



Graduate Medical Education Policy Manual

2024-2025

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Annual Review of Manual

The Graduate Medical Education Committee must approve all Graduate Medical Education policies annually. Updates will be made accordingly throughout the year with approval of the GMEC. All policy updates were reviewed and approved by the GMEC members on May 9, 2024.

Policy Update Disclaimer

The policies, regulations, procedures, and fees in this manual are subject to change without prior notice, if necessary, to keep Bayhealth policies in compliance with State and Federal laws and/or with rules and regulations of the ACGME. Bayhealth reserves the right to change curricula, rules, salary, and other requirements, of any kind, affecting residents/fellows. Updated policies will be disseminated electronically as changes occur.

NRMP Agreement

Bayhealth participates in the National Residency Matching Program (NRMP) for all PGY-1 and fellowship positions. As program participants, Bayhealth adheres to all NRMP policies including Section 4.0 item 7 which states the program must disclose to applicants all eligibility requirements for training set forth by the sponsoring institution and the program during the recruitment period and before the Rank Order List Certification Deadline. These requirements may include pre [1] employment testing (e.g., illicit drug screening), background checks (e.g., criminal, financial, etc.), visa sponsorship, and any other requirement(s). Programs must be able to demonstrate that eligibility requirements are made available to each applicant during recruitment and before the Rank Order List Certification Deadline, either electronically or in writing. The complete match agreement for 2024 can be viewed at [The Match Agreement | NRMP](#)

Appointment Agreement

THIS AGREEMENT by and between Bayhealth Medical Center, Inc. (Bayhealth) and First Name, Last Name residing at: ADDRESS sets forth the terms and conditions of the Residents/fellows' appointment by Bayhealth as a PGY-level in Bayhealth's graduate medical educational training program in PROGRAM.

In consideration of the mutual promises and covenants herein agreed to and intending to be legally bound, Bayhealth and Residents/fellows each agree as follows:

1. Policies and Procedures

- a. The Residents/fellows and Staff Graduate Medical Education Policies and Procedures (Manual) contains the institutional guidelines, policies and procedures governing the selection, appointment, evaluation, and retention of residents/fellows at Bayhealth Graduate Medical Education Consortium (Bayhealth Consortium). The Residents/fellows will receive a copy of the Manual during orientation, and it is posted on the GME website <https://bayhealthgme.org/>; however, the Manual is subject to revision. The provisions of the Manual referred to in this Agreement, in their most recent version, are hereby incorporated into this document by reference. It is the responsibility of the Residents/fellows to familiarize him/herself with the information contained in the Manual, including any revisions, and to assure that they follow all policies and procedures contained therein at all times during the term of this agreement.
- b. If Residents/fellows fail to comply with Bayhealth Institutional policies and procedures, Residents/fellows will be subject to disciplinary action including possible termination of Residents/fellows' appointment and employment

2. Duration of Appointment

- a. Commencement Date. Commencing on {CDATE}, {NAME_F} {NAME_L} will serve as a PGY-{LEVEL_ROMAN} residents/fellows in the Residency Program under the sponsorship of and supervision by faculty members of Bayhealth Consortium.
- b. Term. The term of this agreement is for one year beginning on the Commencement Date, and no guarantee of a subsequent contract(s) is expressed or implied even though the Residents/fellows may be participating in a multi-year residency program.
- c. Orientation. As a condition of this initial appointment, the residents/fellows must attend GME Institutional Orientation during (DATE), through (DATE) or as otherwise scheduled by Bayhealth in Bayhealth's sole discretion should Bayhealth be unable to have the GME Institutional Orientation on those specific days.
- d. Termination with Cause. During the term of this agreement, Bayhealth Consortium may terminate this agreement with cause according to the conditions described in the Residents/fellows Promotion/Non-Renewal/ Dismissal policy section of the Manual.
- e. Closures or Reduction in Funding. Should any affiliated hospital close or reduce their funding of residency slots during a residency training program, every attempt will be made to replace those training slots at another affiliated institution and to locate funds for completion of the academic year as set forth in the Residency Closure & Reduction section of the Manual. Should that not be available, and it is necessary to reduce the number of residency positions in a given department, the affected house officers will be informed as early as possible. Every effort will be made to allow residents/fellows to finish the program. Assistance will be provided in finding a training position at another hospital, as outlined in the Residency Closure & Reduction policy section of the Manual.

3. Residents/fellows Responsibilities IV.C.2.a

1. Residents/fellows agree to be responsible for the following:
 - a. Meet the qualifications for residents/fellows' eligibility outlined in the Residents/fellows Promotion/Non-Renewal/ Dismissal policy.
 - b. Comply with Bayhealth's verification procedures, which includes:
 - i. Documentation of identity and right to work.
 - ii. Proof of compliance with immunization policy.
 - c. Accurate completion of the Bayhealth Consortium application for appointment to the house staff, listing all information requested and returning the document in a timely manner prior to the hiring date so all information can be verified including medical school and previous residency training prior to beginning patient responsibilities.
 - d. Obtain a valid, unrestricted Delaware State Medical license or a training permit from the Delaware State Board of Medical Examiners.
 - e. Develop a personal program of self-study and professional growth under the general supervision of appropriately credentialed attending teaching staff.
 - f. Participate in safe, effective, and compassionate patient care under supervision, commensurate with level of advancement and responsibility.
 - g. Participate fully in the educational activities of your program and as required, assume responsibility for teaching and supervising medical students, and other residents/fellows and participate fully in institutional orientation and at least 50% in education programs and other activities involving the clinical staff.
 - h. Participate in institutional programs and activities involving the medical staff and adhere to established practices, procedures, and policies of the Institution.
 - i. Develop an understanding of ethical, socioeconomic, and medical/legal issues that affect graduate medical education and participate in institutional committees and councils, especially those that relate to patient care review activities, quality assurance, and apply cost containment measures in the provision of patient care.
 - j. Keep charts, records, and/or reports up to date and signed at all times. Failure to complete outstanding paperwork will result in discipline, including, but not limited to, suspension without pay.
 - k. Follow the rules, regulations, policies, practices, and procedures of Bayhealth Consortium and its affiliated institutions that relate to graduate medical education.
 - l. Act in a professional and ethical manner.
 - m. Comply with any and all laws, rules, regulations, licensing requirements, or standards that are now or hereafter promulgated by any local, state, and federal governmental authority/agency or accrediting/administrative body that governs or applies to their respective duties and obligations hereunder (Applicable Laws and Standards). The Applicable Laws and Standards shall include, but not be limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the requirements of the Department of Health ("DOH"), The Joint Commission and the National Committee on Quality Assurance ("NCQA"), as applicable.
 - n. Fulfill the educational requirements of the program.
 - o. Provide clinical services commensurate with Residents/fellows' level of advancement and responsibilities under appropriate supervision at sites specifically approved by Bayhealth Consortium.

- p. Cooperate fully and completely with Bayhealth Consortium in coordinating and completing ACGME accreditation submissions and activities including, but not limited to, timely medical charting.
- q. Cooperate fully in any investigations, discovery, and defenses that arise.
- r. If Residents/fellows receives, or anyone with whom Residents/fellows works or resides receives on his or her behalf, any summons, complaint, subpoena, or court paper of any kind or nature relating to activities in connection with this Agreement, immediately report the receipt of any such legal documents or papers to Bayhealth Consortium.
- s. Cooperate fully in with Bayhealth, Bayhealth Consortium, Bayhealth's legal counsel, investigators, committees, and departments in connection with evaluation of patient care; review of an incident or claim; or preparation for litigation whether Residents/fellows is a named party or not.
- t. Residents/fellows understands and acknowledges that this Agreement and Program participation is contingent upon meeting pre-employment requirements established by state and federal laws, and requirements established by Hospital prior to the start date, including, but not limited to, the below. Residents/fellows acknowledges and agrees that if pre-employment requirements are not met prior to the start date, this Agreement may be delayed without pay to Residents/fellows in the interim, or terminated by Hospital, at Hospital's sole discretion. In either case, such action will be taken without the due process provisions that may otherwise be applicable as provided herein:
 - i. Documentation of eligibility for employment, including work and training via status, if applicable.
 - ii. Completion of a pre-employment health screening which includes a TB test, titer draw to ensure immunity to MMR, Varicella, Hepatitis B, TDAP, Tetanus, Flu Vaccination (when applicable), documentation of COVID-19 vaccination, and a laboratory screening test for abuse of controlled substances, including marijuana.
 - iii. Failure of any pre-employment conditions including, but not limited to, failure to obtain COVID-19 vaccination in accordance with Hospital's policies, or testing positive for any controlled substance, will result in ineligibility for employment at Bayhealth.
 - iv. Successful completion of a criminal background screening.
 - v. Obtaining and maintaining a valid training or unrestricted medical license in the State of Delaware.
 - vi. Proof of graduation from a U.S. or Canadian medical school accredited by the LCME, and osteopathic school accredited by the AOA or documentation of graduation from an international medical school and a valid ECFMG certificate.
 - vii. Failure to meet any of the responsibilities listed in this section may result in discipline, up to and including termination.

4. Institutions Responsibilities

- a. Bayhealth agrees to be responsible for and to:
 - i. Monitor and supervise the Program with regard to the implementation of these terms and conditions of appointment.
 - ii. Maintain an environment conducive to learning and strictly enforce its Equal Opportunity and Anti-Harassment policies.

- iii. Provide Residents/fellows with appropriate and adequate faculty and Medical Staff supervision for educational and clinical activities and evaluate the educational and professional progress of the Residents/fellows on a regular basis through the Program Director.
- iv. Provide free parking while on rotation at Bayhealth facilities; sleeping quarters and meals while on-call; and lab coats and a work cell phone (iPhone) at no charge.
- v. Provide oversight and documentation of Residents/fellows engagement in Patient Safety, Quality Improvement, Transitions of Care, Supervision and Accountability, and Clinical Education and Experience.
- vi. Provide a culture of professionalism that supports patient safety and personal responsibility.
- vii. Educate Residents/fellows concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients.
- viii. Address the well-being of Residents/fellows consistent with the Program Requirements.
- ix. Provide a process and mechanism to fairly deal with academic or disciplinary actions or other issues related to the program, faculty, or work environment.
- x. Provide Residents/fellows with written policies for alcohol and substance abuse and procedures for handling physician impairment including impairment related to substance abuse.
- xi. Comply with any federal or state authority pertaining to the evaluation of disabilities including, but not limited to, the Americans with Disabilities Act of 1990.

5. Clinical and Educational Work Hours

- a. Clinical Experience and Education Hours. It is understood that training, research, teaching, and clinical assignments will be approved by the Director of the program. Clinical Experience and Education Hours will be consistent with institutional and program requirements based on educational rationale and patient need, including continuity of care with supervision available at all times and are discussed in the Clinical Experience and Educational Hours policy section of the Manual. Residents/fellows shall perform his or her duties under this Agreement during such hours as set in advance by Bayhealth Consortium and in accordance with written policy. Duty hours shall be in accordance with state, federal, and ACGME requirements.
- b. If a scheduled duty assignment is inconsistent with this Agreement or written policies, Residents/fellows shall bring the non-compliance to the attention of the Program Director for investigation and correction.
- c. Moonlighting. Bayhealth Consortium has incorporated policies covering professional activities outside of the residency program (moonlighting) in the Moonlighting policy section of the Manual and Residents/fellows agree to abide by such policy. Residents/fellows may not engage in patient care outside of the Program unless (a) Bayhealth approves the specific employment in writing, in advance; (b) the outside care does not affect Residents/fellows' performance or ability to participate in the Program; and (c) Residents/fellows provides Bayhealth Consortium with proof of insurance (at no expense to Bayhealth) covering all of Residents/fellows' care activities outside of the Program.

6. Residents/fellows Review

- a. It is understood that as the position of house staff physician involves a combination of supervised, progressively more complex, and independent patient evaluation and management functions and

formal educational activities. The competence of the house staff physician is evaluated on a regular basis. The program maintains a confidential record of the evaluations.

7. Reappointment and Promotion

- a. Conditions for the offer of any subsequent training agreement following an initial appointment and for promotion within the program are described in the Residents/fellows Promotion/Non-Renewal/Dismissal policy section of the Manual. Reappointment or promotion to the next level of training is at the recommendation of Bayhealth Consortium and is expressly contingent upon several factors including, but not limited to, satisfactory completion of all training components; the availability of a position; satisfactory performance evaluations; full compliance with the terms of this Agreement, the continuation of Bayhealth's ACGME accreditation; Bayhealth's financial ability; and furtherance of Bayhealth's objectives.
- b. Neither this Agreement nor the Residents/fellows' appointment hereunder constitute an option to renew or extend the Residents/fellows' appointment by Bayhealth or a benefit, promise, or other commitment that Bayhealth will appoint Residents/fellows for a period beyond the termination date of this Agreement or that Residents/fellows will be promoted to the next level of training.
- c. A written notice of non-renewal or decision to delay promotion to the next PGY level shall be provided to Residents/fellows in accordance with the Residents/fellows Promotion/Non-Renewal/Dismissal section of the Manual. Residents/fellows may appeal a notice of non-renewal or non-advancement in accordance with the Residents/fellows Grievance Procedure and Conflict Resolution section of the Manual.

8. Corrective Action, Termination, and Suspension

- a. **Corrective Action.** Residents/fellows' appointment and continued participation in the Program is expressly conditioned upon satisfactory performance of all Program elements by the Residents/fellows, including but not limited to the Residents/fellows requirements set forth hereinabove. If at any time, Residents/fellows' actions, conduct, or performance, professional or otherwise, are inconsistent with the terms of this Agreement or the policies or standards of care and of patient welfare of Bayhealth or its affiliates or reflect adversely on the Program or Bayhealth or its affiliates, or disrupts operations or patient care in the Program or at Bayhealth or its affiliates, corrective action may be taken by Bayhealth Consortium in accordance with Residents/fellows Grievance Procedure and Conflict Resolution policy section of the Manual.
- b. **Suspension or Termination.** Bayhealth Consortium shall have the authority to summarily suspend or terminate the Residents/fellows' appointment granted by Bayhealth if Bayhealth Consortium, in good faith, determines that the continued appointment of the Residents/fellows places the safety or health of patients or students, faculty or staff in jeopardy or to prevent imminent or further disruption of the Program or when the Residents/fellows has failed adequately to correct deficiencies in his or her performance or conduct of which he or she has been made aware.
- c. **Appeal.** The Residents/fellows may seek review of a decision to suspend or terminate his or her appointment by following the Residents/fellows Promotion/Non-Renewal/Dismissal policy section of the Manual. The Residents/fellows acknowledges that under no circumstances shall he or she be entitled to hearing or other due process rights available to physician members of Bayhealth or its affiliates as described in the Medical Staff bylaws thereof.

9. Hospital, Health, Financial Support and Benefits

- a. Stipend. Commencing {PROM_SD} thru {PROM_ED}, the Residents/fellows will receive an annualized stipend of \$_ USD. This amount will be subject to the appropriate federal and state income tax, social security tax, and any other applicable deductions.
- b. Vacation, Parental, Sick and Other Leaves. Bayhealth Consortium provides for vacation/sick leave, parental leave, personal leave, leave of absence, and professional leave as set forth in the Residents/fellows Paid Time Off & Leave of Absence policy section of the Manual. Bayhealth Consortium will provide timely notice of the effect of leave on the ability of residents/fellows to satisfy requirements for program completion and meet eligibility requirements to sit for the appropriate board certification exam. The use of leave exceeding the limits established by Bayhealth Consortium or the Program may require extension of the residents/fellows' training as described in the Residents/fellows Paid Time Off & Leave of Absence policy section of the Manual.
- c. Hospital and Health Insurance Benefits. Health, life, and disability insurance will be provided and are effective on the first day of Residency program unless specifically refused. Dental, as well as family medical insurance coverage may be purchased for eligible dependents through payroll deduction as described in the Benefits Section of the Program's Residents/fellows Manual
- d. Professional Insurance. Bayhealth will provide professional liability coverage to each residents/fellows in amounts of not less than one million dollars (\$1,000,000) per claim and three million dollars (\$3,000,000) in the aggregate. The coverage may be provided through a combination of commercial insurance and a self-insured retention through Bayhealth Consortium's Self-Insurance Trust Program. Insurance coverage will be provided in accordance with the pertinent laws and requirements established by the State of Delaware, or by the State or Federal plans when rotating through their supported facilities. Bayhealth will obtain and provide appropriate tail coverage for claims, demands, or actions reported in future years for Residents/fellows' acts or omissions during the term of this Agreement.
- e. Support Services. Bayhealth Consortium will provide access and/or referral to medical, psychological and/or financial counseling, and support services as described in the Well-Being policy section of the Manual. The Accommodation for Disabilities policy section of the Manual describes the policies pertaining to residents/fellows with disabilities. The Well-Bring policy section of the Manual includes policies relating to physician impairment and substance abuse. It is understood that counseling, medical and psychological supportive services will be made available on an as needed basis.
- f. Educational Resources. Residents/fellows shall have access to information related to eligibility for specialty-based examinations as described in the Statement of Commitment to Graduate Medical Education policy section of the Manual.

10. Grievances and Fair Hearing

- a. In the event of an adverse decision regarding Residents/fellows' training, advancement, or appointment, Residents/fellows may appeal such decision. Residents/fellows may also initiate complaint and grievance procedures regarding the Program. The policies relating to residents/fellows' grievances and the appeal and fair hearing process are presented in the Residents/fellows Grievance Procedure and Conflict Resolution policy section of the Manual.

11. Harassment/Discrimination

- a. Issues related to all forms of unlawful harassment or discrimination will be handled as described in Bayhealth Consortium's EO/Anti-Discrimination Policy, an updated copy of which is on Bayhealth

Consortium's website. Any complaints of discrimination or harassment must be directed to the Office of Institutional Equity.

12. General Provisions

- a. **Severability.** If any provision of this agreement is held invalid, such invalidity shall not affect any other provision of this agreement not held so invalid, and each such other provision shall, to the full extent consistent with law, continue in full force and effect.
- b. **Modification and Waiver.** This agreement may not be modified or amended except by an instrument in writing signed by the parties hereto. No term or condition of this agreement shall be deemed to have been waived, nor shall there be any estoppel against the enforcement of any provision of this agreement, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.
- c. **Venue, Jurisdiction, and Choice of Law.** The laws of the State of Delaware, without giving effect to its conflict of law principles, govern all matters arising out of or relating to this Agreement. The courts located in the State of Delaware shall have exclusive jurisdiction over all matters arising out of or relating to this Agreement. Each party waives, to the fullest extent permitted by law, any objection that it may now or later have to the laying of venue of any legal or equitable action or proceeding arising out of or relating to this Agreement brought in any such court, or any claim that any action or proceeding brought in any such court has been brought in an inconvenient forum.
- d. **OBRA.** In accordance with Section 952 of the Omnibus Reconciliation Act of 1980 (PL 96-499), Residents/fellows agrees to make available for a period of four (4) years following completion of the term of this Agreement, upon request of the Secretary of Health and Human Services of the United States or of the United States Comptroller General or any of their authorized agents, all books, documents and records necessary to certify the nature and extent of the cost of the services rendered pursuant to this Agreement as required by federal statute or duly promulgated regulations.
- e. **Corporate Compliance Program.** Bayhealth is committed to serving its patients and community and conducting its business and activities in a professional, lawful, and ethical manner. Bayhealth has adopted a Corporate Compliance Program and a Code of Conduct establishing policies and procedures to ensure that the organization and its employees comply with the corporate compliance program. These policies govern Bayhealth's relationships with its patients, contractors, suppliers, community, and other organizations with which it interacts. The Parties shall, at all times, conduct their relationships with others in accordance with all applicable laws, rules, and regulations and adhere to ethical and professional standards consistent with Bayhealth's Corporate Compliance Program and Code of Conduct and report actual or possible violations of Bayhealth's Corporate Compliance Program and/or Code of Conduct to Bayhealth's Corporate Compliance officers. Residents/fellows' failure to do so shall be deemed a breach of this Agreement.
- f. **Entire Agreement.** This Agreement and its exhibits, if any, contain the final and complete expression of all agreements between the parties with respect to the subject matter of this Agreement, and supersedes all prior and contemporaneous Agreements and/or negotiations between the parties, whether oral or written.
- g. **Waiver.** The failure by either party at any time to require performance of any provisions of this Agreement shall not constitute a waiver of such party of such provision and shall not affect the right to require performance at a later time.

- h. Regulatory Restrictions. Each party represents that neither it nor its agents or employees are "Ineligible Persons" which is defined as any individual or entity who is (a) currently excluded, debarred, or otherwise ineligible to participate in the federal or state health care programs or in federal or state procurement or non-procurement programs; or (b) has been convicted of a criminal offense relating to the provision of health services or health care items, but has not yet been excluded, debarred, or otherwise declared ineligible. Each party shall have an affirmative obligation to notify the other party immediately of any debarment or exclusion or other event that would make it and/or its agents or employees an Ineligible Person.
- i. Notice. Whenever, under the terms of this Agreement, written notice is required or permitted to be given by one party to any other party, such notice shall be deemed to have been sufficiently given when received by the party to whom it is to be given via overnight courier or certified mail/return receipt requested. Notices shall be addressed as follows:

To Bayhealth:
Bayhealth Medical Center, Inc. 640 S. State Street
Dover, DE 19901
Ph.: (302) 744-6999
Email: GME@bayhealth.org

I accept the appointment outlined above and agree to all rules and regulations of Bayhealth Consortium and affiliated institutions to which I am assigned. I agree to discharge all the duties of a residents/fellows as determined jointly by the affiliated institutions and the respective directors of training programs at Bayhealth Consortium, and I acknowledge that I have read and understand the Institutional Policies referred to in Paragraph 1.

Guidelines for Use of the GME Manual

Purpose Statement: To consolidate the policies pertaining to the Graduate Medical Education (GME) program into one central manual

1. Definitions
 - 1.1 Policy Manual – Materials assembled within one resource for all members of GME to have an easy reference to current procedures within the department
 - 1.2 Residents/fellow - Interns, residents/fellow, and subspecialty residents/fellow (fellows) enrolled in a Bayhealth sponsored postgraduate training program
2. Areas Involved:
 - 2.1 Graduate Medical Education (GME) Department, Graduate Medical Education Residency and Fellowship Programs
3. Forms Involved:
 - 3.1 None
4. Procedure:
 - 4.1 GME will establish a Policy Manual for staff, faculty, residents/fellows, and contractors
 - 4.2 GME staff, faculty, residents/fellows, and contractors will be held accountable to follow procedures within the Policy manual
 - 4.3 The policy manual will be reviewed yearly and revised as needed to guarantee GME staff, faculty, residents/fellows, and contractors are following the most current requirements as required by the Accreditation Council for Graduate Medical Education (ACGME)
 - 4.4 Any request for changes to the Policy manual will be given to the GME Institutional Coordinator for review at the Graduate Medical Education Committee (GMEC) meeting
 - 4.4.1 GME Institutional Coordinator will present the suggestions and proposed changes to the GMEC chair and add the revised manual to the meeting agenda for approval by the committee
 - 4.4.2 No change to policy manual is still required to be reviewed by the GMEC for approval annually

Glossary

Acronyms:

ACGME - Accreditation Council for Graduate Medical Education

AIR - Annual Institutional Review

AOA – American Osteopathic Association

APMA - American Podiatric Medical Association

CLER - Clinical Learning Environment Review

CODA - Commission on Dental Accreditation

CPME - Council on Podiatric medical education

CSA - Clinical Skills Assessment

DIO - Designated Institutional Official

ECFMG - Educational Commission for Foreign Medical Graduates

GME - Graduate Medical Education

GMEC - Graduate Medical Education Committee

LCME - Liaison Committee on Medical Education

PGY – Post Graduate Year

USMLE - United States Medical Licensing Examination

Definitions:

1. Academic Year- July 1 through June 30
2. Bereavement – Time off with pay for a residents/fellow in the event of a death in the residents/fellow's immediate or extended family as defined below.
3. The Americans with Disabilities Act (ADA) of 1990: a person with a disability as someone with a physical or mental impairment that substantially limits one or more “major life activities.” The ADA Amendments Act of 2008 (ADA-AA) expands the ADA definition of “major life activities” from walking, seeing, speaking, breathing, learning, working, etc. to also include eating, sleeping, standing, lifting, bending, reading, concentrating, thinking, as well as the “operation of a major bodily function.” Transitory or minor conditions (<6 months duration) do not qualify as a disability under the laws. Further information can be obtained from the ADA website.
4. Reasonable Accommodation: A reasonable accommodation is a modification or adjustment to a job, an employment practice, or the work environment that makes it possible for a qualified individual with a disability to enjoy an equal employment opportunity.
5. Approved residency training program - Fully accredited during the time of the practitioner's attendance by the Liaison Committee on Medical Education (LCME), by the American Osteopathic Association (AOA), by the Commission on Dental Accreditation (CODA), by the Council on Podiatric medical education (CPME) of the American Podiatric Medical Association (APMA), Accreditation Council for Graduate Medical Education (ACGME) or by a successor agency to any of these entities or an accrediting agency on file with the U.S. Secretary of Education.
6. At-home Call – Call taken from outside the assigned institution.
7. Bereavement – Additional time off with pay for a residents/fellow in the event of a death in the residents/fellow immediate or extended family as defined below.
8. Immediate family – 3 days off - Residents/fellow's parent, stepparent, foster parent, sister, brother, spouse, child, stepchild, grandchild, grandparent, great-grandparent, daughter-in-law, son-in-law, parent-in-law,

significant other, domestic partner, or a relative who resided in the residents/fellow's household at the time of death.

9. Extended family – 1 day off - Residents/fellow's grandparent-in-law, uncle, aunt, niece, nephew, brother-in-law, and sister-in-law.
10. Clinical Experience and Education Hours – Clinical and academic activities related to the residency or fellowship 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, all moonlighting activities, research activities, and scheduled academic activities such as conferences.
11. Family and Medical Leave Act of 1993 (FMLA) – A leave of absence may be granted once a residents/fellow has been with Bayhealth for a total of 12 months for time lost due to FMLA qualifying events (serious personal health condition, birth/adoption of a child, and care of an immediate family member with a serious health condition). Consistent with federal regulations, Bayhealth provides up to twelve (12) weeks unpaid, protected leave for qualifying individuals.
12. In-house Call – Clinical Experience and Education Hours beyond the normal workday when residents/fellows are required to be immediately available in the assigned institution.
13. Moonlighting – Voluntary, compensated, medically-related work performed outside the duties of the residents/fellow's training program. Moonlighting includes work at any Bayhealth facility and work outside the institution (external moonlighting).
14. Night Float – A residency rotation in which one or more residents/fellows are assigned to night duty, with little or no daytime responsibilities. Night Float responsibilities begin and end at set times. During the period of coverage, a Night Float residents/fellow will cover phone calls about already-admitted patients (cross-coverage) and admit new patients to the covered service. Daytime residents/fellows must sign out to Night Float residents/fellows in the evening and receive sign out from Night Float the following morning. A Night Float system is meant to protect residency work-hour restrictions, ensure sufficient periods of rest for both day and night residents/fellows, and provide continuous coverage for hospitalized patients.
15. Paid Time Off (PTO) – paid time for such absences as personal vacation, holiday time, serious illness of an immediate family member, extended bereavement time off, and other similar occasions.
16. Program Director – The director of the specific residency program the residents/fellow is currently enrolled in.
17. Residents/fellow - Interns, residents/fellow, and subspecialty residents/fellow (fellows) enrolled in a Bayhealth sponsored postgraduate training program.
18. Scheduled Clinical Experience and Education periods – Assigned duty within Bayhealth or participating sites in the education program encompassing hours, which may be within the normal workday, beyond the normal workday, or a combination of both.
19. Vendor - A company, its representative or the agent of a company that either produces or markets drugs, devices, nutritional products, or other products or services.
20. Visiting Residents/fellow – A resident/fellow that is in an approved residency training program other than Bayhealth that is participating in a Bayhealth rotation.

Accommodations for Disabilities

Purpose Statement: To ensure the principles of the Americans with Disabilities Act (ADA) are enacted within all Bayhealth Medical Center residency programs.

