The University of Arizona

EMERGENCY MEDICINE

RESIDENCY POLICIES

July 1, 2021

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Last Updated: July 19, 2021

DUTY HOUR RULES

The purpose of duty hour rules is to protect the resident and to ensure safe patient care. Emergency medicine (EM) residents will accept responsibility to do everything in their power to follow the duty hour rules. This includes personally accounting for all time relevant to the rules. The resident is responsible for making the program aware of any potential duty hour breach prior to being breached. This should be done as far in advance of the breach as possible. The resident must identify the potential breach or already breached rule in the following order and manner:

1. Notify the Clinical Service resident and attending. If this does not result in a prevention of the breach go to #2.
2. Notify the Administrative EM Chief Resident by email or phone. If this does not result in a prevention of the breach go to #3.
3. Notify Program Director by phone.
4. Notify the residency office of all breaches by documenting in New Innovations.

Duty Hour Rules –
As per Accreditation Council for Graduate Medical Education (ACGME) Program Requirements for Graduate Medical Education in Emergency Medicine, effective July 1, 2020 (RRC policies)

Relevant portions listed here:

VI.E.1.a) When emergency medicine residents are on emergency medicine rotations, the following standards apply: (Core)

VI.E.1.a).(1) While on duty in the emergency department, residents may not work longer than 12 continuous scheduled hours. (Core)

VI.E.1.a).(1).(a) There must be at least one equivalent period of continuous time off between scheduled work periods.

VI.E.1.a).(2) A resident must not work more than 60 scheduled hours per week seeing patients in the emergency department, and no more than 72 total hours per week. (Core)

VI.E.1.a).(3) Emergency medicine residents must have a minimum of one day (24-hour period) free per each seven-day period. This cannot be averaged over a four-week period. (Core)

VI.F.1. Maximum Hours of Clinical and Educational Work per Week
Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. (Core)

VI.F.2. Mandatory Time Free of Clinical Work and Education

VI.F.2.a) The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being. (Core)

VI.F.2.b) Residents should have eight hours off between scheduled clinical work and education periods. (Detail)

VI.F.2.b).(1) There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements. (Detail)

VI.F.2.c) Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)

VI.F.2.d) Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days. (Core)

VI.F.3. Maximum Clinical Work and Education Period Length

VI.F.3.a) Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (Core)

VI.F.3.a).(1) Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. (Core)

VI.F.3.a).(1).(a) Additional patient care responsibilities must not be assigned to a resident during this time. (Core)

VI.F.4. Clinical and Educational Work Hour Exceptions

VI.F.4.a) In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:

VI.F.4.a).(1) to continue to provide care to a single severely ill or unstable patient; (Detail)

VI.F.4.a).(2) humanistic attention to the needs of a patient or family; or, (Detail)

VI.F.4.a).(3) to attend unique educational events. (Detail)

VI.F.4.b) These additional hours of care or education will be counted toward the 80-hour weekly limit. (Detail)

VI.F.5. Moonlighting

VI.F.5.a) Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. (Core)

VI.F.5.b) Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core)

VI.F.5.c) PGY-1 residents are not permitted to moonlight. (Core)

VI.F.6. In-House Night Float

Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. (Core)

VI.F.7. Maximum In-House On-Call Frequency

Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). (Core)

VI.F.8. At-Home Call

VI.F.8.a) Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. (Core)

VI.F.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. (Core)

VI.F.8.b) Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit. (Detail)

MOONLIGHTING POLICY

This policy supplements the College of Medicine's Moonlighting Policy, as promulgated by the Graduate Medical Education Committee (see next section). Moonlighting is considered outside employment under University policies. Residents who externally moonlight must maintain an independent license to practice medicine and appropriate professional liability insurance in the State of Arizona and will conduct themselves in this outside employment solely under that license and insurance.

Approval for outside employment will not be construed in any way to be part of the training program or sanctioned as a component of resident's training program. This outside employment is not part of a resident's assigned University duties, nor will it be considered within the course and scope of a resident's employment with Banner Health should a claim for malpractice or a lawsuit alleging malpractice arise out of such outside employment. The University and Banner Health will not provide professional liability coverage either for the resident or others for these outside activities.

