First Night On Call:

Using Simulation to Assess Resident Hospital Care Management and Supervision Skills

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AMERICAN ACADEMY OF FAMILY PHYSICIANS

Disclosures

- Dr. Dschida has nothing to disclose

Affiliations

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Special Thanks

- To my collaborating faculty
  - Dr Deborah Edberg
  - Dr Meredith Hirshfeld
  - Dr Anuj Shah

Session Objectives

- Demonstrate a simulation approach for evaluation of appropriate graded supervision
- Evaluate resident clinical performance on key milestones for promotion
- Brainstorm other approaches to evaluation of graded supervision

Common Program Requirements

Note: The term "resident" in this document refers to both specialty residents and subspecialty fellows. Once the Common Program Requirements are inserted into each set of specialty and subspecialty requirements, the terms "resident" and "fellow" will be used respectively.

Introduction

Int.A. Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident.

The specialty education of physicians to practice independently is experiential.

As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept--graded and progressive responsibility--is one of the core tenets of American graduate medical education.

to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept--graded and progressive responsibility--is one of the core tenets of American graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.

ACGME Requirement

VI.D.4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. (Core)

- How do we assess learners and what level of supervision they require?
  - Evaluations, observations in clinical settings…
  - And now with simulation!

Our Program Needs

- Unopposed THC program
  - ~200 beds, urban community safety-net hospital
- Night float
  - FMS nights as second years

Your Program Needs?

- Please describe your current role
  A. Program director or associate director
  B. Faculty member
  C. Residency administrative staff
  D. Residency clinical staff
  E. Other

Your Program Needs?

- Do you currently have a process for evaluating residents for indirect supervision?
  A. Yes
  B. No

The Sim Center

Sim Session Overview

- Groups
  - Faculty, R3, two R2s, two-three R1s
- Cases
  - Three cases run in parallel
    - First for practice/orientation
    - Next for evaluation of R2s

Sim Session Overview- Roles

- Provides opportunity for each level of training
  - R1: initial assessment of patients
  - R2: supervising R1s, appropriately activating team
  - R3: junior faculty

Note on Sim

- Lo-fi vs. Hi-fi
  - Useful for all types of centers, can be run with fully automated mannequin, or full “analog” ☺

Case Development

- Create your own vs. adapt
  - Based on your clinical setting, common scenarios
  - Choose those that will demonstrated MS's
  - Based on resident feedback

Sim Session Overview- Evaluation

- Debrief after each case
  - Led by R3, constructive, focused on MK for whole group
- Evaluation for promotion at end of session
  - Led by faculty with each R2, reviews each milestone associated with promotion

Milestone Assessment

Patient Care - 1

1) Recognizes level of urgency and responds appropriately (i.e. allowing interns to work through care when less urgent, taking over when patient's condition destabilizes) *Level 3*

2) Recognizes condition accurately and initiates appropriate intervention/work up at appropriate pace *Level 2*

Medical Knowledge- 2

1) Correctly interprets information from all sources *Level 1* and makes appropriate decisions based on information *Level 2*

2) Appropriately anticipates expected and unexpected outcomes based on data *Level 3*

Systems Based Practice -2

1) Understands that effective team-based care plays a role in patient safety *Level 1*

2) Understands and follows protocols to promote patient safety and prevent medical errors *Level 2*

Milestone Assessment

Systems Based Practice- 4

1) Utilizes team *Level 1* and own role in team to direct team and promote patient safety *Level 4*

2) Follows appropriate protocols to promote patient safety with appropriate level of supervision *Level 2*

3) Appropriately assumes leadership role when acuity of patient escalates *Level 4*

Communication- 3

1) Communicates effectively with team including the sharing of information, teaching and giving feedback in a constructive way *Level 3*

Professionalism- 2

1) Attends to responsibilities and completes duties required, presents him/herself in a respectful and professional manner *Level 1*