1. Procedure:

- 1.1 Bayhealth recruitment and selection process and employment procedures for residents/fellows in any of its graduate medical education (GME) programs will adhere to guidelines and policies set forth by the ADA.
- 1.2 Applicants for residency positions will be considered based on relevant and academic qualifications without regard to race, color, religion, national origin, age, weight, height, sex, sexual orientation, marital status, or disabilities.
- 1.3 Qualified applicants must be able to perform the essential functions of the selected medical specialty and may request reasonable accommodation to perform these functions.
- 1.4 Reasonable Accommodation for Resident/Fellow
 - 1.4.1 Reasonable accommodations will be made to accomplish the following:
 - 1.4.1.1 To ensure equal opportunity to all candidates through the application and interview process.
 - 1.4.1.2 To enable a qualified individual with a disability to perform the essential functions of the position; and
 - 1.4.1.3 To allow a resident/fellow with a disability to enjoy equal benefits of employment in the program.
 - 1.4.2 Reasonable accommodations (as defined above) for residents/fellows at Bayhealth may include such examples as making facilities readily accessible; modifying training materials; modifying work schedules; and acquiring or modifying equipment or devices.
 - 1.4.3 Reasonable accommodation, when necessary, will be made for current and future activities, but cannot be made retroactively to remove remediation, probation, or termination if they were not requested at the time.
 - 1.4.3.1 If a resident/fellow feels that reasonable accommodation was wrongly denied in the past which resulted in remediation, probation, or termination, he or she may invoke due process.
 - 1.4.4 Residents/fellows must be able to successfully complete requirements for the specialty as defined by the Accreditation Council for Graduate Medical Education (ACGME) and the subspecialty board with the approved accommodations.
- 1.5 Application Process
 - 1.5.1 The Program Director and the appropriate Bayhealth Human Resources faculty will work with a resident/fellow in the development and implementation of reasonable accommodations for a disability as defined in the ADA.
 - 1.5.2 It is the responsibility of a resident/fellow to communicate directly with the Program Director and request accommodations prior to starting the training program when possible. Documentation and additional testing may be required to validate that the individual is covered under the ADA as a disabled individual.

- 1.5.3 When a request for accommodation, has been made, the Human Resources designee may meet with the resident/fellow and the Program Director to:
 - 1.5.3.1 Discuss the purpose and the essential functions of the position, specifically identifying any aspects which may require reasonable accommodation to be made for the resident/fellow.
 - 1.5.3.2 Identify the potential accommodation and assess the effectiveness each would have in allowing the resident/fellow to perform the essential job functions.
 - 1.5.3.3 Select and implement the accommodation that is the most appropriate for both the resident/fellow and Bayhealth; and,
 - 1.5.3.4 Work with the resident/fellow to obtain technical or other assistance, as needed.
- 1.5.4 If several equally effective accommodations are available, the preference of the resident/fellow in the accommodation is given consideration; however, it is the ultimate choice of Bayhealth which of these equally effective accommodations is enacted.

Ambulatory Note and Electronic Health Record Task Completion

Purpose Statement: Documentation of patient care is critical to continuity, for communication to other team members and to meet requirements of the Centers for Medicare and Medicaid for finalization of notes after a patient office visit. The Medical Director and Program Director are charged with ensuring our patients are provided the highest quality care in a patient-centered manner which includes appropriate and timely documentation of patient care, reviewing and addressing diagnostic studies, approximately fulfilling patient requests, and assisting the front office and clinical staff with patient care when requested. The Medical Director and Program Director are charged with addressing any failure to meet these responsibilities.

1. Procedure:

1.1 Resident/Fellow Responsibilities

- 1.1.1 Must complete office notes within 48 hours of the visit and send to faculty for co-signature
- 1.1.2 Review and complete any diagnostic and lab test results within 3 business days including documentation of action in the patient chart
- 1.1.3 Complete My Chart Patient Portal Messages within 48 hours if forwarded by clinical staff for action
- 1.1.4 Assist front office or clinical staff with any patient care task request
- 1.1.5 Complete Medication Renewal requests per clinic policy

1.2 Faculty Responsibilities

- 1.2.1 Must complete office notes within 48 hours of the visit
- 1.2.2 Must co-sign all precepting notes forwarded by clinical staff for co-signature within 7 business days of the date of visit
- 1.2.3 Review any diagnostic and lab test results within 3 business days including documentation of action in the patient chart
- 1.2.4 Complete My Chart Patient Portal Messages within 48 hours if forwarded by clinical staff for action
- 1.2.5 Assist front office or clinical staff with any patient care task request
- 1.2.6 Complete Medication Renewal requests per clinic policy

1.3 All patient care notes will be completed within 48 hours of the office visit

- 1.3.1 This applies to Residents, Fellows, Faculty, or any other member of the interprofessional team providing direct patient care in the Outpatient Residency Continuity practices.

1.4 Messages should be addressed by the primary care physician in consultation with a supervising physician when needed

- 1.4.1 Task should be marked “Done” with action documented in the patient chart.
 - 1.4.1.1 Any patient care tasks including diagnostic test and lab results (normal and abnormal) must be reviewed and completed within 3 business days
 - 1.4.1.2 Medication authorization must be processed within 48 hours
 - 1.4.1.3 MyChart Patient Portal Messages are to be addressed within 48 hours

1.4.1.3.1 Portal messages will be retrieved by clinical staff who will determine the appropriate action to be taken or the person most appropriate to address the patient request.

1.5 Failure to meet above requirements

1.5.1 Any Resident/fellow failing to meet these requirements will be subject to disciplinary action at the discretion of the Clinical Competency Committee (CCC) and the Program Director. Disciplinary action can include remediation and probation with repeated violations

1.5.2 Any Faculty failing to meet these requirements will be forwarded to the Medical Director and Program Director. Repeated violations will be subject to disciplinary action at the discretion of the faculty member's immediate supervisor. With repeated violations, the faculty member will be subject to additional disciplinary action determined by the Program Director.

Annual Institutional Review Protocol

Purpose Statement: To define the process for which the Graduate Medical Education Committee (GMEC) at Bayhealth will demonstrate effective oversight of the Sponsoring Institution's accreditation through an Annual Institutional Review (AIR).

1. Procedure:

- 1.1 At the end of each academic year, Bayhealth GMEC will form an AIR subcommittee. The AIR subcommittee will review the institutional performance indicators for the AIR, which must always include the most recent Accreditation Council for Graduate Medical Education (ACGME) institutional letter of notification, results of ACGME surveys of residents and core faculty members, and each of its ACGME-accredited programs' ACGME accreditation information, including accreditation statuses and citations, at a minimum.
- 1.2 Following the subcommittee meeting, the Designated Institutional Official (DIO) is required to submit an annual written executive summary of the AIR to the GMEC as well as the Bayhealth Board of Directors.
- 1.3 The AIR subcommittee must consist of the DIO, GME Director, GME Chair, Institutional Supervisor, Program Directors, One Peer-Selected Resident/Fellow, and one GME faculty member from each program. Additional membership may be included as the DIO and GMEC determine necessary.
- 1.4 The following list represents a sampling of the performance indicators that will be reviewed by the subcommittee:
 - 1.4.1 Results of the most recent ACGME institutional letter of notification
 - 1.4.2 Results of the most recent institutional self-study visit
 - 1.4.3 Information regarding each of the Bayhealth ACGME-accredited programs' ACGME accreditation information, including accreditation statuses and citations
 - 1.4.4 Aggregate results of ACGME-Accredited Program performance indicators
 - 1.4.5 Results of Annual Program Evaluation
 - 1.4.6 Results of most recent Clinical Learning Environment Review (CLER)
 - 1.4.7 Results of ACGME Surveys of Residents and Core Faculty
 - 1.4.8 Board Pass Rate (first time takers, 5-year rolling average)
 - 1.4.9 In-Training Exam Results
 - 1.4.10 Resident/Fellow Scholarly Pursuits
 - 1.4.11 Resident/Fellow Patient Safety/Quality Improvement Projects
 - 1.4.12 Faculty Scholarly Pursuits
 - 1.4.13 Faculty Patient Safety/Quality Improvements
 - 1.4.14 Compliance with up to date, signed institutional agreements, specifically the Affiliation Agreements and Program Letters of Agreement

- 1.5 The written executive summary provided by the DIO must include a summary of institutional performance on indicators for the AIR, any resultant action plans and performance monitoring procedures resulting from the AIR.
- 1.6 The GMEC is responsible for monitoring any item listed above that is found to be out of compliance. The frequency of the reporting will be determined by the DIO based upon the nature of the noncompliant item.
- 1.7 The GMEC may opt to appoint a Subcommittee for additional document review, development of objectives and/or corrective action plan, citation correction progress review and/or mentoring for any non-complaint areas.
- 1.8 Recommendations of the Subcommittee will report to the full GMEC for approval.
 - 1.8.1 The GMEC may also specify additional monitoring procedures for action plans resulting from the Subcommittees review.

Away and Elective Rotations

Purpose Statement: To describe the procedure for requesting and completing an elective away rotation. These rotations are intended to aid the resident in obtaining fellowship after completion of the residency program.

1. Procedure:
 - 1.1 Residents/fellows may request to complete up to one, four-week elective away rotation during the duration of the program
 - 1.1.1 In special circumstances, approval for additional away rotations may be granted, but are subject to Program Director and DIO approval
 - 1.2 The away rotation must be in a specialty area not offered by Bayhealth Medical Center
 - 1.3 Approval of any away rotation is subject to the rules and laws surrounding visa sponsorship when applicable
 - 1.4 Bayhealth does not pay for costs associated with housing, licensing, travel, fees, or other expenses
 - 1.5 Away rotations must be approved by the Program Director and DIO
 - 1.6 Steps for Applying
 - 1.6.1 Residents/fellows must first discuss the away rotation with the Program Director or other program designee
 - 1.6.2 Resident must then complete the Elective Approval Form and send it to the Program Director and Program Coordinator to sign
 - 1.6.3 The Program Coordinator will then send the request to the GME office for the DIO to review the request
 - 1.6.4 The GME office will return the request to the Program Coordinator and contact the resident with the response
 - 1.6.5 The Elective Away Rotation form should be completed at least six months prior to the rotation
 - 1.6.6 If the request is approved by both the Program Director and DIO, the Program Coordinator will begin the paperwork process by contacting the hosting institution and starting a Program Letter of Agreement
 - 1.6.6.1 The Program Letter of Agreement must be approved by the Host Institution, Bayhealth's Risk Management department and the DIO
 - 1.6.7 The Program Coordinator will contact Bayhealth's Risk Management department to ensure the resident has malpractice coverage for the rotation
 - 1.6.7.1 Residents/fellows must have the state medical license for medical malpractice to be issued
 - 1.6.7.2 This must be given to risk management prior to the resident beginning the away rotation
 - 1.6.8 Residents/fellows are responsible to obtaining the state medical or training license, housing, and any other expenses necessary to complete the rotation
 - 1.7 Risk Management Requires the following
 - 1.7.1 Program Letter of Agreement between Bayhealth and Program Site

- 1.7.2 Elective Approval Form signed/approved by Program Director and DIO
- 1.7.3 Copy of state license
 - 1.7.3.1 Risk management will submit the approved elective form and state license to the malpractice carrier for approval
 - 1.7.3.2 Upon approval, risk management will provide a certificate of insurance to the hosting institution
 - 1.7.3.3 Program Coordinator must notify risk management of any changes with the rotation
- 1.8 Even if the site location accepts the resident's Delaware license, the malpractice carrier requires the resident to apply and be approved to practice in that state. Failure to practice without the state license of the rotation site may put Bayhealth at risk for claims, penalties, and fines. In this situation, a claim against a resident at Bayhealth could have a significant impact on our residency programs and future malpractice coverage.
- 1.9 Trainees on J-1 Visas
 - 1.9.1 Federal regulations require that ECFMG maintain up-to-date records on the locations and activities of the exchange visitor physicians it sponsors. Therefore, ECFMG must be informed at least 30 days (about 4 and a half weeks) in advance of any proposed off-site rotation or elective that will be conducted at a location other than the approved "Sponsoring Institution" or a "Participating Site" for the training program as reported to and recognized by the ACGME, including international rotations. The institutions TPL will need to complete the following form and upload it to the applicant's record for review and processing. [Required Notification of Off-site Rotation / Elective](#)
 - 1.9.2 It is the program coordinator's responsibility to communicate with the TPL when residents are requesting to do away rotations when they are on a J-1 Visa. This should be communicated to the TPL at least 60 days in advance.
- 1.10 Trainees on H1B Visas
 - 1.10.1 Trainees on H1B Visas are not permitted to do away elective rotations due to the legal/filing fees.

Away Elective Rotation Approval Form

Residents/fellows will be allowed one outside elective if interested in a specialty area not offered at Bayhealth or for the purpose of gaining experience in an area of fellowship interest. In certain circumstances, approval may also be granted for an additional outside rotation. Please complete this form and obtain approval from the program director before submitting it to GME for final approval. **Forms should be submitted at least 90 days in advance; do not make final arrangements until all approvals have been received.**

| General Information | | | |
|---|--|--------------------------------------|--|
| | | | |
| Name of Resident | | Program | |
| PGY Year | | | |
| Name of Away Rotation Organization | | Name of Rotation | |
| | | | |
| Address of Away Rotation Organization | | | |
| | | | |
| Away Rotation Coordinator | | Email Address | |
| Phone Number | | | |
| Physician Supervisor | | Email Address | |
| Phone Number | | | |
| DIO | | Email Address | |
| Type of Rotation <input type="checkbox"/> Clinical only <input type="checkbox"/> Clinical & research combined <input type="checkbox"/> non-clinical, research experience only | | | |
| Start Date of Rotation* (mm/dd/yyyy) | | End Date of Rotation (mm/dd/yyyy) | |
| * Pending Approval by Malpractice Carrier and State Licensure | | | |
| Information on Educational Values of the Rotation | | | |
| Unique educational value of this rotation offers: please explain unique educational values that the rotation offers. | | | |
| | | | |
| Goals and objectives of rotation: please specify how this rotation can enhance the education of the trainee. | | | |

| | |
|--|---|
| Trainee's Acknowledgement | |
| <p><u>By signing below, I am in agreement with the terms of this away rotation.</u></p> <ol style="list-style-type: none"> 1. I must notify my program director as soon as possible if any of the following events occur; <ul style="list-style-type: none"> • If any changes occur in rotation institution, schedule, or supervising faculty; • If I am involved in a patient safety issue at my away rotation site; or • If there is insufficient supervision or unsafe working conditions at my away rotation site. 2. I must seek immediate care by going to the Occupational Health or Emergency Department at my rotation institution in the event I sustain a workplace injury or exposure. I must contact Bayhealth's Employee Health immediately (or on the next business day if exposure occurs after hours or on a weekend to report the incident. 3. I must obtain appropriate licensure if the rotation takes place outside of the State of Delaware. In the event that the physician/resident is named in a suit from an incident that occurs in a state where they are not licensed, the carrier could deny coverage. <ol style="list-style-type: none"> a. Residents/fellows must apply for licensure of the state in which the rotation will take place immediately following approval of application. b. Curi (Malpractice Carrier) will not approve malpractice coverage for locations in New York, Wisconsin, California and International. c. Rotation is subject to licensure and approved from malpractice carrier before the rotation begins. If the rotation takes place prior to approval, Bayhealth is at risk for claims against the resident and subject to fines and penalties. d. Program Letter of Agreements between Bayhealth and the site location is required. PLA must be fully executed and provided to Risk Management prior to the rotation start date. | |
| Signature of Resident | Date |
| Program Director's Acknowledgement | |
| <ol style="list-style-type: none"> 1. I endorse the unique educational value that this rotation offers in the education of the trainee and have approved the rotation for the trainees listed above. I am aware that adequate supervision of the trainee must be provided at the participating institution. 2. I acknowledge that communication has been made with the faculty supervisor at the rotating institution regarding the educational goals and objectives, supervision, and evaluation of the trainee during this rotation. 3. I must notify the GME office immediately when the trainee 1) sustains workplace injury or exposure; 2) encounters insufficient supervision or unsafe working conditions; or 3) gets involved in patient safety issues at the rotation institution. 4. I am aware that the trainee must obtain appropriate licensure if the rotation takes place outside of the State of Delaware by signing below, I am in agreement with the terms of this away rotation. | |
| Signature of Program Director | Date |
| GME Approval | |
| Review Result | <input type="checkbox"/> Recommends approval <input type="checkbox"/> Do not recommend approval |
| Signature of the Approver (DIO, ADIO, ADGME) | Date |
| Risk Management Approval | |

| | | |
|---------------------------------------|--|--|
| Review Result | <input type="checkbox"/> Recommends approval | <input type="checkbox"/> Do not recommend approval |
| Signature of the Approver | Date | |
| Out of State License Required? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No |

Benefits

Purpose Statement: The sponsoring institution (Bayhealth) in partnership with the ACGME accredited programs must provide residents/fellows with financial support and benefits.

1. Procedure:
 - 1.1 The sponsoring institution in partnership with the ACGME-accredited programs must provide residents/fellows with financial support and benefits
 - 1.2 Health and Disability Insurance
 - 1.2.1 Residents/fellows who enroll will receive medical, prescription, dental, vision, supplemental life, voluntary AD&D and flexible spending accounts on the first day of the month following orientation.
 - 1.2.1.1 Residents/fellows are responsible for enrolling and submitting all documentation by the deadline to ensure coverage
 - 1.2.1.2 If enrollment is not completed online or if documentation for self or dependents is not received by enrollment date (given during orientation), you will not be enrolled in the benefit plans and the next opportunity for enrollment will be during fall open enrollment for the benefit year beginning January 1st of the following year.
 - 1.2.1.3 If residents/fellows need coverage between orientation day and the first of the next month when benefits begin, they may opt for interim coverage; information about interim coverage is provided during orientation
 - 1.2.2 Residents/fellows short-term disability coverage will be active within the first 90 days of employment
 - 1.2.2.1 Residents/fellows have the option to purchase interim coverage for the days prior to activation, this information will be provided during orientation
 - 1.2.3 Residents/fellows have the option to sign up for the following benefits:
 - 1.2.3.1 Medical, prescription, dental, vision, and basic life insurance for self and dependents
 - 1.2.3.2 Flexible spending account
 - 1.2.3.3 Retirement and savings plan
 - 1.2.3.4 Short-term disability
 - 1.2.3.5 Accidental Death and Dismemberment (AD&D)
 - 1.2.4 Detailed benefit information can be found on id.mybenefitexpress.com and through Baynet under human resources
 - 1.3 Other Benefits
 - 1.3.1 Employee Assistance Program
 - 1.3.2 Vital Work Life
 - 1.3.3 Free Parking
 - 1.4 Meal Stipend

- 1.4.1 Residents/fellows are provided with a \$2,000 meal stipend for the academic year on their Bayhealth ID badge for use in the hospital campus cafeterias
 - 1.4.1.1 The funds deposited are meant to ensure that you can obtain breakfast, lunch or dinner while working and should not be used to purchase food and beverages for consumption at home
 - 1.4.1.2 This should be used as a personal food allowance and should not be shared with other employees, friends, or family
 - 1.4.1.3 The account will reset at the end of June and be refilled starting July 1 of each academic year
- 1.5 Board Certifications
 - 1.5.1 Residents/fellows can use educational funds in the final academic year to cover board exams
 - 1.5.2 Residents/fellows must register for the board certification during their employment at Bayhealth in order to be reimbursed
- 1.6 CME
 - 1.6.1 Residents/fellows will receive five (5) CME days in accordance with each individual program's criteria
 - 1.6.2 Residents/fellows may use their educational fund or request research funds to attend/present at specialty conferences
- 1.7 Visas
 - 1.7.1 Residents/fellows will be reimbursed for the cost of J-1 Visa fees
 - 1.7.2 Bayhealth will pay for the cost of H1-B sponsorship (when applicable) to highly qualified residents
- 1.8 Education Funds
 - 1.8.1 All PGY-1 residents will receive \$1,500
 - 1.8.2 All PGY-2 and above residents will receive \$2,000.
 - 1.8.3 Residents in their final year of training will receive \$3,000 to cover qualifying board exams (when applicable).
 - 1.8.4 Fellows will receive \$3000 per year
 - 1.8.5 Education Funds can be used for the following:
 - 1.8.5.1 Continuing Education
 - 1.8.5.2 Professional dues not already covered by programs
 - 1.8.5.3 Subscriptions not already covered by programs
 - 1.8.5.4 Association Fees not already covered by programs
 - 1.8.5.5 Textbooks
 - 1.8.5.6 Stethoscope
 - 1.8.5.7 Educational resources such as study materials
 - 1.8.5.8 Reimbursement for repeated or other exam fees

- 1.8.5.9 Specialty board certification exam (if registered prior to ending employment)
 - 1.8.5.10 Travel to attend professional meetings
- 1.8.6 Educational Funds do not roll over into the next academic year
- 1.8.7 Residents/fellows are responsible for saving receipts and completing reimbursements through the Infor system
- 1.8.8 Educational Funds do have some exclusions, residents/fellows should ask the Program Coordinator if there are items not listed that they are interested in using educational funds for
- 1.8.9 Exclusion List
 - 1.8.9.1 Computers (laptops and desktops)
 - 1.8.9.2 Ipads
 - 1.8.9.3 Handheld Ultrasound Devices
 - 1.8.9.4 Scrubs
- 1.9 Research
 - 1.9.1 Residents/fellows have access to support from a statistician on research projects as well as research software including protocol builder and SPSS.
 - 1.9.2 Programs have allocated funds for conducting and presenting research including:
 - 1.9.2.1 Materials needed to conduct research, such as compensation for test subjects or purchase of materials
 - 1.9.2.2 Cost of printing and transporting posters
 - 1.9.2.3 Travel, room, and board to present research at regional or national conference is for resident/fellow only
 - 1.9.2.4 Expenditure for meals should be reasonable and compatible with the area involved. An itemized hotel receipt showing room rate, taxes, and incidentals must accompany submission of expense report.
 - 1.9.2.4.1.1 Residents/fellows will be provided a maximum of \$100 a day for food during travel for resident/fellow only
 - 1.9.3 Residents/fellows must submit budget proposals to their program director to use the research funds 30 days prior to the conference or immediately within notification of acceptance if less than 30 days
 - 1.9.3.1 Residents/fellows must include a copy of their acceptance notification
- 1.10 Travel for Research or CME
 - 1.10.1 Residents/fellows will be reimbursed for reasonable or necessary expenses up to the amount available to them through CME funds or research funds
 - 1.10.1.1 Residents/fellows will pay out of pocket if they do not have enough CME or research money available for travel
 - 1.10.1.2 Requests should be submitted to the program director and program coordinator at least 30 days in advance for approval

1.10.2 Travel should be scheduled in the most practical economic manner. Alternative modes will be at the individual's expense. Resident/fellow will be reimbursed for one round-trip from the hospital where they report to their destination and return.

1.10.2.1 All air travel shall be scheduled coach or economy class airfare, not first class. Several travel sites should be surveyed in order to acquire the most reasonable rates.

1.10.2.2 Travel for conducting and presenting research must be within the continental United States.

1.10.3 The use of rental cars require administration authorization prior to travel. When practical, reservations should be made for a compact car. If compacts are not available, the next larger car should be reserved. Employees rental cars will not incur the expense of the additional insurance coverage for collision offered under the standard rental agreement.

1.11 Mandatory Training

1.11.1 When applicable, Bayhealth provides residents/fellows with mandatory certification classes such as BLS, ACLS, PALS, ATLS, ALSO, and NRP. These expenses are paid by the program and do not come out of the resident/fellows educational fund.

1.12 Fees

1.12.1 Programs will pay for or reimburse residents/fellows for their medical training license, DEA, and fingerprinting

1.12.1.1 Programs will not reimburse or pay for full medical license

1.12.2 Programs will pay for resident/fellows memberships to specific professional associations required by the program

1.13 Apparel

1.13.1 Residents and Fellows will be given a uniform stipend that can only be used at A&H Uniforms

| PGY Level | EM | FM | GS | IM | Hem Onc Fellows | Gastro Fellows |
|--------------------|-----------|----------------|------------------------------------|----------------|----------------------------|---------------------------|
| 1 | \$350 | \$300 | \$150 | \$300 | N/A | N/A |
| 2 | \$100 | \$100 | \$50 | \$100 | N/A | N/A |
| 3 | \$100 | \$100 | \$50 | \$100 | N/A | N/A |
| 4 | N/A | N/A | \$50 | N/A | \$150 | \$300 |
| 5 | N/A | N/A | \$50 | N/A | \$50 | \$100 |
| 6 | N/A | N/A | N/A | N/A | \$50 | \$100 |
| Scrub Color | Black | Pewter Gray | Surgical Scrubs from Machine | Pewter Gray | No Scrubs | Pewter Gray |

1.13.2 New Residents and Fellows will have set time during orientation to go to the uniform store and pick out what they would like to purchase.

1.13.3 Items must follow the resident dress code policy and assigned scrub colors

1.14 Exams

1.14.1 Programs will purchase, schedule, and proctor the In-Training exams

- 1.14.2 Residents will be reimbursed for the cost of USMLE Step 3 or COMLEX Level 3 when applicable
 - 1.14.2.1 Residents will only be reimbursed for one attempt of one exam
 - 1.14.2.2 Residents/fellows will not be reimbursed for any exam taken prior to the start of the employment
- 1.14.3 Specialty board study materials will be purchased for residents/fellows by the program
- 1.15 Resident/Fellow Salary
 - 1.15.1 Annually the GMEC reviews and approve resident/fellow stipends and benefits
 - 1.15.2 Current stipend schedule will be provided to all applicants, incoming residents/fellows and posted online
 - 1.15.3 PGY-3 Chief Residents will receive an additional stipend of \$2,000

Cell Phone

Purpose Statement: Bayhealth Medical Center recognizes the importance of cell phones and data devices in modern healthcare settings. Bayhealth Medical Center also acknowledges the need to maintain patient confidentiality, ensure data security, and promote a safe and professional work environment. This policy outlines guidelines for the appropriate use of cell phones and data devices by resident/fellow physicians.

1. Procedure:

1.1 Patient Privacy and Confidentiality

- 1.1.1 Cell phones and data devices should not be used in a manner that compromises patient privacy or confidentiality. Avoid discussing patient information in public areas or using devices to capture or transmit patient data without proper authorization.
- 1.1.2 Resident/fellow physicians must protect patient information and hospital data by ensuring that cell phones and data devices are secured with passcodes
- 1.1.3 Resident/fellow physicians should only use secure messaging platforms approved by the hospital for communication related to patient care
- 1.1.4 Resident/fellow physicians should avoid sending patient information through unsecure means such as standard text messaging apps
- 1.1.5 Resident/fellow physicians should not take photographs or videos of patients, staff, or sensitive hospital areas without proper authorization. Resident/fellow physicians are required to respect patient and colleagues' privacy.

1.2 Hospital Issued Devices

- 1.2.1 Resident/fellow physicians will be provided with a Bayhealth issued cell phone to use for work purposes only. Each phone is allocated 2GB of data and unlimited phone and text messages each month.
 - 1.2.1.1 All cell phones share a pooled plan of data and are not unlimited. Resident/fellow physicians should utilize Wi-Fi connections whenever possible.
 - 1.2.1.2 Resident/fellow physicians must not use their Bayhealth issued cell phone for research purposes.
 - 1.2.1.3 Resident physicians who repeatedly exceed their data usage will discuss their device usage with the program director. If the data usage continues to exceed their allotted amount, and is not related to patient care, then steps per the Corrective Action policy may be implemented.
 - 1.2.1.4 Resident/fellow physicians are not permitted to access websites on their Bayhealth issued cell phone which do not contribute to the effectiveness, efficiency and/or productivity of healthcare delivery
- 1.2.2 Resident/fellow physicians are not permitted to download or install software or plug-ins from the internet on their Bayhealth issued cell phone unless approved by Bayhealth Information Technology
- 1.2.3 Resident/fellow physicians must keep hospital-issued devices secure and must not share login credentials
- 1.2.4 Personal use of Bayhealth owned devices is prohibited other than on limited basis
- 1.2.5 Resident/fellow physicians must act responsibly in using electronic devices
- 1.2.6 Resident/fellow physicians are not permitted to take their Bayhealth mobile devices outside of the United States

1.3 Personal Devices

1.3.1 Personal cell phones and data devices may be used during breaks and in designated areas. However, personal use should not interfere with job duties or patient care responsibilities.

1.3.2 Personal calls and text messages should be kept brief and should not disrupt work or patient care

1.3.3 Resident/fellow physicians are prohibited from using personal cell phones or other devices for patient care responsibilities

1.4 Resident/fellow physicians must report any lost or stolen cell phones or other data devices immediately to the GME office, IT, and security

1.5 Resident/fellow physicians must report any suspected security breaches or unauthorized access to hospital data immediately to the GME office, IT, and security

2. References:

2.1 HIPAA (Health Insurance Portability and Accountability Act)

2.2 HITECH Act (Health Information Technology for Economic and Clinical Health Act)

2.3 Use of Bayhealth Medical Center Electronic Facilities and Equipment Policy (B9060.16)

By signing this agreement I understand and acknowledge the policy

Print Name

Signature and Date

Clinical Experience and Educational Hours

Purpose Statement: Medical care at Bayhealth will be provided by healthy, alert, responsible and responsive trainees/fellows by creating a balanced environment between education and patient care. Clinical Experience and Education Hours will be consistent with the Accreditation Council for Graduate Medical Education (ACGME) Institutional, Common and Program Requirements that apply to each residency/fellowship program.

