Supervision:

- Attending physician direct and/or indirect supervision must be provided for all patient care activities in which residents are engaged. The degree and type of supervision must be based upon patient census, complexity and acuity of illness as well as resident level of training, competency, comfort level and fitness for duty.
- The resident must notify the attending physician and/or fellow of all new admissions, consultations and changes in patient status including:
  - Decompensation
  - Transfer to a higher level of care
  - End of life planning and decision making
  - Death
  - Invasive procedures
  - Request for leave against medical advice
- Orders for new patients or consultations must be reviewed with the supervising fellow or attending physician.

Patient Limits on Hospital Medicine Service:

- A first-year resident must not be assigned more than five new patients per admitting day; an additional two patients may be assigned if they are in-house transfers from the medical services
- A first-year resident must not be assigned more than eight new patients in a 48-hour period
- A first-year resident must not be responsible for the ongoing care of more than 10 patients and 2 transfers
- When supervising more than one first-year resident, the supervising resident must not be responsible for the supervision or admission of more than 10 new patients and four transfer patients per admitting day or more than 16 new patients in a 48-hour period
- When supervising one first-year resident, the supervising resident must not be responsible for the ongoing care of more than 14 patients
- When supervising more than one first-year resident, the supervising resident must not be responsible for the ongoing care of more than 20 patients and 4 transfers

Patient Limits on Subspecialty Services:

- Residents must reach out to their attending or fellow if the service has a high patient census to seek guidance on which and how many of the patients they should ideally see before rounds.
- Resident patient volume should take into consideration:
  - The guideline # below
  - Skill and comfort level of the resident
  - Complexity and acuity of illness of the patients

<table>
<thead>
<tr>
<th>Service</th>
<th>Pt# for each Intern on the team</th>
<th>Pt# per Upper Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>GI</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>ID</td>
<td>12</td>
<td>14-16</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td>Renal</td>
<td>12</td>
<td>16</td>
</tr>
</tbody>
</table>

- Residents can see new consults above and beyond this number if doing so would enhance their clinical exposure and add educational value without excessive burden and fatigue.
- Upper level residents who are on home beeper call are expected to come to the hospital to see any patients who require acute assessment and to evaluate all new admissions or consultations for the subspecialty services they are covering. The night float supervising resident may be called in the event..
of an urgent or emergent problem, pending the arrival of the resident on home beeper call.
• Interns cannot take home beeper call. Any after hours or weekend assignments must include direct supervision by an attending or fellow on the service.
• Upper level residents should be mindful of the intensity of home call when arranging home call coverage prior to the beginning of the rotation. Should the intensity of home call on the service escalate, creating excessive fatigue and resident burden, this should be communicated promptly to the service attending and the program director.
• Time spent providing clinical care from home and in the hospital on home call should be logged as duty hours.

Patient Limits on ICU Services:
• The academic ICU team census should range from 16-20 with consideration for:
  ➢ Skill and comfort level of the residents
  ➢ Complexity and acuity of illness of the patients
• Residents should NOT perform consultations on patients intended to be placed on the non-academic ICU team.

Transfer of Care Process for HMS: Calling in Back-Up
• If a first-year night float resident exceeds the threshold while covering in-house call, they are responsible for contacting the supervisory resident to assume primary patient responsibility for subsequent admissions. If the number of patients exceeds the limits for both the R1 and the supervising resident, the resident assigned to back-up call for the period must be notified and shall assume responsibility for any additional admissions. The backup call resident covers night float if the night float resident of any level becomes ill or unfit for duty for any reason.
• Attending physicians are on-call and available to provide continuous indirect and/or direct supervision to the residents for the evaluation or care of patients, as needed, dictated by the patient census, complexity and acuity of illness.
• If the back-up resident does not answer their page for back-up call and cannot be reached on their cell, then the other facility's back-up call resident should be contacted. Failure to respond to back-up call responsibilities will be reported to the Clinical Competency Committee.

Transfer of Care Process for ICU:
• ICU Resident exceeding their capacity to provide ongoing, safe patient care for any reason, during any shift should notify their fellow and attending of their limitations and seek direction on who to hand off the care of their patients.

Transfer of Care Process for Subspecialty Services:
• Subspecialty Residents exceeding their capacity to provide ongoing, safe patient care for any reason, during any shift should notify their attending and/or fellow of their limitations and seek direction on who to hand off the care of their patients.

Transfer of Care Process for Ambulatory Medicine Services:
• Any resident who becomes ill or unfit for duty must utilize the program’s Sick Leave Process and notify their supervisor of their limitations and seek direction on who to hand off the care of their patients.