAP, Cont.Clinic	XX	XX	XX

9. Patient Lists

All residents are expected, under the current RRC guidelines, to maintain patient lists as a means of documenting sufficient numbers and diversity of patients. This list should be compiled during the resident's continuity clinic experience. The **ACGME Patient Log or the My Evaluations Patient Log** must be used to maintain all patient lists. The log needs to include the age of the patient, the

diagnosis and the date the patient was seen. The resident should log patients they see as the primary provider in both the Inpatient and Emergency Room settings as well, to support the resident's application for clinical privileges in the future.

10. Confidentiality

Confidentiality of Information

The confidentiality of patient/family and staff information must be respected. Confidential information includes, but is not limited to, information acquired by discussion, consultation, examination, treatment and/or access to records. Be sensitive to your surroundings when discussing cases with your colleagues.

Passwords used to access the Hospital Information System (HIS) must not be disclosed or shared with anyone. The HIS system is not to be used to access patient or Hospital information except to conduct legitimate business. You must log off of the system when work is completed to prevent access to information by unauthorized persons.

Children's Hospital & Research Center Oakland values confidentiality rights, with regards to patients families, and restricted Hospital information. Any person working here authorized to access such information, who violates these rights, is subject to disciplinary action, up to and including termination.

F. Resident Supervision by Attending Physicians

All patients seen at or admitted to Children's Hospital & Research Center Oakland will have a designated Attending Physician who is a member of the Medical Staff.

As required by the Medical Staff Rules and Regulations, the Attending Physician is ultimately responsible for all decisions related to the patient's diagnostic and treatment plan, and outcomes.

The diagnostic and treatment plan must be discussed with the Attending Physician at the time of admission and subsequently on a daily basis. Ideally, "discussion" will be by verbal communication, but may as circumstances dictate, be by entries into the Progress Note section of the Medical Records.

Any significant changes in the diagnostic or treatment plan must be communicated to and be approved by the Attending Physician, unless a delay in intervention might compromise the patient's course. Under such circumstances the proposed changes must be discussed and approved by the appropriate senior resident.

Residents are given progressive responsibility under close supervision by Attending Physicians. Hospital Units, for the purposes of teaching, are organized into teams. Each team is supervised by an Attending Physician who is a member of the Active Medical Staff. For specific responsibilities of residents at each level on each inpatient

team, please see Section 3: Educational Expectations and Resident Responsibilities by Rotation - B.1. Inpatient Rotations.

A diagnostic procedure, after approval by the Attending Physician, may be performed under the supervision of a senior resident with documented competency in that procedure.

Residents may participate in the provision of consultative services but only under the supervision of a member of the Medical Staff with privileges in the consulting specialty or subspecialty.

G. Evaluations

General Policies

Evaluations procedures in use at Children's Hospital & Research Center Oakland are in accordance with the most recent guidelines of the American Board of Pediatrics and the current RRC requirements. The purpose of the evaluation process at Children's Hospital & Research Center Oakland is to:

- Provide formative feedback, in as continuous a fashion as possible during residency training, to allow the resident to obtain maximum educational benefit from their residency training.
- Help the resident identify strengths and weaknesses, set learning and improvement goals, and incorporate formative feedback into daily practice.
- Identify residents experiencing significant difficulties as early as possible in their training so as to provide support and effective remediation.
- Provide a consistent method to determine the appropriateness of promotion of an individual resident from year to year.
- Provide adequate documentation to protect both the resident and the residency program in the event of disciplinary proceedings.
- Provide a record of resident performance that allows for a final evaluation of the resident and verification of the resident's ability to practice competently and independently, and a record that facilitates the writing of future letters of recommendation that accurately reflect the overall residency performance.

The methods used for evaluation must produce an accurate assessment of the resident's competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. The evaluation process utilizes the MyEvaluations.com program for most evaluations, including faculty, resident,

and rotational evaluations. All written/electronic evaluations will become part of the resident's permanent file. All written evaluations are available for review at any time in the presence of the Director of Medical Education, Associate Program Director, Chief Resident or designee. Electronic evaluations completed by an attending are available for review online as soon as they are completed. Mechanisms for providing regular and timely feedback to residents and faculty include:

- Each resident will receive both written/electronic and verbal evaluation on every rotation. These evaluations should be conducted by both the supervising faculty and supervising residents. Verbal feedback regarding performance should occur midway through the rotation and again at the end of the rotation. Electronic evaluations should be completed within 2-4 weeks of being assigned.
- Each resident is also evaluated by nursing staff (inpatient and outpatient setting) at least semi-annually and by patients at least annually in the competency areas of professionalism and interpersonal and communication skills. (360 degree evaluation)
- Faculty evaluations are sought from the residents after every rotation and submitted anonymously to promote honesty and prevent the possible concern of ill will towards the resident. Faculty has the opportunity to review the anonymous resident evaluations after at least 5 have been completed by logging into their MyEvaluations.com account. A summary of the yearly evaluations of faculty is included in the annual faculty evaluation by the program.
- Evaluations will be requested from residents for each clinical rotation. These evaluations are used in the annual program review and for feedback to departments for continual educational improvement.
- The resident giving Journal Club is evaluated with the Evidence Based Checklist Evaluation by the supervising faculty member. Noon Conference given by a fellow is evaluated with the written Noon Conference Evaluation form. Faculty noon conference is evaluated under the teaching section of the faculty evaluation form on the MyEvaluations.com system. The result of the Journal Club evaluation is shared at the resident's semi-annual feedback session with the Program Director. The results of the Noon Conference evaluation is shared with the department as part of the annual program review of faculty.
- Residents and faculty are asked to perform a Program evaluation on an annual basis. The Program Directors will review these evaluations and if any deficiencies arise, construct a plan of action to address these deficiencies. Results of the Program evaluation and any plan of action are discussed annually with the Graduate Medical Education Committee.
- Faculty are evaluated annually by the program. Faculty evaluations are based on confidential resident evaluations throughout the year and on the

faculty's commitment to medical education. The faculty use their evaluations to strengthen their teaching skills and their departmental rotation.

- Residents have a detailed semi-annual feedback/evaluation meeting with one of the Program Directors. During this evaluation session all clinical evaluations, in-training examinations, progress toward procedure competency, duty hours and patient logs are reviewed in the context of the six competency based areas (interpersonal and communication skills, medical knowledge, patient care, practice-based learning and improvement and system-based practice). Constructive feedback is given to the resident based on the preceding information. During this session, the resident is asked to do a self assessment and outline learning and improvement goals to accomplish in the subsequent 6 months of training. Finally, career planning is discussed, and a mentor team initiated or modified depending on the career interest of the resident.
- The Program Director conducts a final evaluation for each resident at the completion of the program. The evaluation includes a review of the resident's performance during training program including the final period of education. The final evaluation verifies that the resident has demonstrated sufficient professional ability to practice competently and independently. The final evaluation becomes part of the resident's permanent record maintained by Medical Education.

Written evaluations are part of the resident's permanent record, which is maintained in a confidential manner, by the Department of Medical Education. Only the Program Directors and their administrative staff have direct access to these evaluations. These may be utilized in the future by the Program Directors for attestation of clinical competence for board application and for future job references.

H. Discipline, Remediation, Academic Probation, Due Process

Discipline

Section 1: A House Officer shall not be suspended or disciplined without just cause.

Section 2: Alleged administrative misconduct, which is misconduct by a House Officer not based on clinical performance or competence and/or which is not related to their satisfactory fulfillment of the clinical and academic standards of their residency program shall be subject to the grievance and arbitration set forth in this Agreement. The procedure may be expedited if agreed to by both parties.

Section 3: Disciplinary actions, including assignment of a remediation program, requiring the resident to repeat clinical rotations which were unsatisfactory, imposition of Academic Probation, reporting of marginal or unsatisfactory performance ratings to the American Board of Pediatrics, and non-renewal of a House Officer, when based on issues of clinical performance or competence, shall not be subject to Section 1 and/or

the grievance and arbitration procedure set forth in this Agreement, but shall instead be subject to the following procedure:

(a) The Program will maintain an evaluation and promotional review procedure that is in accordance with the guidelines issued by the relevant accreditation bodies. Written evaluations based on clinical performance will become part of each resident's permanent file. If a resident disagrees with a written evaluation and this disagreement cannot be resolved through discussions with the Director of Medical Education, the involved evaluator (resident or faculty) and the resident, then the resident shall have recourse to the formal appeal process outlined in this Section 3 to resolve the disagreement.

Remediation

(b) If significant deficiencies are identified by the program directors, a remediation plan will be developed in conjunction with the individual resident and the Chief Resident or an assigned faculty preceptor. A timetable of re-evaluation and performance expectations will be formulated. If, in the opinion of the Director of Medical Education, these performance deficiencies are sufficiently serious, the resident may be placed on Academic Probation.

Academic Probation

(c) Academic Probation may be imposed for academic or clinical performance deficiencies that are sufficiently serious and/or continue to occur despite attempts at remediation.

Academic Probation involves the following:

- A Letter of Academic Probation is placed in the resident's file.
- The resident must participate in, and complete in a satisfactory manner, an academic remediation program which generally consists of assigned readings, periodic sessions with an assigned attending or Chief Resident preceptor, mandatory conference attendance above that required for other residents, and other educational interventions. Other interventions such as psychiatric evaluation and/or counseling and testing for learning disabilities may also be required as deemed appropriate by the Director of Medical Education.
- Loss of moonlighting privileges.
- Probationary status shall be for a minimum of one month. Actual duration is contingent upon the resident's progress and success in correcting identified deficiencies as determined by the Director of Medical Education.

(d) Failure to achieve required performance expectations upon re-evaluation, continued marginal or unsatisfactory evaluations, or failure to comply with the assigned remediation plan may result in either a "marginal" rating being issued to the American Board of Pediatrics (ABP) with or without additional time being required at the current or previous level of training, or an "unsatisfactory" rating to the ABP with a requirement to

repeat the year of training in question. If failure to achieve required performance expectations occurs despite remediation, or the resident fails to comply with the terms of academic probation, the Hospital may also notify the resident that the Hospital does not intend to renew the House Officer's agreement, in accordance with the "Individual Contracts" section of this Agreement (See Section 2.C. of this Manual "Reappointment").

(e) In exceptional circumstances, where the Director of Medical Education has evidence that there is immediate danger to Hospital personnel, patients or the public by the continued functioning of the resident, such resident may be immediately suspended from patient care duties until a definitive course of action is determined.

(f) Residents have the right of formal appeal of evaluations and actions taken by the Director of Medical Education for academic deficiencies. The resident must formally request such an appeal, in writing, within fourteen (14) days of notification of the contested action or evaluation.

(g) The Hospital, within seven (7) days of the written request of the House Officer, shall convene an ad hoc committee of the Medical Staff of the Hospital to review de novo any actions made pursuant to the sections above. The ad hoc committee shall be composed of five (5) members of the Medical Staff, as follows: one appointed by the Chair of the Graduate Medical Education Committee, one appointed by the Chief Medical Officer, one selected by the affected House Officer, a Chief Resident selected by the Medical Director, and the Chair of the Department of Medicine or his/her designee. One member shall be designated as a Chairperson. No staff member who has participated in the disciplinary action shall be appointed as a member of the ad hoc committee.

(h) The ad hoc committee shall meet within one (1) week of its appointment. The affected House Officer shall be informed of each and every meeting of the ad hoc committee and shall have the right to have a CIR representative present at the meeting and shall be able to bring relevant witnesses. A majority vote of the ad hoc committee shall be necessary to overturn the disciplinary action under review.

(i) The parties agree that the procedures described in this article shall be the sole and exclusive avenue of recourse for the aggrieved House Officer under this Agreement.

I. Grievance Procedure

The procedure set forth in this section shall be the exclusive procedure for the handling and settling of any and all claims, grievances, differences or disputes (hereafter called "grievances") raised by the Hospital, a House Staff Officer(s) or the Union concerning the interpretation and/or application of this Agreement. The time limits set forth below may be extended on a case by case basis only by a mutual written agreement of the parties.

Step 1: The grievance must be presented in writing to the Hospital within twenty (20) days after the event complained of or within twenty (20) days after the time when such event could reasonably have been discovered, whichever is later, not to exceed one (1) year from the event. A grievance addressed to the Hospital shall be delivered to the Director of Medical Education, with a copy to the Human Resources Department.

Disposition in Step 1 shall be deemed to have occurred on the earliest of the following dates: the date when the grievance is settled or rejected, or the tenth day after it is presented in Step 1 without a response satisfactory to the grieving party.