1. Procedure:

1.1 Program Specific Work Hour Policy

1.1.1 Each training program must have a written policy and procedure consistent with this Institutional policy as well as program-specific Review Committee requirements for clinical trainee, clinical experience, and educational work hours. The policy must regularly be distributed to the trainees and faculty within their program and reviewed annually to assure accuracy

1.1.1.1 The program must be designed in such a manner that trainees are provided with time for rest and well-being as well as educational opportunities

1.1.1.2 Each program must ensure that the goals and objectives of the program are not compromised by excessive reliance on clinical trainees to fulfill service obligations

1.1.1.3 Clinical experience and educational work hours must reflect the fact that responsibilities for continuing patient care are not automatically discharged at specific times

1.1.1.4 Programs must mandate that clinical trainees are provided with appropriate senior and/or faculty back-up support at all time

1.2 Maximum Hours of Clinical and Educational Work per Week

1.2.1 Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting

1.3 Mandatory Time Free of Clinical Work and Education

1.3.1 Trainees must have eight hours off between scheduled clinical work and education periods

1.3.2 Trainees must have at least 14 hours free of clinical work and education after 24 hours of in-house call

1.3.3 Trainees 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

1.3.4 There may be circumstances when trainees 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

1.4 Maximum Clinical Work and Education Period Length

1.4.1 Clinical and educational work periods for trainees must not exceed 24 hours of continuous scheduled clinical assignments

1.4.2 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 trainee education. Additional patient care responsibilities must not be assigned to a trainee during this time

1.5 Clinical and Educational Work Hour Exceptions

1.5.1 In rare circumstances, after handing off all other responsibilities, a trainee, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:

1.5.1.1 to continue to provide care to a single severely ill or unstable patient

1.5.1.2 humanistic attention to the needs of a patient or family; or,

1.5.1.3 to attend unique educational events.

1.5.2 These additional hours of care or education will be counted toward the 80-hour weekly limit

1.5.3 A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale

1.5.3.1 In preparing a request for an exception, the Program Director must follow the clinical and educational work hour exception policy from the ACGME Manual of Policies and Procedures

1.5.3.2 Prior to submitting the request to the Review Committee, the Program Director must obtain approval from the Sponsoring Institution's Graduate Medical Education Committee (GMEC) and Designated Institutional Official (DIO)

1.6 Averaging Clinical and Educational Work Hours

1.6.1 The 80-hour maximum and one day off in 7 are averaged over four weeks

1.6.2 If a trainee takes vacation or other leave, those vacation or leave days are omitted from the numerator and the denominator when calculating clinical and educational work hours and days off. For example, if a trainee is on vacation for one week, the hours will be averaged over the remaining 3 weeks or the remainder of the rotation if shorter than 4 weeks

1.7 Work Hour Submission

1.7.1 Trainees are expected to report their work hours in an honest, accurate, and timely manner

1.7.2 Failure to report work hours is considered a breach of professionalism; repeated failure to complete timesheets will be considered by the CCC at the time of the semi-annual review

1.7.3 Trainees are required to use the MedHub app to report work hours daily to ensure accuracy

1.7.4 Trainees have access to the previous and current calendar week in MedHub (the week ends on Sunday at midnight)

1.7.5 In special circumstances like emergencies or an unexpected leave of absence, trainees can contact their program coordinator via email to report hours they were unable to submit prior to the deadline

1.7.5.1 The program coordinator can enter missing work hours for up to one month

1.7.5.2 After one month the program coordinator can no longer access the timesheet and is unable to enter past hours. Hours will need to be entered by the Institutional Coordinator or GME Director, this action will result in a professionalism issue

1.7.6 Trainees that have failed to log any duty hours for the prior week will be reminded by email and alert on their Medhub portal page. Trainees will have a full week to document duty hours for the previous week however, as stated above this function should be performed daily

1.7.7 Trainees must still submit their timesheets in Medhub even when using Paid Time Off

1.8 Reporting Concerns Regarding Work Hours

- 1.8.1 Graduate Medical Education is committed to ensuring that trainees can report concerns regarding work hours without retribution
- 1.8.2 Concerns may be discussed with the program director or associate director
- 1.8.3 Concerns may be reported to the trainee's forum leaders who can bring the concerns to GME Leadership
- 1.8.4 Trainees may request to meet with the DIO, GME Chair or GME Director at any time
 - 1.8.4.1 Please contact GME to schedule an appointment or drop by the office to discuss
 - 1.8.4.2 Concerns may also be communicated anonymously through the GME link [GME Residency Anonymous Feedback Form | Bayhealth Intranet](#) which is automatically forwarded to the DIO and Director of GME for review and further investigation
- 1.9 Working from Home
 - 1.9.1 Schedules should be structured so that trainees are able to complete work on site and not take work home; however, we recognize this is not always possible. When trainees must complete work from home it should be incorporated into their work hours
 - 1.9.2 Work in the EMR should be recorded as should calls taken from home
 - 1.9.3 Reading done to prepare for cases, studying and research done at home do not count towards work hours
 - 1.9.4 Decisions whether to report or aggregate short interruptions for phone calls, etc. are left up to the individual trainees
 - 1.9.5 Trainees who leave before work is done and finish later at home should obtain approval before doing so
- 1.10 Moonlighting
 - 1.10.1 Moonlighting must not interfere with the ability of the trainee to achieve the goals and objectives of the educational program and must not interfere with the trainees' fitness for work nor compromise patient safety
 - 1.10.2 Time spent by trainees moonlighting must be counted toward the 80-hour maximum weekly limit
 - 1.10.3 Refer to moonlighting policy for additional details
- 1.11 In-House Night Float
 - 1.11.1 Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements
- 1.12 Maximum In-House On-Call Frequency
 - 1.12.1 Trainees must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period)
- 1.13 At-Home Call
 - 1.13.1 Time spent on patient care activities by trainees on at-home call must count toward the 80-hour maximum weekly limit
 - 1.13.2 The frequency of at-home call is not subject to 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

- 1.13.3 At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each trainee
- 1.13.4 Trainees 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

Code of Conduct

Purpose Statement: This document addresses Bayhealth Hospitals, facilities, and departments (Bayhealth). Bayhealth is committed to conducting its business lawfully and ethically. As Bayhealth's reputation is the sum of the reputations of its employees, it is critically important that all of its employees meet the highest standards of legal and ethical conduct. To protect Bayhealth's reputation and to assure uniformity in standards of conduct, it has established this Code of Conduct as part of its Corporate Compliance Program. Under the Corporate Compliance Program, Compliance Officers have been appointed to ensure compliance with the Corporate Compliance Program, to serve as a contact for employees to report any potential violations of laws, regulations, or this Corporate Compliance Program, and to take appropriate action against violators of any such laws, regulations, or this Corporate Compliance Program.

This Code of Conduct establishes the general policies and procedures with which all Bayhealth employees must comply as a condition of employment with Bayhealth in order to ensure that their conduct conforms to the highest ethical standards and is in accordance with all applicable laws, rules, and regulations. These policies and procedures are not meant to cover all situations. Any doubts whatsoever as to the propriety of a particular situation, whether or not the situation is described within this Code of Conduct, should be submitted either to your immediate supervisor or to one of the Compliance Officers. The intent of Bayhealth's Corporate Compliance Program is to safeguard the tradition of strong moral, ethical and legal standards of conduct.

Every employee of Bayhealth is required to understand and comply fully with both the rules and approval procedures established by this Code of Conduct. The standards of conduct that govern Bayhealth's relationship with the government are applicable to all employees whether or not the employee is directly engaged in performing activities relevant to any federal, state, or private contracts. Any employee violating any provision of this Code of Conduct will be subject to disciplinary action, up to and including discharge from employment. In addition, promotion of and adherence to this Code of Conduct and to the Corporate Compliance Program will be one criterion used in evaluating the performance of supervisors, managers, and directors. To the extent that any additional policies are set forth in any other manual, those policies should be consistent with this Code of Conduct. In case of any inconsistency, this Code of Conduct shall govern.

Compliance with all Laws and Regulations

- All of Bayhealth's employees must scrupulously comply with all federal, state, and local laws and government regulations and must immediately and directly report to the Compliance Officers any actual or perceived violation of this Code of Conduct, the Corporate Compliance Program or any other policy covered in the Corporate Compliance Program. Bayhealth further expects all employees to comply with all licensures, certification and Condition of Participation laws and regulations.

Compliance with all Hospital Policies and Procedures

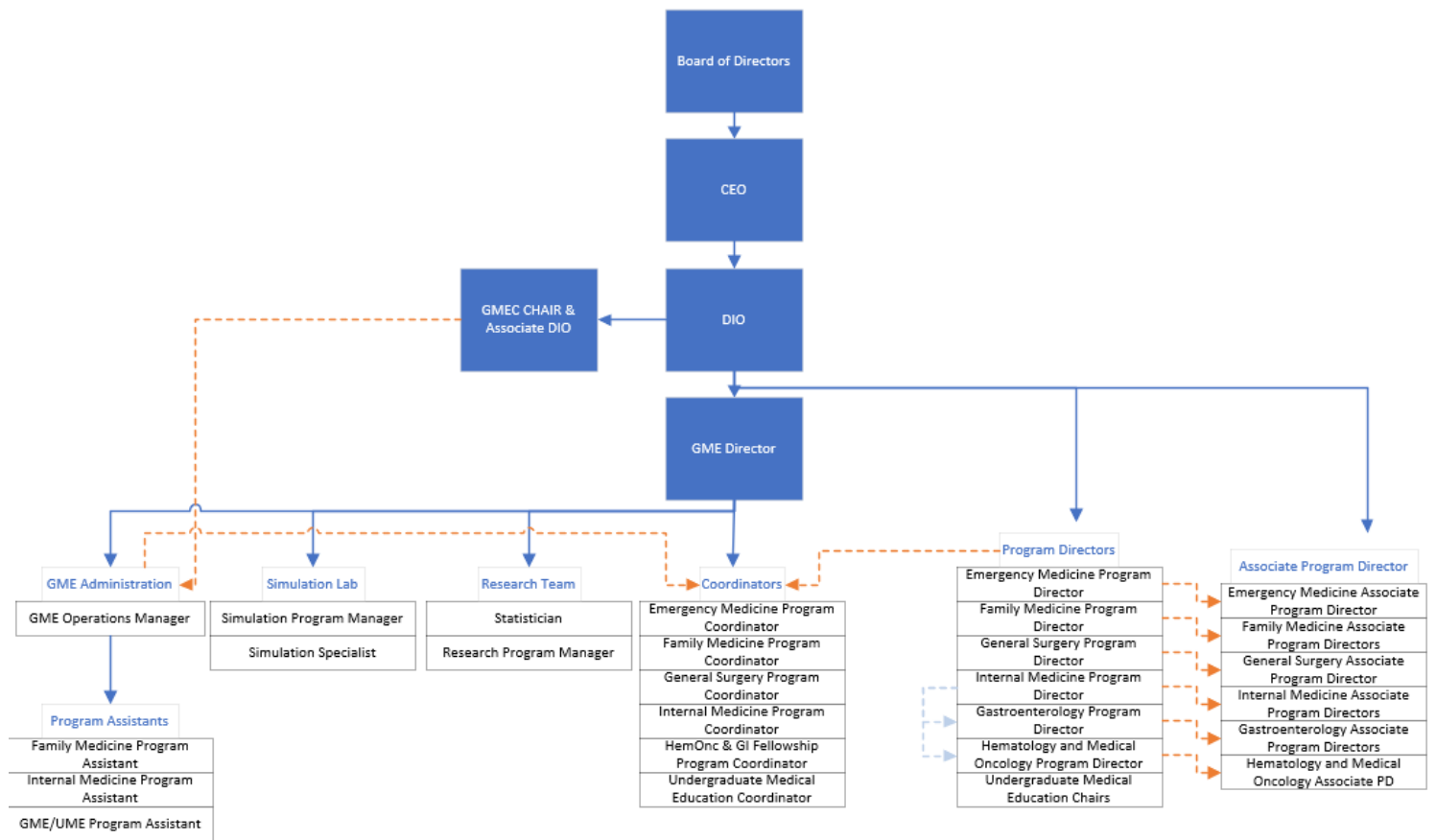
- All of Bayhealth's employees must also scrupulously comply with all policies and procedures.
- Compliance with the Patients' Bill of Rights Statement
- All of Bayhealth's employees must comply scrupulously with all standards set forth in the Patients' Bill of Rights and the Delaware Mental Health Patient's Bill of Rights, including the patients' right to refuse to perform tasks in or for the hospital and the patient's right to protective services.
- Dealing Ethically and Honestly with Customers, Suppliers and Consultants
- Quality of Service
- Bayhealth is committed to providing services that meet all contractual obligations and quality standards.

- Contract Negotiation
- Bayhealth has an affirmative duty to disclose current, accurate and complete cost and pricing data where such data are required under appropriate federal or state law or regulation. Employees involved in the pricing of contract proposals, or the negotiation of a contract must ensure the accuracy, completeness and currency of all data generated and given to supervisors and other employees and all representations made to customers and suppliers, both government and commercial. The submission to a federal government customer of a representation, quotation, statement, or certification that is false, incomplete, or misleading can result in civil and/or criminal liability for Bayhealth, the involved employee and any supervisors who condone such a practice.
- Admissions, Transfers, and Discharges
- Decisions regarding admissions, transfers and discharges are to be based on the best interests of the patient and in accordance with hospital policies. Care is to be provided only to those patients for which Bayhealth possesses the necessary knowledge, skills, capacity, and environment in which to provide services. Referrals outside Bayhealth will occur when appropriate services are not available within the system or when the patient desires to be transferred.

10/27/2021

Designated Institutional Office Organizational Chart

Purpose Statement: To establish the organizational structure and the reporting relationships of the Designated Institutional Official (DIO).



Diversity

Purpose Statement: To provide diversity in the recruitment, selection, and employment of all residents, and faculty in the Bayhealth graduate medical education (GME) programs.

1. Procedure:

- 1.1 Bayhealth is committed to recruiting and employing diverse residents, fellows, and faculty in every Graduate Medical Education program.
- 1.2 Bayhealth believes that diversity enhances the educational experience of every resident in the program and impacts the ability of an individual to competently practice following completion of the program. Additionally, the constantly changing patient demographics locally, nationally, and internationally create an impetus for a future physician workforce that can understand, communicate competently, and provide care to patients of varied backgrounds.
- 1.3 Bayhealth Medical Center is committed to increasing the diversity of our residents, fellows, and faculty and ensuring the success of our residents/fellows who come from backgrounds currently underrepresented in medicine.
- 1.4 Bayhealth Medical Center will ensure that resident/fellow recruitment materials and advertisements include language that conveys a level of commitment to diversity promotion beyond that required by regulation.
 - 1.4.1 Bayhealth Medical Center will place advertisements widely to attract a diverse pool of candidates.
- 1.5 All interviewers and decision makers in the selection of residents/fellows will be required to complete training regarding diversity and inclusion.
- 1.6 Graduate Medical Education will make residents/fellows aware of how to report issues regarding diversity, equity, and inclusion without recourse.
- 1.7 Bayhealth Medical Center will preferentially hire program faculty candidates who can articulate a commitment to diversity.

Drug and Alcohol Abuse

Institutional Policy B9065.14 (Last Updated 5/2/23)

Purpose Statement: Bayhealth complies with all state and federal laws regarding alcohol and drug use. Bayhealth sets forth its commitment to providing the highest quality of healthcare delivery services and promoting a safe and secure environment for patients and their families, employees, volunteers, Bayhealth affiliate members, and the general public. Employee, volunteer, contractor, and/or affiliate member use of alcohol and/or drugs which cause impairment either immediately prior to or during work hours jeopardizes the safety and welfare of the community whom Bayhealth is charged to serve. This policy includes testing for pre-employment, post-accident, reasonable cause, return-to-duty, and unannounced testing as a condition of continued employment.

Definitions:

- Under the Influence (Alcohol): The employee is affected by alcohol in any detectable manner which may be established by observation of impairment and a scientifically valid test. For purposes of clarification, an employee found to have a blood-alcohol concentration of .02% or more as determined by a diagnostic test such as a breathalyzer, will be classified as under the influence of alcohol.
- Under the Influence (Drugs): The employee is affected by illegal or controlled drugs in any detectable manner which may be established by observation of impairment and/or a scientifically valid test.
- Reasonable Suspicion: Significant knowledge and observation obtained to believe that an employee is impaired secondary to the use of alcohol and/or illegal or controlled drugs. It is important to note that there may be reasonable explanations for signs and behaviors; supervisors must consider behaviors in aggregate before making a conclusion of reasonable suspicion. Knowledge may be obtained through observable signs to include, but not limited to the following:
 - Significant changes in normal activity level
 - Slurred speech or unusually rapid or slow speech
 - Unsteady, staggering walk
 - Loss of coordination
 - Smell of alcohol or marijuana on employee's breath or person
 - Glassy, red, or bloodshot eyes
 - Disoriented or bizarre behavior
 - Unusually unkempt appearance
 - Sudden change in work quality, lapses in concentration (repeated errors), difficulty recalling instructions
 - A pattern of unexplained disappearances from the job, unable to locate employee
 - Employee involvement in a workplace accident that appears to result from the employee's lack of attention and/or coordination, negligence, or where the accident is otherwise unexplainable
 - Medication withdrawals from automated network dispensing cabinets where a physician order is not present, multiple system overrides are engaged, and/or follow-up documentation is not completed.
- Accident: An occurrence associated with the operation of a vehicle and/or use of equipment which results in bodily injury necessitating medical care above and beyond first aid.
- Incident: An occurrence associated with the provision of services, care, and/or treatment of patients wherein a patient suffers a catastrophic outcome, e.g., death, threat to life, avoidable injury, or damage, proximate to an employee's failure to follow established departmental

and/or organizational procedures.

- Property or Equipment Damage: Impaired use or harm to either property or equipment requiring repair caused by inattention to detail or a failure to comply with established safety procedures.
- Affiliate Members: Non-employed physicians, allied health professionals, volunteers, temporary staff members, student interns/externs, and contractors.
- Bayhealth Premises: Any office, building, facility, or property (including parking lots, vehicles, and/or equipment) owned, operated, or leased by Bayhealth.
- Safety Sensitive Positions: Any job classification within Bayhealth which calls for the participation in direct patient care; security duties; operation of motor vehicles; operation and maintenance of heavy and/or electrical equipment; maintenance of hazardous systems such as boilers, elevators, electrical systems, and chillers; and duties associated with the measurement and administration of pharmaceutical products.

1. Procedure:

- Bayhealth recognizes that alcohol and drug addiction are problems which can be successfully overcome. Employees who acknowledge drug and/or alcohol addictions, without first being discovered by Bayhealth and seek assistance through either the Employee Assistance Program or directly through a rehabilitation program, maybe considered for continued employment subject to position availability and agreement to participate in periodic unannounced drug/alcohol tests.
- Employees and affiliate members are not permitted to possess, use, purchase, sell, or transfer illegal drugs of any amount on Bayhealth property (to include parking lots), in Bayhealth vehicles (either owned or leased by Bayhealth), and/or while on duty performing services for Bayhealth, including during unpaid meal breaks and paid break periods.
- Employees are prohibited from consuming alcohol while on or off Bayhealth property during work hours to include unpaid meal breaks and paid breaks.
- Employees may not report to work under the influence of alcohol, illegal drugs, and/or controlled substances which may cause physical or mental impairment.
- Employees and/or affiliate members who engage in diverting, possessing, obtaining, supplying, or administering prescription drugs to any person, including self, except as prescribed by a licensed medical professional who is authorized by law to prescribe drugs, shall be subject to discharge from employment and/or referral to the appropriate administrative governing body for action.
- Procedures for employed and non-employed practitioners credentialed or granted limited privileges by the Bayhealth Medical Center Board of Directors, who violate Bayhealth drug and alcohol policies, shall be managed as set forth in Bayhealth Medical Staff Services Policy B9085.05, Practitioner Health Policy. Final disposition regarding matters involving employed and non-employed practitioners shall be left to the Chief Medical, Chief Operating, and Chief Executive Officers.
- Employees who take over-the-counter medication and/or other lawful medication, even controlled substances such as marijuana for medicinal purposes, to treat a medical condition, should inform his/her supervisors if they believe that the medication will impair their job performance, safety, or the safety of others or if they believe they need a reasonable accommodation before reporting to work while under the influence of that

medication.

- Where Bayhealth has reason to believe that an employee is in violation of Bayhealth alcohol and drug policies, the employee may be asked to submit immediately to a search of his or her person, and/or all personal belongings located on Bayhealth property, including vehicles, employee lockers, desks, and any other receptacles used. Bayhealth reserves this right to search all of an employee's personal property when it is brought on to Bayhealth property. A failure to submit to an inspection when reasonable suspicion has been established is grounds for immediate termination

Pre-Employment Testing

- All applicants for employment who have received and accepted a bona fide offer of employment are subject to pre-employment drug urinalysis testing for controlled and illegal substances. All employment offers are contingent upon the satisfactory completion of a controlled substance screening test and a passing result. Employment offers will be rescinded for applicants testing positive for an illegal substance or non-prescribed controlled substance and are not eligible to reapply for employment with Bayhealth for one year following the unfavorable drug screen. Failure to consent to drug urinalysis testing will result in the employment offer being rescinded.
- Urine specimens will be collected by Occupational Health in accordance with the Drug and Alcohol Testing Industry Association (DATIA) and sent [complying with chain of custody procedures] to a contract laboratory for resulting.
- Any attempt to tamper with the specimen, or if there is reasonable suspicion the specimen was tampered with, offer of employment is immediately rescinded.
- Any applicant who has a urine specimen where the temperature is out of range must provide another urine specimen during the same Occupational Health visit. If the applicant refuses to provide a second urine specimen, their offer of employment is immediately rescinded. If they provide a second urine specimen and the specimen's temperature is out of range again, the applicant's offer of employment is immediately rescinded. The applicant is not eligible for hire for one year.
- An applicant testing positive for any controlled substance will be denied employment unless it can be shown the drug in question is prescribed by a licensed physician or healthcare provider to treat a current diagnosed condition and will not interfere with the applicant's ability to safely perform the job. The Bayhealth Medical Review Officer will evaluate all positive results and consult with the prescribing physician if applicable.
- Recommendations for a re-test for dilute specimens by the Medical Review Officer must be upheld in order to continue with pre-employment processing. Failure to submit to a re-test when requested results in the employment offer being rescinded. Re-tests for dilute specimens are permitted to be completed through direct observation.
- All information regarding drug and/or alcohol testing and test results will be maintained as confidential information in the online drug screen system. Drug screen results will not be released to employees for their own record. For pre-employment testing, only Bayhealth's Human Resources team is on a "need to know" basis regarding outcomes of drug and/or alcohol testing for employment processing purposes. Access requested by agencies outside of Bayhealth must produce a valid subpoena in order to obtain access.
- All applicants for Bayhealth employment will be advised of the policy regarding drug

urinalysis testing at the time of interview.

Reasonable Cause Testing During Regular Business Hours

- If an employee reports to work and a manager has reason to believe, based upon observation of employee behavior and/or appearance, the employee is not able to safely and satisfactorily perform duties required, the manager will request, after consultation with Human Resources, that the employee submit to drug urinalysis and/or alcohol testing.
- The manager will complete the “Supervisor’s Checklist for Reasonable Suspicion Determination,” sign and date the document. Human Resources should be contacted (during normal business hours) to discuss observations recorded on the checklist and the need to send the employee for drug testing. If after normal business hours, the Administrator On-Call should be contacted.
A copy of the checklist will be attached to the consent form and maintained in the Occupational Health record.
- During regular business hours (7:30 a.m.-5:00 p.m.), the manager and/or Human Resources will contact Occupational Health to arrange for drug and/or alcohol testing. The employee will be escorted to Occupational Health by Public Safety, as necessary. If results are not available that day, Public Safety will work to make arrangements to have the employee transported to his/her place of residence. Every effort should be made to ensure the employee does not operate a motorized vehicle.
- If the employee refuses to consent and there exists reasonable suspicion that he/she is impaired, the manager will notify the employee that he/she will be placed on administrative leave without pay pending further investigation, advise the employee not to operate a motor vehicle, and work with Public Safety to make arrangements to have the employee transported to his/her place of residence. Every effort should be made to ensure the employee does not operate a motorized vehicle. Refusal to consent to a drug and/or alcohol screening may result in corrective action, up to and including termination of employment.
- If consent is obtained, Occupational Health personnel will administer a Breathalyzer and/or drug urinalysis test.
- If the test reveals a positive result for prescription medication, properly prescribed to the employee, the employee will be directed to contact his/her healthcare provider to assess fit for duty. The employee will be placed on an administrative leave of absence, permitted to access accrued paid-time-off until a disposition is made. The Medical Review Officer will make the determination regarding if the employee can return to work and when.
- If the test reveals a positive result for prescription medication not prescribed to the employee, the employee will be subject to disciplinary action, up to and including termination of employment.
- If there is reasonable suspicion of an employee removing a prescription medicine from automated network dispensing cabinets where a physician order is not present, an additional controlled substance test will be performed in addition to normal testing procedures.
- In the instance where there is reasonable suspicion of alcohol and/or drug use during an employee’s working hours, the employee will not be permitted to return to work until the results of the test(s) are known by Bayhealth and provided that the results for alcohol and/or illicit drugs are negative. Should results of the test(s) be positive and it be determined that the employee was under the influence of alcohol and/or drugs while on duty at Bayhealth, they will be subject to corrective action, up to and including termination of employment. Should the results of the

test(s) be negative, the employee will be allowed to return to work with full back pay.

Reasonable Cause Testing After Hours

- In the event that a supervisor believes an employee to be impaired during other than normal business hours, the supervisor must notify the House Supervisor on duty to discuss observations of the employee.
- The supervisor or House Supervisor will complete the Supervisor's Checklist for Reasonable Suspicion Determination. If there is reasonable suspicion that the employee is impaired, the supervisor will escort the employee to the Emergency Department. The Emergency Department will contact the on-call employee at Occupational Health for a drug screening.
- The Supervisor's Checklist for Reasonable Suspicion will be attached to the consent form and ultimately forwarded to Occupational Health for insertion in the employee's drug screen record.
- Alcohol testing will be released immediately to the responsible supervisor; results of drug testing will be forwarded to Occupational Health for release during regular business hours.
- Until all test results are received, the employee will be placed on Administrative Leave, pending the outcome of the tests. Should results of the test(s) be positive and it be determined that the employee was under the influence of alcohol and/or drugs while on duty at Bayhealth, they will be subject to corrective action, up to and including termination of employment. Should the results of the test(s) be negative, the employee will be allowed to return to work with full back pay. While results are pending, the supervisor or House Supervisor should work with Public Safety to make arrangements to have the employee transported to his/her place of residence. Every effort should be made to ensure the employee does not operate a motorized vehicle. Refusal to consent to a drug and/or alcohol screening may result in corrective action, up to and including termination of employment.

Post-Accident Testing

- As a condition of continued employment and/or continued privileges to provide services at Bayhealth, employees and affiliate members are required to submit to post-accident, reasonable cause, return- to-duty, or follow-up alcohol or drug testing, as requested by Bayhealth. Bayhealth does not require these drug tests to be done through direct observation.
- When an employee performing services for Bayhealth is involved in an accident or incident which results in any of the following: 1) damage to property and/or equipment, 2) a personal injury, and/or 3) a catastrophic patient outcome, when such accidents and/or incidents are the result of inattention, disregard for established safety procedures, and/or a failure to comply with established operating procedures, he/she will be asked to consent to drug and alcohol testing. The employee's supervisor must coordinate with Human Resources, during normal business hours, or the Administrator On-Call, if outside of normal business hours, to arrange the drug and alcohol screening.
- Post-accident testing will be performed within 1 hour after the accident, so long as the employee is able to consent. The procedures will mirror those set forth for reasonable suspicion testing. If the 1-hour time limit cannot be met, testing will be performed as soon as reasonably possible.
- In the event that the employee is so seriously injured that he/she cannot provide a specimen at the time of the accident, the employee must provide necessary authorization to Bayhealth to obtain hospital records or other documents that may indicate whether controlled substances or

alcohol were present in the employee's system at the time of the accident.

- In the event that federal, state, or local officials, following an accident, conduct breath and/or blood tests to determine the presence of alcohol and/or controlled or illegal drugs, these tests will meet the requirements of this policy. In such a case, the employee must consent to allow Bayhealth to obtain the test results.
- A refusal to consent to drug and alcohol testing, or to consent to release results to Bayhealth when such testing was completed by a third party, will constitute grounds for termination.