Outside employment may not conflict with or affect resident performance in any component of the training program, including attendance at didactic conferences. Additionally, such outside employment may not negatively affect resident performance, nor will it alter performance expectations for clinical competence and productivity in the Banner University Medical Center Tucson or South Campuses' Emergency Departments or any other training site to which a resident may be assigned.

Outside employment is not to be undertaken during any period of time when a resident is on call at either Banner University Medical Center Tucson or South Campus, or another assigned training site, irrespective of whether resident call is on site or on pager.

It is expressly prohibited for a resident to compensate another resident to work his/her scheduled clinical shift in order to moonlight. Violation of this rule will result in immediate academic probation and permanent revocation of approval to moonlight for the duration of the residency. Sanctions also may be taken against any resident accepting payment to work a shift for this purpose.

All residents must have their moonlighting plans cleared by the Program Director PRIOR to committing to any moonlighting activities. Residents must sign a moonlighting agreement. Any contemplated changes in moonlighting activity need approval by the Program Director PRIOR to changes.

Should any of the above conditions not be met or should the Program Director believe that such outside employment conflicts or interferes with a resident's assigned duties, the Program Director reserves the right to withdraw approval of permission to participate in outside employment. All outside non-residency employment must be reported to the Program Director, including the site and the number of hours worked, using the Duty Hours Logging tool in New Innovations.

Internal Moonlighting may only occur within the Department of Emergency Medicine and only in approved Educational Enrichment activities approved by the Program Director. All outside employment hours count toward the 80-hour weekly limit on duty hours. No work may break duty hour rules.

If a resident no-shows for their scheduled internal moonlighting shift or fails to find a substitute for their shift, then

- The resident shall be issued a letter of concern related to a lapse in professionalism. This letter will be place in their academic file.
- Internal and external moonlighting privileges will be revoked for three months.
- Repeated no-shows for internal moonlighting shifts may result in progression on the College of Medicine Tucson Due Process pathway.

Resident moonlighting hours plus assigned work must not exceed the ACGME duty hours guidelines (see previous section). Residents who moonlight must document their moonlighting schedule and send this schedule to the residency office prior to those shifts. In addition, residents must document their moonlighting hours in New Innovations. Noncompliance with this policy may result in academic probation or other disciplinary action, as appropriate.

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Moonlighting Policy

Graduate Medical Education Committee - Policies and Procedures

Purpose

In order to comply with the ACGME Common Program Requirements for Graduate Medical Education, the University of Arizona College of Medicine Graduate Medical Education Committee (GMEC) establishes this policy to ensure that any moonlighting activities, whether internal or external, do not interfere with the resident's/fellow's ability to achieve the goals and objectives of their educational program, interfere with the resident's/fellow's fitness for work nor compromise patient safety.

Policy

External Moonlighting

1. Any resident/fellow who wishes to engage in professional activities outside the educational program for remuneration ("Moonlighting") must obtain prior written approval from the Program Director of his/her training program.
    a. This statement of permission will be included in the resident/fellow's file.
    b. Residents and fellows will not be required to engage in Moonlighting.
    c. Moonlighting must not interfere with the ability of the resident/fellow to achieve the goals and objectives of the educational program.
    d. Time spent in External Moonlighting must be counted towards the 80-hour maximum weekly hour limit.
    e. J-1 visa holders and PGY-1 residents are not permitted to moonlight.
2. The Program Director will:
    a. Require a prospective written request to moonlight.
    b. Monitor the resident/fellow's performance to assure that the duty hour limits are not violated. Program Directors are also responsible for making sure that resident/fellow fatigue is not contributing to diminished learning, or performance, or interfering with patient safety. If duty hours are exceeded, or resident/fellow's performance is noted to be suboptimal, the Program Director has the authority to revoke the resident/fellow's Moonlighting privileges.
    c. The resident/fellow will acknowledge by signature, that if required he/she:
        i. Has an independent medical license to participate in such activity;
        ii. Has the necessary DEA number (independent of the hospital's DEA number) to prescribe controlled substances, if applicable;
        iii. Has the necessary professional liability coverage separate and apart from the training program coverage; and,
        iv. Will not depend upon hospital personnel, supplies, equipment, e.g., hospital operators, secretaries, etc., for providing assistance in fulfilling the duties and responsibilities of such activities.