Step 2: If a satisfactory settlement of the grievance is not reached in Step 1, the grievance must be presented in writing to the Director of Employee/Labor Relations within (10) days after disposition in Step 1. Grievances presented by the Hospital to the Union shall begin at Step 2, and be presented in writing to the Union within the time limits described in Step 1. Authorized representatives of the Union and the Hospital shall discuss the grievance. A decision must be made within ten (10) days after presentation of the grievance at Step 2. Any grievance in Step 2 which is not settled to the satisfaction of the grieving party within ten (10) days after it has been so presented shall be deemed rejected.

Settlement Without Proper Appeal: Any mutual settlement of the grievance pursuant to the procedures set forth in this Agreement, or any disposition of a grievance not properly appealed to the next step or arbitration pursuant to this Agreement, shall be final and binding upon all parties and upon the House Staff Officer(s) involved, to the same extent as a final arbitration award.

Step 3-Arbitration: Any grievance that remains unsettled after having been fully processed pursuant to the grievance procedure may be submitted to arbitration upon the written request of the Union or Hospital, provided such request is made within twenty (20) days after the disposition of the grievance in Step 2. Upon receipt of a timely, written request for arbitration, the Union and the Hospital shall select an arbitrator. If the parties cannot agree upon the selection of an arbitrator, they shall request a list of arbitrators from the Federal Mediation and Conciliation service. The parties shall alternately strike names from such list until one name remains, which person shall be the arbitrator.

The award of an arbitrator pursuant to this Section upon any grievance subject to arbitration shall be final and binding upon all parties to this Agreement and the House Staff Officers covered by it; provided, however, that such award may not add to, subtract from or change any of the terms and provisions of this Agreement, giving the words used their common and ordinary meaning. The arbitrator's jurisdiction shall extend solely to claims of violation of specific written provisions of the Agreement and involve only the interpretation and application of such Agreement.

Each party shall bear all the expenses of its own representatives and witnesses. The arbitrator's fees, as well as other expenses connected with the formal hearing, shall be borne equally by both parties.

J. Malpractice Insurance / Professional Liability

Malpractice Insurance

The Hospital will maintain malpractice coverage for House Officers consistent with that provided to the Hospital's employed physician staff. CIR shall be provided once per year with certificates evidencing the coverage. The Hospital will notify CIR, within thirty (30) days, of any notice of cancellation or lapse in professional liability insurance coverage applicable to House Officers. The Hospital shall notify CIR at least thirty (30) days in advance of any prospective change in professional liability coverage.

K. Health, Vision, Dental, Disability, and Life Insurance

Group Health, disability, and life insurance benefits as of June 30, 2010 shall be continued in effect unless or until the California Nurses Association ratifies a change in those benefits, at which point such change shall automatically be applicable to the employees covered by this Agreement.

L. Schedules

Yearly Tracks

The incoming Chief Residents will distribute yearly schedule tracks to all residents continuing their training at Children's Hospital & Research Center Oakland as soon as possible prior to the start of the new academic year. Residents will be asked to rank these tracks based on order of preference and return their rankings to the Chief Residents by the designated return date. The Chief Residents will make every effort to assign schedule tracks based on individual resident preferences and RRC requirement needs. Any PL-2 who has not obtained a California Medical License cannot be assigned a PL-3 track.

Following yearly schedule track assignments, residents will be allowed a reasonable period of time to arrange trades with other residents to optimize their yearly schedule. The final yearly schedule track must represent a balanced educational experience, conform to the requirements for graduation delineated by the RRC and Children's Hospital & Research Center Oakland, and be approved by both the Chief Residents and Directors of Medical Education.

The rotation schedule is based on 13 four week blocks per academic year. Periodically, the length of Blocks #13 and/or #1 are lengthened to maintain a PL-1 orientation start date no earlier than June 15th.

Monthly Schedules

Monthly call schedules will be distributed a minimum of one month prior to the start date of the rotation. It is important for the resident to review the monthly call schedule for errors or conflicts and notify the Chief Residents promptly.

On average over the month, in-house overnight call will generally be no more than every fourth night. Home-based call such as 1st Transport and Jeopardy call will generally be no more frequent than every third night.

Schedule Requests

All schedule requests must be submitted by e-mail to the Chief Residents by the designated cut off date. While reasonable efforts to accommodate all schedule requests will be made, not all schedule requests can be granted.

Schedule Changes

Schedule changes in the published monthly call schedule, no matter how minor, must be approved in advance by the Chief Residents. Requests for schedule changes must be made in writing and a "Request For Schedule Change" form must be submitted for approval. Schedule change approval requires that all residents involved must be in compliance with Medical Records, must not interfere with resident Continuity Clinics, and that there be no adverse impact on patient care or other residents. All steps, including notification of telephone operators, must be followed. Subject to the above, schedule changes will not be unreasonably denied.

M. Vacations, Holidays, and Leaves of Absence

1. Vacation and Holidays

- A) Vacation: All residents shall be provided a total of four weeks vacation annually, normally divided into two week blocks. The dates of assigned vacation shall be included in the assigned yearly schedule tracks and changes in vacation dates are subject to the usual schedule change procedures.
- B) Holidays: The following are recognized holidays at Children's Hospital & Research Center Oakland: Independence Day, Labor Day, Thanksgiving Day, Christmas Day, New Year's Day, Presidents Day, Martin Luther King Jr. Day and Memorial Day.

Holiday coverage is similar to weekend coverage. If a resident is not on call that day, then they are not required to come into the Hospital. Exceptions to this include the Emergency Department, ED Annex, and Night Float for which holidays are treated as usual working days. All conferences and continuity clinics are cancelled on recognized holidays.

Each resident will also be assigned a specific three-day holiday at one of three times during the year, which is designated on their yearly track assignment. This is called a three-day holiday because some residents will be post-call on the first day of their four days off. Availability of these holidays is based on patient care needs.

2. Maternity/Paternity/Adoptive/Domestic Partner Leave

- A) Maternity Leave: Pregnant residents are encouraged to contact the Chief Resident and the Program Director as soon as possible to begin arrangements for maternity leave. The Hospital will grant up to 26 weeks (6.5 four-week blocks) of unpaid maternity leave for pregnant employees from the time they can no longer perform normal housestaff functions. Maternity leave must be scheduled to begin and end at either the beginning or middle of a four-week rotation. In circumstances when a resident is unable to perform her scheduled duties prior to the scheduled leave, the maternity leave will still be limited to 26 weeks total, and the resident is required to make up any rotations that are missed. The Hospital will provide

health insurance coverage for up to three months of approved maternity leave. Limited disability payments through the California State Disability Insurance Program are available during maternity leave;

- (B) Paternity/Adoptive/Domestic Partner Leave: Prospective fathers, adoptive parents and domestic partners are entitled to three months of unpaid leave. The Hospital will provide health insurance coverage for up to three months of approved leave. Residents anticipating such leave should contact the Chief resident and Director of Medical Education as soon as possible to begin arrangements;
- (C) Any leave of absence, depending on length, may require the resident to extend the period of training to meet the RRC requirements for Board Certification;
- (D) The Hospital shall amend or change the leave provisions of this article as is necessary to comply with current law

3. Sick Leave

Residents shall be allowed a maximum of ten (10) sick days per academic year, for which they shall not lose payment. Out of these ten (10) days, residents shall be allowed one (1) sick day per year for an absence necessitating replacement, which if unused at the end of the academic year, will be paid back to the resident at the rate of \$200.00 for the unused day. For each additional sick day a resident uses for an absence necessitating replacement, the resident's name shall be added to the "back up pool". Absences that do not necessitate replacements shall count as one of the resident's ten (10) sick days, but will not result in a jeopardy pool obligation. Unused sick days shall not roll over to the following academic year, nor shall they convert to cash bonuses at any time, except as specifically set forth above.

When the Hospital determines that coverage is needed, the Chief Resident shall call residents from the "back up pool" in rotating order. Residents shall monitor the placement of their name on the list, and shall be required to ensure their availability when called. This requirement shall not apply if the Resident is on vacation or on an elective rotation out of the Bay Area. A resident's name shall be skipped temporarily if calling that resident would violate the applicable duty hour requirements, but that resident's name shall remain at the top of the list until he/she can be called consistent with the duty hour requirement.

The Chief Resident may modify this system as they deem advisable.

If a Resident is exposed to a communicable disease, the Hospital may offer the resident an alternative assignment that does not present exposure issues, such as preparing teaching materials. If the resident performs the alternative assignment, or if the Hospital does not offer an alternative assignment, the resident's absence will not count as a sick day, and will not cause the resident to incur a jeopardy obligation. If the resident does not perform an offered alternative assignment, the resident's absence due to communicable disease exposure will

count as a sick day and will incur a jeopardy obligation, in accordance with the guidelines set forth above.

4. Other Absences

Residents are expected to remain in the hospital during the usual working hours of their assigned rotation. For most rotations - excluding ED Annex, ED, and Night Float - the resident should not leave the hospital prior to 4:00 p.m. except if post call. Exceptions to this policy require the notification and approval of both the faculty (or resident supervisor on the rotation) and the Chief Resident.

Absences due to personal or family crisis (including death or illness of family members), necessity for fellowship or job-related interviews, routine medical/dental/vision appointments and other circumstances not covered above are allowed, are subject to notification and approval by the Chief Resident.

Leaves of Absence

Leaves of absence shall be administered within the purview of the family and Medical Leave act of 1993 (FMLA) and the California Family Rights Act (CFRA). For specific information on leaves of absence, please contact Human Resources.

N. Duty Hours

Duty Hour Limits

General

Children's Hospital and Research Center at Oakland recognizes the importance of duty hour policies that support the physical and emotional well-being of residents, promote an appropriate educational environment and facilitate patient care. It is the policy of the Pediatric Residency Program to fully comply with the general duty hour requirements adopted by the ACGME and any additional requirements of the RRC for Pediatrics. Required education for residents regarding sleep deprivation and fatigue starts during Intern Orientation and continues on a regular basis with the Professionalism Series at Noon Conferences.

- Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.
- Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.

- Residents will be provided a minimum of one day free of duty every week (when averaged over four weeks).
- Adequate time for rest and personal activities will always be provided. All residents must have a minimum of 8 hours (should have 10 hours) free of duty between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.
- Moonlighting that occurs within the residency program and/or Children's Hospital & Research Center Oakland, i.e., internal moonlighting, must be counted toward the 80-hour weekly limit on duty hours. The Residency Director will monitor internal moonlighting by residents to ensure that duty hour limits are not violated.
- Maximum duty period length: PL-1 residents must not exceed 16 hours in duration. PL-2 and PL-3 residents may be scheduled for 24 hours of continuous duty plus an additional 4 hours for education and effective transitions of care.
- Residents will not be scheduled for more than 6 consecutive nights of night float.
- Duty Hours **must** be entered weekly into your "MyEvaluation" time sheet

O. On-Call Activities

The objective of on-call activities is to provide residents with continuity of patient care experiences between daytime and nighttime hours. In-house call is defined as those duty hours beyond the normal workday when residents are required to be immediately available in the assigned institution.

- In-house call will never occur more frequently than every third night, averaged over a four-week period.
- For senior residents, no new patients may be accepted after 24 hours of continuous duty. A new patient is defined as any patient for whom the resident has not provided care during the previous 24 hour period or who is not a part of the resident's continuity panel.
- At-home call (pager call) is defined as call taken from outside Children's Hospital & Research Center Oakland and any participating institutions.
- At-home call will never occur more frequently than every third night, averaged over a four-week period. Residents taking at-home call will also be provided a minimum of one day free of duty every week (when averaged over four weeks).

- When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.
- The Residency Director and the faculty will monitor the demands of at-home call in the program and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

P. Moonlighting

Moonlighting is an allowed activity for Children's Hospital & Research Center Oakland PL-2 and PL-3 residents subject to the following guidelines:

- Moonlighting is defined as any professional and patient care activities that are external to the educational program.
- The Residency Director is responsible for deciding whether individual residents are allowed to moonlight. Any resident who desires to engage in moonlighting must prospectively obtain a written statement of permission from the Residency Director that will be placed in their file.
- Because residency education is a full-time endeavor, the Residency Director must ensure that moonlighting does not interfere with the ability of an individual resident to achieve the goals and objectives of the educational program.
- The Residency Director will monitor individual resident performance for any adverse effects of moonlighting on their performance. Adverse effects may lead to withdrawal of permission.
- Moonlighting that occurs within the residency program and/or Children's Hospital & Research Center Oakland, i.e., internal moonlighting, must be counted toward the 80-hour weekly limit on duty hours. The Residency Director will monitor internal moonlighting by residents to ensure that duty hour limits are not violated.
- Residents have a primary responsibility to the care of patients at Children's Hospital & Research Center Oakland.
- Residents must not be required to engage in moonlighting.
- Residents moonlighting outside Children's Hospital & Research Center Oakland are not covered by the hospital malpractice insurance.