Random Alcohol and Drug Testing

- Employees in safety and/or security-sensitive positions and positions regulated by federal regulatory bodies are required to submit to random alcohol and drug testing, as requested by Bayhealth.
- Employees in positions subject to random testing will be notified that such positions are subject to the testing. However, the employees will not be given advance notice of the actual random testing.
- Urine specimens and/or breathalyzer testing will be collected by Occupational Health in accordance with the Drug and Alcohol Testing Industry Association (DATIA) and sent [complying with chain of custody procedures] to a contract laboratory for resulting. Specimens will be collected during the employee's normal working hours.
- A refusal to consent to drug and alcohol testing, or to consent to release results to Bayhealth, will constitute grounds for termination.
- Employees who fail such tests are subject to discipline, up to and including termination, as noted within this policy.

Voluntary Disclosure and Referral to the Employee Assistance Program

- An employee who voluntarily discloses drug and/or alcohol dependence to a supervisor or Human Resources, and asks for assistance upon their own volition, will be referred to the Bayhealth Employee Assistance Program for assessment and referral and/or voluntary treatment options offered by licensing bodies.
- Employees may request assistance directly from the Employee Assistance Program and such will remain confidential.
- If voluntary disclosure is made to a supervisor and/or Human Resources, independent from any allegations of misconduct or investigation, Bayhealth will not pursue any form of discipline or corrective action. This practice will only be followed one time during an employee's entire career at Bayhealth.
- In the event that the referring agency recommends a formal rehabilitation program, the employee will be permitted to apply for a leave of absence or family medical leave (if eligible).
- Upon returning to employment at Bayhealth, the employee must furnish a Fit for Duty release from their provider and Occupational Health.
- All healthcare costs, with the exception of the Employee Assistance Program, will be the employee's responsibility.

Mandatory Referral to the Employee Assistance Program

- Employees referred for reasonable suspicion or random drug and/or alcohol testing which confirms the presence of alcohol and/or controlled substances (illicit or legal drugs without a

prescription), may be referred to the Employee Assistance Program rather than processing the employee for termination. Such a decision will be left to the discretion of the Division Vice President/Senior Vice President, in consultation with the Vice President of Human Resources, after considering the facts of the case, the type of position held by the employee, and the employee's employment record with Bayhealth.

- In the event of a referral, the employee will be informed that such a referral is mandatory requiring that, as a condition of continued employment, the employee attend sessions and follow the treatment plan (if applicable) as directed by the referral agency.
- The employee is subject to corrective action for the infraction(s) committed, up to and including suspension/final written warning.
- Upon completion of the treatment plan, the employee must be released to return to work by the healthcare provider overseeing treatment as well as Occupational Health. Moreover, the employee will be required to consent to drug and alcohol testing with satisfactory results before being permitted to return to work.
- All healthcare costs, with the exception of the Employee Assistance Program, will be the employee's responsibility.
- Employees recommended to return to work will be required to agree to a "Last Chance Agreement" (LCA) as a condition of continued employment. The Human Resources department will craft the LCA. A copy of the LCA will be filed in the employee's personnel file and in the employee's drug screen record. At minimum, the LCA will contain the following statements:
 - A clear statement indicating that Bayhealth has grounds to terminate employment at the present time but is agreeing to forego that right in exchange for the employee's commitment to abide by the terms of the LCA.
 - A statement describing the employee's misconduct which constituted grounds for dismissal.
 - The requirement that the employee comply with the treatment plan recommended by his/her healthcare provider.
 - State that the employee has the responsibility to inform Occupational Health of any prescribed controlled substances.
 - Plainly state that improved performance must be continued and sustained and that any violation of terms of the LCA will result in immediate termination.
 - Make it clear that the employee is required to comply with all standards of performance.
 - Include a statement regarding any modifications of scheduling as a condition of continued employment.
 - Comprehensive instructions regarding the requirement for unannounced follow-up substance abuse testing include a statement which clearly states that follow-up unannounced drug and alcohol testing is a condition of continued employment. Clearly state that from the time notified to appearance for testing must not exceed two (2) hours
 - A clear statement that breach of any of the conditions contained within the agreement will be grounds for immediate termination.
 - Establish the term of the LCA – no longer than two (2) years.

Reporting Requirements

When evidence exists that an employee licensed by the State of Delaware to practice in a specific vocation has been classified as impaired while on duty because of the use or abuse of alcohol and/or drugs, the responsible executive will file a complaint with the appropriate State Board of Practice.

Dress Code

Purpose Statement: Personal appearance is an important component of professional demeanor. Each resident is expected to dress in a manner which conveys a professional image and inspires confidence in patients and colleagues. Apparel should be consistent with each resident's duties.

1. Procedure:

- 1.1 Training program directors, along with applicable clinical supervisors, are responsible for interpreting and enforcing the dress and grooming code in their areas of responsibility. Reasonable accommodation will be made for a Trainee's religious beliefs as related to attire whenever possible, consistent with the business necessity to present a professional appearance in public. Please use good judgment and dress appropriately, neatly, and professionally.
- 1.2 As medical professionals, trainees are expected to dress professionally, maintain good personal hygiene, and show consideration for cultural sensitivities of patients and co-workers, avoiding attire or grooming that could be offensive or unsafe.

1.2.1 Dress

- 1.2.1.1 Trainees dress must be appropriate to the work situation

- 1.2.1.1.1 The wearing of Jeans/denim are prohibited

- 1.2.1.2 Business Professional clothing should be worn within the outpatient/practice setting and when designated by the program

- 1.2.1.3 Clothes should be neat, clean, wrinkle-free, and in good condition.

- 1.2.1.4 Lab coats are expected to be worn over professional attire

1.2.2 Uniforms

- 1.2.2.1 Trainees are responsible for laundering all uniforms issued to them by Bayhealth

- 1.2.2.2 Trainees will be issued three white lab coats during onboarding

- 1.2.2.2.1 Trainees' white coats will be embroidered with their program logo on the right side and their name and resident/fellow physician in royal blue on the left side

- 1.2.2.2.2 Trainees are expected to wear their white coat over professional attire in all outpatient settings, when rounding or conducting consults

- 1.2.2.2.3 Trainees are also expected to wear their white coat over scrubs when worn in accordance with policy denoted below

- 1.2.2.3 Family Medicine and Internal Medicine residents are issued three sets of pewter scrubs at the time of onboarding

- 1.2.2.3.1 Pewter scrubs may be worn in the following locations: ICU, NICU, and the Emergency Department, as well as when on the night float service

- 1.2.2.3.2 Pewter scrubs may be worn in the following areas at the discretion of the program director: inpatient wards

- 1.2.2.3.3 White lab coats are to be worn over pewter scrubs

- 1.2.2.4 Emergency Medicine residents are issued five sets of black scrubs at the time of onboarding
 - 1.2.2.4.1 EM Residents are permitted to wear these during all rotations
- 1.2.2.5 Residents may obtain ceil blue scrubs from the Scrubex[®] machine when on a surgical service
 - 1.2.2.5.1 Surgical scrubs are not to be worn into or out of the hospital
 - 1.2.2.5.2 A white lab coat should be worn over scrubs outside of the Operating Room.
 - 1.2.2.5.3 Surgical scrubs must be worn when in the Operating Room, or on inpatient Obstetrics
 - 1.2.2.5.4 Soiled or stained scrubs should not be worn. Scrubs soiled with biological material should be changed as soon as appropriate and should be treated in accordance with the blood borne pathogen policy
 - 1.2.2.5.5 Scrubs should be placed in the appropriate linen hamper at the end of each workday
- 1.2.3 Personal Appearance and Hygiene
 - 1.2.3.1 Hair should be clean, combed and neatly trimmed or arranged. Unkept hair is not permitted. Sideburns, mustaches, and beards should be neatly trimmed. Hairstyles should be appropriately professional and should not present a distraction in the performance of the employee's job function. Hair color should be within naturally occurring color tones
 - 1.2.3.1.1 Extreme hair colors such as green, purple, blue, pink, etc. are prohibited
- 1.2.4 The use of cosmetics including nail polish and fragrances, will be conservative in nature
 - 1.2.4.1 Nail polish will not be chipped
 - 1.2.4.2 Artificial fingernails are not to be worn in patient care areas
 - 1.2.4.3 Natural nails must be kept short (less than ¼ inch long)
- 1.2.5 Body Piercings and Tattoos
 - 1.2.5.1 Trainees are permitted to wear up to three earrings per ear. Large holes/spacers in the ear are not permitted unless filled with flesh-colored inserts
 - 1.2.5.2 Visible piercings are limited to one small, unobtrusive nose stud; one small eyebrow ring, no other facial piercing. Tongue piercings are not acceptable
 - 1.2.5.3 Visible tattoos will be in good taste, may not be offensive, no depicting logos, slogans, nudity, violence, skulls, blood, representations associated with death, pin-ups, racial slurs, political views, or profanity
 - 1.2.5.3.1 The GME office reserves the ability to require an employee to cover a tattoo that does not meet these qualifications
- 1.2.6 Identification Badges & Pins

- 1.2.6.1 Trainees are required to wear their identification badge when on duty to be identified by patients and visitors
- 1.2.6.2 The identification badge is to be easily visible, with full name, photo, and department name visible
- 1.2.6.3 The badge will be worn above the waist unless determined to be a safety hazard
- 1.2.6.4 Trainees are prohibited from covering their picture or any part of their name on their badge
- 1.2.6.5 Trainees will wear black “resident/fellow doctor” title tags behind their name tags. These will be given during GME onboarding
- 1.2.6.6 Trainees are always required to wear their Ecobadge for handwashing within the hospital
- 1.2.6.7 Trainees are prohibited from wearing any tags, buttons, stickers, or other items in support of any cause in any work area unless issued or sponsored by Bayhealth
 - 1.2.6.7.1 Service award pins and pins recognizing an employees or affiliate member’s professional licensure, certification, or registration are permitted

1.3 Safety and PPE

- 1.3.1 Trainees who encounter blood or other body fluids are required to wear Personal Protective Equipment (PPE) in accordance with Bayhealth Policy B9000.05 OSHA Exposure Control/Blood Borne Pathogens. PPE include, but are not limited to, gloves, gowns, masks, and protective eyewear
- 1.3.2 As specified by OSHA standards, trainees providing direct patient care will wear shoes with enclosed toes. Shoes will be clean and in good condition

Employment of Relatives or Significant Others

Institutional Policy: B9065.25, last updated 3/28/2024

Purpose Statement: Bayhealth strives to employ the best qualified individuals. The employment of qualified relatives and partners of current team members is permitted as long as such employment does not create a conflict of interest or apparent conflict of interest. It is the policy of Bayhealth that no team member will be permitted to work under the direct supervision of any person who is a member of his/her/their immediate or extended family or persons who have a “consensual personal relationship.” Bayhealth management may permit a team member to work the same shift or in the same department as an immediate or extended family member or team member with whom he/she/they have a “consensual personal relationship.” The purpose of this policy is to avoid nepotism, conflicts of interests, or any appearance of a conflict of interest in the workplace. This policy also ensures favoritism or the perception of favoritism among relatives or consensual relationships is not a factor in the selection, development, and promotion of team members.

1. Procedure:

1. Reporting Requirements:

- i. Applicants for employment are required to fully disclose if a relative or consensual partner is employed by Bayhealth at the time of application. Team members are required to disclose within 30 days if a relative or consensual partner becomes employed by Bayhealth while the team member is employed by Bayhealth. Such relationships should be disclosed to the team member’s supervisor and to Human Resources.
 - ii. Current team members seeking an internal transfer are required to fully disclose if a relative or consensual partner works in the department the current team member is seeking employment. This disclosure must be made at the time of the application for transfer.
 - iii. Current team members working under the direct or indirect supervision of a relative or consensual partner must immediately disclose the relationship to the next level of management above such as supervisor and Human Resources.
2. When an applicant identifies that he/she/they have a relative or consensual partner working at Bayhealth, Human Resources, in consultation with the hiring manager, will ensure that the applicant is not referred to departments in which the applicant has a relative or consensual partner employed in a supervisory role.
3. For any team member that has disclosed a relative or consensual partner, Bayhealth management and HR will ensure that there is a layer of management between a team member and his/her/their relative or consensual partner so that there is never a direct line of supervision between the team members. This may include transfer to another position or department, or if necessary, termination of one of the team members. Team members are forbidden from reporting directly to a relative or consensual partner.
4. Team members permitted to work in the same department as their relative or consensual partner may be required to work a different shift, location, and/or work schedule than that of the member of their relative or consensual partner. This decision will be at the sole discretion of Bayhealth management and a factor for such a decision may include conflicts of interests and staffing needs.
5. Should two team members become relatives or consensual partners and one team member is in a supervisory position, the supervising team member shall inform their supervisor and Human Resources of the relationship. A team member shall not supervise a relative

or consensual partner for longer than two months, at which time one team member must transfer to a position not supervised by their relative or consensual partner. Every effort will be made to affect a transfer that will be mutually advantageous.

6. Exceptions to this policy may be considered on a case-by-case basis with the review and approval of the appropriate VP, SVP over the appropriate department in consultation with the SVP CHRO. Consideration may be given to alter the reporting relationships as well as workforce shortage issues that may necessitate the need to consider employing individuals in critical roles. Review and documentation of these situations will be maintained by the Employee Relations department.

Evaluations

Purpose Statement: Timely feedback is important to trainees to help them recognize areas of their performance that require improvement and areas in which performance meets or exceeds expectations.

1. Procedure:

1.1 Feedback and Evaluation

1.1.1 Faculty members must directly observe, evaluate, and frequently provide feedback on trainee performance during each rotation or similar educational assignments

1.1.2 Verbal feedback in real time is the most valuable for a trainee to reflect on their behaviors, actions and determine what modifications need to be made

1.1.2.1 Verbal feedback, including what the trainee is doing well and what the trainee should improve upon, should be provided on an ongoing basis

1.1.3 Formal Evaluations need to be completed on trainees at the completion of each rotation by faculty that they worked with

1.1.3.1 These Evaluations will be available for the trainee's review in Medhub

1.1.3.2 Faculty should be available for discussion of the trainee's performance and Evaluation

1.1.4 Trainees are expected to provide feedback to others such as peers, faculty, and the program

1.1.5 Feedback should be constructive in nature and help in further development of the person or program being evaluated

1.2 Evaluations in Medhub can be linked to both the Milestones and the six ACGME competency areas (Patient Care, Systems Based Practice, Interpersonal and Communication Skills, Practice-Based Learning, Medical Knowledge, and Professionalism)

1.3 Teaching faculty are strongly encouraged to include specific, narrative feedback on the evaluations

1.3.1 These comments can be used formally by the trainees and provide important data for the Clinical Competency Committee (CCC) semiannual review

1.4 The number of Evaluations that each faculty member is required to complete varies with their individual service assignment and/or number of trainees in a program

1.4.1 Medhub will assign performance Evaluations to faculty by matching their service dates to the program's rotation schedule, or as requested by the Program Coordinator

1.4.2 MedHub notifies faculty via e-mail that they have an Evaluation to complete

1.4.3 Upon logging into MedHub, faculty can view a list of their assigned Evaluations

1.4.3.1 MedHub will continue to send weekly reminders until assigned Evaluations have been completed

1.4.3.2 Faculty who have had limited or no teaching contact with the trainee may remove the evaluation from their listing by denoting insufficient contact to evaluate

1.4.3.3 Faculty are encouraged to provide feedback based on their observations of single encounters

- 1.5 Programs are encouraged to use peer-to-peer, 360-degree, and self-Evaluations which contain an individual learning plan designed by the trainee
 - 1.5.1 360-degree evaluations are helpful to the Clinical Competence Committee (CCC) due to the variety of stakeholders who have an opportunity to participate
 - 1.5.2 The forms for these Evaluations will be developed, deployed, and reviewed by individual programs
- 1.6 Summative Evaluation
 - 1.6.1 Summative Evaluations are used to evaluate trainees learning, skill acquisition, and milestone achievement at the conclusion of each six months of training
 - 1.6.2 All Evaluation data should be considered by the program for the overall Evaluation of a trainee's performance
 - 1.6.3 Documentation must be completed by the Program Director and shared with the trainee using the Summative Evaluation of Trainee Performance Evaluation
 - 1.6.4 This documentation should indicate if the trainee is achieving level appropriate specialty specific competency Milestones and thereby is ready to progress to the next level of training or graduate from the program
 - 1.6.5 Summative Evaluations are required for a trainee's permanent education file at least twice a year
 - 1.6.6 The Clinical Competency Committee is tasked with synthesizing Evaluations data to advise the Program Director on the trainee's competency-based Milestones
 - 1.6.7 Program Directors are required to review the CCC's recommendations, make appropriate determinations regarding the trainee's current level of competency and provide their objective Evaluations of program to the ACGME at 6-month intervals
- 1.7 Evaluation of Teaching Faculty
 - 1.7.1 Trainees are required to complete anonymous assessments of their supervising teaching faculty at the end of each rotation
 - 1.7.1.1 These assessments are administered via Medhub and will be assigned to trainees by matching their service dates to the programs faculty rotation schedule or as queued by the Program Coordinator
 - 1.7.2 At the end of each rotation, Medhub notifies trainees via email that they have assessments to complete
 - 1.7.3 Upon logging into Medhub, trainees can view a list of the assigned evaluations; MedHub will send weekly reminders until all assigned assessments have been completed
 - 1.7.4 Trainees are not able to view their assessments until the assessments of faculty are submitted
 - 1.7.5 Faculty will be unable to review individual assessments completed on them
 - 1.7.6 Access to the aggregate staff teaching assessments is intended to afford each staff physician the opportunity to make improvements to their methodology for teaching clinical trainees
- 1.8 Program Evaluations

- 1.8.1 Clinical trainees and faculty are required to complete an annual survey in Medhub that anonymously evaluates the strengths and targeted areas for improvement of the training program
- 1.8.2 The results from each program are summarized by evaluator group and only provided to the Program Director and the GMEC if 5 or more assessments were completed
- 1.8.3 Any program with five or less assessments submitted per year in each data set will not receive specific data for that academic year
- 1.8.4 The results are also used during the ACGME required Annual Program Evaluation (APE) process, which is monitored by the GMEC yearly

Fatigue Mitigation

Purpose Statement: Bayhealth provides systems of care and learning and working environments that facilitate fatigue mitigation for trainees, as well as an educational program for trainees and core faculty members in fatigue mitigation.

1. Procedure:

- 1.1 The Accreditation Council for Graduate Medical Education (ACGME) requires all training programs to educate faculty and trainees to recognize the signs of fatigue and sleep deprivation. As the sponsoring institution, Bayhealth must oversee and ensure the following:
 - 1.1.1 Trainee clinical and educational work hours, consistent with the common and specialty/subspecialty-specific program requirements across all programs, addressing areas of non-compliance in a timely manner
 - 1.1.2 Systems of care and learning and working environments that facilitate fatigue mitigation for trainees; and
 - 1.1.3 An educational program for trainees and core faculty members in fatigue mitigation
- 1.2 Each individual residency program, led by the Program Director, is responsible for the facilitating the following:
 - 1.2.1 Educate all faculty members and trainees to recognize the signs of fatigue and sleep deprivation
 - 1.2.2 Educate all faculty members and trainees in alertness management and fatigue mitigation processes
 - 1.2.3 Encourage trainees to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning; and
 - 1.2.4 Define and communicate a process to ensure continuity of patient care if a trainee is unable to perform their patient care duties. These policies must be written and implemented in such a way that negates fear of negative consequences for the trainee who is unable to provide the clinical work
- 1.3 Bayhealth, in partnership with its ACGME-accredited program(s), will provide adequate sleep facilities and safe transportation options for trainees who may be too fatigued to return home safely
 - 1.3.1 Bayhealth will ensure that trainee sleep facilities are safe, quiet, private, and available and accessible for trainees to support education and safe patient care
 - 1.3.2 Bayhealth will ensure safe transportation options exist for trainees who may be too fatigued to safely return home, including assistance in calling a taxi or other transportation method
 - 1.3.3 If a trainee is unable to return home due to fatigue but must return home, Bayhealth will provide reimbursement for the cost of a taxi or other transportation method
 - 1.3.3.1 Trainees are responsible for obtaining receipts for reimbursement submitting for reimbursement through Infor

Family and Medical Leave

Institutional Policy: B9065.27, last updated 3/16/2023

1. General Provisions

- 1.1. Bayhealth grants up to 12 weeks of family and medical leave during a rolling 12-month period to eligible employees, in accordance with the Family and Medical Leave Act of 1993 (FMLA) as well as up to 26 weeks of leave to care for an ill or injured service member or veteran or for another qualifying exigency. The leave may be paid, unpaid or a combination of paid and unpaid leave, depending on the circumstances of the leave and as specified in this policy.
- 1.2. A rolling 12-month period, measured backward from the date the leave will begin, will be used to calculate the amount of leave available to an employee.

2. Eligibility

- 2.1. To qualify for FMLA leave, the employee must meet all of the following conditions:
 - 2.1.1. Employed by Bayhealth for a total of 12 months.
 - 2.1.2. Worked at least 1,250 hours during the 12-month period immediately before the date when the leave is requested to commence. Only hours *worked* during the 12 months prior to the date leave is to begin are included; hours used for vacation, sick leave, bereavement leave, etc. are excluded. The determination of whether the employee has worked 1,250 hours in the past 12 months and has been employed for at least 12 months is made as of the date the FMLA leave is to start.

3. Qualified Events

- 3.1. To qualify as FMLA leave under this policy, the leave must be for one of the reasons listed below:
 - 3.1.1. The birth of an employee's child, and to care for the newborn child
 - 3.1.2. The placement of a child with the employee for adoption or foster care
 - 3.1.3. Care of a family member (spouse, dependent child, or parent, but not parent-in-law) with a serious health condition
 - 3.1.4. The serious health condition (described below) of the employee which renders the employee unable to perform the functions of his/her position
 - 3.1.5. Any qualifying exigency arising out of the fact that the employee's spouse, child, or parent is on active duty (or has been notified of an impending call to order to active duty) in support of a contingency operation; or to care for a covered service member with a serious injury or illness if the employee is the spouse, son, daughter, parent, or next of kin of the service member.

4. Definitions

- 4.1. A "*serious health condition*" is an illness, injury, impairment, or physical or mental condition that involves inpatient care or continuing treatment by a healthcare provider:
 - 4.1.1. *Inpatient care*: an overnight stay in a hospital, hospice, or residents/fellows medical care facility, including any period of incapacity which results in inability to work, attend school, or perform other regular daily activities due to the serious health condition, or treatment for or recovery from the serious health condition, or any subsequent treatment in connection with this inpatient care; or
 - 4.1.2. *Continuing treatment by a healthcare provider*: a serious health condition

involving continuing treatment by a healthcare provider includes any one or more of the following:

- 4.1.2.1 *Incapacity and treatment.* A period of incapacity of more than 3 consecutive full calendar days, and any later treatment or period of incapacity related to the same condition, that also involves: (i) two or more treatments within 30 days of the first day of incapacity, unless extenuating circumstances exist, by a healthcare provider, by a nurse under a healthcare provider's direct supervision, or by a provider of healthcare services under orders of or on referral by, a healthcare provider; or (ii) treatment by a healthcare provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the healthcare provider.
- 4.1.2.2 The requirements under (i) and (ii) above regarding treatment by a healthcare provider means an in-person visit to a healthcare provider. The first (or only) in- person treatment visit must take place within 7 days of the first day of incapacity.
- 4.1.2.3 A regimen of continuing treatment that includes taking of over-the-counter medications, or bed rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a healthcare provider, is not sufficient for purpose of FMLA leave.
- 4.2. *Pregnancy or prenatal care.* Any period of incapacity because of pregnancy, childbirth, or for prenatal care.
- 4.3. *Chronic conditions.* Any period of incapacity or treatment for an incapacity due to a chronic serious condition which: requires periodic visits (at least twice a year) for treatment by a healthcare provider
 - 4.3.1. continues over an extended time period, including recurring episodes of a single underlying condition; and
 - 4.3.2. may cause episodic periods rather than one continuing period of incapacity (examples include asthma, diabetes, epilepsy, migraine headaches, etc.).
- 4.4. *Permanent or long-term conditions.* A period of incapacity which is permanent or long-term because of a condition for which treatment may not be effective (examples include Alzheimer's, a severe stroke, or the terminal stages of cancer). The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a healthcare provider.
- 4.5. *Conditions requiring multiple treatments.* Any period of absence to receive multiple treatments (and any period of recovery from those treatments), by a healthcare provider or by a provider of healthcare services under orders of, or on referral by, a healthcare provider, either for restorative surgery after an accident or other injury, or for a condition that would likely cause a period of incapacity of more than 3 consecutive days if there were no medical intervention or treatment (examples include chemotherapy, radiation, etc. for cancer; physical therapy for severe arthritis; and dialysis for kidney disease).
- 4.6. Dental appointments, eye exams and similar routine procedures are not considered serious health conditions. Ordinarily, minor health problems such as the common cold, flu, earaches,

upset stomachs, headaches (other than migraine), and routine cosmetic surgery are not considered as “serious health conditions” for FMLA purposes unless complications arise. FMLA leave is available for treatment for substance abuse (provided the employee otherwise meets the conditions for a “serious health condition”), but not for absences due to drug/alcohol use or time off to recover from drug/alcohol use.

5. Types of Leave

- 5.1. An employee may be eligible to take FMLA on a continuous basis.
- 5.2. Intermittent FMLA is available to an employee if the need is certified by a healthcare provider as medically necessary. “Intermittent” means taking time off for a qualifying reason in shorter increments than a continuous leave of absence.
- 5.3. A reduced or modified work schedule is also available to an employee if the need is certified by a healthcare provider as medically necessary.
- 5.4. The employee will coordinate with their department leader regarding any request for a reduced work schedule and/or intermittent leave.
- 5.5. When scheduling appointments related to intermittent leave, employees are required to use their best efforts to schedule appointments at such times that will not unreasonably disrupt the department.

6. Employee Status and Benefits during Leave

- 6.1. While an employee is on leave, Bayhealth will continue the employee's health benefits at the same level and under the same conditions as if the employee had continued to work. However, any employee on FMLA leave must timely pay his/her portion of the premiums to retain group insurance coverage during the absence.
- 6.2. If an employee does not timely pay his/her portion of benefits premiums for more than 4 pay periods, all benefits coverage will cease.
- 6.3. When an employee fails to return to work (other than when it is due to the continuation of the serious health condition or other circumstances beyond the employee’s control), unpaid premiums paid by Bayhealth are considered a debt owed by the non-returning employee. Bayhealth may recover the costs through deduction from any sums due to the employee (e.g., unpaid wages, paid time off, bonuses, etc.), in accordance with applicable federal and state laws. Alternatively, Bayhealth may initiate legal action against the employee to recover such costs.
- 6.4. Employees will not accrue Paid Time Off (PTO) or Extended Sick (EXS) hours during unpaid FMLA leaves. Accruals will begin upon return to active employment.

7. Coordination with Other Leaves

- 7.1. FMLA leave shall be coordinated with leaves granted under other Bayhealth policies and run concurrently. For example, if an employee has 2 weeks of PTO/EXS available, the employee must use the paid PTO/EXS which will run concurrently with the FMLA leave, i.e., if the employee takes 12 weeks of FMLA leave, the first 2 weeks will be paid by way of the available PTO/EXS and the remaining 10 weeks will be unpaid. For the duration of the paid leave, the usual authorized deductions from the employee's pay will be made.
- 7.2. If an employee is eligible for disability leave or workers’ compensation, the employee must take the disability leave or workers’ compensation and such leave will also count as part or all of the 12 weeks of FMLA leave. If the employee is receiving pay through Bayhealth’s short term disability plan (STD), the employee is not permitted to use PTO or EXS while

receiving these payments; employees are required to use PTO/EXS during the elimination period.

8. Employment During FMLA Leave

8.1. Generally, an employee may not work for any other employer during FMLA leave. Violation of this policy will be deemed a falsification of the reason for leave, and subject to disciplinary action up to and including termination.

9. Duration of Leave

9.1. FMLA leave is limited to a total of 12 weeks within each rolling 12-month period even if an employee experiences more than one qualifying event per rolling 12-month period. Eligible employees are entitled to 26 weeks of leave to care for a military member with a qualifying serious health condition. *See* Section 10 below.

10. Military FMLA Leave

10.1. *Qualifying Exigency Leave*. Eligible employees may take FMLA leave while the employee's spouse, child, or parent (the "military member") is on covered active duty or call to order to active-duty status a qualifying exigency.