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Internal Professional Activities

3. Any resident/fellow who wishes to engage in professional activities outside the educational program for remuneration but within the Banner Health network ("additional work/shifts") may be eligible to receive additional compensation, as set by his/her home department. These additional duties may include, but are not limited to, working additional on-call shifts or covering responsibilities which are not part of the resident's/fellow's normal scheduled scope of training, but within the course and scope of the resident's/fellow's work as a trainee. J-1 visa holders and PGY-1 residents are not permitted to participate in internal additional work duties for remuneration. Any internal professional activities for which resident/fellow receives additional compensation must:
    a. Be voluntary;
    b. Be pre-approved by the Program Director;
    c. Be supervised;
    d. Count hours worked towards the 80-hour maximum weekly hour limit.
4. Each residency or fellowship program may add to the requirements or restrict moonlighting as it sees fit so long as the above basic elements are met.

Reviewed: 04/01/2018

SHIFT TRADE POLICIES

Penalties for making a shift trade that does not comply with The University of Arizona Department of Emergency Medicine and ACGME Duty Hour policies are as follows:

- First Offense: You will be reminded of the relevant policies and warned about the penalties of future offenses.

- Second Offense: You will lose the privilege of requesting any further days off during the following three EM blocks.

- Third Offense: You will lose the privilege of requesting days off for the remainder of the academic year.

SICK LEAVE POLICY

This policy is established to provide adequate resident physician coverage in the emergency department (ED) in the event that a resident physician becomes ill or has a family emergency that requires him/her to miss a shift(s).

- In the emergency department we have limited resident physician coverage, and each missed scheduled shift must be replaced to provide sufficient patient care. Using this policy requires considerable resources and only the resident can determine if they are truly too ill to work.
- A resident must not work more than 60 scheduled hours per week seeing patients in the ED and no more than 72 total hours per week. This expectation allows for unexpected sick and emergency absence without a need for payback, as well as state holidays off.
- However, after discussion and agreement with the resident body, a backup call system will not be implemented until the resident body votes otherwise. Thus, the expectation is that the ill resident will pay back the substitute resident for every shift covered as directed by this policy. The shift(s) is expected to be paid back in the next EM block or as soon as reasonably possible if high in number. The scheduling chief resident may make payback arrangements when scheduling for the residents involved if logistically easier.
- This policy will remain in effect until the residency body and residency leadership reaches a consensus to implement a backup call system.

- Each resident that cannot fulfill a shift requirement shall use the following algorithm:

    1. Contact the scheduling chief no later than 2 hours prior to the start of the shift to inform them you cannot work your shift.

    2. Review the existing emergency resident schedule and contact the individuals who are not scheduled to work during your shift to find a replacement. This action will result in a “trade” and the ill resident will pay back the shift to the substitute resident at a later date and at the earliest possible time. The "trade" must follow ACGME work hour guidelines.

    3. An emergency medicine resident on a non-core shift on the day of need may be asked to cover the shift in need to replace their currently scheduled non-core shift. This change must follow ACGME work hour guidelines.

    4. The scheduling chief may contact off-service emergency medicine residents, including those on anesthesia/selective, ultrasound, toxicology, and in-town selective, to cover the shift. The substitute resident will receive payback for each shift worked during the next possible emergency medicine block.

5. If the ill resident cannot find adequate coverage for his/her shift, the scheduling chief will contact the two residents currently working during the day of need and determine if they could work an additional 4 hours each to cover the shift. For instance, if the junior evening resident calls in sick, the junior morning resident would work an additional 4 hours and the junior night resident would come to work 4 hours earlier to cover the clinical hours of the junior evening shift. These additional hours must follow ACGME work hour guidelines. The ill resident will pay back these hours to the covering residents during the next possible emergency medicine block.

6. A chief resident will work the shift in need.

The scheduling chief resident must receive unscheduled absence calls no later than 2 hours before the shift starts. If the ill resident fails to notify the scheduling chief resident that s/he is unable to work with at least 2 hours' notice or does not make an effort to find adequate coverage for his/her shift, the resident will have a written notice placed in his/her residency file, will owe one shift to the resident who worked their shift, and will also be assigned one extra shift in the next possible emergency medicine block (unless approved for emergent reasons by the Program Director).