Residents may moonlight only under such circumstances and to the extent provided in: (1) written permission received from the Program Director; (2) the guidelines set forth above in the Residents' Manual, as amended from time to time by the Hospital; and, (3) the ACGME Guidelines. The Hospital shall notify the Union prior to implementing any changes to the moonlighting guidelines in the Residents' Manual.

Q. Shared Positions

The following guidelines apply to shared positions in the Children's Hospital & Research Center Oakland Residency Program:

- Granting of shared positions is at the discretion of the Director of Medical Education.
- Any resident desiring a shared position must submit a formal written request as early in the year as possible, preferably by October 1st.
- If there is another resident already interested in being a partner in a shared position, both residents should jointly submit a request.
- If there is no other resident in a shared position at the time of request, the application will remain on file and will be matched with the next compatible request submitted.
- Residents entering a shared position must agree to complete a total residency year before re-entering the program as a full-time resident. In other words, once a commitment is made to share a position, it will be with the full understanding that it will take two years to complete one year of residency.
- All shared positions must be designed such that each resident will work alternate six consecutive month periods.
- The availability of shared positions is completely dependent upon the ability of the residency training program to recruit an acceptable senior resident's replacement.
- Salary, medical/dental/vision benefits and malpractice insurance coverage will not be provided during the six months away from the hospital.

R. Counseling Services

Employee Assistance Program

All residents have access to confidential counseling services through the Children's Hospital & Research Center Oakland Employees Assistance Program (EAP). Professional assistance is available for stress, depression, marital difficulties, alcoholism, drug abuse, legal, financial, and other problems. Subject to certain restrictions, these services are provided free of charge. Participation in this program is strictly voluntary.

Interested residents should contact the EAP directly at **1-800-834-3773**. All calls and services are completely confidential.

S. Physician Impairment/Substance Abuse

Early identification and intervention for residents who may be exhibiting signs of impairment due to substance or alcohol abuse, chemical dependency, mental illness, or stress-related conditions is an important responsibility of the Director of Medical Education, Chief Residents, supervising faculty and fellow residents.

The following policies apply to physician impairment/substance abuse at Children's Hospital & Research Center Oakland:

- Program directors and hospital management will treat all communications regarding a potentially impaired resident, including those involving alcohol or drug use, with the strictest confidentiality.
- All residents have access to confidential counseling services through the Employee Assistance Program (EAP). Professional assistance is provided free of charge for stress, depression, marital difficulties, alcohol and drug use and other problems. All calls and services provided by the EAP for self-referred services are completely confidential.
- Children's Hospital & Research Center Oakland has a strong commitment to provide a safe workplace for its employees and to promote employee health. The hospital's policy regarding alcohol and drug use reinforces this commitment and is in compliance with the Drug-Free Workplace Act of 1988. For this reason, alcohol and/or non-medically authorized drug use which adversely affects or is likely to affect a resident's job performance or jeopardizes the safety of the resident, other employees or patients may result in disciplinary action.
- Disciplinary action for alcohol or drug use in the workplace depends on the nature and seriousness of the problem. If deemed appropriate by the Director of Medical Education, the resident may be required to undergo psychiatric evaluation, counseling and/or successfully participate in a formal drug rehabilitation program in order to continue residency training.
- Failure to successfully complete such a program would result in further disciplinary action, including failure to be re-appointed to the next level of training or termination of employment as a resident prior to the end of the academic year.
- All disciplinary action taken against individual residents is subject to formal appeal through the written grievance procedures outlined in the Resident Manual.

Required education for residents regarding Physician Impairment and Sleep Deprivation starts during Intern Orientation and continues on a regular basis with the Professionalism Series at Noon Conferences.

T. Harassment

It is the policy of Children's Hospital & Research Center Oakland to provide a work environment free from harassment. Children's Hospital & Research Center Oakland maintains a strict policy prohibiting sexual harassment and harassment because of race, religious creed, color, national origin, ancestry, disability of physical handicap, medical condition, marital status, age, sexual preference or any other basis made unlawful by federal, state, or local ordinance or regulation. Residents that are subject to or are witness to prohibited harassment should immediately report such conduct to either the Chief Resident or Director of Medical Education. If the Chief Resident or Director of Medical Education is the source of the harassment, the employee should report directly to the Director of Human Resources. Upon receiving the complaint, a full investigation will be conducted. Details on this policy are available from the Personnel Department.

U. Accommodation for Disabilities

CHRCO ADA COMPLIANCE POLICY #E05

POLICY

Children's Hospital & Research Center at Oakland (CHRCO) provides job accommodations which are both reasonable and necessary to known limitations of qualified applicants and employees with disabilities and employees who develop disabilities. In accordance with the Americans with Disabilities Act of 1990, CHRCO does not discriminate on the basis of mental or physical disability.

1. PURPOSE

The purpose of this policy is to ensure employment opportunities for qualified individuals with disabilities and to describe the process for providing job accommodations to enable individuals with disabilities to perform the essential functions of a job.

2. COVERAGE

All qualified applicants and employees who need an accommodation of a disability in order to perform the essential functions of a job.

3. PROVISIONS

- a. Individuals are considered qualified for employment if they

meet the minimum job requirements and can perform the essential functions of a job, with or without reasonable job accommodation.

- b. CHRCO provides job accommodations unless they create an undue hardship. In general, an accommodation may be considered an undue hardship if it is unduly costly, extensive, substantial, disruptive, or would fundamentally change the essential functions of the job. Undue hardship is determined on a case-by-case basis.
- c. Individual accommodations may include revised procedures, personal assistance, adapted workplaces and devices, and job restructuring which permits the individual to perform the essential functions of the job.
- d. Revised procedures might include, but are not limited to:
 - Arranging to have a presentation recorded for a blind employee, providing instructions in writing to a deaf employee, and conference call arrangements for mobility limited workers where travel to a meeting is difficult.
 - Personal assistance might include, but is not limited to, parttime readers for blind employees, qualified interpreters for deaf persons, and accommodations for assistive dogs.
 - Adapted workplaces and devices might include, but are not limited to, speech synthesizers, telecommunication devices for deaf persons, personal computers with special accessories, Braille printers, raised desks, and lowered file cabinets or desk tops.
 - Job restructuring might include, but is not limited to, reallocating nonessential job functions or altering when or how an essential function is performed if this permits the individual to perform the essential functions of the job.
- e. Job accommodation for a current employee could also include reassignment to a similar, vacant position except when accommodation would pose an undue hardship. (Reassignment for bargaining unit employees is in accordance with applicable collective bargaining agreements.)

- f. Applicants for employment, who cannot be reasonably accommodated for the original position applied for, may apply for other CHRCO positions.
- g. Physical structural accommodations such as ramps, wider door, handrails, accessible restroom facilities and disabled parking spaces are provided and maintained in working order by Facilities Management.
- h. Personal aids, such as hearing aids, guide dogs, and wheelchairs are the individual's responsibility to supply and are not provided by CHRCO.

4. PROCEDURE

- a. If an applicant or employee needs an accommodation Human Resources will initiate an interactive meeting. In the interactive meeting they will review the job and ask the applicant or employee if there are any essential functions of the job that the individual might be or is unable to perform. If there are, they ask if the individual can suggest an accommodation. The focus is on the individual's ability to perform the essential functions of the job, not the nature or severity of the disability. It is not permissible to inquire about the applicant's previous attendance records. The interactive meeting will identify how an accommodation can address the limitation and how the specific tasks can be done.
- b. The applicant or employee may be asked to submit documentation from their medical provider. Human Resources will provide a job description prior to the interactive meeting. An applicant or employee should have their medical provider review their job description to determine any limitations or restrictions. The medical provider should indicate in writing any limitations or restrictions. The medical provider may be contacted by an Employee Health Clinician. The Employee Health Clinician will receive any additional medical information/documentation related to the accommodation request and clarify it with the medical provider(s) if necessary. All communications will be kept confidential. The employee may also be required to be examined by a

medical provider selected by CHRCO or have a functional capacity evaluation at CHRCO's expense.

- c. If an accommodation requires a modification to the building, Human Resources will contact the Facilities Department. If an accommodation requires expenses which exceeds the facility budget a discussion must occur between the appropriate administrative parties.
- d. If sufficient accommodation does not seem feasible, Human Resources may include an Employee Health Representative in the interactive process. If the employee has been disabled due to a work-related injury or illness, Human Resources will contact the Employee Health Department to review accommodation possibilities.
- e. Before disqualifying a candidate because an accommodation cannot be made, Human Resources may request additional interactive meetings with the applicant.
- f. If there is a question as to whether the necessary accommodation creates an undue hardship, the determination is made by the Vice President of Human Resources and Chief Operating Officer within two weeks.
- g. Once the needs and possible accommodations are understood, Human Resources will discuss the recommendation with the applicant or employee. Although the applicant or employee's suggestions are fully considered, CHRCO makes the final determination as to what accommodations will be provided.
- h. Supplies and equipment needed for an accommodation are acquired in accordance with applicable Purchasing Procedures. If the cost of the accommodation exceeds the departmental budget, the determination as to if and where to charge the expense is made by the COO/Vice President.
- i. Accommodations are made available within 30 days of acceptance of the job offer.

- j. Human Resources informs the Department Manager when accommodations are made and the Manager periodically checks to ensure that accommodations remain effective.
- k. Any person who believes he/she has been subjected to discrimination on the basis of disability, in contradiction of the policy stated above, may file a complaint. It is against the law for CHRCO to retaliate against anyone who files a complaint or cooperates in the investigation of a complaint.
- l. Complaints must be submitted to Human Resources within 30 days of the date the person filing the complaint becomes aware of the alleged discriminatory action. If a complaint relates to a matter that is more than 30 days old, the reason for the delay will be taken into consideration.
- m. A complaint should be in writing and must state the problem or action alleged to be discriminatory and the remedy or relief sought by the claimant. Complaints must be signed and dated, and must contain the name and address of the person(s) filing the complaint.
- n. Human Resources will conduct an investigation of the complaint to determine its validity. This investigation may be informal, but it will be thorough, allowing all interested persons an opportunity to submit evidence relevant to the complaint. Human Resources will maintain the files and records for such complaints.
- o. A written decision on the complaint will be issued no later than 30 days after its filing.
- p. The complainant may appeal the decision, in writing, to the Director of Labor and Employee Relations within 15 days of receiving the decision.
- q. The Director of Labor Relations and Employee Relations will issue a written decision in response to the appeal no later than 30 days after its filing.
- r. Use of this CHRCO procedure does not preclude a person from filing a complaint of discrimination on the basis of

disability with the U.S. Department of Health and Human Services, Office for Civil Rights.

- s. CHRCO will make appropriate arrangements to assure that disabled persons can participate in or make use of this procedure on the same basis as the non-disabled. Such arrangements may include, but are not limited to, the provision of interpreters for the deaf, providing taped cassettes of material for the blind, or assuring a barrier-free location for the proceedings. Human Resources is responsible for providing such arrangements.

V. Program Closure/Reduction

If the Hospital intends to reduce the size of or close the Pediatric Residency Program, or if the Hospital's program is placed on probation by the ACGME, the following guidelines must be followed.

- a) All affected House Officers and the GMEC will be informed of the decision or development as soon as possible; and,
- b) In the event of such a reduction or closure, the Hospital will make reasonable efforts to allow affected House Officers already in the program to complete their education, or assist those House Officers in enrolling in an ACGME-accredited program in which they can continue their education.

W. Disaster Policy

Policy on Administrative Support for GME Programs in the Event of Disaster

Purpose: As the Sponsor of Graduate Medical Education Programs, Children's Hospital and Research Center Oakland (CHRCO) will provide administrative support in reconstituting and restructuring residents' and fellows educational experiences as quickly as possible in the event of a disaster that causes significant disruption of the residents' or fellows' experience.

Procedure:

1. As soon as possible, but no later than five days after the declaration of such a disaster, the DIO or GMEC Chair will arrange a meeting of all program directors to determine whether or not each program can provide adequate educational experience to its trainees.
2. If any of the above individuals are unable to participate in the meeting, designees determined by the CEO, CMO, or Senior Ranking Physician Official at CHRCO, will be appointed as substitutes.

3. For any programs unable to provide adequate training, alternative arrangements will be sought for the trainees, and the ACGME will be consulted in all such arrangements.
4. Program Directors will contact the appropriate Review Committee Director with information or requests for information.
5. Program Directors will arrange temporary transfers of residents to other programs until the CHRCO program can provide adequate educational experience, or program directors will expedite permanent transfers if necessary.
6. If more than one program is available for temporary or permanent transfer of a particular resident, the preference of that resident must be considered.
7. All arrangements of temporary or permanent transfers will be done expeditiously so to maximize the likelihood that each resident will complete the year in a timely fashion.
8. Within 10 days after the declaration of a disaster, the DIO will contact the ACGME to discuss due dates that the ACGME will establish for the programs:
 - to submit program reconfigurations to ACGME
 - to inform each program's residents of resident transfer decisions
 - The due dates for submission will be no later than 30 days after the disaster unless other due dates are approved by the ACGME.