10.1.1. A "qualifying exigency" arising out of the fact that the spouse, child or parent of the employee is on active duty (or has been notified of an impending call to order to active duty) in the Armed Forces in support of a contingency operation means: short notice deployment, military events and related activities, childcare and school activities related to the deployment or active duty, financial and legal arrangements, counseling, rest and recuperation for up to fifteen (15) calendar days for each instance of the covered Service member's leave, post-deployment activities, care or arranging for care for the Service member's parent who is incapable of self-care, and additional activities which arise out of the military member's covered active duty or call to covered active duty status provided that Bayhealth and the employee agree that such leave shall qualify as an exigency, and agree to both the timing and duration of such leave.

10.1.2. A "military member" means the employee's spouse, son, daughter, or parent on active duty or call to active-duty status.

10.1.3. "Covered active duty" means: (1) for members of the regular Armed Forces, duty during deployment to a foreign country; or
(2) for members of the National Guard and reserves, duty during deployment to a foreign country under a call to order to active duty in support of a contingency operation."

10.2. Leave to Care for Covered Service Member with Serious Injury or Illness

10.2.1. Eligible employees may take up to a total of 26 weeks of leave during a single 12-month period to care for a spouse, child, parent or next of kin who is a covered service member or a covered veteran.

10.2.2. A covered service member means: a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status or is otherwise on temporary disability retired list for a serious injury or illness.
Covered veteran means an individual who was a member of the Armed Forces (including a member of the National Guard or Reserves) and was discharged or

released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran.

- 10.2.3. A “*serious injury or illness*” means: In the case of a current member of the Armed Forces, an injury or illness that was incurred by the covered service member in the line of duty on active duty in the Armed Forces or that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces, and that may render the member medically unfit to perform the duties of the member's office, grade, rank or rating. In the case of a covered veteran, an injury or illness that was incurred by the member in the line of duty on active duty in the Armed Forces (or existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces).
- 10.2.4. “*Next of kin of a covered service member*” means the nearest blood relative other than the covered service member’s spouse, parent, son, or daughter, in the following order of priority: Blood relatives who have been granted legal custody of the covered service member, brothers and sisters, grandparents, aunts and uncles, and first cousins, unless the covered service member has specifically designated in writing another blood relative as his/her nearest blood relative for purposes of military caregiver leave under the FMLA.
- 10.2.5. The 12-month period begins on the first day the eligible employee takes FMLA leave to care for a covered service member and ends 12 months after that date. If an eligible employee does not take all of his/her 26 work weeks of leave entitled, it is forfeited. If an employee takes FMLA leave for reasons other than care for a covered service member during the 12-month period, that leave cannot exceed 12 weeks and the total of the leaves combined cannot exceed 26 weeks.
- 10.2.6. When leave is taken to care for a covered service member with a serious injury or illness, an employer may require an employee to obtain a certification completed by an authorized healthcare provider of the covered service member.
- 10.2.7. Bayhealth may seek authentication and/or clarification of the certification as well as obtain second and third opinions under certain circumstances as permitted by the regulations. Bayhealth will require an employee to provide confirmation of covered family relationship to the seriously injured or ill service member.
- 10.2.8. When Bayhealth requests medical certification, an employee will not be held liable for administrative delays in the issuance of military documents, despite the employee's diligent, good-faith efforts to obtain such documents. However, in all instances in which certification is requested, it is the employee's responsibility to provide Bayhealth with complete and sufficient certification, and failure to do so may result in the denial of FMLA leave.

11. Request for Leave/Certification of the Serious Health Condition

- 11.1. An employee requesting leave under this policy shall submit a claim through Bayhealth’s Third Party Administrator accompanied by a completed Certification of Healthcare Provider form. These forms must be completed and returned to the Third-Party Administrator at least 30 calendar days before taking leave, or within 15 calendar days following an emergency.

- 11.2. Employees may be required to undergo an examination by a second medical provider designated by Bayhealth. If the first and second opinions differ, Bayhealth may require the binding opinion of a third healthcare provider, approved jointly by Bayhealth and the employee.
- 11.3. Bayhealth reserves the right to require periodic medical updates. Furthermore, Bayhealth also reserves the right to require recertification no more than once every 30 days or as provided for by law. The employee must provide the recertification within 15 calendar days after Bayhealth requests it.
- 11.4. If the employee's healthcare provider fails to cooperate by completing the Certification of Healthcare Provider form or fails to complete the form on a timely basis, the employee is expected to find a healthcare provider who will meet the deadline. If the employee does not provide the Certification of Healthcare Provider form, Bayhealth may refuse to designate or may remove its conditional designation of the leave as FMLA leave.
12. Procedure for Requesting Leave
 - 12.1. When an employee plans to take leave under this policy, the employee must give Bayhealth 30 days' notice. If it is not possible to give 30 days' notice, the employee must give as much notice as is practicable.
 - 12.2. If an employee fails to provide 30 days' notice for foreseeable leave with no reasonable excuse for the delay, failure to provide timely certification could result in Bayhealth delaying the leave until the certification is provided.
 - 12.3. An employee giving notice of the need for FMLA leave must explain the reasons for the needed leave so as to allow Bayhealth to determine whether the leave qualifies. If the employee fails to explain the reasons, leave may be denied. In giving appropriate notice, the employee must explain whether:
 - 12.3.1.1 a condition renders the employee unable to perform the functions of the job
 - 12.3.1.2 the employee is pregnant or has been hospitalized overnight
 - 12.3.1.3 the employee or the employee's family member is under the continuing care of a healthcare provider
 - 12.3.1.4 the leave is due to a qualifying exigency, that a military member is on active duty or call to active-duty status, and that the requested leave is for one of the reasons listed above; or
 - 12.3.1.5 the leave is for a family member, that the condition renders the family member unable to perform daily activities, or the family member is a covered service member with a serious injury or illness.
 - 12.3.2. The employee is also required to state the anticipated duration of the leave, if known.
 - 12.3.3. Employees are required to abide by Bayhealth's call off procedures contained in Bayhealth's policies and procedures. If an employee fails to call off of work under Bayhealth's procedures, and no unusual circumstances justify the failure to comply, FMLA-protected leave may be delayed or denied.
 - 12.3.4. If an employee is to undergo planned medical treatment, the employee must make a reasonable effort to schedule the treatment in order to minimize disruptions to Bayhealth's operations.

- 12.3.5. When an employee seeks leave due to a FMLA-qualifying reason, the employee must specifically reference the qualifying reason or need for the FMLA leave. Employees have an obligation to respond to Bayhealth's and the Third-Party Administrator's questions about whether an absence is potentially FMLA-qualifying.
 - 12.3.6. Calling in "sick" without providing more information will not be considered sufficient notice to trigger Bayhealth's obligations under the FMLA. Failure to respond to reasonable inquiries regarding the leave request may result in denial of FMLA protection if Bayhealth is unable to determine whether the leave is FMLA-qualifying.
- 13. Return to Work After Leave
 - 13.1. When an employee returns to active employment, he/she shall return to the same or an equivalent position with equivalent employee benefits and compensation and other conditions of employment. "*Equivalent*" means substantially the same but not exactly equal.
 - 13.2. If the employee was ill, injured or incapacitated for 5 or more calendar days (includes working and non-working days), the employee must present written certification from the healthcare provider indicating that the employee is able to return to work (excludes uncomplicated pregnancies). Employees are also required to be evaluated by Bayhealth's Occupational Health facility to determine whether the employee is cleared to return to work. Employees cannot return to work unless cleared by Occupational Health.
 - 13.3. If restrictions are indicated by Occupational Health, the employee will be referred to Human Resources for further accommodation consideration.
 - 13.4. "Key Employee" Exception: If the employee on leave is a salaried employee and is among the highest paid 10% of all Bayhealth employees within 75 miles of the employee's worksite and keeping the job open for the employee would result in substantial economic injury to Bayhealth, leave is provided, but reinstatement can be denied; or restoration may be delayed if the employee fails to provide a Fit for Duty certification to return to work. If restoration of the "key employee" to employment will cause substantial and grievous economic injury to Bayhealth, the employee will be given a reasonable time in which to return to work.
- 14. Administration:
 - 14.1. Bayhealth reserves the right to modify, revoke, suspend, terminate, or change this policy in whole or in part, at any time, with or without notice to employees except as required by applicable statutory law.

Influenza Vaccination

Institutional Policy: B9806-9807.16, last updated 9/29/23

Purpose Statement: The purpose of this policy is to protect the patients of Bayhealth Medical Center from healthcare associated influenza and to protect the Bayhealth Medical Center employees and non-Bayhealth employees.

1. Procedure:

- 1.1 The vaccination program is coordinated through Occupational Health Services and officially begins in late September/early October of each year.
 - 1.1.1 The official onset of the influenza season will be determined by the Infection Prevention Team, in consultation with the Delaware Division of Public Health, based on local influenza incidence. Likewise, the conclusion of influenza season, after which vaccine is no longer offered and masks are no longer needed to be worn, is determined by the Infection Prevention Team, based on local epidemiology.
 - 1.1.2 Vaccinations are available through March 31 or later depending on the influenza season for new personnel.
 - 1.1.3 The Influenza vaccine is available free of charge to HCP's, excluding students and vendors.
 - 1.1.3.1 Students are required to obtain the influenza vaccine prior to clinical rotations within the hospital or off-site centers, per contract.
 - 1.1.3.2 Vendors are required to obtain the influenza vaccine according to their contract with Bayhealth.
 - 1.1.3.3 The vaccine is available at the Occupational Health offices for a fee.
- 1.2 Any HCP who are vaccinated through services other than Bayhealth Occupational Health (private physician office, public clinic, and drugstore) will provide proof of vaccination to Occupational Health Services along with the Bayhealth Consent form indicating that "I have already been vaccinated against flu."
 - 1.2.1 Proof of vaccination may include a physician's note, a receipt listing influenza vaccination, or a copy of a signed consent form showing the vaccine was administered.
- 1.3 Any HCP who is returning from a leave of absence will be vaccinated or show proof of vaccination, prior to returning to work. Human Resources and Occupational Health Services are to be contacted by the HCP to arrange for the vaccination to be administered.
- 1.4 HCP have until November 1 at 11:59 PM to receive an influenza vaccination or decline the vaccination. There is a limited supply of egg free influenza vaccine that does not use the influenza virus in chicken eggs in its manufacturing process. Anyone with an egg allergy needs to communicate with Occupational Health prior to the time of the scheduled flu clinic, so that staff may bring the vaccine to the hospital/site. If this is not possible, the HCP needs to come to one of the Occupational Health offices for immunization.
- 1.5 There will be a supply of latex free influenza vaccine that will be available to HCP. Anyone requiring this vaccine needs to communicate with Occupational Health prior to the time of the scheduled flu clinic, so that staff may bring the vaccine to the hospital/site. If this is not possible, the HCP needs to come to one of the Occupational Health offices for immunization.
- 1.6 To decline the influenza vaccination the HCP needs to sign a declination form, send form to

- Occupational Health, and wear a mask throughout the flu season. Reasons to decline the flu shot may include the following:
- 1.6.1 Guillain-Barre syndrome within six weeks of a prior influenza vaccine.
 - 1.6.2 Severe allergy to the vaccine or components as defined by the most current recommendations of the CDC's Advisory Committee on Immunization Practices (ACIP).
 - 1.7 Any Non-vaccinated HCP will protect their patients from Influenza by wearing surgical masks while in any patient care area within any Bayhealth inpatient or outpatient facility. For the purpose of this policy, Bayhealth will also include Bayhealth Childcare Center personnel in this requirement.
 - 1.7.1 Masks are required to be worn for the duration of the influenza season.
 - 1.8 "Specialized stickers" denoting that immunization has occurred are placed on the immunized HCP's badge by an Occupational Health employee or Manager/supervisor.
 - 1.9 Any HCP and Childcare personnel without the "specialized sticker" are expected to wear masks throughout the defined influenza season, while in those designated patient care areas.
 - 1.10 Non-compliance
 - 1.10.1 Employees
 - 1.10.1.1 Employees who fail to get vaccinated or complete a declination form are subject to corrective action per Bayhealth's Corrective Action policy. This means that violation of this Bayhealth Policy results in progressive discipline up/to and including termination. Example – If John Doe is at a suspension level, failure to comply with this policy results to termination. Employees who are required to wear a mask but are non-compliant are subject to corrective action, in accordance with the Bayhealth Corrective Action policy. This means that violation of this Bayhealth Policy results in progressive discipline up/to and including termination. Example – If John Doe is at a suspension level, failure to comply with this policy results to termination.
 - 1.10.2 Non-Employees
 - 1.10.2.1 A Safety-First Report is written and submitted on any credentialed medical staff member who fails to get vaccinated or complete an exemption or declination form.
 - 1.10.2.1.1 The department chairs get a weekly list of credentialed Medical Staff who have not been vaccinated or completed an exemption or declination form.
 - 1.10.2.1.2 The department chair is responsible to follow-up with non-compliant Medical Staff.
 - 1.10.2.2 A Safety-First Report is written and submitted on any credentialed Medical Staff who are required to wear a mask but are non-compliant.
 - 1.10.2.2.1 The department chair is responsible to follow-up with non-compliant Medical Staff.
 - 1.10.2.3 Other non-employees are referred to their department Director for further recommendations.
 - 1.11 The Managers/Supervisors are actively engaged in supporting the influenza policy and monitoring the vaccination status of their employees.
 - 1.11.1 A list of non-compliant HCPs is provided to the managers/supervisors from Occupational

Health at the following program intervals: beginning of week 4, beginning of week 5 and beginning of week 6 (week including Nov 1).

- 1.12 In the event of an influenza vaccination shortage, the situation is evaluated by Bayhealth for the entire organization. Occupational Health, Infection Prevention, Human Resources, Pharmacy and Administration conducts the evaluation with other departments as needed when vaccine shortages occur. Influenza vaccine is offered to healthcare providers based on job function and risk of exposure to influenza. Priority is given to those who provide direct hands-on patient care with prolonged face-to-face contact with patient and/or have the highest risk of exposure to patients with influenza.

9/28/2022

Graduate Medical Education Committee Responsibilities

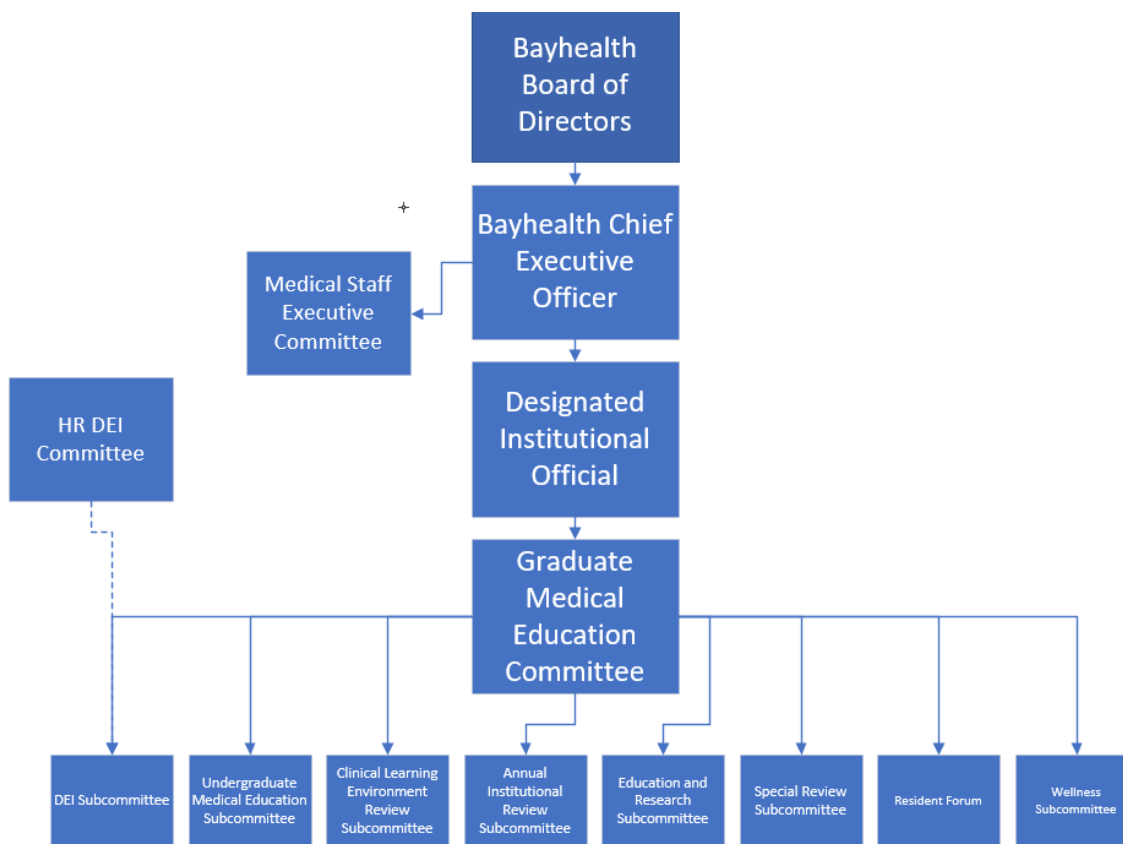
Purpose Statement: The purpose of this policy is to outline the Graduate Medical Education Committee Members (GMEC) responsibilities in compliance with ACGME.

1. Procedure:
 - 1.1 GMEC provides oversight of the following:
 - 1.1.1 ACGME accreditation and recognition statuses of the Sponsoring Institution and each of its ACGME-accredited programs
 - 1.1.2 The quality of the GME learning and working environment within the Sponsoring Institution, each of its ACGME-accredited programs, and its participating sites
 - 1.1.3 The quality of educational experiences in each ACGME-accredited program that led to measurable achievement of education outcomes as identified in the ACGME Common and specialty-/subspecialty-specific Program Requirements
 - 1.1.4 The ACGME-accredited program(s) annual program evaluations and self-studies
 - 1.1.5 ACGME accredited programs implementation of institutional policies for vacation and leaves of absence, including medical, parental, and caregiver leaves of absence at least annually
 - 1.1.6 All processes related to reductions and closures of individual ACGME-accredited programs, major participating sites, and the sponsoring institution
 - 1.1.7 The provision of summary information of patient safety reports to residents, faculty members, and other clinical staff members. At a minimum, this oversight must include verification that such summary information is being provided
 - 1.2 GMEC reviews and approves of the following:
 - 1.2.1 Institutional GME policies and procedures
 - 1.2.2 Annual recommendations to the Sponsoring Institutions administration regarding resident stipends and benefits
 - 1.2.3 Applications for ACGME accreditation of new programs
 - 1.2.4 Requests for permanent changes in resident complement
 - 1.2.5 Major changes in each of its ACGME-accredited programs structure or duration of education, including any change in the designation of a program's primary clinical site
 - 1.2.6 Additions and deletions of each of its ACGME-accredited programs participating sites
 - 1.2.7 Appointment of new program directors
 - 1.2.8 Progress reports requested by the Review committee
 - 1.2.9 Responses to Clinical Learning Environment Review (CLER) reports
 - 1.2.10 Requests for exceptions to clinical and educational work hour requirements
 - 1.2.11 Voluntary withdrawal of ACGME program accreditation
 - 1.2.12 Requests for appeal of an adverse action by a Review Committee
 - 1.2.13 Appeal presentations to an ACGME Appeals Panel

- 1.2.14 Exceptionally qualified candidates for resident appointments who do not satisfy the Sponsoring Institution's resident eligibility policy and/or resident eligibility requirements in the Common Program Requirements
- 1.3 The GMEC must demonstrate effective oversight of the Sponsoring Institution's accreditation through an Annual Institutional Review (AIR) as outlined in the Annual Institutional Review Policy
- 1.4 The GMEC must demonstrate effective oversight of underperforming programs through a Special Review process as outlined in the Special Review Policy
- 1.5 Membership of GMEC must include:
 - 1.5.1 The DIO
 - 1.5.2 A representative sample of program directors (minimum of two) from its ACGME-accredited programs
 - 1.5.3 A minimum of two peer-selected residents from among its ACGME-accredited programs
 - 1.5.4 A quality improvement or patient safety officer or designee

Graduate Medical Education Committee Organizational Chart

Purpose Statement: To establish the organizational structure and the reporting relationships of the Graduate Medical Education Committee (GMEC).



Grievance and Conflict Resolution

Purpose Statement: This policy establishes a uniform mechanism for grievance procedures for all trainees in the Graduate Medical Education (GME) program. It is the belief and philosophy of Bayhealth Medical Center that good work relationships can exist only if trainees believe they have been treated equitably and fairly. It is also recognized that there are occasions when honest differences of opinion may occur regarding the interpretation and application of policies and/or procedures and counseling for Disciplinary Action. The following process is established to provide an effective method for trainees to bring problems to the attention of program leadership for resolution without fear of recrimination or retaliation. Trainees may also use this grievance procedure to address any concerns with the application of the trainee's contract, policies, rules, and regulations of the program. However, if the grievance pertains to any dispute or controversy between the trainee and the policies, rules, and regulations of the program, the Program Director will notify the Designated Institutional Official (DIO) and Bayhealth's legal counsel.

1. Procedure:

1.1 Step 1 of the Grievance Process

1.1.1 Program Director

- 1.1.1.1 All grievances must be submitted in writing to the Program Director. It is anticipated that every effort will be made to resolve the matter in a fair and amicable manner at this level
- 1.1.1.2 In situations where the grievance is not resolved within fifteen (15) business days of submission, or if the grievance involves the Program Director, the resident/fellow should proceed to Step 2

1.2 Step 2 of the Grievance Process

1.2.1 Designated Institutional Official (DIO)

- 1.2.1.1 If the trainee is not satisfied with the result Step 1 in the grievance process, the trainee should schedule an appointment with the DIO and submit in writing to the DIO a description of the issue and the date(s) that it occurred. The trainee's description of the matter should identify all pertinent facts of which the trainee has firsthand knowledge
- 1.2.1.2 The trainee may directly report to the DIO should the grievance involve the Program Director.
- 1.2.1.3 A copy of the written document should be sent to the VP of Human Resources
- 1.2.1.4 The DIO will hear and consider the trainee's concern and take appropriate action. The action of the DIO will be communicated in a letter sent to the trainee and to the Program Director within ten (10) days

1.3 Step 3 of the Grievance Process

- 1.3.1 Time Limits: Time limits set forth in this procedure must be followed unless extended for good cause at the discretion of the GME office. A trainee who fails to meet the time limits for appealing the Program's decision may be deemed to have withdrawn the appeal
- 1.3.2 Burden of Proof: The appealing trainee has the burden to demonstrate, by clear and convincing evidence, that the decision issued by the program was arbitrary and capricious. "Clear and convincing evidence" means the evidence presented by the

trainee is highly and substantially more probable to be true than not. “Arbitrary and capricious” means there was no reasonable basis for the Program’s decision

1.3.3 Appeal of DIO Decision: A trainee may appeal a DIO’s corrective action as follows:

- 1.3.3.1 To initiate the appeal process, the trainee must submit a written appeal to the GME office within five (5) business days of receipt of the DIO’s decision being appealed. The trainee’s appeal should state the facts on which the appeal is based, the reason(s) the trainee believes the DIO’s decision was in error, and the remedy requested
- 1.3.3.2 The GME office will appoint an ad hoc Review Panel to hear the trainee’s appeal. The Review Panel will consist of one program director from a program not being reviewed acting as chairperson and two additional faculty members
- 1.3.3.3 The Review Panel will schedule the appeal hearing and notify the GME office of the hearing date. Schedules permitting, the appeal hearing should occur within thirty (30) business days of the Review Panel’s receipt of the trainee’s appeal
- 1.3.3.4 The GME office will send a Hearing Notice to the trainee. The Hearing Notice will contain the names of the Review Panel members, the date, time and location of the appeal hearing, and the deadline to submit evidence. The trainee should receive at least ten (10) business days’ notice of the hearing date
 - 1.3.3.4.1 Any evidence the trainee wants the Review Panel to consider must be submitted to the Review Panel at least five (5) business days prior to the appeal hearing
 - 1.3.3.4.2 Submissions should contain any evidence (including witness statements and written, recorded, or electronic material) believed to be relevant to the appeal. Failure to submit evidence in that time and manner may result in the material not being considered by the Review Panel
 - 1.3.3.4.3 The GME office will facilitate the exchange of evidence between the trainee and the Program Director and will provide copies of all evidence to the Review Panel

1.4 Appeal Hearing

- 1.4.1 The Review Panel chairperson has wide discretion with respect to conducting the appeal hearing. In general, appeal hearings will proceed according to the following format:
 - 1.4.1.1 The Program Director may make a presentation to the Review Panel of up to twenty (20) minutes
 - 1.4.1.2 The trainee may make a presentation to the Review Panel of up to twenty (20) minutes
 - 1.4.1.3 The Program Director will have up to ten (10) minutes to respond to the statements made by the trainee
 - 1.4.1.4 The trainee will have up to ten (10) minutes to respond to the statements made by the program director

- 1.4.1.5 Review Panel members may ask questions of the trainee and/or the program director
- 1.4.2 Witnesses other than the Program Director and the trainee will not be permitted to participate in the appeal hearing unless called by the Review Panel. In the event the Review Panel elects to hear from additional witnesses, the Program Director and the trainee may question those witnesses
- 1.4.3 The Review Panel and the Program Director will be assisted during the appeal process and accompanied at the appeal hearing by Bayhealth's attorneys
- 1.4.4 The trainee may be assisted during the appeal process and accompanied at the appeal hearing by an advisor of the trainee's choosing, who may be an attorney at the trainee's own expense
- 1.4.5 Advisors and attorneys may consult with the parties but will not actively participate in the appeal hearing
- 1.4.6 Appeal hearings are confidential. Only participants, advisors or attorneys, and Review Panel members may attend
- 1.5 Panel Deliberation and Decision
 - 1.5.1 Following the appeal hearing, the Review Panel will deliberate privately
 - 1.5.2 The final decision will be made by a majority vote of the Review Panel members
 - 1.5.3 The Review Panel will prepare a written decision setting forth its conclusions and its reasoning in support of those calculations
 - 1.5.4 The Review Panel's discussion will be sent to the trainee, the Program Director, and the DIO within 10 business days after the hearing
- 1.6 Trainee or faculty supervisors, during any step in the process, may avail themselves to the VP of Human Resources or designee for advice and counsel, but it is encouraged that the general process be followed, whenever possible
- 1.7 It is expected that trainee and/or former trainee will initiate and follow through with the process in a reasonable amount of time following the incident or onset of concerns and that management responses and determinations will be made in a timely manner that is appropriate to the issue under investigation
- 1.8 It is understood that trainee electing to utilize this process will be treated courteously and that the case will be handled confidentially and discreetly, to the greatest extent possible, at all times. No trainee will be subjected to discourteous treatment, recrimination or retaliation resulting from recourse to the grievance procedure

Hand Hygiene

Institutional Policy: B6030.03, last updated 12/6/23

Purpose Statement: Hand hygiene assists in elimination of transient microbial contamination that can be acquired by recent contact with infected or colonized patients and environmental surfaces. Hand hygiene is the single most important procedure for prevention of healthcare-associated infections.