Special circumstances:

- If the ill resident is hospitalized or instructed not to work by physician order, then the ill resident will pay back shifts up to and including five (5) missed shifts. If the ill resident misses 6-10 shifts, then those shifts above 5 do not need to paid back directly to the substitute resident(s). Those substitute residents will instead be paid back with a shift reduction on a subsequent ED block.
- If the ill resident will miss more than 10 shifts, then the ill resident must consider taking a leave of absence (i.e. short-term disability or FMLA). Either of these options may extend the total duration of residency training.

EFFECTS OF LEAVES OF ABSENCE

In order to comply with the ACGME Common Program Requirements for Graduate Medical Education, this policy is set forth by The University of Arizona College of Medicine Graduate Medical Education Committee (GMEC). All requests for unpaid leaves of absence must be submitted to the Program Director with a letter indicating the reason for the leave and the proposed leave schedule, which first must be approved by the Program Director. Leaves of absence will be granted in accordance with the Banner Health policy, and as per guidelines set forth in the GME Resident/Fellow Manual.

Any protracted leave of absence may affect the completion date of the residency program. Any effect on the completion of residency will be determined by the Program Director in consultation with the requirements of the American Board of Emergency Medicine's criteria.

ABEM Policy on Parental, Caregiver, and Medical Leave

The American Board of Emergency Medicine in July 2020 released their "Policy on Paternal, Caregiver, and Medical Leave." This local policy is based on the ABEM policy.

- The minimum amount of total training required to become proficient in the specialty is 138 weeks for EM 1-3 programs.
- A minimum of 46 weeks of training is required at every level.
- Our residents have 4 weeks of scheduled vacation per year.
- Two additional weeks per year may be granted to accommodate leaves of absence for parental, caregiver, and personal medical leave, if the Program Director attests that competency has been achieved without an extension of training.
- In the final year of training, a resident must complete 30 weeks of training in the Emergency Department, including experiences dedicated to the care of pediatric patients less than 18 years of age, under the supervision of Emergency Medicine faculty members.

If a resident desires to take 2 weeks of paternal/caregiver/medical leave during an academic year, the resident should discuss this as early as possible with the Program Director. If the Program Director believes that competency at the resident's level of training can be achieved without an extension of training, this leave will be approved.

If the 2-week leave is approved, the resident will work with Banner HR to either utilize accrued Arizona Sick Time or short-term disability, to assure continued pay during this period.

If the Program Director is concerned that competency at the resident's level of training cannot be achieved without an extension of training, alternatives to the 2-week leave

will be discussed, including other rearranging of the resident's schedule or extension of training. If the leave is not approved due to concerns for not achieving competency without extending training, the resident can appeal this decision to the Academic Affairs committee. The Academic Affairs committee will review the resident's file and progress and make a recommendation to the Program Director, but the ultimate decision will be that of the Program Director and will be final.

This policy applies to categorical Emergency Medicine training. Per ABEM policy, residents in combined training programs are not eligible for additional leave and must adhere to the applicable combined training program guidelines.

SUPERVISION

The Emergency Medicine Residency Program clinical learning environments are all supervised by American Board of Emergency Medicine prepared, ACGME-approved, attending faculty who have credentials to practice in the clinical setting. These attendings are readily identifiable by schedule and on site.

1. Emergency Medicine faculty directly supervise all residents and medical students assigned to the ED while they are on duty. The attendings are involved with and physically present for the key portions of assessments, procedures, and medical decision making of all ED patients. Although progressive autonomy and conditional independence is an integral part of resident maturity, all emergency medicine residents are directly supervised throughout all emergency department clinical experiences.

2. Emergency medicine residents are supervised by attending faculty while on off-service clinical assignments according to the supervisory policy of those specific departments.

PROGRESSIVE RESPONSIBILITY

Resident responsibilities related to supervision, clinical responsibility, teaching, and administration vary according to specific objectives. Clinical responsibilities for patient volume and acuity increase with level of training and also individual capabilities. The EM faculty carefully distribute case responsibility, autonomy, and supervised learning opportunities. Residents from all three levels are always present in the ED (24/7/365) for continuous overlap.

First year residents clinically focus on core competencies, the emergency medicine approach, chief complaint-based approaches, and key procedures. They are supervised closely. They learn how to compose and present case conferences for continuous process improvement and participate in a first-year level specific scholarly curriculum for research, critical-appraisal journal club, and evidence based medicine.