X. GMEC and Other Committee Representation

Residents are encouraged to join a number of Hospital and Medical Staff Committees. These include both standing committees and ad hoc committees.

GMEC:

Two representatives for the residents, the House Staff Presidents selected by their peers, are appointed to the Graduate Medical Education Committee.

House Staff Association:

The House Staff Association acts as a representative body for the House Staff. The House Staff Association maintains a set of bylaws outlining its activities, procedures and organization. Two House Staff Presidents are elected from the PL-1 group at the end of the academic year by a majority vote of all of the residents in the program. These two House Staff Presidents serve on the GMEC. One representative from each of the other two classes is also selected.

During the monthly "PL-1,2,3" meeting with the Program Directors, the House Staff are encouraged to discuss any issues pertinent to their educational and work environment or any other aspects of the residency program. Additional individual meetings are also held in order to address the concerns of the House

Staff in a confidential, protected manner. The House Staff Presidents also have the opportunity to meet with the Director of Medical Education, Associate Program Director, and Chief Residents.

Intern Selection Committee:

Two residents per class are appointed by the Program Directors to the Intern Selection Committee.

Other Committees:

Residents are encouraged to participate in at least one of the Hospital's Quality Improvement Committees. Appointment of residents to a Hospital or Medical Staff Committee is at the discretion of the Director of Medical Education, the Medical Staff President, and the relevant committee chairperson.

The Joint Committee:

The Joint Committee shall be composed of three (3) interns, residents and/or fellows appointed by CIR who are covered by the agreement and three (3) representatives of the Hospital appointed by the Medical Director. The members of the Committee may vary depending on the issues identified.

There shall be designated Co-Chairpersons of the Committee, one designated by CIR and one designated by the Hospital, who shall alternate the Chair of the Committee. These designations may be changed by the appropriate party from time to time.

The Co-Chairpersons shall confer in advance of each committee meeting to establish an agenda for the meeting. The Co-Chairpersons shall alternate responsibility for drafting the minutes, which shall be subject to the Committee's approval.

The members appointed by CIR shall be excused from their clinical duties for the purpose of attending Joint Committee meetings, provided that a maximum of one employee per service may be so excused. These meetings will not be grievance meetings or collective bargaining meetings.

The responsibilities of the Committee shall be advisory only. Objectives of the Joint Committee shall be:

1. consider constructively the professional practice of housestaff;
2. to work constructively for the improvement of patient care;
3. to recommend to the Hospital ways and means to improve patient care;
4. to make recommendations to the Hospital where, in the opinion of the Committee, housestaff responsibilities should be adjusted;
5. to consider constructively the improvement of safety and health conditions which may be hazardous.

Limitations

The Joint committee will not discuss economic issues or other matters subject to collective bargaining or the CIR contract.

The Joint Committee activities are advisory and are not subject to the CIR grievance procedure.

Minority Retention and Recruitment

Effective July 1, 2010, the Hospital will designate \$7,000.00 per academic year (July -June) of the contract for purposes of recruiting and retaining minority housestaff. The Joint Committee shall make recommendations for the expenditure of this money, which shall be subject to the approval of the Graduate Medical Education Committee and the Hospital. All expenditures must be consistent with the rules, regulations, policies, and procedures of the Medical Staff and the Hospital. Unused funds shall not roll over to the following academic year.***

Y. Health and Safety

The Hospital will comply with all applicable federal laws and regulations concerning occupational safety and health. Likewise, it is the duty of each employee to comply with all of the Hospital's health and safety regulations.

Meals

Residents will have their yearly meal allowance placed on their badge at the beginning of the academic year, in the following amounts:

PL 1 \$2080

PL 2 \$1872

PL 3 \$1768

Effective 7/1/11 and 7/1/12, change existing meal allowance to the same extent the cafeteria increases prices, up to a maximum of 4% per year. Unused balances at the end of the academic year shall not roll over to the next academic year. Residents may charge up to a maximum of sixty dollars (\$60.00) per day on their badge.

Call Rooms, Scrubs, and White Coats

Residents on call will be provided with adequate and appropriate sleeping quarters. The Hospital will provide or, at the Hospital's option, reimburse each new Resident for the cost of two (2) sets of scrubs and one (1) white coat, including the cost of embroidering the Resident's name on the white coat.

Parking

All House Staff Officers shall be granted free access to at least one Hospital parking lot, as designated by the Hospital. The Hospital shall make reasonable efforts to provide this parking within one block walking distance from the main Hospital. Upon request, a security escort shall be made available to and from the parking lot.

Lockers

Children's Hospital & Research Center Oakland will provide each resident with a secure locker located in the Resident's Lounge. In addition, lockers are available in or near many resident call rooms in the hospital as well as 5220 Claremont for use when residents are in continuity clinic.

E-mail

The Hospital will provide groupwise (or equivalent) e-mail accounts (although not dedicated terminals) to all Residents.

Z. Vendor Interactions and Physician Conflict of Interest Policy

It is the policy of Children's Hospital & Research Center Oakland ("Hospital") that its residents and fellows are to refrain from any actual or perceived conflicts of interest with industry. Conflicts of interest arise where there is a divergence between an individual's private interests and his/her professional obligations to the Hospital, other medical staff, patients or employees such that an independent observer might reasonably question whether the individual's professional actions or decisions are determined by considerations of personal gain, financial or otherwise. A conflict of interest depends on the situation and not on the character of the individual.

General Principles

At Hospital clinical decision making and patient care must not be influenced by any relationships with vendors of pharmaceuticals or equipment. If conflicts arise they must be addressed appropriately and expeditiously. Hospital recognizes that interactions are the responsibility of both industry and Hospital personnel.

All faculty, students and staff have a responsibility to ensure, to the best of their abilities that all decisions about clinical care, research and educational content are independent and unbiased. The following guidelines have been adopted to minimize the potential for real or perceived bias in clinical care, education and research. These guidelines cannot identify every potential conflict, but rather serve as a general guideline upon which residents and fellows should act.

Guidelines

This policy incorporates:

1. Gifts, Meals, Books, Online Subscriptions, Promotional Items and Compensation
2. Drug Samples, Supplies and Equipment
3. Support for Educational and Other Professional Activities
4. Provision of Scholarships or Other Educational Funds
5. Travel funds
6. Speakers and Ghostwriting
7. Research Contracts
8. Disclosure of Relationships with Industry
9. Compliance by Industry

1. Gifts, Meals, Books, Online Subscriptions, Promotional Items and Compensation

a. Personal Gifts, regardless of value, from any industry representative may not be accepted by any resident or fellow as part of any work-related activity or during any clinical or other educational rotation. This includes, but is not limited to loans, economic opportunities, meals, tickets or vouchers for entertainment events, textbooks, software, online subscriptions, pens, notepads or cash. Under no circumstances can promotional items be used in patient care areas.

b. Individuals cannot accept compensation, including but not limited to, reimbursement for expenses associated with attending a CME presentation, sales talk or other activity in which the individual has no other role.

c. Payment of expenses may be provided for speakers at accredited educational meetings, consistent with guidelines developed by the Accreditation Council for Continuing Medical Education (ACCME) and Hospital policy.

d. Residents and fellows are strongly discouraged from accepting gifts of any kind from industry as part of non-professional activities

e. Meals and other gifts or donations given by industry may not be provided to any Hospital location. Industry may provide unrestricted funds to departments or divisions for educational programs. The funds will be managed in accordance with the Standards for Commercial Support of the ACCME.

f. Gifts may not be accepted in exchange for modifying patient care, such as prescribing or changing a patient's prescription.

2. *Drug Samples, Supplies and Equipment*

a. Proper discretion will be utilized to assure the distribution of drug samples are for the benefit of the patient, not for promotion.

b. Unrestricted donations of drug samples, supplies, equipment can be given to Departments and Divisions, who will then be able to determine the appropriate use.

c. Vendors may donate products for evaluation or educational purposes to a department or division, if there is a formal evaluation process and Hospital invites the donation. Items provided to Hospital at a discount or free as part of a formal contract are not considered a gift.

3. *Support for Educational and Other Professional Activities*
- a. Commercial support for educational programs must be free of actual or perceived conflict of interest.
 - b. All of Hospital's educational programs must abide by the Standards for Commercial Support established by the ACCME.
 - c. All funds provided by industry or an industry representative to support educational programs must be given to Hospital as an unrestricted grant. The funds can be provided to the Department, Program or Division, but cannot be given to an individual faculty member, student or staff. This requirement applies to all funds for meals or refreshments, speaker honoraria, or any other expense related to an educational program and includes noon conferences, case conferences, grand rounds, and lectures at all Hospital sites. Funds that are provided by educational groups or other entities that act as 'intermediaries' for industry, must also be provided as unrestricted grants.
 - d. If they are requested to do so by the department / division chair or designee, vendors may provide education activities at a Hospital site. Fellows and residents are not required to attend.
 - e. To ensure accountability and to acknowledge generosity, records of the amount of funds contributed and the purposes for which they were used, will be kept by each Division or Training Program Director. These records should be available for review upon request by the Chair of the GMEC, the DIO (Designated Institutional Official) and training program directors.
 - f. Industry sponsors of educational programs may not determine the content or selection of speakers for educational programs.
 - g. Residents and fellows should carefully evaluate whether it is appropriate to participate in off-campus meetings or conferences that are partially or fully sponsored by industry, because of the potential for perceived or real conflict of interest.
 - h. If trainees elect to participate such above activities, then they should abide by the following requirements:
 - Financial support should be fully disclosed by the meeting sponsor;
 - The content of the meeting or session must be determined by the speaker, not the industry sponsor;
 - The speaker must provide a fair and balanced discussion; and
 - The speaker must make clear that the content reflects that of the speaker and not the Sponsor.

4. *Provision of Scholarships or Other Educational Funds*
 - a. Industry support for residents' and fellows' participation in educational programs must be free from any real or perceived conflicts of interest. All educational grants or programs must comply with the following requirements:
 - The Training Program Directors must select the student(s) or trainee(s) for participation.
 - The funds must be provided to the Department, Program or Division and not directly to the student or trainee.
 - The Department, Program or Division must determine that the conference or program has educational merit.
 - There is no expectation that the participant provide something in return for participation in the educational program.
 - b. This provision does not apply to merit based awards which will be considered on a case-by-case basis.
5. **Travel Funds**
 - a. Industry that is interested in having Hospital residents and fellows attend meetings should provide unrestricted grants to a designated fund for educational conferences and meetings. The DIO will disburse the funds.
6. **Speakers and Ghostwriting**
 - a. Residents and fellows are prohibited from publishing articles that are substantially or completely "ghost" written by industry representatives. Residents and fellows who publish articles with industry representatives must participate in a meaningful way to the interpretation of data and/or the writing of the article and their opinion must be data-driven and not for hire. Residents and fellows shall be listed as authors or otherwise be cited for their contribution.
 - b. All financial interests of the authors shall be listed in accordance with the standards of the journal.
7. **Research Contracts**
 - a. To promote scientific progress, Hospital will accept grants for general support of research (no specific deliverable products) from pharmaceutical and device companies in accordance with established CHORI policies. (See CHORI Policy Conflict of Interest-Objectivity in Research attached hereto as Appendix A).
8. **Disclosure of Relationships with Industry**
 - a. Residents and fellows must disclose all financial interests with

outside entities in accordance with Hospital policy. Depending on the activity, the disclosure requirements are set forth below.

- For research activities the relationship must be disclosed to the CHORI Conflict of Interest Committee.
- All publications should be in compliance with the guidelines of the International Committee of Medical Journal Editors (www.icmje.org).
- All continuing medical education activities must be disclosed and resolved as defined by the Office of Continuing Medical Education and the ACCME (<http://www.accme.org>).

b. Residents and fellows who serve as consultants, members of a speakers' bureau or have an equity interest in or similar relationship with industry for which they receive personal compensation or other support must recuse themselves from decision making regarding the selection of products or services to be provided to Hospital (i.e. selection of drugs to be added to the formulary). Similarly, residents and fellows with such ties to industry shall not participate in decisions regarding the purchase of related items, drugs, procedures in their department unless requested to do so by the purchasing unit and after full disclosure of the industry relationship. In all circumstances, the financial relationship must be disclosed and any conflict resolved prior to participation any decision making.

c. Residents and fellows with financial relationships with industry must ensure that their responsibilities do not affect the ability to properly supervise and educate students and trainees or influence employment decisions for Hospital. All relationships must be disclosed and resolved as defined by ACCME.