1. Procedure:

1.1 Hand hygiene is completed in the following situations:

- 1.1.1 Upon arrival at the clinical department and before leaving the healthcare setting
- 1.1.2 Before, between (if necessary) and after contact with patients and patient surroundings
- 1.1.3 Before preparing medication and accessing medication automatic dispensing cabinet (ADC)
- 1.1.4 Before and after performing invasive or clean/aseptic procedures
- 1.1.5 Before and after glove use
- 1.1.6 After touching sources that are likely to be contaminated with pathogens, such as bedrails, blood pressure cuffs, telephones, computer keyboard, common workspaces
- 1.1.7 After touching excretions such as urine, feces, emesis, or secretions such as blood, wound drainage or respiratory secretions or material or surface contaminated by pathogens even when gloves were worn
- 1.1.8 After performing laboratory procedures where contact with specimen is required
- 1.1.9 After performing personal hygiene, before eating and after using a restroom

- 1.2 Handwashing with soap and water and/or alcohol-based handrubs are used to perform hand hygiene
- 1.3 Handwashing with soap and water is used if hands are contaminated with bioburden, debris is on hands, visibly soiled or the patient has been placed on Enhanced Contact Precautions
- 1.4 Hand hygiene requirement for the Special Care Nursery is identified in the Infection Prevention Guidelines for Women's and Children's Services policy

1.5 Procedure for Handwashing:

- 1.5.1 Wet hands thoroughly with running water
- 1.5.2 Apply one pump of soap or antimicrobial skin cleaner and rub vigorously to obtain lather
- 1.5.3 Use friction to clean fingers, palms, back of hands, wrists, and areas around fingernails
- 1.5.4 Maintain vigorous washing for at least 15 seconds for routine hand washing
- 1.5.5 Rinse hands thoroughly under running water, allowing the water to flow from the fingertips
- 1.5.6 Use paper towels to dry hands thoroughly
- 1.5.7 Turn off faucet with paper towel as faucets are considered contaminated

1.5.8 Discard paper towel in appropriate trash

1.6 Procedure for Use of Alcohol-Based Hand Rubs:

- 1.6.1 Dispense one pump of product into hands (dime to quarter size amount of product to palm of hand).
- 1.6.2 Rub hands together to cover surfaces, including backs of hands and between fingers. Wait for surface to dry to assure effectiveness.
- 1.6.3 Rub until dry, do not rinse off
- 1.6.4 Healthcare providers may repeat the use of the product many times (approximately 8-20) before finding it necessary to wash hands with soap and water or when gritty, tacky feeling results
- 1.6.5 For patients with *Clostridium difficile* and gastrointestinal associated disease, use only soap and water for hand hygiene, in addition to Enhanced Contact Precautions

1.7 Other Aspects of Hand Hygiene

- 1.7.1 Employees who work in departments that have patients, have contact with patients, or will handle items that will come in contact with patients are not to wear artificial fingernails or extenders
 - 1.7.1.1 Artificial nails are also known as nail enhancements, acrylic nails, Color Street, Jamberry's, nail stickers, press on nails, bonding, tips, sculpting products, dips, nail wraps, extensions, fake nails, gels, crackles, vinyl's, stencils, decals, stickers, stamps, plates, silks, jewels, and overlays to name a few.
- 1.7.2 Keep natural nail tips less than ¼-inch long. No chipped nail polish
- 1.7.3 Use of gloves during procedures does not eliminate the need for hand hygiene before glove application and following glove removal
 - 1.7.3.1 Wear gloves when contact with blood or other potentially infectious materials, mucous membranes, and non-intact skin could occur
 - 1.7.3.2 Remove gloves after caring for a patient. Do not wear the same pair of gloves for the care of more than one patient, and do not wash gloves between uses with different patients
 - 1.7.3.3 Change gloves during patient care if moving from a contaminated body site to a clean body site, such as between performing trach care and ostomy care
- 1.7.4 Bayhealth approved hand lotion is available that minimizes the occurrence of dryness and maintains skin moisture. Frequent use of the lotion helps prevent dryness and irritation
- 1.7.5 Providers/employees are not to utilize products brought in from home as they may contain ingredients that can cause skin problems

- 1.7.6 Providers/employees that experience irritant contact dermatitis notify their supervisors and are referred to Occupational Health for an evaluation
 - 1.7.6.1 When medically necessary, employees are referred to Human Resources to assist with accommodation of alternative hand hygiene product(s). Alternative products are purchased for the employee by their home department
 - 1.7.6.2 If a trial of an alternative product fails, the employee provides documentation from a treating provider indicating specific allergens to determine how Bayhealth can further accommodate

1.8 Hand Hygiene Compliance Monitoring

- 1.8.1 Electronic hand hygiene compliance monitoring allows for accurately recording hand hygiene events which helps to promote better patient outcomes
- 1.8.2 Follow hand hygiene recommendations as outlined in this policy
- 1.8.3 Providers/employees who care for patients on the inpatient units and qualify, receive a hand hygiene monitoring badge
- 1.8.4 Badges are worn above the waist and during scheduled shift
- 1.8.5 Providers/employees receive individual compliance reports weekly and monthly. These reports are reviewed for improvement opportunities
- 1.8.6 Direct observation is done in areas that do not have electronic hand hygiene, monitoring such as outpatient service areas

Hand Hygiene Agreement for Graduate Medical Education

Purpose Statement: To provide instruction on the Ecolab Hand Hygiene system in place at Bayhealth Hospitals.

1. Procedure

- 1.1 The Infection Prevention department supplies residents/fellows with an Ecolab Hand Hygiene badge. Hand hygiene is monitored at both Kent and Sussex Campuses. See Bayhealth policy B6030.03 'Hand Hygiene' for specific hygiene guidelines.
- 1.2 To activate the badge, pull the plastic tab. The badge should display green and yellow blinking lights for a moment and then go to "sleep."
- 1.3 Badges must be worn above waist level to properly interact with handwashing stations and patient zones within the hospitals.
- 1.4 The light system operates as follows:
 - Green: hand hygiene has been completed, you may enter a patient zone
 - Green/Yellow: you have left the patient zone
 - Yellow: sanitize or wash before entering another patient zone
 - Red: missed opportunity for hand hygiene
 - Blinking Red: the battery is dying or dead
- 1.5 If the battery dies or you suspect the badge is not working properly, contact the GME office as soon as possible for a replacement.
- 1.6 Additional information is available on BayNet → Infection Prevention → Electronic Hand Hygiene
- 1.7 The GME office will provide monthly hand hygiene reports to all residents/fellows, individually. Hand hygiene scores are expected to be at least 80%. Consistently low scores will be reported to the residents/fellows' Program Director.
- 1.8 The GME office will provide quarterly hand hygiene reports to Program Directors.

Signature below indicates the trainee agrees to abide by the above.

Print Name:

Employee ID:

Program:

Date:

Signature:

Harassment

Institutional Policy, last updated 9/7/2021

Purpose Statement: This policy addresses Bayhealth's commitment to providing work environments free from sexual harassment for all Bayhealth employees and affiliate members. Bayhealth also adheres to all relevant federal and state laws and regulations regarding sexual harassment. Bayhealth strictly prohibits any and all forms of sexual harassment, including harassment based on sexual orientation. Bayhealth is committed to maintaining a positive working environment, and in so doing, will not tolerate any sexually harassing behavior on the part of employees and/or affiliate staff members.

Employees who engage in sexually harassing behavior shall be subject to disciplinary action up to and including termination from employment. Bayhealth affiliate members who include, but are not limited to, physicians with hospital privileges, Board members, volunteers, interns, and/or students, who engage in sexually harassing behavior, shall be subject to appropriate sanctions as set forth by Bayhealth policies and procedures. The principles of this policy apply to independent contractors, temporary staffing personnel, and any other persons or organizations doing business for or with Bayhealth. Retaliatory action of any kind against an employee making a report of sexual harassment is strictly prohibited. Employees and/or Bayhealth affiliate members who engage in retaliatory conduct shall be subject to sanctions set forth by Bayhealth policies and procedures. Any supervisor who becomes aware of possible sexual harassment must immediately advise the Employee Relations Manager in Human Resources so an investigation may be initiated. New employees will be provided with a Delaware Sexual Harassment Notice at the time of hire. Annual Sexual Harassment Training will be mandatory for all Bayhealth employees, included as part of employees' annual mandatory education.

1. Definitions:

- **Sexual Harassment:** Conduct between individuals of the same or opposite sex which is characterized by unwelcome and unwanted sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when:
 - Submission to the conduct is made either explicitly or implicitly a term or condition of an individual's employment, i.e., a supervisor tells a subordinate that he will agree to transfer the subordinate if she engages in a sexual relationship with him
 - Submission to or rejection of the conduct by an individual is used as a basis for employment decisions affecting such individual, i.e., a supervisor makes an overture to engage in sexual relationship with a subordinate, the subordinate refuses, and is discharged the following day; or
 - The conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive work environment, i.e., co-workers discussing sexual activities, telling off-color jokes, engaging in unwanted/unwelcome physical contact, using crude and/or offensive language, and/or indecent gestures when all of the above are based upon the affected employee's gender.
- **Quid Pro Quo Sexual Harassment:** Harassment which results in a tangible employment action as defined in 1.1.1 and 1.1.2 above. Such harassment may be committed only by someone who can make or effectively influence employment actions, e.g., discharge, promotion, demotion, and transfer.
- **Hostile Work Environment Harassment:** Unwelcome conduct based upon a protected status that is severe and pervasive enough to create a work environment that a reasonable person would find hostile

or abusive. Such harassment includes, but is not limited to, the examples in 1.1.3 above.

- Inappropriate and Unprofessional Conduct: A phrase used for conduct which does not reach the threshold of the legal definition of sexual harassment but violates established Bayhealth policies for appropriate conduct in the workplace.

2. Areas Involved:

- Bayhealth Departments & Facilities
- Bayhealth Emergency Physicians
- Graduate Medical Education (GME) Department, Graduate Medical Education Residency and Fellowship Programs

3. Forms:

- Discrimination Complaint Form

4. Procedure:

- FILING A COMPLAINT
- Any employee who reasonably believes that a supervisor, non-supervisory employee, Bayhealth affiliate member (physicians, volunteers, student interns), or other non-employees (vendors or contractors), has engaged in sexually harassing conduct, towards themselves or another employee or affiliate member has an obligation to initiate a complaint with any one of the following:
 - Immediate Supervisor,
 - Department Manager,
 - Department Director,
 - Division Vice Presidents,
 - Any Corporate Compliance Officer,
 - Vice Presidents, Human Resources, or
 - Employee Relations Manager
- All complaints should be documented using the Discrimination Complaint Form.
- The Discrimination Complaint Form must be forwarded to the Human Resources department, using the contact information at the bottom of the form, immediately.

The Human Resources Department is responsible for investigating all complaints of discriminatory conduct and/or harassment.
- All complaints will be investigated, including situations in which the complainant does not request that any disciplinary action be pursued or if the complaint is made anonymously.
- A formal investigation will be initiated within twenty-four (24) hours of receiving a complaint alleging discriminatory conduct and/or harassment.
- A report of investigation will be issued by the Human Resources department to those on a “need to know” basis. As a minimum, the report will consist of the following components:
 - Summary of the Complaint,
 - A statement of the governing rules, policies, federal and state laws,
 - Statement of Facts and Interviews,
 - Analysis,
 - Conclusion(s),
 - Recommendations.
- At the conclusion of the investigation, the Employee Relations team within Human Resources will personally communicate the conclusion(s) to the complainant and the

accused; however, the specifics of any disciplinary action will not be disclosed.

- INVESTIGATION PROCESS

- Investigations shall, to the extent possible, be confidential. Information obtained through investigation will be disclosed to only those persons in management positions with a legitimate need to know, outside legal counsel, or if compelled by administrative or judicial bodies.
- The complainant, accused, and witnesses are strictly prohibited from discussing the investigation with co-workers.
- In the event that the allegation(s) is particularly severe, the accused may be placed upon administrative leave until which time the investigation has been completed and conclusions communicated.
- Findings and conclusions will be communicated to management personnel with a legitimate need to know, the complainant, and the accused immediately upon completion of the investigation.

- RETALIATION

- Bayhealth exercises a “zero tolerance” policy for retaliation against any employee who complains about sexual harassment, helps someone else complain about sexual harassment, or provides information regarding a complaint.
- Any employee who feels that he/she has been subjected to any retaliatory treatment must report such conduct to Human Resources immediately.
- Bayhealth exercises a “zero tolerance” policy for supervisors who engage in retaliatory conduct by making an adverse employment decision on the basis of an employee’s good faith complaint about conduct prohibited under this policy or participation in a complaint, investigation or proceeding under this policy. Accordingly, any supervisor who engages in such conduct will be subject to corrective action up to and including termination of employment.
- An employee, who intentionally brings forth a false complaint, knowingly helps another employee bring forth a false complaint, or intentionally provides false information during an investigation, shall be subject to disciplinary action up to and including termination of employment.

5. References:

- Title VII of the Civil Rights Act of 1964 (42 U.S.C. §§ 2000 *et seq.*)
- Delaware Discrimination in Employment Act (19 Del. C. §§ 710 *et seq.*)

Inpatient Note Electronic Health Record Completion Policy

Purpose Statement: Documentation of patient care is critical to continuity, for communication with other team members and to meet requirements of the Centers for Medicare and Medicaid for finalization of notes after a patient encounter. The supervising physician is charged with ensuring our patients are provided the highest quality care in a patient-centered manner which includes appropriate and timely documentation of patient care, reviewing and addressing diagnostic studies and lab results, responding to pages, and completing patient care tasks when requested. The CCC and Program Director is charged with addressing any failure to meet these responsibilities.

1. Procedure:

1.1 Trainee Responsibilities

- 1.1.1 Must complete daily progress notes on same day by 6pm and send to faculty for co-signature
- 1.1.2 Complete new patient H and P within 24 hours and send to faculty for co-signature
- 1.1.3 Complete discharge summaries within 24 hours and send to faculty for co-signature
- 1.1.4 Complete initial consult notes within 24 hours and send to faculty for co-signature
- 1.1.5 Respond to all pages as soon as possible and must not exceed 30 minutes
- 1.1.6 Review all inpatient diagnostic and lab test results when available and document actions taken in the patient chart
- 1.1.7 Place admission orders within 30 minutes after ED notification of a new patient. All other patient care orders should be as completed as soon as possible

1.2 Faculty Responsibilities

- 1.2.1 Co-sign trainee progress notes by the end of each day
- 1.2.2 Co-sign H and Ps, discharge summaries, and initial consult notes within 24 hours
- 1.2.3 Indirectly supervise trainee completing patient care tasks
- 1.2.4 Indirectly supervise trainee responding to pages in appropriate time frame
- 1.2.5 Indirectly supervise trainee review of diagnostic studies and lab tests
- 1.2.6 Complete My Chart Patient Portal Messages within 48 hours if forwarded by clinical staff for action

1.3 All patient care notes will be completed within 24 hours of the patient encounter

- 1.3.1 This applies to Trainees, Faculty or any other member of the interprofessional team providing direct patient care

1.4 Failure to meet above requirements

- 1.4.1 Any Trainee failing to meet these requirements will be subject to review by the Clinical Competency Committee (CCC) and the Program Director. Actions can include focused skill development, coaching, and remediation. Repeated violations of this policy can result in disciplinary action.
- 1.4.2 Any Faculty failing to meet these requirements will be forwarded to the Program Director. Actions can include skill development and coaching. With repeated violations, the faculty member will be subject to action determined by the Program Director including removal from trainee supervising responsibilities.

Lactation

Purpose Statement: Recognizing the well documented health advantages of breastfeeding for infants and mothers, this policy provides clear expectations for a supportive environment to enable breastfeeding trainees to express their milk during work hours.

1. Procedure:

- 1.1 Trainees should be supported to meet this need without concern, retaliation, or negative impact on clinical training and educational experience.
- 1.2 The time required for lactation is a critical part of well-being for the trainee and the trainee's family.
- 1.3 Employers are required to provide a reasonable amount of break time to express milk as frequently needed by the nursing mother.
 - 1.3.1 The frequency of breaks needed to express milk as well as the duration of each break will likely vary.
 - 1.3.1.1 To whatever extent possible, programs should proactively determine how direct patient care responsibilities could be covered during the pumping time.
 - 1.3.1.2 Trainees should not have to "make up" time spent in pumping unless there is a concern for meeting ACGME requirements.
 - 1.3.1.3 Programs should explore options for accommodations that would not significantly impact the educational experience over the course of a year of lactation.
- 1.4 Trainees will be provided with clean and private facilities for lactation that have refrigeration capabilities and allow for safe patient care.
- 1.5 Trainee lactation areas include a computer and phone for the continued care of patients.
- 1.6 Lactation areas are designated areas that are free from intrusion of co-workers and shielded from view.
 - 1.6.1 The trainee lactation areas are located within the on-call rooms at both Kent and Sussex campuses.
 - 1.6.2 Trainee lactation areas are available at all trainee practices.

Locker Agreement

Purpose Statement: To provide a facility where GME residents/fellows can secure their belongings. Lockers will be provided to residents/fellows as determined by the GME office based on program needs.

Procedure/Policy:

1. Lockers are assigned by GME and considered property of Bayhealth Medical Center.
2. Lockers may be assigned to more than one residents/fellow. Family Medicine Residents/fellows will share 8 lockers at the Kent Campus, due to having individually assigned lockers at the Family Medicine Outpatient Practice.
3. Use of a locker by a person other than whom it is assigned is forbidden.
4. GME and Bayhealth retain the right to conduct routine and random locker inspections at any time and without warning or approval. Misuse of these facilities may be the cause for corrective action.
5. GME and Bayhealth are not responsible for personal property that is lost or stolen. All residents/fellows are encouraged to leave valuables at home.
6. All personal property must be stored within the locker. All items left outside of a locker will be removed and disposed of accordingly.
7. Flammable materials, dangerous chemicals, explosives, or weapons of any kind, illegal or controlled substances such as drugs and alcohol, as well as perishable food items are strictly prohibited inside of the lockers and locker rooms.
8. Upon assignment and during use, residents/fellows are responsible for reporting any damage or needed repairs to the GME office by contacting 302-744-6999 or GME@bayhealth.org. Trainees will assume the cost of any unreported damages.
9. Residents/fellows may not adhere any material(s) to the inside or outside of their locker.
10. Residents/fellows may provide their own lock and must notify anyone sharing the locker of the combination or provide them with a key.
11. Misuse of a locker may result in loss of locker privileges and/or a professionalism warning.

Signature below indicates the trainee agrees to abide by the above.

Print Name:

Employee ID:

Program:

Date:

Locker Location:

Locker #:

Signature:

Mandatory Certifications

Purpose Statement: The purpose of this policy is to define and standardize life support training requirements for all residents and fellows in Bayhealth training programs.

1. Procedure:

- 1.1 All clinical trainees who are involved in direct patient care are required to obtain and maintain active applicable certifications throughout their training to ensure they are capable of assessing the need for and initiating cardiopulmonary resuscitation according to established standards by the American Heart Association.
- 1.2 All clinical trainees are required to complete all mandatory training within the first 30 days of employment unless otherwise discussed with GME and/or Program Directors.
- 1.3 Initial Certification
 - 1.3.1 GME, with collaboration from the program is responsible to arrange training for residents/fellows, to attend new or recertification course(s).
 - 1.3.2 Residents/trainees will be provided with the required certification books during GME orientation.
 - 1.3.2.1 Residents/trainees must return the books to the GME office after the classes are completed or trainees will have funds removed from their educational funds

| | |
|---|-------------------------|
| Basic Life Support Provider Manual (2020) | ISBN: 978-1-61669-768-6 |
| Advanced Cardiovascular Life Support Provider Manual (2020) | ISBN: 978-1-61669-772-3 |
| Pediatric Advanced Life Support Provider Manual (2020) | ISBN: 978-1-61669-785-3 |
| Neonatal Resuscitation (8 th Edition) | ISBN: 978-1-61002-524-9 |

- 1.3.3 Residents/fellows who fail to attend their scheduled courses will be held responsible for the cost of the course
- 1.4 Bayhealth only recognizes course certifications from the American Heart Association, United States Military, and the American Red Cross
- 1.5 Recertification
 - 1.5.1 Recertification must be obtained prior to the expiration date of certificates.
 - 1.5.2 GME will monitor certification status on an ongoing basis and notify clinical trainees of upcoming expiration
 - 1.5.3 Ongoing certification renewal will be completed through HeartCode
- 1.6 Required Certifications for Residents/fellows:

| Program | A C L S | B L S | A T L S | P A L S | N R P |
|---------|------------------|-------------|------------------|------------------|-------------|
|---------|------------------|-------------|------------------|------------------|-------------|

| | | | | | |
|---------------------------------|---|---|---|---|---|
| Family Medicine | X | X | | X | X |
| Internal Medicine | X | X | | | |
| General Surgery | X | X | X | | |
| Emergency Medicine | X | X | X | X | X |
| Hematology and Medical Oncology | X | X | | | |
| Gastroenterology | X | X | | | |

1.6.1 Basic Life Support (BLS) is required for all programs during the PGY1 year

1.6.1.1 BLS is valid for two years and will need to be recertified by all programs during PGY3

1.6.2 Advanced Cardiac Life Support (ACLS) is required for all programs

1.6.2.1 ACLS is valid for two years and will need to be recertified by all programs during PGY3

1.6.3 Neonatal Resuscitation Program (NRP) is required for Family Medicine and Emergency Medicine residents

1.6.3.1 NRP is valid for two years and will need to be recertified by all required programs during PGY3

1.6.4 Pediatric Advanced Life Support (PALS) is required for Family Medicine and Emergency Medicine residents during PGY1

1.6.4.1 PALS is valid for two years and will need to be recertified by all required programs during PGY3

1.6.5 Advanced Trauma Life Support (ATLS) is required for General Surgery and Emergency Medicine residents during PGY1

1.6.5.1 ATLS certification is current for four years

1.6.5.2 General Surgery residents will need to complete a refresher course during their PGY4 year

1.7 The programs will pay the following fees to the Education Department for the initial certification/renewal of residents:

| | |
|---------------|--------------------|
| BLS | \$60 per resident |
| ACLS and PALS | \$175 per resident |
| NRP | \$45 per resident |

1.8 Residents that require ATLS will be asked to attend this class at a nearby facility

1.8.1 The Program Coordinator will assist with scheduling the ATLS course and will provide the residents with dates and other information

- 1.9 Participants completing the mentioned certification courses are expected to perform within their scope of practice and licensure per Delaware law as well as job role
- 1.10 Certifications
 - 1.10.1 Residents must send certification cards to GME@bayhealth.org once received so they can be uploaded into MedHub
 - 1.10.2 Residents must upload certification cards into Healthstreams once received for Institutional documentation
 - 1.10.3 Residents can access a copy of their e-card via their LMS account without cost

Moonlighting

Purpose Statement: To specify the circumstances under which Bayhealth residents/fellows may engage in Moonlighting, as well as the specifications that must be satisfied by the resident who engages in such activities.

- 1.1 Residents/Fellows should refer to program policies on moonlighting for more specific details
- 1.2 PGY-2 and PGY-3 Emergency Medicine, Internal Medicine and Family Medicine residents may be permitted to moonlight at the discretion of their Program Director and DIO
- 1.3 General Surgery residents are not permitted to moonlight.
- 1.4 Hematology and Medical Oncology and Gastroenterology fellows can moonlight based on Program Director discretion
- 1.5 Moonlighting is prohibited internally (at Bayhealth) due to liability insurance and other restrictions
- 1.6 Moonlighting is prohibited unless specifically approved in advance by the Program Director and DIO
 - 1.6.1 Such approval must be submitted through MedHub annually
- 1.7 The hospital does not provide professional liability coverage for duties assumed outside of the hospital
- 1.8 Only a resident who has applied for and been granted an unrestricted license to practice in the state they are moonlighting, a DEA number, and any other applicable licensure, is eligible to apply for permission to moonlight as a physician. Residents must pay for all licensure and will not be reimbursed by Bayhealth
- 1.9 Time spent by residents in Moonlighting must be counted towards the 80-hour maximum weekly hour limit
- 1.10 The individual programs will be responsible for monitoring clinical and education work hours through the residency management software system (Medhub) to ensure compliance
- 1.11 Moonlighting must not interfere with the ability of the resident/fellow 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
- 1.12 Approval may be withdrawn if moonlighting activities are associated with a decline in the resident's performance
- 1.13 Individual programs will be responsible for monitoring the effect of moonlighting activities on a resident's/fellow's performance in the program, including adverse effects that may lead to withdrawal of permission to moonlight

Non-Compete

Purpose Statement: To comply with requirements set forth by the Accreditation Council for Graduate Medical Education (ACGME) for Institutional Accreditation. Residents/fellows training in Bayhealth sponsored ACGME accredited programs will not be held to the same non-compete clause written in the Employee Physician Handbook

1. Procedure:
 - 1.1 Neither the Sponsoring Institution nor any of its ACGME-accredited programs will require a residents/fellow to sign a non-competition guarantee or restrictive covenant.
 - 1.2 Bayhealth GME programs will never require a residents/fellows training in an ACGME-accredited program to sign a non-compete document nor restrict where the residents/fellow's physician trains post-residency.

Non-Discriminatory Work Environment

Institutional Policy: B9065.1, last updated 8/11/23

Purpose Statement: To create and maintain a fair and equal work environment characteristic of mutual respect, dignity, professionalism, and harmony among all Bayhealth employees. Bayhealth strictly prohibits and has zero tolerance for all forms of discriminatory conduct based upon race, color, religion, sex, pregnancy, national origin, ancestry, citizenship, age, marital status, disability, veteran status, sexual orientation, gender identity, genetic information, or any other basis protected by law.

Employees who engage in discriminatory conduct shall be subject to disciplinary action up to and including termination of employment. Bayhealth affiliate members who include, but are not limited to, physicians with hospital privileges, volunteers, interns, and/or students, who engage in discriminatory conduct, shall be subject to appropriate sanctions as set forth by Bayhealth policies and procedures. The principles of this policy apply to independent contractors, temporary staffing personnel, and any other persons or organizations doing business for or with Bayhealth and Bayhealth Emergency Physicians. Retaliatory action of any kind against an employee making a report of discriminatory conduct is strictly prohibited. Employees and/or Bayhealth affiliate members engaging in retaliatory conduct will be subject to disciplinary action, up to and including termination of employment, as outlined in Bayhealth's policies. Any supervisor who becomes aware of possible discriminatory conduct must immediately advise the Human Resources Department so it can be investigated in a timely manner. Contents of this policy are reviewed during general orientation and during annual mandatory education. This policy is located on Bayhealth's intranet for all employees to access and is included in the organization's employee handbook.

1. Procedure

1.1 Governing Authority

- 1.1.1 Title VII of the Civil Rights Act of 1964 (42 U.S.C. § 2000 *et seq.*)
- 1.1.2 Americans with Disabilities Act (42 U.S.C. § 12101 *et seq.*)
- 1.1.3 Age Discrimination in Employment Act (29 U.S.C. § 621 *et seq.*)
- 1.1.4 Delaware Discrimination in Employment Act (19 Del. C. § 711)

1.2 Management of Complaints

- 1.2.1 Any employee who reasonably believes that another Bayhealth employee, Bayhealth affiliate member (physicians, volunteers, student interns, vendor, contractor), or Bayhealth Emergency Physicians employee has engaged in conduct which constitutes discrimination and/or harassment, has an obligation to initiate a complaint with any one of the following:
 - 1.2.1.1 Immediate Supervisor,
 - 1.2.1.2 Department Manager,
 - 1.2.1.3 Department Director
 - 1.2.1.4 Division Vice President,
 - 1.2.1.5 Any Corporate Compliance Officer,
 - 1.2.1.6 Vice President, Human Resources, or
 - 1.2.1.7 A Representative of the Employee Relations Team.

- 1.2.2 All complaints shall be documented using the Bayhealth Discrimination Complaint Form. Forms must be completed in the Employee Self-Service Portal. Individuals requiring assistance in completing the form are encouraged to contact Human Resources for assistance.
- 1.2.3 The Human Resources Department is responsible for investigating all complaints of discriminatory conduct and/or harassment.
- 1.2.4 All complaints will be investigated even if the complainant does not request that any disciplinary action be pursued or if the complaint is made anonymously.
- 1.2.5 A formal investigation shall be initiated within twenty-four (24) hours of receiving a complaint, or as soon as practical, alleging discriminatory conduct and/or harassment.
- 1.2.6 A report of the investigation will be kept on file with the initial discrimination complaint.
- 1.2.7 At the conclusion of the investigation, the investigator will personally communicate the conclusion(s) to the complainant and the accused; however, the specifics of any disciplinary action shall not be disclosed.
- 1.3 Investigation Process
 - 1.3.1 Investigations shall, to the extent possible, be confidential. Information obtained through investigation will be disclosed to only those persons in management positions with a legitimate need to know, outside legal counsel, or administrative or judicial bodies as appropriate.
 - 1.3.2 The complainant, accused, and witnesses are strictly prohibited from discussing the investigation with anyone outside of a need-to-know basis.
 - 1.3.3 Upon receipt of the complaint, the investigator will review the complaint and immediately conduct a climate assessment. If the investigator concludes that continued interaction between the complainant and the accused would be inappropriate, the investigator will work to separate all parties, i.e., through separate shifts, administrative leave, etc.
 - 1.3.4 In the event that the allegation(s) are particularly severe, the accused may be placed on administrative leave until which time the investigation has been completed and conclusions communicated.
 - 1.3.5 The investigation will consist of the following general components:
 - 1.3.5.1 Documentation of the complaint,

- 1.3.5.2 Interviews and statements, as applicable, of the complainant, witnesses, and the accused,
 - 1.3.5.3 Documentation of key facts and witness statements,
 - 1.3.5.4 An objective assessment of the facts, determination of credibility, and an analysis of the facts as compared to the applicable rules, policies and laws, and
 - 1.3.5.5 Setting forth findings, conclusions, and recommendations based upon the material facts of the case.
 - 1.3.6 Members of the management team with a legitimate need-to-know will be kept informed of findings and conclusions to the extent possible. Findings and conclusions will be communicated to the complainant and the accused immediately upon completion of the investigation.
- 1.4 Retaliation
- 1.4.1 There shall be no retaliation against any employee who complains about discriminatory conduct/harassment, helps someone else complain about discriminatory conduct/harassment, or provides information regarding a complaint.
 - 1.4.2 Any employee who feels that he/she has been subjected to any retaliatory treatment must report such conduct to Human Resources immediately.
 - 1.4.3 Bayhealth exercises a zero-tolerance policy for supervisors who engage in retaliatory conduct by making an adverse employment decision on the basis of an employee's good faith complaint about conduct prohibited under this policy or participation in a complaint, investigation or proceeding under this policy. Accordingly, any supervisor who engages in such conduct shall be subject to disciplinary action, up to and including termination of employment.
 - 1.4.4 An employee, who intentionally brings forth a false complaint, knowingly helps another employee bring forth a false complaint, or intentionally provides false information during an investigation, shall be subject to disciplinary action up to and including termination of employment.