2) Consistently recognizes limits of knowledge and asks for assistance *Level 2*

PC-1: Care of Acutely Ill

Patient Care 1: Cares for acutely ill or injured patients in urgent and emergent situations in all settings: FMC, Inpatient, ER					
Date: **Resident Name and Year:** **Observer Name:**			**Did resident receive this feedback verbally:** ☐**Yes** ☐**No- If no, why not:**		
Has not achieved Level 1	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**
	Gathered essential information about the patient (history, exam, diagnostictesting, psychosocial context) Generated differential diagnoses Recognized role of clinical protocols and guidelines in acute situation	Recognizes a common situation that required urgent or emergent medical care Stabilized the acutely ill patient utilizing appropriate clinical protocols and guidelines Generated appropriate differential diagnoses for the presenting complaint **Developed appropriate diagnostic and therapeutic management plan for acute condition**	**Recognizes complex situation requiring urgent or emergent medical care** **Prioritized appropriately the response to the acutely ill patient** Developed appropriate diagnostic and therapeutic management plans for less common acute condition Addressed the psychosocial implications of acute illness on patients and families Arranged appropriate transitions of care (i.e. to ER or admission to hospital or outpatient follow up)	Coordinated care of acutely ill patient with consultants and community services Demonstrated awareness of personal limitations regarding procedures, knowledge and experience in the care of acutely ill patients	Provided and coordinated care for acutely ill patients within local and regional systems of care (i.e transfer to tertiary care setting, hospital, rehab facility, etc.)
☐	☐	☐	☐	☐	☐

FMS Standards for Attending Notification and Direct Supervision (SANDS)	
Mandatory Direct Supervisions (Attending must come in)	**Time Frame**
Admission to GMF	12 Hours
Admission to ICU	6 hours
Resident Request ("I need you to come in to help . . . ")	30 minutes
Transfer (downgrade or upgrade)	12 hours
Death (unexpected)	1 hour
Death (anticipated)	2 hours
Code	direct supervision by attending or hospitalist immediately, notify FM Attending within 30 min
Attending Must Be Called	
Mandatory Notifications (Senior Resident in-house)	**Time Frame**
Attending Request ("Call me if . . . ")	30 minutes
Significant change in patient status :	30 min
*Mental Status	
*Respiratory Status (Increasing oxygen requirement, work of breathing, change in ABG)	
*Cardiac status (change in HR to and from brady/tachy, change in BP to severe htn/hypotn, EKG change)	
*Hematologic status? (significant change in hgb)	
*Change of diagnosis or management based on new labs/results	

SANDS

- Our protocol for supervision
  - SBP-4

Sample Case

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Simulator Guide

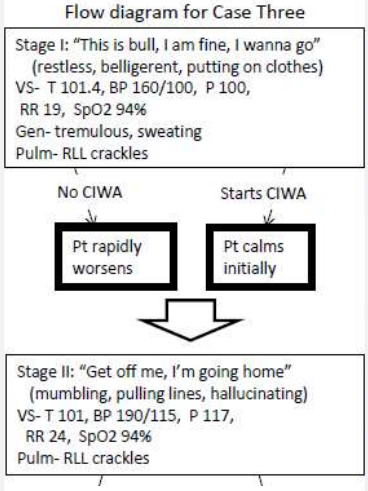
Stage I:

Give initial prompt:
RN- "Doc, Mr Kennedy is asking to sign out AMA"
Additional prompts:
RN- "should we do something to calm him down?"
Pt- calms with redirection

Stage II:

Given initial prompt:
RN- "Mr K just pulled out his IV"
Additional prompts:
RN- "Doc, his BP is really high, should we give something?"