9. Compliance by Representatives

- a. Industry representatives are permitted in non-patient care areas by appointment only. Industry representatives are not permitted in any patient care areas except to provide scheduled and approved in-service training on devices and other equipment for which there is an executed Hospital contract for these services.

3. Educational Expectations, Resident Responsibilities by Rotation, Other Hospital Policies and Procedures

A. Didactic Sessions

Much of the educational curriculum occurs in the setting of didactic sessions and conferences. For this reason, resident attendance is extremely important. In keeping with the RRC requirement to establish expected attendance levels and monitor individual resident compliance with these expectations, the following guidelines applying to didactic sessions/ teaching conferences:

- Grand Rounds are held every Tuesday from 8:00 to 9:00 a.m. Speakers are national and local as well as our CHRCO faculty. Attendance by all residents is mandatory.
- Case Conference is held each Thursday from 8:00 to 9:00 a.m. Attendance by all residents is mandatory. Case Conference is an interactive session prepared by senior residents, with discussion by Chief Residents and CHRCO Attendings about one of our challenging cases. Each senior resident is encouraged to present one case in a Morbidity and Mortality Format which focuses on the ACGME Competencies.
- Noon Conference is a formal teaching session by the faculty held every weekday from 12:00-1:00 p.m. in the OPC Auditorium. Noon Conference is carefully designed to cover essential topics in each pediatric specialty and primary care, our Professionalism Series, as well as many required ACGME topics.
- Attendance records at Grand Rounds, Case Conference and Noon Conference shall be kept. The Chief Residents shall make available sign-in sheets at each of these conferences. It is the resident's responsibility to sign in on these sheets at each of the conferences they attend. Conference attendance shall be compiled and communicated to individual residents at least twice a year.
- The CHRCO EBM Pediatric Journal Club is held twice a month. Each member of the intern class, with guidance from primary care, hospitalist, and subspecialty faculty, is required explore an important clinical question by reading and analyzing the medical literature. The CHRCO EBM Pediatric Journal Club is intended to allow residents to:
 - Learn and apply basic critical appraisal skills
 - Change their clinical practice or institute new practices based on critical appraisal of the medical literature
 - Develop the ability to further practice these skills in real time during morning rounds, on-call at night, during conferences, in the outpatient setting, etc. and to teach them to each other

- Morning Report is held on Monday, Wednesday, Friday at 8:30 AM. All senior residents on acute care teams, as well as Night Float and Day Admit, are expected to attend. Patients to be discussed will be chosen by the Chief Resident. The Admitting Resident or admitting PI-1 shall present the patient concisely, concentrating on pertinent issues of history, physical exam, lab and other data. Residents will be asked to generate the differential diagnosis and plan for care. The Chief Resident may also give brief didactic talks on specific disease entities or questions of management that have arisen on the teams. Subspecialty Attendings and Hospitalists are invited to add their expertise to morning report.
- Children's Hospital Oakland Research Institute (CHORI) hosts one noon conference a month, given by the CHORI staff or visiting scientists.
- Each Inpatient Subspecialty Service (Pediatric Critical Care, Hematology-Oncology, Neonatology) has required regularly scheduled specialty-specific didactic sessions for the residents on that rotation.
- Primary Care has a required Morning Conference at 8AM Monday, Wednesday, and Friday, and short Clinic Talks every day prior to Continuity Clinic.
- Radiology Rounds are held twice a week for the Acute Care teams, Critical Care teams, and once a week for Hematology-Oncology Teams

B. Rotations

All Rotations have essential Level-specific, Competency-based Goals and Objectives to be reviewed by the resident prior to the rotation. These are available on the shared computer drive (Res Drive) as well as the hard copy given to each resident yearly. Descriptions of the structure and clinical responsibilities of each rotation are below.

1. Inpatient Rotations

Orange/Purple/Silver Team

Team Composition

The Orange, Purple and Silver Teams are composed of an attending physician, two senior residents and two to four interns, one of which may be a visiting resident. In addition, there will generally be one or more fourth year medical students whose function is as an acting intern. Team sizes will flex during the year based on anticipated patient census.

Daily Rounds

On weekdays, the workday starts at 7:00 a.m. or earlier if an intern needs. On weekends the workday starts at 8:00 a.m. (see below for weekend schedules)

Morning Sign-Out

Interns will receive sign-out on their patients from the previous night's night float intern at 7:00 a.m. On weekdays, the intern on-call for the day must also call Night Float by 7:15 a.m. to get report on overnight admissions. Senior residents receive sign-out report from the previous admitting resident and Night Float resident from 7:00 to 7:30 a.m. in the Resident's Lounge. Senior resident sign-out must be completed by 7:30 a.m.

Pre-Rounds

Interns should complete pre-rounds on their patients by 8:00 a.m. Pre-rounds consist of review of progress and nursing notes, review of patient's course with parent, physical exam and collection of lab and other data pertinent to the patient, which must be reported in the team rounds. Interns must strive to write progress notes before team rounds. Notes are not to be written during team rounds.

Morning Report

Morning Report is held on Monday, Wednesday, and Friday at 8:30 AM. All senior residents on acute care teams, as well as Night Float and Day Admit, are expected to attend. Patients to be discussed will be chosen by the Chief Resident. The Admitting Resident or admitting PI-1 shall present the patient concisely, concentrating on pertinent issues of history, physical exam, lab and other data. Residents will be asked to generate the differential diagnosis and plan for care. The Chief Resident may also give brief didactic talks on specific disease entities or questions of management that have arisen on the teams. Subspecialty Attendings and Hospitalists are invited to add their expertise to morning reports.

Work Rounds

From 9:00 to 10:00 a.m. daily, following Morning Report, Grand Rounds, or Case Conference, teams will meet on the floor to begin work rounds. The purpose of work rounds is to discuss the history, physical exam, lab findings, differential diagnosis, overnight occurrences, and treatment plan for all patients.

Attending Rounds

On Monday, Wednesday, and Friday, teams will meet with their Ward Attending for teaching rounds in their respective conference rooms from approximately 10:00 to 11:00 a.m. Rounds will be conference style or walk rounds at the discretion of individual attending.

Interdisciplinary Rounds

Occur daily from 1:30 pm until 2:00 pm for all senior residents on the inpatient wards teams. These rounds are interdisciplinary and focus on issues relevant to all team members. They are led by the senior resident who is responsible for presenting succinct summaries of each patient and guiding subsequent discussion. They are held in the 4 Medical conference room.

Afternoon Sign-Out Rounds

The purpose of afternoon sign-out is to accurately convey the current status, overnight plan, and anticipated problems of all patients to the on-call interns and residents, using the IPOD format (see below). These rounds occur no earlier than 4:00 p.m. (unless a resident is going to clinic or is post call). Before intern sign-out, preparations for discharges must be completed. Once these tasks are completed, interns are eligible to sign-out, giving a verbal report and a detailed, complete, readable sign out sheet to the on-call intern. Senior residents may determine the time at which interns sign out occurs and be present for the rounds. Interns are not to sign out or leave the hospital without the approval of the senior resident.

Senior residents must secure the team (i.e. review the team with the interns, facilitate procedures and studies, review and co-sign all progress notes, work-up new patients with interns and students and communicate with attendings) before signing out. Besides conveying the medical status and overnight plan, discharge issues and needs will be discussed so the team can facilitate anticipated discharges. The on-call admitting resident also receives sign-out from Day Admit.

When a resident is going to clinic, sign-out must be given before 1:15 p.m. so the resident can arrive at clinic by 1:30 p.m. A resident who is post-call must sign-out by 11 a.m.

On weekends and holidays the workday starts at 8:00 a.m. when the incoming intern and Admitting Resident receive sign-out, intern-to-intern and Admitting Resident-to-Admitting Resident. The outgoing intern writes notes on his/her own patients and up to one-half of the total patients on the team. The incoming intern writes the remaining notes. Admitting resident sign-out includes the Chief Resident As possible, the Admitting Resident will work-up patients until noon, so interns can complete their notes. The Admitting Resident will also communicate with the Charge Nurses regarding potential discharges.

Other Rounds

X-ray rounds for the ward teams are held Tuesday and Thursday mornings beginning at 11:00 am in the radiology conference room.

Team Member Responsibilities

The Attending Physician is responsible for all decisions related to the patients diagnostic and treatment plan. The intern has responsibility for performing the day to day tasks required to provide the patient's care. The interns perform and document a complete history and physical examination, write accurate daily progress notes, write transfer notes and off-service notes, write all orders, follow labs and other studies, present patients in rounds, formulate and carry out care plans with guidance and assistance of the senior residents and attending. The intern must discuss each newly admitted patient with the attending and put the H & P in the chart within 8 hours of admittance. The intern must maintain communication with the attending, reporting any significant changes in patient status, and insuring that the attending receives a discharge summary. The intern is also responsible for IV insertions, LPs and other procedures, and discharge abstracts and dictations.

Senior residents take responsibility for the day-to-day supervision and functioning of the team. Seniors organize and lead daily rounds, assign admissions to the interns, supervise the work-up of patients, examine and interview all new patients, write accept notes on all new patients, co-sign admission notes and all medical student notes, teach and supervise procedures, communicate with attendings regarding patient care and team management, provide sign-out to on-call residents and nursing staff, give teaching seminars, and provide evidenced-based literature on topics relevant to the team.

Night Call Duties

After afternoon sign-out, the intern assumes primary responsibility for the entire service. This includes working up all new patients, follow-up on tasks or studies which are or need to be completed, performing IV insertions, lumbar punctures or other procedures, addressing nursing questions or concerns, providing teaching or trouble-shooting for patients and families, and updating the senior resident about developments on the team. The intern should confer with their senior resident about any significant occurrences on the floor. In general, night duties are equivalent to daytime duties. The intern must be prepared to sign-out to the oncoming night float intern before the end of their 16 hour shift.

Senior residents are responsible for their respective team following afternoon sign-out. The admitting resident takes all admission calls, gives input on bed placement, facilitates direct admission calls, assigns new admissions and transfers to the interns, delegates tasks to interns, provides teaching, and in general oversees the care of all acute care admissions. Senior call will be no more than 28 hours total.

Summit Team

Team Composition The Summit Team is composed of an Attending physician, one senior resident (PL-2) and two interns. There may be one or more fourth year medical students as well.

Morning Sign-Out

Interns and the senior resident will receive sign-out from the post-call intern/resident/attending. On weekdays, sign-out begins at 7 a.m. On weekends, sign-out begins at 8 a.m.

Pre-Rounding

Interns will Pre-Round as described above. During this time, every effort should be made to complete discharge summaries/instructions (DCA2) for patients being discharged that day as well as daily progress notes.

Teaching Rounds

The team meets in the conference room for morning teaching for approximately one hour before family-centered rounds. Because the Summit Unit is offsite, interns/residents will generally not be able to attend morning conferences at the main hospital, but they are expected to return for noon conference daily. The Attending will cover the unit during this time.

Family-Centered Rounds

From 10 a.m. to 11 a.m. daily, the team performs walk rounds at each patient's bedside. Presentations and care-plan discussions are the same as at the main hospital.

Guidelines for Family-Centered Rounds

- The entire interdisciplinary team is required to attend rounds, including the bedside nurse, charge nurse, respiratory therapist, social worker, child life, and dietician. Language interpreters will also participate as needed.
- The patient and family are invited to participate. Every attempt is made to present in lay-person language.
- The intern or bedside nurse explains the process to the family and introduces the members of the interdisciplinary team.
- After the intern presents, the senior resident summarizes the presentation briefly to the family and invites questions. All members of the interdisciplinary team are encouraged to contribute.
- The process is facilitated primarily by the senior resident with help from the Attending.
- Family-centered rounds merge work rounds and interdisciplinary rounds (occur separately at the main hospital).

Team Member Responsibilities

Night Call Duties

Night call duties are the same as the main hospital with the exception that an Attending takes call every night.

PL-3 Night Float

The PL-3 Night Float will supervise the Intern Night Float for all new admits to the Orange/Purple/Silver teams for approximately 9 hours overnight for six nights in a row. When the Red team is covered by an intern, they will also supervise

these admissions. On nights when Red team is covered by a senior, the Night Float senior will do the admission. They will also be responsible for Aqua and Rehab team admissions.

Whenever possible, they will help cover Orange and Purple senior duties to allow these seniors to take a nap.

Will sign-out patients to the acute care unit seniors at the end of their shift.

PL-1 Night Float

The PL-1 Night Float will be responsible for covering one of the main hospital ward teams (Orange or Purple) as well as completing all admissions for approximately 9 hours overnight for six nights in a row.