National Provider Identifier (NPI) for GME Trainees

Purpose Statement: All trainees that file electronic claims are required by HIPAA law to obtain a National Provider Identifier (NPI). The purpose for the NPI is to utilize one number per health care provider for all health plans. As a clinical trainee at Bayhealth, it is required to have an NPI number.

1. Procedure:
 - 1.1 All residents/fellows beginning training at Bayhealth must provide GME with a valid NPI number issued by the National Plan and Provider Enumeration System (NPPES) prior to orientation; instructions for applying are in the GME onboarding package
 - 1.1.1 Fellows who previously applied for an NPI number are responsible for updating the program address and other applicable information through NPPES prior to starting at Bayhealth
 - 1.2 GME will assure that the clinical trainees NPI is loaded into the EPIC profile to assure they are able to enter e-scripts and orders once they begin training
 - 1.3 Clinical Trainees can apply online for an NPI number. Trainees must go to [NPPES \(hhs.gov\)](https://www.hhs.gov/nppes) and apply as an individual
 - 1.3.1 There is no charge for this process.
 - 1.4 CMS has granted an exception for International Residents to apply for a NPI before they obtain a required Social Security Number (SSN).
 - 1.4.1 An International Resident without a Social Security Number will have to provide CMS with these documents:
 - 1.4.1.1 The completed, signed, and dated NPI Application, CMS-10114.
 - 1.4.1.2 A copy of two acceptable proofs of identification (birth certificate, the identifying page of a passport, US issued driver's license or US issued State Identification)
 - 1.4.1.3 A brief letter explaining why the applicant has no Social Security Number, this letter will be provided by the program through the GME office
 - 1.4.1.4 IMG's who obtain a NPI number must submit their Social Security card to NPPES once received
 - 1.5 It is the trainee's responsibility to complete the application through NPPES during Graduate Medical Education onboarding
 - 1.5.1 NPI's are unique to the provider and therefore will be used throughout the trainee's entire career

Paid Time off and Leave of Absence

Purpose Statement: To allow eligible resident/fellows to take approved time off from the program in accordance with the Accreditation Council for Graduate Medical Education (ACGME) and Bayhealth requirements.

1. Procedure:
 - 1.1 Resident/fellows will receive information regarding PTO and FMLA during orientation.
 - 1.2 PTO
 - 1.2.1 On July 1 at the start of each academic year, resident/fellows will receive 120 hours (15 days) of PTO and 40 hours (5 days) of personal time.
 - 1.2.1.1 PTO is defined as scheduled time off and is used for absences such as personal vacations.
 - 1.2.1.2 Resident/fellows are required to take at least one scheduled one-week PTO break per academic year. This is to provide respite and promote resident/fellow well-being during the program.
 - 1.2.1.3 PTO balance does not accrue and will not rollover into the next Post Graduate Year (PGY). PTO balances are not paid out when the resident/fellow graduates and/or terminates from the program.
 - 1.2.1.4 Borrowing or taking advances against future PTO is prohibited per Bayhealth's PTO policy B9065.32.
 - 1.2.2 Approval is based on the program needs and requires the program director's prior approval.
 - 1.2.2.1 Each program may restrict certain blocks/rotations or timeframes in which PTO may not be used unless the absence is due to an FMLA qualifying reason.
 - 1.2.2.2 Requests for scheduled PTO will be given equal consideration and every effort will be made to accommodate the resident/fellows request per the Program Director's discretion.
 - 1.2.3 In situations where the absence cannot be scheduled the resident/fellow is to use personal time.
 - 1.2.3.1 The Resident/fellow will notify the Program Director and the Coordinator (or designee) at least 2 hours prior to the start of the shift when possible.
 - 1.2.3.2 If a resident/fellow experiences an unscheduled absence due to unforeseen circumstances, too fatigued to complete their call or is unwell during a time when they are designated as "on call", the Program Director (or designee) will aid the resident/fellow

in covering the call but is expected to make up the call at a later date per the Program Director's (or designee) discretion. In cases where the absence is covered under an FMLA claim, the resident/fellow will not be required to arrange coverage for the call.

1.2.3.3 If a resident/fellow is sick more than 5 calendar days, regardless of number of shifts worked or scheduled (including weekends/days off), a Fit for Duty physical exam must be done with Occupational Health and medical clearance must be received from the treating physician before returning to work.

1.2.4 Bayhealth observed holidays do not apply to resident/fellows. Due to the nature of the medical education training program and the responsibilities for patient care, resident/fellows will be scheduled for work.

1.3 Leave of Absence(s)

1.3.1 Per ACGME requirements, resident/fellows will be provided 100% of salary for the first six weeks of approved medical, parental, or caregiver (for spouse, child, or parent with serious health condition) leave

1.3.2 Resident/fellows will be provided with one additional week of paid time off reserved for use outside of the first six weeks of the first approved medical, parental, or caregiver (for spouse, child, or parent with serious health condition) leave of absence taken

1.3.2.1 This is available to resident/fellows after all PTO is depleted (up to 120 hours)

1.3.2.1.1 Bayhealth will pay the remainder of the six weeks in full

1.3.2.2 This benefit should be used in conjunction with FMLA after first year of employment

1.3.3 Resident/fellows are required to notify their program director and submit their request 30 days in advance for foreseeable leaves and as soon as possible for qualifying exigency.

1.3.3.1 Resident/fellows should reach out to the benefits department by calling 302-744-7143, option 3 and supply appropriate supporting documentation to the third-party administrator for review. Failure to do so will result in denial of paid leave.

1.4 Bereavement

1.4.1 To be eligible for bereavement pay, the resident/fellow may be required to submit proof, when requested by the program director which includes the date of death, date of the funeral, and relationship of the deceased to the resident/fellow.

1.4.1.1 Proof of death may be the obituary, a written statement on the funeral director's stationary, death certificate, or any

substantive proof which includes the appropriate information/dates.

- 1.4.2 Upon receipt of a request for bereavement pay for a resident/fellow, the program director may do one of the following:
 - 1.4.2.1 Grant up to three (3) scheduled working shifts off with pay immediately following the death or to coincide with funeral/memorial services of an immediate family member. PTO must be used for any additional time over the three (3) the resident/fellow requests off.
 - 1.4.2.1.1 Immediate family – 3 days - Resident/fellow's parent, stepparent, foster parent, sister, brother, spouse, child, stepchild, grandchild, grandparent, great-grandparent, daughter-in-law, son-in-law, parent-in-law, significant other, domestic partner, or a relative who resided in the resident/fellow's household at the time of death.
 - 1.4.2.2 Grant one (1) scheduled working shift off with pay to attend the funeral of an extended family member.
 - 1.4.2.2.1 Extended family – 1 day - Resident/fellow's grandparent-in-law, uncle, aunt, niece, nephew, brother-in-law, and sister-in-law.
- 1.4.3 Bereavement leave is considered in addition to the Paid Time Off referenced above. Additional missed days beyond those allowed above pay impact the resident/fellow's ability to complete the program in the originally anticipated timeframe.
- 1.5 FMLA
 - 1.5.1 To be eligible for FMLA leave, the resident/fellow must be employed by Bayhealth for a total of 12 months and worked at least 1,250 hours during the 12-month period immediately before the date when the leave requested is to commence. Only hours *worked* during the 12 months prior to the date leave is to begin are included; hours used for vacation, sick leave, bereavement leave, etc. are excluded. The determination of whether the resident/fellow has worked 1,250 hours in the past 12 months and has been employed for at least 12 months is made as of the date the FMLA leave is to start.
 - 1.5.2 A leave of absence may be granted to qualifying individuals for time lost due to FMLA qualifying events (serious personal health condition, birth/adoption of a child, and care of an immediate family member with a serious health condition).
 - 1.5.2.1 Consistent with federal regulations, Bayhealth provides up to twelve (12) weeks unpaid, job protected leave for qualifying individuals.

- 1.5.3 FMLA shall be coordinated with leave granted under other Bayhealth policies in B9065.27 and run concurrently.
- 1.5.4 If a resident/fellow is eligible for disability leave or workers' compensation, the resident/fellow must take the disability leave or workers' compensation and such leave will also count as part or all of the 12 weeks of FMLA leave. If the resident/fellow has elected Bayhealth's short-term disability plan (STD) and receiving STD payments, the resident/fellow is not permitted to use PTO while receiving these payments; resident/fellows are required to use PTO during the elimination period.
- 1.5.5 Resident/fellows requesting FMLA must notify the Program Director and submit a claim through Bayhealth's Third Party Administrator accompanied by a completed Certification of Healthcare Provider form. These forms must be completed and returned to the Third-Party Administrator at least 30 calendar days before taking scheduled leave, or within 15 calendar days following an emergency.
- 1.5.6 Absences due to FMLA will not result in a resident/fellow's dismissal from the program but may result in an extension of the resident/fellow's time in the program.
- 1.5.7 Extended leave of absence may impact a resident/fellow's eligibility to participate in examinations by the relevant certifying board(s) and may result in unsatisfactory completion of the criteria for the program.
 - 1.5.7.1 Any resident/fellow who is concerned about the impact of extended leave of absence or time away from the program should discuss the implications with their Program Director immediately.
 - 1.5.7.2 Should a resident/fellow's time away from the program exceed the maximum allowed by program requirements, the resident/fellow may extend their training.
- 1.6 Continued Medical Education (CME)
 - 1.6.1 There will be five (5) CME days available in accordance with each individual program's criteria.
 - 1.6.2 Resident/fellows may use their CME benefit for continuing education, professional dues, subscriptions, license, association fees, textbooks and any other educational resources like exam prep and board preparation courses.
- 1.7 Administrative Leave
 - 1.7.1 Resident/fellows who are underperforming or need to study for an exam may be granted administrative leave by the Program Director
 - 1.7.2 When placed on administrative leave all PTO will be exhausted, the remaining time will be unpaid leave

Patient Safety and Quality Improvement

Purpose Statement: To comply with patient safety and quality improvement requirements set forth by the Accreditation Council for Graduate Medical Education (ACGME) for Institutional Accreditation.

1. Procedure:
 - 1.1 Resident/fellows must demonstrate the ability to analyze the care they provide, understand their roles within healthcare teams, and play an active role in the system improvement process
 - 1.2 GME programs must ensure that resident/fellows have active participation in Quality Improvement and Patient Safety systems
 - 1.3 All resident/fellows will be required to complete IHI Modules within the first six months of the PGY-1 year. Instructions on this will be provided during GME orientation
 - 1.4 Each ACGME-accredited program will provide resident/fellows with feedback on how they are managing their patient population and procedure outcomes. Including quality metrics and benchmarks related to their patient population
 - 1.5 Resident/fellows will have opportunities to participate on Patient Safety and Quality Improvement Committees
 - 1.6 Resident/fellows will participate in root cause analyses and will conduct research projects to help improve the overall performance within the system
 - 1.7 Resident/fellows will have opportunities to participate on interprofessional teams. These teams will work together to perform root cause analyses, safety review meetings, peer review committees, and will meet to discuss patient safety culture and areas for improvement
 - 1.8 Each ACGME-accredited program will provide opportunities for the resident/fellows to participate in quality improvement activities, including but not limited to:
 - 1.8.1 Processes aimed at understanding and reducing Health Care Disparities
 - 1.8.2 Participation in Institutional Quality Improvement and Patient Safety committees
 - 1.8.3 Transitions in Care improvement processes
 - 1.8.4 Participation on interprofessional teams to promote Quality Improvement
 - 1.8.5 Participation in Quality Improvement projects that improve systems of care and patient care outcomes.

Trainee CVC Procedures

Purpose Statement: Bayhealth is committed to excellent patient care, with the highest priority towards patient safety and excellent clinical outcomes. As a graduate medical education training site, Bayhealth will standardize the basic education, competency assessment, supervision and procedural methods for medical students, resident physicians and fellows inserting central venous catheters (CVCs) under this policy. This policy will guide the education of trainees in the use of proper sterile technique, anatomical landmarks and ultrasound guidance when inserting CVCs.

The CVCs covered by this policy are all percutaneously inserted central catheters including large bore central catheters such as dialysis and resuscitation catheters.

This policy supports the routine use of ultrasound guidance for internal jugular and femoral venous sites of CVC placement unless the clinical urgency and/or immediate unavailability of ultrasound precludes sonographic guidance.

At times, extraordinary clinical circumstances or clinical judgment of the attending physician may dictate that different approaches to central line placement may be utilized. It is expected that these will be an unusual occurrence. This policy outlines the education, training and supervision of all trainees involved in CVC insertion. All postgraduate medical trainees performing CVC placement in their clinical duties will be trained in anatomical landmarks and ultrasound guided CVC insertion techniques as appropriate to location. This policy designates the minimum standard by which a trainee will be educated to place CVCs, when they may place central lines WITHOUT direct supervision, and who may supervise and teach central line placement.

This policy is applicable for ALL trainees, including transferring residents/fellows, and visiting residents/fellows.

- 1.9 **Trainee:** Any postgraduate trainee in the institution, including residents, fellows, and students.
- 1.10 **Supervising Attending:** Attending physician skilled in CVC insertion and credentialed by the Bayhealth Medical staff to perform this procedure. The supervising attending can delegate to an Advanced Practice Clinician who is credentialed to perform CVC insertion to assist the resident. (Reviewed in IM ACGME requirements)
- 1.11 **Clinical Supervisor: Supervising Attending** or all trainees who have reached **Teaching Competency** for CVC insertion.
- 1.12 **Direct Supervision:** Supervision of the procedure with the clinical supervisor in the room with the trainee.
- 1.13 **Indirect Supervision:** Supervision of the procedure with the clinical supervisor not present but available to assist if required.
- 1.14 **Learner, Competency, Teaching:** Designation of varying levels of training designed to lead to the achievement of varying levels of

proficiency in the insertion of CVCs. Section 5 of this policy defines the required training and supervision at each level.

- 1.15 **CVC sites:** Subclavian, Internal Jugular, Femoral.
- 1.16 **Difficult Patient:** Any patient in whom a CVC placement is being considered and is at increased risk of complications. Trainees in Learner phase are not to attempt CVC placement in this group of patients. Trainees deemed competent are encouraged to have a **Clinical Supervisor** immediately available when placing lines in this group of patients. The following are examples of conditions which may make the CVC placement difficult:
 - 1.17 Extremes of body habitus: BMI <20 or >40
 - Coagulopathy (platelets <50,000, INR >1.5, APTT>50 seconds)
 - Unresuscitated shock with inadequate vein filling noted by completely collapsed vessel on ultrasound
 - Altered anatomy (prior radiation therapy or prior insertion at this site) or previous surgery at or near the intended vein location
 - Agitated patient/lack of cooperation in being immobile or positioned correctly
 - Previous thrombosis of intended vein
 - 1.18 **Large Bore Catheter:** CVCs greater than 7.5 fr such as those used for hemodialysis (commonly referred to as Vas Cath's) or rapid resuscitation from hypovolemic or septic shock (commonly referred to as trauma catheters)
 - 1.19 **Seldinger Technique:** A method of percutaneous insertion of a catheter into a blood vessel or space. A needle is used to puncture the structure and a guide wire is threaded through the needle; when the needle is withdrawn, a catheter is threaded over the wire; the wire is then withdrawn, leaving the catheter in place.
 - 1.20 **Site Specific Competency:** Femoral and Internal Jugular (IJ) sites are routinely placed using ultrasound guidance while subclavian lines are placed using anatomic guidance. Competency with one approach does not indicate competency with the other. For the purposes Bayhealth, Femoral and IJ approach will be considered together and subclavian separately. Further, a trainee can be certified at just the **Femoral/IJ sites** or at **All Sites** based on demonstrated successfully supervised CVCs placed at each site.

1. Procedure:

2. Procedure:

2.1 Procedure to Obtain Competency Levels:

2.1.1 Learner phase

- 2.1.1.1 Definition: Trainee has completed requisite educational material referenced for CVC insertion and is placing CVC under **direct supervision**. The goal is to progress

to the competency phase and be able to place lines independently (Indirect supervision) after a minimum of ten (10) lines. Medical students will not progress beyond this stage.

2.1.1.2 Requirements:

2.1.1.2.1 Bayhealth CVC simulation training course.

2.1.1.2.2 **Appropriate Patient Selection:** The following are **NOT** appropriate patients for a Learner to place a CVC

2.1.1.2.2.1 **Difficult patient**

2.1.1.2.2.2 **Large Bore Catheter**

2.1.1.2.2.3 **Patient in extremis or who placement must be accomplished in a limited time frame**

2.1.2 **Supervision: Direct Supervision** is required for all lines and may be provided by supervising attending with appropriate credentialing, fellow or senior resident who has attained **Teaching Phase in the specific site utilized (Clinical Supervisor). The patient's attending physician should be notified prior to the placement of a CVC.** All CVC should be placed following the Bayhealth standardized CVC insertion guideline. (See Appendix A)

2.1.3 Competency Phase

2.1.3.1 Definition: Trainee has completed all the training steps in the Learning phase, has had a CVC MedHub competency attestation completed (Appendix B), and has been approved by their Residency Program Director (PD) or faculty designee to place CVC **with indirect supervision.** The goal of this phase is to develop further skill in placing central lines independently with the potential to progress to the Teaching phase. However, this may be the terminal achievement for a trainee; they are competent to place central venous catheters independently and be credentialed upon graduation as competent in this procedure by specific sites but are not considered competent to teach the procedure.

2.1.3.2 Requirements:

2.1.3.2.1 Successful placement of ten (10) Central lines (completed during the learner phase)

2.1.3.2.2 CVC Competency attestation (See Appendix B)

2.1.3.2.3 Program Director certification of meeting Competency Phase (MedHub)

2.1.3.3 **Appropriate patient selection**

2.1.3.3.1 **Difficult patients:** trainees may place CVC on these patients with direct or indirect supervision BUT SHOULD HAVE direct supervision immediately available

2.1.3.3.2 **Large Bore Catheters:** May be placed but require Direct Supervision by appropriate **Supervisor** until a total of five (5) at any site have been successfully placed.

2.1.3.4 **Supervision:** Indirect supervision by clinical supervisor. The resident should notify the patient's attending physician prior to placing a CVC. If the patient's attending physician is not credentialed to place a CVC, the attending physician will consult (either formally or informally) a credentialed physician who can provide assistance if required. While not required, Residents should seek direct supervision when available for continued learning and progression of skill during this phase.

2.1.4 **Teaching Phase**

2.1.4.1 Definition: Trainee may serve as a **Clinical Supervisor** to a **Learner**. The goal is to develop competency and expertise in supervision and teaching central line placement including corrective actions and troubleshooting and appropriate patient selection for learner phase trainees.

2.1.4.2 Trainee is proficient in central line insertion in all circumstances in site specific manner. See below for site specific competency.

2.1.4.3 **Requirements:**

2.1.4.3.1 Resident physician who has completed the competency phase

2.1.4.3.2 Successful insertion of a minimum total of 15 CVC placements at femoral and IJ sites. **Subclavian** placement is unique (see 3)

2.1.4.3.3 Subclavian Exception: At least FIVE successful CVC placements at the subclavian site are required to be a **Teacher Phase** for CVC placed at **THIS SITE**. For example, a trainee may have 15 total lines and if only two are Subclavian, the

trainee would need three additional Subclavian lines to teach/supervise at this site.

2.1.4.3.4 The resident must demonstrate the ability to supervise a resident in the learner phase performing a CVC insertion in the simulation lab.

2.1.4.3.5 The resident must be approved by their PD to move to **Teaching Competency**. **Note:** **Teaching Competency** can be achieved at only the **Femoral/IJ** sites or at **All Sites**

2.1.4.3.6 **Patient Selection:** All patients and all sites, though residents in Teaching phase should continue to seek out guidance and support in difficult or unusual circumstances during their training

2.1.4.4 **Supervision:** Indirect supervision by clinical supervisor. The resident should notify the patient's attending physician prior to placing a CVC. If the patient's attending physician is not credentialed to place a CVC, the attending physician will consult (either formally or informally) a credentialed physician who can provide assistance if required. While not required, Residents should seek direct supervision when available for continued learning and progression of skill.

2.1.5 **Large Bore Catheter Placement Exception:** The goal for this exception is to be able to independently place large bore catheters safely and competently. They are considered separate from routine multi-med type CVC catheters due to their increased risk for complications.

2.1.5.1 **Catheter definition:** CVC larger than 7.5 Fr, which includes Dialysis catheters, Resuscitation catheters (Arrow, trauma catheter) and Cordis

2.1.5.2 introducer/sheath introducer.

2.1.5.3 **Requirements:**

2.1.5.3.1 Be in the competency phase of CVC placement

2.1.5.3.2 The trainee must successfully place a minimum of five (5) large bore catheters under **direct supervision** by an Attending Physician or Teacher Phase resident prior to placing these CVCs

2.1.5.3.3 The trainee must be approved by their PD to move to Indirect Supervision for **Large Bore Catheters**

2.1.5.3.4 **Patient Selection: Large Bore Catheters** have a demonstrated higher morbidity and are not considered appropriate for placement by someone in the Learner Phase: Preferred sites for large bore catheter placement are **Femoral/ or Right IJ**

2.1.5.4 **Supervision:** Direct Supervision by Attending or Teacher Phase Resident who has completed five (5) Large Bore CVC is required until five (5) Large Bore CVC are placed. Afterwards, indirect supervision is required.

2.2 **Residents Entering Graduate Medical Education Programs at the PGY – 2 level, Transferring Residents, Visiting Residents and Fellows:**

2.2.1 The trainee needs to provide written documentation from their prior residency PD (residents entering at the PGY – 2 level, transferring residents or fellows) or current residency PD (visiting residents) of successful completion of comparable training and supervision regarding CVC insertion (including the number of CVC insertion) to their PD.

2.2.2 All trainees must complete the Bayhealth CVC simulation training course.

2.2.3 All trainees must demonstrate competency in the insertion of at least one (1) CVC at the bedside with direct supervision by a clinical supervisor.

2.2.4 All trainees must be approved by their residency/fellowship Program Director.

2.2.5 Trainees who have not successfully completed comparable training / supervision regarding CVC insertion, or if not competent on demonstration, must complete the entire program for independent CVC insertion.

2.3 **Tracking and documentation**

2.3.1 All Central Lines will be documented through the CVC procedure navigator in EPIC. The appropriate information of the catheter placement attempt along with the required quality indicators must be filled out on every attempted CVC placement. Failure to do so will result in suspension of the trainee's CVC insertion privileges until remediation is completed. Training on documentation of CVC is part of the Central Line Course.

2.4 **Competency Assessment**

- 2.4.1 Once the requirements for **Competency** are achieved, trainees may send a Competency Assessment Form to the qualified attending who was present for the entire procedure. Trainees should complete the entire procedure without faltering or assistance to receive a satisfactory score. The supervising attending is responsible for determining independent practice of the individual resident. (See Appendix B)
- 2.4.2 Any qualified attending (per Bayhealth medical staff privileges) may make this assessment for any resident on any service participating in the central line training program.

2.5 **Escalation**

- 2.5.1 A qualified supervising physician (Attending or **Supervisor**) must take over the procedure if:
 - 2.5.1.1 If an arterial puncture has occurred on ANY attempt
 - 2.5.1.2 If there is any suspicion that a pneumothorax may have occurred on ANY attempt, or the patient is in any sign of medical distress felt to be due to placement of the CVC.
 - 2.5.1.3 Any complication, suspected complication and need to escalate should be reported on the CVC procedure template.
- 2.5.2 Escalation may not be assumed by a qualified trainee at Competency level but rather the attending or trainee at Teaching Competency level.
- 2.5.3 For additional escalation procedures, please see Appendix A.

Appendix A: Standard Central Venous Catheter (CVC) Insertion

This policy is intended to promote patient safety during the placement of routine central venous catheters. This policy is not intended as a substitute for the clinical judgment of an attending physician involved in a CVC placement.

- A. Indications: Clinical indication and reasoning of site must be documented after the procedure in the EPIC CVC documentation tool.
- B. Difficult Patients or Sites: A resident at Learner Phase must have an attending or resident at Teacher Phase assess the patient to determine level of difficulty in CVC insertion prior to initiating the procedure. Competency Phase residents should communicate this assessment, specifically identifying any complicating conditions directly to the supervising attending prior to initiating the procedure.
- C. Trainees at Learner and Competency Phases must notify the supervising clinician prior to CVC placement or have a qualified physician (attending or competency level 3) provide direct supervision if the following conditions are present:
 - 1. Agitation/lack of cooperation in being immobile or positioned correctly
 - 2. Shock states with inadequate vein filling noted by completely collapsed vessel on ultrasound
 - 3. Previous thrombosis of intended vein
 - 4. Extremes of body habitus (BMI <20 or >50)
 - 5. Coagulopathy (platelets <50,000, INR >1.5, APTT>50 seconds)
 - 6. Previous surgery at or near the intended vein location
 - 7. Previous radiation at the proposed site of CVC insertion
 - 8. Previous CVC insertion at the intended site
- D. Site Insertion Selection: Appropriate site selection is dependent on the particular clinical situation and is best determined by the clinician's experience with central line placement. At times, clinical circumstances may dictate that approaches to central line placement that diverge from the Bayhealth Central Line Guidelines be utilized. It is expected that this will be an unusual occurrence.
- E. PREPARATION
 - 1. The patient on whom the procedure is being performed is to be identified with two identifiers per hospital protocol with appropriate consent obtained, the site to be cannulated identified, and risk factors for complications assessed.
 - 2. The equipment required for insertion of the CVC is to be present before starting the procedure.
 - 3. Prior to the application of sterile precautions, the clinician should use ultrasound as indicated above (on IJ and femoral sites) to determine:
 - i. Vascular anatomy and location of the target vessel with ultrasound. The provider must be able to reliably distinguish the artery from the vein using anatomy, location, and compressibility and/or Doppler.
 - ii. Demonstrate the patency of the target vessel.

4. A qualified supervisory physician (based on the trainee's level of competency) must be identified prior to starting the procedure. This qualified physician must be aware of the procedure prior to any attempt, unless the placement is a true emergency (e.g. code blue, profound shock). Anticipated site selection, patient-related difficulties, and appropriateness for CVC placement must be reviewed with the supervising physician.
 5. An attending physician responsible for the placement must also be identified and documented in the medical record. The attending physician should be notified prior to placement unless urgency of the clinical situation precludes it, at which time the attending will be notified immediately after placement.
- F. PROCEDURE (routine, non-emergency CVC insertion)
1. The patient on whom the procedure is being performed is to be identified per the protocol. A time out will be performed prior to the procedure.
 2. Personal protective equipment that fulfills sterile precautions will be utilized: sterile gown, mask, cap, and sterile gloves. A sterile ultrasound probe cover is required even if a second clinician will provide ultrasound assistance.
 3. An initial prep of chlorhexidine should be applied and then the patient draped appropriately. For non-urgent CVC, this should be head to toe.
 4. The clinician is expected to maintain sterile technique throughout the procedure. If sterile technique is accidentally broken, the clinician should stop the procedure and restart sterile preparations as clinically indicated (e.g., replace gloves, obtain second sterile instrument/tray).
 5. The clinician will deliver local anesthesia to completely anesthetize the insertion and secondary securing site.
 6. The clinician will identify anatomical landmarks and then sonographically reassess the anatomy, location, and patency of the target vessel. The clinician will correctly identify the position/location of introducer needle.
 7. Under direct ultrasound guidance (IJ and femoral), the clinician should puncture the vein, determine return of dark venous blood with non-pulsatile flow, and advance the wire into the vessel only if no resistance is met. If pulsatile or bright red blood is returned, stop the procedure, and refer to escalation guidelines.
 8. With the needle and wire in place, the clinician should sonographically confirm that the wire is in the venous lumen by visualizing the artery and vein simultaneously. The following views are recommended:
 - i. Demonstrate collapsibility of the vessel where the wire is located
 - ii. Use flow and Doppler to document venous flow
 - iii. Follow the wire down the vessel, visualizing the target sign
 - iv. The probe is then switched to the longitudinal view to again visualize that the wire is not cross threaded into adjacent artery.

The clinician is encouraged to electronically archive or print hard copy images for QA review and reimbursement.