Flow diagram for Case Three



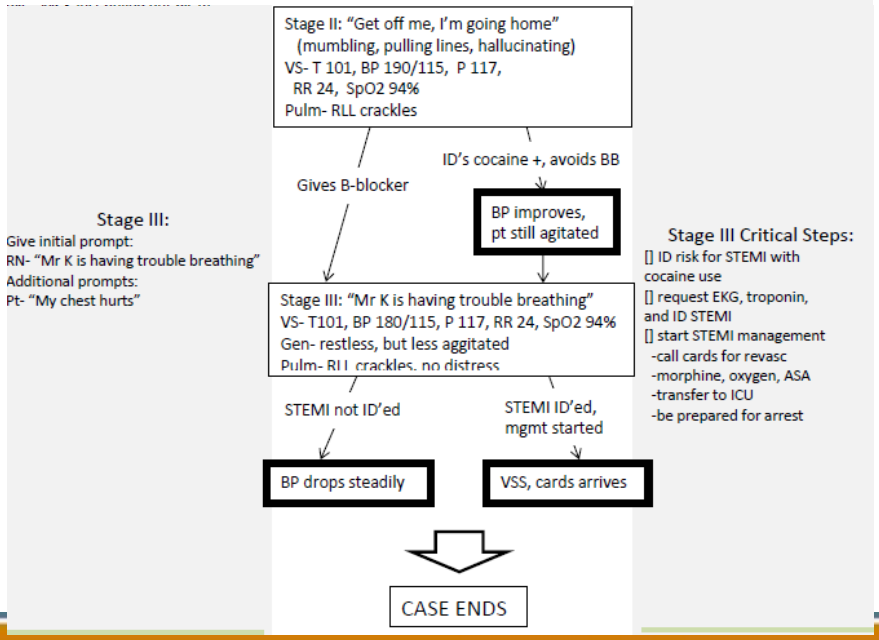
Faculty Guide

Stage I Critical Steps:

[] gather appropriate history -including h/o w/d, seizure, last drink
[] ID withdrawal symptoms
[] start CIWA, behavioral redirection (quiet, 1:1 sitter), medications (benzos, banana bag)
[] additional labs (UDS)
[] notify seniors

Stage II Critical Steps:

[] continue CIWA, give benzos
[] evaluate for soft restraints
[] review DDx (alcohol vs other substances)
[] ID elevated BP, need for medications
[] review UDS, ID cocaine +, avoids B-blockers
[] transfer to tele vs ICU
[] notify attending



NOC Session Evaluations & Outcomes

Progress Toward Promotion

- Started session in 2011
- Identify focused areas for improvement
- Structured rotations

Resident Confidence

- Statistics pending….

	Milestone
Assessing severity of patient's clinical risks and safety	PC-1, MK-2
Assessing intern's developmental level of experience and functioning	C-3
Monitoring resident intern's competency in assessing risks and patient safety	SBP 2, C-3
Balancing resident intern's opportunities for learning with patient's safety and care	SBP 2, C-3
Taking responsibility for decision-making when needed	Prof 2
Working effectively with other team members	C-3
Determining when to intervene in clinical care of patient	PC-1, MK 2 SBP 2
Determining when to consult with attending physician	C-3, MK 2
Providing team leadership and decision-making	C-3
Giving feedback to resident intern	C-3, Prof 2

Overall Session Evaluation

Learning Environment	Average
1. I felt that I got what I was supposed to out of this session	4.27
2. During the session I felt comfortable making mistakes and asking questions in order to improve	4.24
Clinical Practice	
1. The session was relevant to my current/future clinical practice	4.76
2. I plan to change patient care based on what I learned today	4.51
3. The cases portrayed situations that I see in the hospital	4.59
Logistics	
1. I felt that I had adequate time to go through each case	4.62
2. The debriefing session helped me to learn.	4.73

Overall Session Evaluation

- Comments
  - Learning points
    - Ask for help, use POC resources, team communication
  - Cases
    - Clarify clinical setting, case variety
  - Overall
    - More sessions, more mock codes

Future Directions

- Evaluating data
  - Tracking of milestones over time
- Current NOC curriculum
  - “Second Night on Call”
  - Addition of “practice/procedure” sessions

Poll Question:

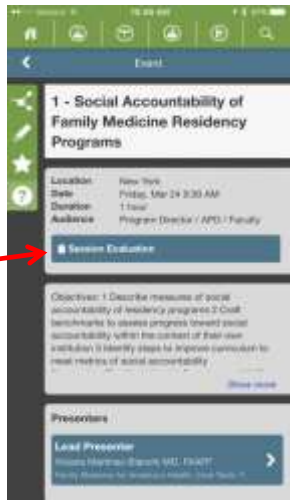
Enter your email address to be included in any follow-up communication from the presenter(s).

Social Q & A

Please…

Complete the session evaluation.

Thank you.



Group Discussion

Other approaches?

Contact information

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