Day Admit

The workday for the Day Admit/Float resident begins at 7:00 a.m. when sign-out on pending admissions is taken from Night Float. Day Admit/Night Float will carry the admitting beeper 7:00 a.m. until sign-out at approximately 4:00 p.m. on Mondays through Fridays. The duties of this resident (a PL-2 or PL-3) include taking all admission calls from the Emergency Department, PICU, or community attendings, giving input about bed placement to Emergency Department charge nurses or bed control, completing the work-up and initial care of admissions and PICU transfers that occur before noon, notifying the acute care unit seniors of all admissions or transfers to the floor, providing transport services and other duties as designated by the chief resident. Sign-out of pending admissions to the Admitting Resident occurs at or after 4:00 p.m. On weekends, the transport and admitting residents cover these duties. Night call duty begins at 4:00 p.m. and will be transport call.

Hematology/Oncology

Team Composition

There are two teams on Hematology-Oncology, the Aqua Team composed of two PL-2s, and the Red Team composed of a PL-3 and two interns. There are two hematologist/oncologists present daily during the week, one assigned to the Aqua Team (in general the higher acuity patient service) and the other to the Red Team (the lower acuity service). A Physician's Assistant (PA) is assigned to the Aqua Team as well to help provide care of the bone marrow transplant patients during the day. A Nurse Practitioner (NP) is assigned to routine chemotherapy admissions for both teams. For approximately half of the year there will be a fellow on service as well. Residents will manage patients in conjunction with the hematology/oncology attendings and fellow.

Daily Rounds

On weekdays, the workday starts at 7:00 a.m. On weekends, the workday starts at 8:00 a.m.

Morning Sign-Out

Interns will receive sign-out from the previous night's on-call intern at 7:00 a.m. On weekdays, the intern taking call must call the Night Float residents by 7:15 a.m. to receive sign-out on overnight admissions and pre-round on the patients prior to work rounds. Senior residents receive sign-out from the 5 South overnight senior resident.

Pre - Rounds

Interns will complete pre-rounds by 8:00 a.m. Pre-rounds consist of review of progress and nursing notes, review of patients and collection of lab and other pertinent data. From 8:00 a.m. to 9:00 a.m., interns may attend conferences such as Grand Rounds, Case Management Conference or discuss management problems with the senior residents, write notes or orders, etc. Notes are not to be written during rounds. Senior residents are expected to attend morning report and to round quickly on their team, helping the interns with any problems that arise and checking lab and other data.

Teaching Rounds

Joint Teaching Rounds led by an attending will occur on Mondays, Wednesdays, and Fridays from 10:30 to 11:30 a.m. These sessions may be didactic or case-oriented and are designed to cover a core curriculum in hematology/oncology.

Work Rounds

Work rounds begin at 9:00 a.m. and are attended daily by the fellow (if on service) and attending. Work rounds are often attended by charge nurses, case managers, social workers, or pharmacists. The purposes of work rounds are:

To discuss the history, physical exam, lab and other data, overnight events, differential diagnosis, and treatment plan for all patients.

To write orders and make efficient plans for lab tests, chemotherapy, procedures and discharges.

To maximize communication between all extended team members.

To actively address the needs and concerns of patients and families. Interns are responsible to present all patients thoroughly and succinctly during rounds and senior residents are responsible for directing rounds.

Team Member Responsibilities

Please see Section Inpatient Rotations – Orange/Purple/Silver Team section above under the same heading. The Red and Aqua Teams are functionally separate teams. The two PL-2's take primary responsibility for the patients admitted to the Aqua Team and the two PL-1's take primary responsibility for the patients admitted to the Red Team. The PL-3 on the Red Team takes primarily a supervisory role.

Night Call Duties

Same as the Orange/Purple/Silver Team as described above with the following exceptions. For the Red team, the two interns, Red team senior, and the Red team cross cover will alternate night shifts (3-6 nights in a row). The Red team intern on night shift should complete daily progress notes on their patients prior to the end of their shift.

The senior resident taking Aqua Team call will also get sign out in the afternoon from the PA and/or the fellow for the patients on the Bone Marrow Transplant service. Senior resident call for Aqua team will be a maximum of 28 hours long.

Pediatric Intensive Care Unit (PICU)

Team Composition

There are two teams in the PICU, called the Red and Blue teams. A PICU attending and a PICU fellow lead each team. There are at least two residents on each team, and may be more depending on the number of visiting residents. All residents in the PICU serve as primary care providers.

Daily Rounds

On weekdays, the workday starts at 7:00 a.m. On weekends, the workday starts at 8:00 a.m. Sign out occurs at the table in the PICU at the physicians work station. All residents are required to take pre and post computerized ICU test.

Morning Sign-Out

Team members receive sign-out on their patients from the resident who was on the previous night at 7:00 a.m. Night Float does not admit patients to the PICU.

Pre - Rounds

See Orange/Purple/Silver Team section above under the same heading.

Attending/Work Rounds

Rounds start at a time designated by the attending and in general occur about 9:00 a.m. The purposes of rounds are to discuss the history, physical exam, labs, overnight events, differential and treatment plan for each patient; to write orders and plan procedures, to maximize team communication and to address family needs and concerns. Rounds are attended by all physician team members, and may also include bedside and charge nurses, surgeons, consultants, social workers, and case managers. Walking rounds are encouraged. Notes should be written before rounds begin.

Other Rounds

X-ray rounds begin at 9:30 a.m. on Mondays and Fridays. Other teaching rounds will be determined by attending and fellows.

Sign-Out Rounds

The purpose of afternoon sign-out rounds is to convey the current status, overnight plan, and anticipated problems of all patients to the on-call resident. These rounds occur no earlier 4:00 p.m., unless a resident is going to clinic or is

post call. Before sign-out, residents must have written all notes, performed procedures, collected lab and other data, updated the physical exam, prepared any transfer, and checked in with the fellow or attending. Once those tasks are complete, residents may sign-out, giving complete and readable sign-out on all patients.

Team Member Responsibilities

Please see Section Inpatient Rotations – Orange/Purple/Silver Team section above under the same heading. The same principles apply. All residents in the PICU assume primary responsibility for the care of their patients. Senior residents may be asked to provide transport services as necessary.

Night Call Duties

Same as the Orange/Purple/Silver Team section above with the following exceptions. Intern night call will be a maximum of 16 hours long, and the remaining hours of the night will be covered by a cross-cover senior resident. Senior resident call will be a maximum of 28 hours long.

Intensive Care Nursery (ICN)

Team Composition

There are two teams in the ICN, called the Blue team (rooms A & B), and Yellow Team (Room C). Each team is led by a neonatologist and includes one intern and one senior resident.

Daily Rounds

On weekdays, the workday starts at 7:00 a.m. On weekends, the workday starts at 8:00 a.m.

Morning Sign-Out

Team members receive sign-out on their patients from the resident who was on the previous night at 7:00 a.m. Night Float does not admit patients to the ICN. Sign out is held either in the resident lounge or the ICN.

Pre - Rounds

See Section Inpatient Rotations – Orange/Purple/Silver Team page 53. X-rays on all patients should be checked using the PACS system prior to the start of rounds.

Attending/Work Rounds

Rounds start at a time designated by the attending and in general occur at 9:00 a.m. Rounds are attended by all physician team members and may also include bedside and charge nurses, surgeons, consultants, social workers, or respiratory therapists. Notes should be written before rounds begin.

Other Rounds

X-ray rounds begin promptly at 11:00 a.m. on Wednesdays. Other teaching rounds will be determined by the attendings.

Sign-Out Rounds

The purpose of afternoon sign-out is to convey the current status and overnight plan, and anticipated problems of all patients to the on-call resident. These rounds occur no earlier than 4:00 p.m., unless a resident is going to clinic or is post call. Before sign-out, residents must have written all notes, performed procedures, collected lab and other data, updated the physical exam, and checked in with the attending. Once those tasks are complete, residents may sign-out, giving complete and legible sign-out on all patients.

Team Member Responsibilities

Please see Orange/Purple/Silver Team section above under the same heading. The same principles apply. The maximum number of patients to be cared for by one resident is ten (10). When both senior residents are on-call in the NICU, one will serve at 1st Transport overnight.

Night Call Duties

Same as the Orange/Purple/Silver Team section above with the following exceptions. Intern night call will be a maximum of 16 hours long, and the remaining hours of the night will be covered by a cross-cover senior resident. Senior resident call will be a maximum of 28 hours long. The on call resident is expected to attend daily 5 p.m. sign out walk rounds with the neonatologists.

Kaiser Nursery: First Week of Life Rotation**Team Composition**

The Kaiser Nursery is a well baby and delivery room experience for PL-1's. The Kaiser team consists of a Kaiser Attending and for most months a Kaiser resident or intern and a CHRCO PL-1.

Sign Out

The normal workday is from about 8:15 until 4:45 on weekdays. Residents arrive and obtain the First Week of Life (FWOL) pager from the post call person.

Work/Attending Rounds

After sign out, the residents and attending divide the morning work to include admissions and discharges, circumcisions, and writing progress notes.

Afternoon Sign-Out Rounds

Please see Section Inpatient Rotations – Orange/Purple/Silver Team page 54 under this heading. Sign out is at approximately 4:30 p.m. on weekdays. The resident on call for the night should check in with the on call neonatologist who will serve as the back up for resident throughout the night.

Team Member Responsibilities

- Carrying the well baby pager and answering any calls about newborn babies.
- Performing admission exams and initial orders on all babies born within 24hours of birth and writing daily progress notes.
- Performing discharge exams and completing discharge paperwork on all babies, which must be co-signed by the attending.
- Attend deliveries to gain experience in neonatal resuscitation when you are on call
- All patients admitted to the nursery are considered the primary responsibility of the resident to whom each patient is assigned.

Night Call Duties

The interns and Kaiser residents will alternate night shifts (3-6 in a row). The resident on call will keep the FWOL pager and receive an updated sign out sheet. Call duties include answering all questions on newly born babies, admitting all newborns during the shift, and attending deliveries. The resident should check in with both the on call neonatologist and the ALS nurses (x28776) to inform the nurse that the resident would like to be called for all deliveries.

Day Back Up

Day Back Up is a randomized position that provides daytime coverage when necessitated by illness, transports, Board exams, in-service exams, medical emergencies, court appearances, interviews, or other events. Residents eligible to be randomized for Day Back Up duty include all residents on Elective rotations with call. Residents will not be randomized on their post call days. Day Back Up schedules will be posted in advance so residents may notify their preceptors on their elective rotations. If residents encounter any problems being excused when needed, they are to call the chief resident who will resolve the problem.

Anesthesia/Transport

The Anesthesia rotation is a two-week experience for PL-2 residents with a primary responsibility for daytime transport. While not on transport, the Anesthesia resident is assigned to the Operating Room under the supervision of the attending anesthesiologists to learn techniques of airway management, sedation and other skills. The Anesthesia/Transport resident is expected to be in the hospital at 7:00 am.

2. Outpatient Rotations

Emergency Department

PI-1's will work 10 hour shifts with a combination of day shifts and night shifts depending on the number of PI-1's in the Emergency Department at any given time. Shifts will average five days out of every 7 days.

Senior residents will work 10-hour shifts that include a variety of day time and overnight shifts, averaging 10 shifts every 14 days of rotation.

All residents will participate in the assessment, stabilization and initial work-up of patients who present to the Emergency Department. This includes the history and physical exam and all procedures requiring a physician in the work-up or treatment of patient. All residents are expected to completely sign-out their patients to another resident or the attending physician at the end of their shift before leaving the Emergency Department.

All residents will participate in half-day continuity clinics during their Emergency Department rotation. These clinics will not necessarily fall on the resident's usual continuity clinic day and will generally result in a work day longer than 10 hours.

Community, Advocacy, Primary Care Rotation (CAP)

Residents will actively participate in the CAP rotation, involving community outreach and primary care activities, as well as advocacy projects. Regular evaluations of the sites and experiences are required. The rotation will also involve time in ED Annex and the New Illness Clinic of the Claremont Clinic.

PL-1's do not have night call on this rotation
PL-2's and PL-3's will take call during this CAP rotation

ED Annex (Urgent Care)

Residents will spend two weeks working in the ED- Too each year from early afternoon until the clinic closes. Hours will vary depending on clinic volume but will not exceed 12 hours. Shifts will occur on five-six consecutive days each week including one weekend day, and will have two consecutive days off during the rotation. When the resident has Continuity Clinic, the ED Annex shift will begin after Continuity Clinic.

The resident will participate in the assessment, stabilization and initial work-up of patients who present to ED Annex. This includes the history and physical exam as well as all procedures requiring a physician in the work-up or treatment of the patient.

Adolescent Medicine

All PL-1's will be assigned a one-month block-rotation in Adolescent Medicine. This rotation will utilize a variety of clinical settings including Teen Clinic, School-based clinics and other community clinics. In addition, residents assigned to this rotation will have inpatient consultation duties during the month. Night call during the Adolescent rotation will be during evening hours on 2 weekends out of the month in the ED Annex Clinic.