Second year residents focus on developing efficiency, directing medical and surgical resuscitations, incorporating evidence-based approaches, and further mastery of key procedures. They learn how to teach material related to core EM topics. They continue to compose and present case conferences for continuous process improvement and participate in a second-year level specific scholarly curriculum for research, a critical-appraisal journal club, and evidence based medicine, including initiation of a scholarly project.

Third year residents focus on developing clinical autonomy, teaching effectiveness, and departmental supervision. They learn how to deliver a formal Grand Rounds talk and present case conferences for continuous process improvement. They participate in a third-year level specific scholarly curriculum for research, a critical-appraisal journal club, and evidence based medicine, including completion of a scholarly project.

PROMOTION AND ADVANCEMENT

Residents are advanced to positions of higher responsibility on the evidential basis of their progressive scholarships and professional growth. This evidence includes passing the in-training exam (as defined by each individual residency program), satisfactory completion of rotations, documented attendance at educational activities, and an assessment of the resident's progress in achieving competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. This advancement is communicated to the GME Office by the annual submission of a promotion letter or summative evaluation for graduating residents.

TARDINESS POLICY

Tardiness definition: 5 minutes late to shift

- Resident should arrive at least 5 minutes early to each shift and be prepared to see their first patient on the hour.

Reporting:

- Any EM resident/faculty can submit an email to the scheduling chief or complete an anonymous Speak Freely Form stating the name of the offending resident, scheduled shift date/time, and arrival time.
- This policy may also be used to report tardy off-service residents.

Consequences:

- Each reported tardy will be addressed by the scheduling chief via phone or in person with the offending resident within 72 hours.
- 4 cumulative tardies warrants a meeting with the Program Director.
- 5 tardies in 1 block will result in an extra shift for the offending resident or a rotation failure for an off-service resident.

CHARTING POLICY

Goal: To ensure compliance with medical charting requirements and to create a process to address delinquent resident charting performance for all residencies within the Department of Emergency Medicine at The University of Arizona.

Background: Timely medical record documentation is a critical component of patient care. Residents begin to learn about medical record charting during orientation. Multiple educational sessions occur annually to allow residents to become competent in these skills. Timely completion of charts allows other physicians, health care providers and stakeholders within the healthcare system to understand what took place during a given encounter in the absence of the original provider and ensures continuity of care from provider to provider. Incomplete or missing charts can have a major impact on the healthcare of the patient, on the resident and attending physicians' liability, and on the financial health of the department and institution.

The Department of Emergency Medicine adopts the following requirements for residents to complete medical charting and describes the consequences for failing to comply with these requirements:

1. The Banner HIMS policy on charting is that residents are required to complete charts on all patients within 24 hours of patient disposition. Best practice requires physicians to complete charting on admitted patients prior to leaving shift and on patients transferred to another hospital prior to physical transfer and departure from the ED. Failure to complete charting within this time frame or to complete such charting adequately will result in those charts being considered deficient.

2. If a resident has more than 10 deficient charts on a weekly audit or any incomplete chart that is greater than 5 days old, that resident is considered "delinquent" with his/her charting responsibilities and will be required to appear for clinical shifts one hour before the scheduled time to work on his/her deficient charts until s/he has completed all such charts. Resident will lose his/her schedule request day off privilege in the upcoming EM block for each occurrence. Once a resident has completed all deficient charts, the Program Director or designee will give the resident an "all-clear". Residents must return from off-service rotations to complete delinquent documentation. This could result in residents making up missed expectations on those rotations.

3. If a resident accumulates four (4) "delinquent" audits (4 separate weekly audits in which s/he has more than 10 deficient charts), then s/he will receive a Notice of Deficiency, which will include expectations for improving performance. Residents who receive a Notice of Deficiency due to delinquent audits must meet with the Program Director to document a plan to remediate this deficiency within 5 day(s) of receiving the Notice of Deficiency. The resident and his/her faculty advisor will present the plan to the residency specific Academic Affairs committee at its next scheduled meeting. Moonlighting privileges will be revoked until given an "all-

clear" by the Program Director. Interns will lose days off request privileges on an ED block.

4. The Program Director and faculty advisor will personally deliver, in writing, a warning notice to any resident who is thereafter "delinquent" on ANY weekly audit (after the 5 day remediation period).

5. Residents who are "delinquent" on ANY weekly audit after receiving this warning notice will be placed on probation in accordance with the College of Medicine's Due Process Guidelines for Residents and Fellows.