Behavior/Development

All residents, during their PL-2 and PL-3 year, are required to complete a one month block elective rotation in Behavior/Development. If this rotation is not taken at Children's Hospital & Research Center Oakland, permission must be obtained from the Director or Associate Director of Medical Education to take it at another institution.

C. Continuity Clinic

All residents will have a weekly continuity clinic from 1:30 p.m. to 5:00 p.m. This clinic will provide longitudinal care for a group of patients recruited by the resident from acute care settings, delivery room experiences and inpatient rotations, or assigned randomly when patients call for appointments. The resident becomes the primary care provider for these patients.

Continuity Clinic will occur weekly during all rotations except for rotations undertaken during Electives without call outside of the San Francisco Bay Area. Residents will not be allowed to cancel Continuity Clinics except due to acute illness. There are no post-call continuity clinics.

D. Elective Rotations

Elective rotations allow the resident to individualize their clinical experience and education. Electives enable the resident to explore possible future career paths, acquire in-depth knowledge of particular subject areas, pursue clinical or basic research, and ensure that the Children's Hospital & Research Center Oakland and RRC requirements for graduation are met. Electives may be either without night call duties or with night call duties (the latter formerly referred to as selectives). At a minimum, residents will be assigned the following numbers of elective rotations:

- PL-2 One month elective without call
Two months elective with call (*Selectives*)
- PL-3 Two months elective without call
Three months elective with call (*Selectives*)

The RRC guidelines include the following requirements, which need to be met using a combination of CHRCO required/scheduled rotations and elective rotations:

Excluding the adolescent medicine, developmental/behavioral, and intensive care experiences (both NICU and PICU), the minimum time each resident must commit to subspecialty rotations is 7 months, 4 of which must be taken at the primary teaching site and/or integrated hospitals. Within these 7 months, each resident must complete a minimum of 4 different 1-month block rotations taken from the following list of pediatric subspecialties:

Allergy/Immunology
Cardiology

Infectious Disease
Nephrology

Endocrinology
Genetics
Gastroenterology
Hematology/Oncology

Neurology
Pulmonary
Rheumatology

For the 4 required block months in different subspecialties from the above list, the inpatient/outpatient mix should reflect the standard of practice for the subspecialty.

The additional 3 months may consist of single subspecialties or combinations of specialties from either the list above or the list below. Combinations of subspecialties may be structured as block or longitudinal experiences and, where appropriate, may be combinations of inpatient and outpatient experiences or all outpatient.

Pediatric Anesthesiology
Child Psychiatry
Pediatric Dermatology
Pediatric Ophthalmology
Pediatric Orthopaedics
and Sports Medicine

Pediatric Otolaryngology
Pediatric Radiology
Pediatric Surgery
Pediatric Physical
Medicine and Rehabilitation

During the 3 years of training, no more than 3 block months, or its equivalent, may be spent by a resident in any one of these subspecialties. Subspecialty research electives that involve no clinical activities need not be counted as one of these 3 block months.

Well-defined, non-clinical care experiences with specific, measurable goals and objectives which result in a written piece of work at the conclusion of the experience may be allowed, subject to approval by the Director of Medical Education.

Electives with call are best done at Children's Hospital & Research Center Oakland, although it may be possible to arrange an elective at another Bay Area institution if the resident can ensure that they can reliably return to Children's Hospital & Research Center Oakland on time to begin their night call duties. Residents will attend their weekly continuity clinics during all elective with call rotations.

Electives without call may be done at Children's Hospital & Research Center Oakland or elsewhere. In general, because of the RRC requirements on continuity clinic attendance, residents are limited to one elective month per year without continuity clinic. This effectively limits the number of months that electives may be done at institutions located outside the Bay Area. For all other elective without call months, the resident is required to attend their weekly continuity clinics.

Sign-up for all elective rotations, must occur prior to the start of the academic year by the date designated by the Director of Medical Education. A "Notice of Elective Study" form, including dates, subject, preceptor and signatures must be completed and turned in to the Director of Medical Education for approval prior to the designated cutoff date.

All "Away Electives" must be planned and submitted to the Medical Education Department at least 30 days prior to the start date so that, a Training Affiliation Agreement can be approved by the host institution, and Director of Medical Education.

All changes in scheduled electives after the designated date in June require the submission of a "Change of Elective" form and new "Notice of Elective Study" forms to the Medical Education Office at least one month prior to the start date of the proposed elective.

Detailed guidelines for elective sign-up are available in the Medical Education Office. Failure to comply with these guidelines may result in the loss of elective choice or other disciplinary action.

Outside Electives

Residents will be allowed to take up to one month of an outside elective that is approved by the Director of Medical Education in both the PL-2 and PL-3 years where they do not have to do continuity clinic.

E. Other Night Call & Cross Coverage

First Transport/Back Up

When on transport call the resident participates in all patient transports requiring a physician. It is the responsibility of the on-call resident to be easily accessible (on beeper and within 30 minutes of the hospital) at all times.

The resident covering the weekday daytime jeopardy call system will be assigned randomly by the Chief Residents from the pool of residents on elective with call every month. The residents will be available from 7:00 a.m. - 4:00 p.m. to cover absences anywhere and may be asked to perform transport as requested by the Chief Resident. Nighttime and weekend transport call will be covered by an on call NICU or PICU resident.

The principal coverage responsibilities will include, but are not limited to, resident absences due to personal illness, illness or deaths of family member, court appearances and medical examinations.

The night call and weekend Back Up Call resident is available to cover unavoidable absences during the hours of 4:00 p.m. to 7:00 a.m. and 7:00 a.m. on weekends and holidays. The residents may be asked to perform transports at the request of the Chief Resident.

The average frequency of overnight call actually performed by the Back Up Resident over the month will be monitored by the Chief Residents and shall not exceed every fourth night. Total continuous hours worked will not exceed 28 hours.

Admitting Resident

Duties of the Admitting Resident are detailed in the Admitting Resident Guidelines and include the following:

- Assigns admissions to the PL-1 or other resident on call.
- Examine every patient admitted by the PL-1 he/she covers and writes an appropriate note.
- Consults with, or calls the Chief Resident if needed.
- Is the co-team leader, along with the PICU attending of the Code Blue Team.

Cross Coverage

Acute Care Units (Orange, Purple, Silver Seniors)

Sign-in occurs at 5:00 p.m. on weekdays and 8:00 a.m. on weekend days. The cross-coverage resident assumes all patient care responsibilities for all patients on his/her ward team. This includes all normal duties of the daytime resident acting as a ward senior. Call shifts will not exceed 28 hours.

Intensive Care Nursery (ICN)

Sign-in is 5:00 p.m. on weekdays and 8:00 a.m. on weekend days. The cross-coverage resident assumes patient care responsibilities for all patients on his/her ICN team. This includes all normal duties of the daytime resident in the ICN. Only on weekend mornings is the cross-coverage resident responsible for writing at least half of the progress notes for the team. Seniors may be asked to perform transports. Call shifts will not exceed 28 hours.

Pediatric Intensive Care Unit

Sign-in is 5:00 p.m. on weekdays and 8:00 a.m. on weekend days in the ICU. The cross-coverage resident assumes all patient care responsibilities for all patients on his/her PICU team. This includes all normal duties of the daytime residents in the PICU. Only on the weekend mornings is the cross-coverage resident responsible for writing half of the progress notes for the team. Seniors may be asked to perform transports to the PICU. Call shifts will not exceed 28 hours.

5 South

Sign-in is 5:00 p.m. on weekdays and 8:00 a.m. on weekend days. The cross-coverage resident assumes all patient care responsibilities for all

patients on the Hematology/Oncology team. This includes all normal duties of the daytime resident on the Hematology/Oncology acute care unit. Only on weekend mornings is the cross-coverage resident responsible for writing at least half of the progress notes for the team. Call shifts will not exceed 28 hours.

F. Handoff Communication

Hand-offs occur whenever the responsibility for a patient's care is transferred. The IPOD format should be used.

I	<ul style="list-style-type: none"> • Identify (patient, attending)
P	<ul style="list-style-type: none"> • Principal Dx • Pertinent PMHx including allergies • Active Problems • Pharmacy (meds, treatments, oxygen) • Procedure • Peripherals: IV's, tubes, drains • Pathogens (include isolation) • Pain • Plan
O	<ul style="list-style-type: none"> • Outstanding labs, test and consults • Observation for anticipated problems and their solutions • Desired Outcomes
D	<ul style="list-style-type: none"> • D is for discussion

G. Direct Admits

Direct Admissions

A direct admission is a scheduled or unscheduled admission that is not seen in the Emergency Department prior to admission to the acute care unit.

All direct admissions to the Hospital must fulfill the following criteria:

- The patient must be admitted under the care of a physician with current medical staff admitting privileges at Children's Hospital & Research Center Oakland.
- The patient must be clinically stable and must not require emergent care.

The decision whether an individual patient fulfills these criteria is made by the Attending Hospitalist at our Summit Unit in conjunction with the referring physician.

If the patient fulfills the above criteria, the Summit Attending resident obtains the patient's name, sex, birth date, diagnosis, present location (whether in the admitting staff physician's office or at home), a brief history and the anticipated management plan from the admitting physician. The report of the patient's condition must be from an admitting physician; a nursing report is not sufficient.

Emergency Department Admissions

Patients who are not appropriate for direct admission will be assessed and stabilized in the Emergency Department. Such patients must have an Emergency Department history and physical exam as well as initiation of a diagnostic and therapeutic plan.

The decision to admit is made by the Emergency Department attending physician and the resident. If the patient is to be admitted to the acute care unit at the main hospital, the Emergency Department resident will call the admitting resident and give a complete report on the patient prior to the patient's arrival on the acute care unit. If the patient is to be admitted to the PICU, NICU, hem/onc, or Summit team, the ED resident should call the respective team member directly. It is the responsibility of the resident on the team to call the patient's attending physician and inform him/her of the admission, the bed assignment and discuss the anticipated management plan.

All residents accepting patients from the Emergency department must make their own clinical judgments and diagnoses. It is not appropriate to simply accept the diagnosis that the Emergency Department resident or attending physician has given the patient. Physical exams and symptoms change rapidly. Residents must take full responsibility for the ongoing assessment and management of all patients under their care.

H. Transfers

Other Interfacility Transfers

Transfers of patients from other hospitals to Children's Hospital & Research Center Oakland must be made from the same level of care to the same level of care or a higher level of care. Any other arrangements may be considered patient dumping and are prohibited by law.

If the patient is in a critical care unit at the transferring facility, that patient must go directly to a Children's Hospital & Research Center Oakland critical care unit. This transfer must be arranged by the attending physician in the receiving critical care unit. This attending will determine the mode of transport necessary.

If the patient is in the Emergency Department of any outside institution then that patient must be transferred directly to the Children's Hospital & Research Center Oakland Emergency Department. The Attending Physician in the Children's Hospital & Research Center Oakland Emergency Department will arrange this transfer. Once at Children's Hospital & Research Center Oakland, the patient will be managed in the Emergency Department prior to the admission to the acute care unit. This management will include a history, physical and initiation of an appropriate diagnostic and therapeutic plan.

Inter - Unit Transfers

PICU to Acute Care Unit

Whenever feasible, transfers of patients from the PICU to the acute care unit should be accomplished early in the day, preferably before 4:00 p.m. Evening transfers may be necessary when there is a bed shortage in the PICU. Once a patient has been identified for transfer, the resident caring for the patient must write a transfer note summarizing the patient's history, hospital course, medications, labs, current physical exam, and anticipated management plan. The PICU resident should also notify the admitting resident of the transfer promptly, and discuss the move with the patient's family. If the patient has a community pediatrician, the ICU resident should contact that physician. The transfer order must include the new team assignment, room number if available, and the name of the attending physician who will assume responsibility for the patient on the acute care unit.

All orders must be rewritten when the patient arrives on the acute care unit. The acute care unit intern will examine the patient and write the floor orders and an accept note. The acute care unit senior will also examine the patient, review the intern's orders, and write an accept note. The acute unit team should also contact the private attending or house attending to discuss the case.

Acute Care Unit to PICU

Any patient identified by the acute care unit team as potentially needing PICU care should be very carefully monitored by the acute care unit team. The patient's status should be discussed with the PICU fellow or attending. All assessments, studies and therapies that can be accomplished safely on the floor should be undertaken. Once the patient is identified as a definite transfer, the acute care unit intern must write a concise summary of the patient's history, hospital course, medications, labs, and current physical exam. The senior resident should review this note. The senior is responsible for remaining with the patient and conveying pertinent information to the PICU staff until the transfer is complete. A member of the acute care unit team should discuss the transfer with the family and attending physician as well.

After the patient is stabilized in the PICU, the PICU resident must write orders and an accept note. All orders for patients transferred from the acute care unit to the PICU must be completely rewritten.

I. Interpreter Services

Any patient or family member who cannot adequately speak or understand English is legally entitled to an interpreter at no cost. Procedures are established by the Hospital to provide language assistance services to patients and families with language or communication barriers, except where the patient or family after being informed of the availability of interpreter services chose to use a family member or friend who volunteers to interpret. It is unacceptable for a minor child to be used as an interpreter, even if that is the preference of the patient/family. We are committed to making every effort to insure adequate and speedy communication with patients and families.

More information regarding interpreter services may be found on CHONET.

J. Infection Control

The comprehensive Infection Control Manual for Children's Hospital is available on the Hand Icon (K-Drive) entitled Infection Control. It is essential that residents become familiar with isolation procedures, hand hygiene, and other essential aspects of Infection Control.

K. Pain Management

Pain management is a critical component of patient care. A team approach is used here which involves the patient and family, as well as the health care providers.

While at Children's Hospital & Research Center Oakland patients and families can expect:

- Information about pain, the assessment of pain and pain management.
- Provider commitment to pain prevention which is part of a pain management plan.
- A rapid provider response to reports of pain.
- State of the art pain management.

We encourage patients and families to:

- Ask questions of the providers about pain relief options and pain relief medications.
- Help develop with the providers a pain management program for their child.
- Ask for pain relief when pain first begins.

- Inform providers if pain relief is inadequate.

At Children's Hospital & Research Center Oakland pain is assessed routinely by the nursing staff. A 10 point scale is used with "0" representing no pain, "5" moderate pain and "10" the worst possible pain. As the "fifth" vital sign, it is to be considered daily by the physician staff in the evaluation of the patient's course and in the management plan. A comprehensive pain assessment should include:

- Location of pain
- Intensity
- Quality (prick, ache, burn, throb, sharp)
- Onset, duration, variation and rhythm
- Manner of expressing the pain
- What relieves the pain
- What causes an increase in pain
- Effects of the pain on sleep, appetite, activity, concentration, emotions
- Effect of pain on physiologic parameters (pulse, blood pressure, respiratory rate)

L. Sedation

Sedation by a non-anesthesiologist may be required for pediatric patients in order to facilitate the performance of procedures. The Multidisciplinary Sedation Committee at CHRCO oversees the policies and procedures for procedural sedation at CHRCO and monitors the quality of sedation care at CHRCO. Performing a procedure under sedation requires you to have in attendance an Attending Physician, or PL-2 or PL-3 who has been credentialed for Procedural Sedation. That Attending, PL-2 or PL-3 is responsible for following the Policy and Procedure for Procedural Sedation guidelines in the Medical Staff Rules and Regulations.

M. Seclusion and Restraints

Patient behavior that is potentially dangerous to self or others will be managed in a manner that will maximize the safety, privacy and dignity of patients and staff, and will be consistent with a patient's rights, Hospital policies and staff training. The least restrictive, but effective and clinically appropriate means of intervention will be used. Seclusion or restraints are never used for punitive purposes, or for the convenience of staff.

The term "seclusion" is defined as the involuntary confinement of a patient alone in a room, which the patient is prevented from leaving, for any period of time. A patient is considered to be secluded whenever he/she is not free to leave the room at will, even if the door is unlocked or open.

The term "restraint" is defined as an intervention using a physical mechanical device to involuntarily restrain the movement of the whole or a portion of the patient's body for the purpose of controlling his/her physical activities in order to protect the patient from injury.

Restraint has the potential to produce serious consequences, such as physical or psychological harm, loss of dignity, violation of an individual's rights, and even death. Therefore restraint use must be **clinically appropriate** and **adequately justified**.

Restraint use requires a physician's order and documentation in the Progress Notes of the patient's condition and reason for the need for the restraints. Only attendings or residents at the PL-2 or PL-3 level may write a restraint order. The restraint order must be episode specific, time specific, time limited and specify the type of restraint. Continued use of restraints beyond 24 hours requires renewal of the original order and documentation in the Progress Note of the patient's condition. This process must be repeated daily until the restraint order is discontinued. A "Restraint Form" must also be completed.

The restraint policy does not apply under the following:

- Standard practices that include limitation of mobility or temporary immobilization related to medical, dental, diagnostic, or surgical procedures and the related post-procedure care processes (For example, surgical positioning, armboards, radiotherapy procedures, protection of surgical and treatment sites in pediatric patients).
- Adaptive support in response to assessed patient need (For example, postural support, orthopedic appliances, tabletop chairs).
- Helmets for patient with seizure disorders or self-mutilating behaviors.
- Protective devices used to prevent developmentally related safety incidents (For example, bedrails, tabletops, seat belts, bubble tops).

The entire Restraint Protocol can be found in the Meditech Library under "Restraint Protocol".

N. Abuse and Neglect

Victims of Abuse and Neglect Policy

Any practitioner or Hospital employee who knows of, or has a "reasonable suspicion" that a patient or dependent adult may be the victim of abuse or domestic violence will ensure the patient is urgently evaluated by The Center for Child Protection (CCP). The CCP will notify the appropriate authorities as required by California Law. If you suspect abuse, during regular business hours contact the Social Work Department at Ext. 3742. After hours, on weekends or holidays, the clinical social worker on call can be contacted through the page operator "O". The social worker will do an evaluation and contact the Physician Director of the Center for Child Protection. A more detailed description of the policy and procedures may be found in the Meditech Library under "Abuse and Neglect".

O. Allow Natural Death (AND) Policy

Based on evaluation of an individual patient's condition and prognosis and on discussions with the patient, parents or legal guardian and other members of the healthcare team, the attending physician may decide to write an "Allow Natural Death" order in the medical record. The current policies regarding such orders can be found on CHONET under the hospital policy section

P. Code Blue and Med Stats

Code Blue

A Code Blue Team is available 24 hours a day to respond to emergency medical situations whether or not the patient is in cardiopulmonary arrest. In general, the ICN, PICU and ED have internal systems to handle code blues, although the Code Blue Team is also available to these areas. The off site unit also has their internal code blue response plan which includes PICU telephone consultation and may involve specific Code Blue Team members being dispatched to the unit.

Code Blues may be activated by dialing 55, which will directly access the Operators with priority status. In the acute care areas (4th and 5th floors), Code Blues may be activated by the Code Blue button located in each patient room.

The Code Blue Team at Children's Hospital & Research Center Oakland divided into two major groupings, the inner and the outer core of support. All Code Team Members are designated at the beginning of their work shift and carry a beeper. The inner core provides direct patient care to the patient and is composed of the following:

1. **Code Leader:** The PICU attending physician who is in-house 24 hours a day.
2. **Senior Pediatric Resident:** Co-leader with the PICU attending.
3. **Surgical Resident:** In-house 24 hours per day and assists IV access, CT placement, other surgical related procedures.
4. **Anesthesia:** the anesthesia resident (in-house 24 hours a day) does this role until the attending arrives.
6. **Second Pediatric Resident:** Assist with IV placement, other procedures, and medication administration.
7. **Medication Nurse:** PICU nurse whose primary role is medication administration.
8. **Bedside Nurse:** Designated 4th and 5th floor nurse whose primary role is vital signs and assisting with bedside procedures.
9. **Cart Nurse:** ICN nurse whose role is to deliver the equipment to team members and draw up medications.
10. **Scribe:** Designated 4th and 5th floor nurse whose role is to record the events of the code and complete an unusual occurrence report.

11. **Respiratory Therapist (RT):** This role assists anesthesia with maintaining the airway; assists in obtaining ABG's.
12. **Pharmacist:** This individual's role is for drawing up medications required by the Code Blue Team.

The outer core contains Team Members that help in a support mode and includes:

1. **Chief Resident:** Assist with crowd control.
2. **Nursing Supervisor:** Assist with crowd control, offer family support in absence of social worker, directs resources, as indicated.
3. **Second RT:** Assists in running ABGs and obtaining additional RT equipment.
4. **Social Worker:** Assists in family support. This role has a 20-minute response time between 11:00 p.m. and 8:00am.
5. **Lab:** Is on alert; does not respond. Processes any related labs to code as STAT.
6. **Radiology:** Is on alert; does not respond. Processes any X-rays as STAT.
7. **Pharmacy:** Is on alert for the rapid dispensing of medications not available on the code cart.

The Nursing Education Department coordinates interdisciplinary mock code blues. These educational sessions are done quarterly on all shifts. Resident participation is essential. In addition, unit-based mock code blues with resident involvement are periodically performed.

MED STAT

A Med Stat at Children's Hospital & Research Center Oakland is called when any member of the health care team identifies an emergency medical situation, and there is a need for additional personnel and resources. It is a term used to describe a patient who is NOT in cardiopulmonary arrest but there may be imminent danger of this happening.

Response team is identical to Code Blue Response team, except anesthesia and pharmacy DO NOT COME TO A MED STAT.

Q. DEATH OF A PATIENT

See Details of policies concerning the Death of a Patient on CHONET under Medical Staff, Rules and Regulations, Section 5, page 44
[http://192.168.1.59/inetdocs/mso.rulesregs/MS Rules and Regulations 2010.pdf](http://192.168.1.59/inetdocs/mso.rulesregs/MS_Rules_and_Regulations_2010.pdf)

Also see Meditech Library for review of procedures

R. FIRE RESPONSE PLAN

Clearly, the first obligation of anyone who discovers a fire is to RESCUE anyone from immediate danger and REPORT the fire by:

- Yelling “code red” to nearby staff as you remove a patient from danger.
- Pull a fire alarm box (which causes the fire alarm chimes to ring, the automatic doors to close, and calls the first department) AND call the hospital operator by dialing “55”.
- Tell the operator who you are and what you need. If there’s a odor of smoke but no visible fire or smoke, the operator will page an engineer to investigate.
- The hospital’s fire alarm system will also be activated by smoke detectors located in exhaust ducts and by the flow of water to sprinkler heads that are themselves activated by heat.

Once anyone in immediate danger has been rescued and the first has been reported, the next important point is to CONFINE the fire. In most cases that can be done by closing a door to prevent the spread of fire and smoke from its origin. If the fire is limited in size, you may wish to EXTINGUISH the fire with a blanket, a fire extinguisher or anything else at hand, but do not open a door to fight a fire once it has been closed.

Because hospital buildings have patients who may be difficult to move, CONFINING a hospital fire and the resulting smoke is especially important.

Key points to remember:

- Close all doors and windows. Doors that are blocked or wired open could make it impossible to effectively contain a fire in a room.
- Once you have closed a door into an unoccupied room where there is a fire, do NOT reopen the door.

Taking these simple steps will gain valuable time and prevent smoke from spreading within the building. Keeping patients in rooms with the doors closed until the fire department arrives is far safer than trying to move them through smoke-filled corridors.

If fire and smoke cannot be confined to a room and/or you have been advised by the fire department or someone in authority to leave the immediate area of the fire:

- Evacuation to a smoke-free area on the same floor should be your first choice. Cross-corridor fire doors will serve to block the spread of smoke and fire.
- If you are instructed to evacuate an entire floor in a very large fire, use the stairs and move to a lower floor.
- Elevators may not be safe to use in a fire because they could open on a floor where there is smoke or fire, leaving no escape route.

A mnemonic to remind you of what to do in case of fire – think RACE

R - Rescue

- A - Alert
- C - Confine
- E - Extinguish or Evacuate

S. Needle Sticks

Needle Stick Prevention

Dispose of sharps promptly. If you used a syringe or needle, put it directly into a sharps container yourself. Recapping, bending, or shearing contaminated needles is prohibited.

Dispose of sharps properly. Make sure the sharps container is available and working properly before you use it. If it is $\frac{3}{4}$ full or isn't working properly, don't use it.

Don't eat, drink, or handle contact lenses in an area where blood or body fluids are handled.

Wear protective equipment (gloves, mask, goggles, etc.) appropriate to the task.

Know how to clean up blood and other potentially infectious spills. This information can be found in the Meditech Library under "Safety Information".

Wash your hands and exposed skin with soap and water immediately after handling infectious materials or after taking off gloves or other protective equipment. Handwashing is the single most effective infection control measure, and your intact skin is your final barrier against bloodborne pathogens.

If you accidentally stick yourself with a contaminated needle, wash the wound immediately with soap and water. Then report to Employee Health, or if Employee Health is not open, go to the Emergency Department. Within 24 hours inform the Medical Director's Office of your exposure.

T. Injury while at work

Should you injure yourself while at work, go to Employee Health. If Employee Health is not open, go to the Emergency Department. Within 24 hours inform the Chief Residents and Medical Education Office of your injury.