6. Residents who fail to remediate their delinquencies during a Clinical Competency Committee in accordance with the College of Medicine's Due Process Guidelines for Residents and Fellows.

7. First year residents (interns) are excused from this policy during their first full three blocks in the emergency department. The policy will be in effect for interns beginning with the resident's fourth EM-1 block.

8. The delinquent audit count will re-start each academic year on July 1st.

9. Graduation certificates will not be issued until a resident has completed 100% of his/her charts.

10. Off-service residents rotating in the ED will be held to the same standard of chart completion for all patients within 24 hours of disposition. If an off-service resident has more than 20 deficient charts on a weekly audit, the EM Program Director or designee will notify the resident's Program Director. If an off-service resident has not completed 100% of his/her charts within 7 days of completing the rotation, the resident will fail the rotation.

PROCEDURE DOCUMENTATION/SELECTIVE ROTATIONS

In order to be approved for selective rotations, residents must be in compliance with procedure documentation as follows:

RESIDENT YEAR	SELECTIVE TIME OF YEAR	NEW INNOVATIONS PROCEDURE DOCUMENTATION
EM-2	First half	1/3 of total required procedures
EM-2	Second half	1/2 of total required procedures
EM-3	First half	2/3 of total required procedures
EM-3	Second half	5/6 of total required procedures

Please see separate Selective Approval Process for each respective residency program.

QUALITY ASSURANCE

I. Purpose

All healthcare professionals, including emergency medicine residents, must have training in quality measurement and improvement. The institutional requirements and program requirements of the Accreditation Council for Graduate Medical Education (ACGME) already require that:

> Institutions participating in GME must conduct formal quality assurance programs and review complications and deaths. All residents should receive instruction in quality assurance (QA) and performance improvement. To the degree possible and in conformance with state law, residents should participate in appropriate components of the institution's performance improvement program.

This residency has conducted QA and continuous process improvement (CPI) for many years and has also actively promoted the involvement of emergency medicine residents in hospital committees with these responsibilities. This document will serve to outline the emergency medicine residency training programs' involvement in QA and CPI. All residents participate in the emergency department continuous quality improvement through active involvement in quality assurance audits and continuous process improvement projects.

II. Quality Assurance / Continuous Process Improvement

A. CPI Conference – The residency body and all residents in the emergency medicine training programs are active members of continuous process improvement. The objective of this conference is to critically review morbidities and mortalities that occur within the emergency department. Cases are dissected to review possible errors of all types. All materials are peer review protected. All residents and faculty are encouraged to participate in an open dialogue format. Alternatives in clinical decision-making, evaluation, and management are discussed openly. The Clinical Director creates action item lists to pursue further needed interventions when necessary. Feedback to nursing staff, ancillary departments, consultants, and individual physicians occurs via the Clinical Director. Emphasis is placed on mechanisms to reduce medical error.

B. Autopsy Data – all patients who die in route to Banner University Medical Center Tucson and South Campus EDs, within the ED, or after being cared for in the ED at one point during their course are recommended for autopsy review. All Banner University Medical Center Tucson Department of Pathology completed autopsies are open to resident attendance. Residents may contact the pathology resident on call to arrange this observation. Autopsies may also be reviewed during CPI conference.

C. Discharge Summaries – All Banner University Medical Center Tucson and South Campus patients have an electronic medical record. All emergency medicine residents may access medical charts from their ED workstations. Each EM resident may maintain a personal and ongoing electronic list of their patients on which they wish to follow up within the electronic health system for educational purposes.

III. The Graduate Medical Education goals and objectives for the residency in emergency medicine are reviewed in a quality assurance format. Chief Residents and individual residents review each rotation and overall program goals and objectives on an annual basis. Residents and faculty also review the performance of all members of the residency administration. The institution's Graduate Medical Education Committee also reviews the residency's program goals and implementation of these goals. Monthly faculty meetings focus on mechanisms to improve all aspects of the residency's administration. Process improvement comes through specific suggestions for medical education intervention, which are then reviewed by the GME Committee.

IV. Scholarly work and research with regards to process improvement is encouraged. Residents are urged to access the Banner University Medical Center Tucson and South Campus ED and hospital patient databases, the trauma database, as well as the Southern Arizona VA Health Care System patient databases for novel original research in this area.