9. If the wire is correctly located, the clinician should proceed using the standard Seldinger technique
 - i. If there is concern for INAPPROPRIATE placement, proceed to section **G. Special techniques for confirmation of venous puncture.**
 - ii. If there is an arterial puncture, proceed to section I. **IN CASE OF A SUSPECTED ARTERIAL PUNCTURE DO NOT dilate the vessel.**
 - iii. An ABG can be sent off for confirmation about venous placement.
10. After placement of the catheter: flush all ports with normal saline and secure/suture the CVC in place.
11. The clinician should clean the insertion site following procedure with chlorhexidine.
12. The clinician must apply antibiotic disk or similar infection control measures unless contraindicated.
13. The clinician (or sterile designee/nurse) must apply sterile central line dressing.
14. The clinician is encouraged to subsequently use ultrasound to document the absence of a pneumothorax.
15. The clinician is encouraged to electronically archive or print hard copy images for QA review and reimbursement.
16. The clinician must order post-procedure chest radiograph (Stat, Radiologist to read immediately) for all intrathoracic lines: subclavian, infraclavicular and supraclavicular approach, and internal jugular CVCs.

G. TECHNIQUES FOR CONFIRMATION OF VENOUS PUNCTURE:

In addition to a chest x-ray which is used for intrathoracic CVC placement, the position of the line should be verified by one of the following methods to confirm venous placement of the line:

1. Venous manometry (visual or monitor)
2. Blood gas analysis
3. Catheter identified in vein using ultrasound

Trainee must inform the supervising physician about any abnormal results of the above tests.

H. USING THE CVC

1. If Section F above is performed appropriately and line placement is verified according to Section G, the line may be used. In cases of clinical emergency, the line may be utilized without the above confirmation techniques based on the clinical judgment of the physician.
2. Once correct placement of the CVC is confirmed, the physician must document this in EPIC and inform nursing that the CVC may be used for clinical care.

I. IN CASE OF A SUSPECTED ARTERIAL PUNCTURE:

1. Have someone immediately call the supervising physician if they are not present in the room.
 2. Remove the guide wire and/or needle and apply pressure for five (5) minutes if the patient is not anticoagulated. If the patient is anticoagulated, apply pressure as per the direction of the supervising physician.
 3. Perform secondary attempts at another site with direct supervision by a qualified physician or a teaching level supervisor.
- J. IN THE CASE OF ARTERIAL DILATION with a central line of 7.5f or greater:
1. **Do not remove the line!**
 2. Immediately notify the supervising attending and request immediate Vascular Surgery consultation.
- K. COMPLICATIONS (OR SUSPECTED COMPLICATIONS)
1. Persistent site bleeding: notify supervising physician or teaching level supervisor and apply pressure to site if not contraindicated. Consider blood product replacement (platelets, factor) in consultation with attending physician or teaching level supervisor.
 2. Pneumothorax: For evidence of tension pneumothorax, clinician should perform immediate appropriate needle decompression. If the attending physician is not qualified to place/supervise tube thoracostomy insertion, obtain stat consultation from the ICU service, general surgery, cardiothoracic surgery, the emergency medicine attending (if in the Emergency Room), or inpatient attending if on the floor and the attending is qualified to perform a tube thoracostomy. For any non-tension pneumothorax, consult as appropriate. Consider calling a rapid response.
 3. Persistent pain: Notify attending physician. Consider reapplication of local anesthesia or CVC removal.

Appendix B. Competency attestation form to be sent to the attending/supervising physician by the resident prior to insertion:

Resident X has placed at least ten (10) Central Venous catheters successfully and is now eligible for competency phase certification in CVC placement. Achieving this level allows them to place CVC independently and without direct supervision.

I have directly observed resident X performing this CVC and certify they followed the CVC placement check list and attest to their competency. I certify them as capable of safely performing CVC placement with only indirect supervision.

Yes

No (requires comment): Please comment on areas resident needs to remediate before placing central lines with indirect supervision.

(Check list reminder in MedHub)

1. Obtained informed consent.
2. Timeout:
 - a. Identify patient using two valid patient identifiers.
 - b. Review patient allergies.
 - c. Confirm procedure to be performed, including site and side of patient.
3. Care Provider and all assistants wear caps and masks.
4. Sanitize hands.
5. Select appropriate site of venipuncture and visualize the vein using ultrasound (femoral and internal jugular).
6. Prepare venipuncture site with chlorhexidine.
7. Operator should now don sterile gown and gloves and then place on patient a full-length sterile drape.
8. Identify Anatomical Landmarks appropriately.
9. Reconfirm target vessel location by Ultrasound (femoral and IJ).
10. Anesthetize area using 1% Lidocaine.
11. Cannulate the target vessel using landmarks and ultrasound assistance when appropriate.
12. Venipuncture successful in two or less attempts.
13. Confirm vessel entry by aspiration of venous blood.
14. Insert J wire into needle, advancing wire without resistance. Watch for ectopy.
15. Confirm wire in target vessel with ultrasound using multiple views when appropriate and remove needle.
16. Stab incision with a scalpel at the wire entry site.
17. Dilate the catheter tract using the dilator then remove dilator.
18. Insert catheter over-the-wire to its appropriate length.
19. Remove wire and make sure it is intact. Close the clamp on the port promptly after removing the wire.

20. Attach a 10mL syringe to the distal port and attempt to aspirate venous blood. If successful, follow this by flushing the port with 5-10 cc of saline. Repeat for other ports.
21. Suture catheter in place.
22. Re-clean surgical site to remove all excess blood and apply another chlorhexidine wash.
23. Place Biopatch at cannulation site and cover via an occlusive dressing.
24. Use Ultrasound to check for the presence of Pneumothorax for IJ and SC placed catheters.
25. Verify location of venous location by at least one confirmatory method other than x-ray.
26. Order a STAT: Radiologist to Read Immediately portable CXR for all SC and IJ line placements or attempts.
27. Complete catheter insertion documentation in the medical record, including logging in the CVC EPIC navigator.
28. CRITICAL STEP: Sterile field maintained?
29. CRITICAL STEP: If after two unsuccessful attempts (except if emergent), was escalation protocol followed?

Professionalism

Purpose Statement: To comply with the professionalism requirements set forth by the Accreditation Council for Graduate Medical Education (ACGME) for Institutional Accreditation.

1. Procedure:
 - 1.1 Residents/fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Specifically, they must demonstrate:
 - 1.1.1 Compassion, integrity, and respect for others
 - 1.1.2 Responsiveness to patient needs
 - 1.1.3 Respect for patient privacy and autonomy
 - 1.1.4 Accountability to patients, society, and the profession; and
 - 1.1.5 Sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation
 - 1.2 Each program will establish Overall Goals and Objectives and rotation specific Goals and Objectives which clearly outline standards for Professionalism
 - 1.3 Residents/fellows are expected to behave professionally:
 - 1.3.1 Accept feedback in a non-defensive manner
 - 1.3.2 Demonstrate appropriate sensitivity to patients and their families
 - 1.3.3 Complete tasks in a timely manner (both clinical and administrative)
 - 1.3.4 Be available for professional responsibilities
 - 1.3.5 Demonstrate honesty and integrity
 - 1.3.6 Maintain professional demeanor, including:
 - 1.3.6.1 Have an appearance and dress that are in line with professional standards as established by departmental policies (Resident Dress Code and Personal Appearance and Dress B9065.11)
 - 1.3.6.2 Exhibit respectful and courteous behaviors
 - 1.3.6.3 Be responsive to questions and accommodating to requests
 - 1.3.6.4 Express anger in a non-public and non-physical manner
 - 1.3.6.5 Adhere to professionally accepted boundaries for patient relationships
 - 1.3.6.6 Conform to sexual harassment (B9065.36) and discrimination policies (B9090.05)
 - 1.3.6.7 All programs provide a professional, equitable, respectful, and civil environment that is free from unprofessional behavior,

including discrimination, sexual and other forms of harassment, mistreatment, or abuse

- 1.3.7 Comply with all requirements set forth in the GME Policy and Procedure Manual
- 1.4 Unprofessional conduct, to include but not limited to the following, is unacceptable and may be subject to progressive discipline:
 - 1.4.1 Failure to be truthful in all circumstances
 - 1.4.2 Violation of state and federal rules/laws as standards of practice
 - 1.4.3 Chronic tardiness and/or failure to complete tasks in a timely manner
 - 1.4.4 Rudeness
 - 1.4.5 Disregard for other team members
 - 1.4.6 Disrespect for authority
 - 1.4.7 Inappropriate behavior with patients, families, or other members of the health care team
 - 1.4.8 Public or physical displays of anger
 - 1.4.9 Failure to follow up on clinical activities
 - 1.4.10 Abuse of power
 - 1.4.11 Failure to respect policies of Bayhealth Medical Center and affiliated hospitals
 - 1.4.12 Inappropriate use of social media
 - 1.4.13 Use of personal email for sending Bayhealth business
 - 1.4.14 Unexplained absences
 - 1.4.15 Failure to adhere to departmental dress standards
- 1.5 Unprofessional behavior is grounds for disciplinary academic and/or punitive action(s):
 - 1.5.1 Program directors will investigate complaints and prescribe remediation if indicated
 - 1.5.2 Persistent problems will be brought before the programs' specific evaluation group for recommendations and additional remediation (i.e. Clinical Competency Committee)
- 1.6 Should unprofessional behaviors continue and fail to be remediated at the previous two levels, residents/fellows will be brought before the Graduate Medical Education Committee (GMEC) for a hearing

Promotion/Non-Renewal/Dismissal

Purpose Statement: Establishes the criteria by which residents/fellows may be promoted and discusses the resulting actions that will take place in the event of non-promotion, non-renewal of a contract, or dismissal from a residency program at Bayhealth.

1. Procedure:

- 1.1 After satisfactory completion of each year of GME experience, as attested to by the Program Director, a resident/fellow in good standing may be promoted to the next level of training, subject to the terms, limitations and conditions described in this document and the Resident/Fellow Agreement.
- 1.2 A resident/fellow is promoted based on acceptable periodic clinical evaluations, which may be augmented by other evaluation methods, by recommendation of the programs Clinical Competency Committee and the Program Director, and by final approval of the Graduate Medical Education committee (GMEC). Additional promotion criteria include the following:
 - 1.2.1 Satisfactory completion of all training requirements
 - 1.2.2 Clinical and Academic performance
 - 1.2.3 Documented competence commensurate with level of training: Each program has specific milestones which allow the CCC to track the resident/fellow as they move through the skill acquisition model (novice, advanced beginner, competent, proficient, expert). Individuals will not progress through each milestone within the same time parameters; however, it is recommended that the resident/fellow attain the levels listed in the table below in the majority of their program specific milestones prior to promotion to the next level or graduation.

| Program & Milestone Attainment for Promotion to Next Level or Graduation | | | | | | |
|--|-----|-----|-----|-----|---------|-----|
| PGY | EM | FM | GS | IM | Hem/Onc | GI |
| 1 | 2 | 2 | 1.5 | 2 | N/A | N/A |
| 2 | 3 | 3 | 2 | 3 | N/A | N/A |
| 3 | 4 | 4 | 2.5 | 4 | N/A | N/A |
| 4 | N/A | N/A | 3 | N/A | 2 | 2 |
| 5 | N/A | N/A | 4 | N/A | 3 | 3 |
| 6 | N/A | N/A | N/A | N/A | 4 | 4 |

- 1.2.4 Residents must pass USMLE/COMLEX 3 during their PGY-1 to be promoted to a PGY-2.

- 1.2.4.1 Residents who fail to pass USMLE by the end of their PGY-1 will be extended as a PGY-1 for 90 days and are expected to take and pass the exam during that time.

- 1.2.4.2 Residents should schedule the exam as soon as possible as testing dates fill up and results may take a month to receive
- 1.2.4.3 Residents will NOT be promoted to a PGY-2 until passing results are received; this will result in an off-cycle graduation.
- 1.2.4.4 If a resident fails to pass on the second attempt, they may be extended one additional time for 90 days if necessary
- 1.2.4.5 Failure to pass USMLE/COMLEX 3 after three attempts will result in dismissal from the institution
- 1.2.5 Full compliance with all terms of the Resident/Fellow Agreement
- 1.2.6 Continuation of the Sponsoring Institution and program Accreditation Council for Graduate Medical Education (ACGME) accreditation
- 1.2.7 Additional promotion criteria may be determined by the Clinical Competency Committee and the Program Director for individual programs.
- 1.3 Resident/Fellow Non-Renewal/Dismissal
 - 1.3.1 Grounds for discipline, dismissal, or non-renewal of contract of a resident/fellow include, but are not limited to, the following:
 - 1.3.1.1 Below satisfactory academic performance, defined as a failed rotation; relevant exam scores below program requirements; and/or marginal or unsatisfactory performance as evidenced by faculty evaluation, in the areas of clinical diagnosis and judgment, medical knowledge, technical abilities, interpretation of data, patient management, communication skills, interactions with patients and other healthcare professionals, professionalism, and/or motivation and initiative.
 - 1.3.1.2 Conduct that violates professional and/or ethical standards; disrupts the operations of the Bayhealth facilities or participating sites, its departments, or affiliated hospitals; or disregards the rights or welfare of patients, visitors, or hospital/clinical staff.
 - 1.3.1.3 Failure to comply with the bylaws, policies, rules, or regulations of Bayhealth or affiliate hospitals, medical staff, department, or with the terms and conditions of this document.
 - 1.3.1.4 Commission by the resident/fellow of an offense under federal, state, or local laws or ordinances which impacts

upon the abilities of the resident to appropriately perform their normal duties in the residency program.

1.3.1.5 Ineligible for continued appointment based on ongoing absence/unavailability to perform training duties; failure to satisfy licensure; visa, immunization, registration, or other eligibility requirements for training.

1.3.2 In the event of non-promotion, non-renewal of a contract or dismissal from a program, the resident will receive a written notice of intent not to renew or be dismissed from the program 120 days prior to the end of the contract year. Any written notice of intent to not renew, promote or dismiss will include a copy of the residents/fellows right to due process (Grievance Policy) relating to the above actions when the action is taken during the appointment period, suspension, non-renewal, non-promotion, or dismissal. If a resident/fellow is on probation or in remediation, the 120-day written notice of intent will not apply.

1.3.3 Academic Leave

1.3.3.1 Residents/fellows may request academic leave, please refer to GME Paid Time Off and Leave of Absence Policy

2. References :[ACGME Milestones](#)

Protocol for Special Review

Purpose Statement: This policy provides information on the Special Review process for underperforming graduate medical education programs. Specifically, this policy will establish criteria for identifying underperformance and provide the procedures for conducting the Special Review.

1. Procedure:
 - 1.1 Underperformance by a program can be identified through a wide variety of mechanisms. These may include, but are not limited to the following:
 - 1.1.1 Deviations from expected results in standard performance indicators
 - 1.1.2 Recruitment underperformance, unmatched or unfilled positions over three years
 - 1.1.3 Board passage rates fall below 80%
 - 1.1.4 Change in a program director more frequently than every two years
 - 1.1.5 More than one resident withdraws, transfers or is dismissed over a two-year period
 - 1.1.6 Multiple scores for ACGME resident or faculty surveys that are below 80%
 - 1.1.7 Adverse program accreditation status
 - 1.1.8 Complaints that indicate noncompliance with ACGME requirements or institutional policies
 - 1.1.9 There has been a significant complaint against the program to the ACGME
 - 1.1.10 Changes in major participating sites
 - 1.1.11 Major program structural changes such as adequacy of clinical or didactic experience within the residency
 - 1.1.12 Inadequate core faculty scholarly activity (less than 50%)
 - 1.1.13 Resident/fellow scholarly activity below specialty specific requirements
 - 1.1.14 The Special Review can be initiated by request of the Program Director to the Designated Institutional Official
 - 1.2 Special Review Process
 - 1.2.1 If a residency/fellowship program meets criteria for designation as an underperforming program, the Designated Institutional Official (DIO) will schedule a Special Review.
 - 1.2.2 A Special Review must be completed within 30 to 60 days of a program's designation as underperforming.
 - 1.2.3 Each Special Review will be conducted by a panel of individuals from the sponsoring institution such as the DIO, GME

- administrative member, a Program Director, and a resident/fellow from a program other than the one being reviewed
- 1.2.4 Based on identified special review criteria, the DIO will determine if a focused or full review will be conducted
- 1.3 During the Special Review, the following materials and data may be used in preparation. This list is not exhaustive:
 - 1.3.1 ACGME common, specialty/subspecialty-specific program and institutional requirements in effect at the time of the review
 - 1.3.2 Accreditation letters of notification from the most recent ACGME reviews and progress reports sent to the respective Residency Review Committee (RRC)
 - 1.3.3 Reports from previous internal reviews of the program
 - 1.3.4 Reports from previous Special Reviews
 - 1.3.5 Previous Annual Program Evaluations (APE)
 - 1.3.6 Results from internal or external resident surveys if available
 - 1.3.7 Any other materials the special review panel considers necessary
- 1.4 Following the Special Review meetings and interviews, a clear and concise report must be completed within two weeks. The chair and the graduate medical education office representative will complete the first draft of the report utilizing a standardized template for the panel to review. The report will include the following:
 - 1.4.1 Name of the program being reviewed with the date of review
 - 1.4.2 Names and titles of Special Review panel and level of training of residents/fellows participating
 - 1.4.3 Summary of how the review process was conducted and a list of documents reviewed
 - 1.4.4 Findings, recommendations, and due date for action plan
- 1.5 Finalized copy of the report will be provided to the Program Director who will be given 30 days to create an action plan
- 1.6 The report will be presented by the chair of the Special Review panel at the subsequent GMEC meeting, where they will review and discuss the findings
 - 1.6.1 During the GMEC meeting, the Program Director will have the opportunity to respond to the findings and provide action plan
 - 1.6.2 The GMEC will set a timeline for completion of action items
- 1.7 The DIO and GMEC will monitor the programs action plan to ensure program improvement

- 1.7.1 The Program Director will provide a progress report to GMEC addressing areas of concern identified by the panel at a frequency determined by GMEC
 - 1.7.2 GMEC may continue to ask for the Program Director to report on areas of concern on a regular basis until it is felt that the issues have been adequately addressed
- 1.8 Once the program has resolved all issues identified by the Special Review the DIO will send a letter to the Program Director verifying compliance

Recruitment, Selection and Appointment

Purpose Statement: This policy sets forth Bayhealth guidelines regarding resident/fellow recruitment and selection and is intended to establish valid, fair, effective, and ethical criteria for the recruitment and selection for Bayhealth's graduate medical education programs.

1. Procedure:

1.1 Resident/Fellow Recruitment

1.1.1 Resident/fellow eligibility will be aligned with the ACGME Common and Specialty-Specific Requirements.

1.1.2 Upon invitation to interview for a position, a candidate must be informed of the terms, conditions, and benefits of appointment to the ACGME-accredited program in writing or electronically. This communication to the candidate must include information on the following elements:

1.1.2.1 Stipends, benefits, professional liability coverage, and disability insurance are accessible to residents/fellows

1.1.2.2 All institutional policies for vacation and leaves of absence, including medical, parental and caregiver leaves of absence and health insurance accessible to residents/fellows and dependents

1.1.3 In determining resident/fellow eligibility and appointment, Bayhealth will not discriminate about a resident's/fellow's gender, race, religion, color, creed, national origin, disability, sexual orientation, or veteran status. Residents will be selected based on the above requirements as well as their interpersonal and communication skills, professionalism, integrity, medical knowledge, and perceived preparedness to enter residency training.

1.2 Applicants are required to meet at least one of the following qualifications to be eligible for a position in the graduate medical education program at Bayhealth:

1.2.1 The Applicant must be a:

1.2.1.1 Graduate from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association (AOA) or

1.2.1.2 Graduate from a medical school in the United States or Canada, accredited by the LCME or

1.2.1.3 Graduate from a medical school outside the United States, and meeting one of the following additional qualifications:

- 1.2.1.3.1 Holds a full and unrestricted license to practice medicine in a United States licensing jurisdiction in their ACGME specialty/subspecialty program; or
- 1.2.1.3.2 Holds a valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or
- 1.2.1.3.3 Has graduated from a medical school outside the United States and has completed a Fifth Pathway program provided by an LCME accredited medical school

1.3 Resident/Fellow Selection

1.3.1 The following will be the enforced requirements for Resident/Fellow Selection at Bayhealth:

- 1.3.1.1 Provide both a copy of their diploma and a letter from the dean of their medical school verifying graduation
- 1.3.1.2 Provide at least three (3) letters of recommendation from physicians with whom the candidate has worked
- 1.3.1.3 Complete a personal interview either in person or through video conference
- 1.3.1.4 Applicants must have the ability to obtain licensure in the state of Delaware
- 1.3.1.5 Applicants must complete all required licensing exams as listed below:
 - 1.3.1.5.1 Graduates of an AOA accredited school must successfully complete COMLEX Level 1, COMLEX Level 2 PE and COMLEX CE.
 - 1.3.1.5.2 Graduates of an LCME accredited school must successfully complete USMLE Step 1, USMLE Step 2 CK and USMLE Step 2 CS.
 - 1.3.1.5.3 Graduates of a non-LCME accredited school outside of the United States must successfully complete USMLE Step 1, USMLE Step 2 CK and USMLE Step 2 CS.

1.4 Visa Criteria

- 1.4.1 International medical graduates seeking J-1 sponsorship must fulfill several general requirements detailed in ECFMG exchange visitor sponsorship application materials. Bayhealth Medical Center in coordination with ECFMG will facilitate J-1 sponsorship.

- 1.4.2 All J-1 visas will be processed through the Graduate Medical Education Office. The Training Program Liaison (TPL) will work with the resident/fellow in obtaining the visa.
- 1.4.3 Under certain exceptional circumstances, Bayhealth Medical Center will sponsor H-1B visas. This will be reviewed on a case-by-case basis and must be approved in advance. All applications for H-1B visas will be handled by the Bayhealth Medical Center attorney.
 - 1.4.3.1 For residents/fellows to be eligible for H-1B they must have successfully completed Step 3 prior to the start of the program.
- 1.4.4 It is the visa holder's responsibility to maintain lawful status while in the United States and while training at Bayhealth Medical Center as a resident/fellow
- 1.5 Requirements for Appointment
 - 1.5.1 All residents/fellows must hold a temporary training license from the State of Delaware. A copy of the training license must be given to the GME office prior to appointment.
 - 1.5.1.1 Residents/fellows will be reimbursed for the cost of the training license.
 - 1.5.1.2 Residents/fellows will not be reimbursed for obtaining a license to moonlight.
 - 1.5.2 Residents/fellows are required to provide the GME office/HR/Occupational Health with the following:
 - 1.5.2.1 Proof of MMR, Varicella, Hepatitis B, Tetanus, Diphtheria w Pertussis or Diphtheria-tetanus within the past ten years
 - 1.5.2.1.1 Residents/fellows must have negative titers to the above mentioned or will be required to obtain the appropriate vaccines.
 - 1.5.2.2 Tuberculosis Testing within the 12 weeks prior to the start of training at Bayhealth
 - 1.5.2.2.1 Tuberculosis testing will occur at the occupational health visit
 - 1.5.2.2.2 Residents/fellows are required to be screened annually
 - 1.5.2.3 Residents/fellows who fail to supply the immunization and health records required by the program will be placed on administrative notice.

- 1.5.3 All residents/fellows are required to obtain and upload a copy of their photo identification card, medical license, ECFMG certification (if applicable), medical school diploma, vaccination record, passport (if applicable), Visa (if applicable), demographic information and any other information requested by the GME office.
- 1.5.4 Criminal background checks, drug screening and sexual offender check are required for all newly hired residents/fellows and must be completed prior to appointment at Bayhealth.
 - 1.5.4.1 A resident/fellow testing positive for any controlled substance will be denied employment unless it can be shown the drug in question is prescribed by a licensed physician or healthcare provider to treat a current diagnosed condition and will not interfere with the applicant's ability to safely perform the job. The Bayhealth Medical Review Officer will evaluate all positive results and consult with the prescribing physician if applicable.
 - 1.5.4.2 Residents/fellows must adhere to all drug and alcohol policy requirements listed in the Bayhealth Drug and Alcohol Abuse Policy (B9065.14).
 - 1.5.4.3 Residents/fellows are required to pass the required Human Resources screening prior to appointment.
 - 1.5.4.3.1 Program Director(s) will be notified by Human Resources of any failed pre-employment testing.

Program Closure and Reduction

Purpose Statement: To outline the process which will be followed by Bayhealth Graduate Medical Education (GME) residency/fellowship programs in the event of reduction in size or closure of a program.

1. Procedure:
 - 1.1 Bayhealth senior leadership, Program Director, Designated Institutional Official (DIO) and Graduate Medical Education Committee (GMEC), will make every effort to avoid the closure of the Bayhealth Accreditation Council for Graduate Medical Education (ACGME) accredited programs.
 - 1.2 Bayhealth is required to inform GMEC, the DIO, and the affected residents/fellows within five (5) business days following a decision regarding program reduction or closure (including intended Institutional closure).
 - 1.3 If a decision is made that a training program must decrease in size, the following steps must be taken:
 - 1.3.1 The Program Director will inform the DIO, GMEC and the residents within five (5) business days of the decision.
 - 1.3.2 Complement reductions will be made by first reducing the number of positions available to incoming residents/fellows when possible.
 - 1.3.3 If it is determined that the reduction must include current residents/fellows of the program, Program Director and DIO will assist affected residents/fellows in enrolling in an alternative ACGME-accredited program.
 - 1.3.4 The DIO and GMEC are responsible for monitoring the resident/fellow complement reduction process
 - 1.4 In the event a decision is made that a training program must close, the following steps must be taken:
 - 1.4.1 The Program Director must inform the DIO, GMEC and the residents/fellows within five (5) business days of the decision.
 - 1.4.2 Bayhealth will attempt to structure a closure that allows enrolled residents/fellows to complete the program whenever possible.
 - 1.4.3 If a program must be closed before one or more residents/fellows are able to complete their required training, the Program Director and DIO will work closely with the residents/fellows to assist them in enrolling in an ACGME accredited program(s) to continue their education.
 - 1.4.4 The DIO and GMEC will be responsible for monitoring the closure process.

- 1.5 The DIO must notify the ACGME of the residency/fellowship reduction or closure and arrange to keep in contact with the ACGME throughout the process. The DIO must also abide by all ACGME policies and procedures pertinent to GME-residency/fellowship reduction or closure.

Responsibilities

Purpose Statement: Residents and fellows are physicians in training. They develop and learn the skills necessary for their chosen specialty through didactic sessions, reading and providing direct patient care under the supervision of the Medical Staff and senior residents/fellows. As part of their training program, residents and fellows receive progressively greater responsibility according to their level of education, ability, and experience. Expectations include providing competent and compassionate patient care, as well as working as an effective member of the inter-professional care team. In doing so they must maintain a high degree of professionalism in all interactions (direct patient care, communication with family members, other health care professionals, and support staff).

1. Procedure:

1.1 Patient Care

1.1.1 As part of their education residents/fellows participate in patient care with graduated responsibility based their acquired skillset and level of experience. Under the supervision of attending physicians, general responsibilities of the trainees may include the following:

- 1.1.1.1 Initial and ongoing assessment of patients medical, physical, and psychosocial status
- 1.1.1.2 Performing history and physicals
- 1.1.1.3 Performing rounds
- 1.1.1.4 Recording progress notes
- 1.1.1.5 Ordering tests, examinations, medications, and therapies
- 1.1.1.6 Interpretation of test results
- 1.1.1.7 Arranging for discharge and after care
- 1.1.1.8 Writing or dictating admission notes, progress notes, procedure notes, and discharge summaries
- 1.1.1.9 Providing patient education and counseling health status, test results, disease processes, and discharge planning
- 1.1.1.10 Assisting/performing procedures
- 1.1.1.11 Assisting/performing surgical procedures

- 1.1.2 Trainees must recognize that under certain circumstances, the best interests of the patient necessitate transitioning care to another qualified and rested provider
- 1.1.3 Trainees should be able to communicate with patients and families about the disease process and the plan of care as outlined by the Attending
- 1.1.4 Trainees are expected to demonstrate an understanding of the socioeconomic, cultural, and managerial factors inherent in providing cost-effective care
- 1.1.5 Trainees must be able to demonstrate graduated competency in the acquisition of knowledge and skills in the selected specialty and further ability to function independently in evaluating patient problems and developing a plan for patient care
- 1.1.6 Trainees may respond to consultations and learn the elements of an appropriate response to consultation in conjunction with the faculty member
 - 1.1.6.1 Trainees should be capable of managing patients with virtually any routine or complicated condition and are responsible for coordinating the care of multiple patients on the team they are assigned
 - 1.1.6.2 Trainees can perform progressively more complex procedures under the direct supervision of the faculty.
 - 1.1.6.3 At the completion of the program, trainees should be ready to assume independent practice responsibilities
 - 1.1.6.4 In residency programs that require longer training, trainees should demonstrate skills needed to manage a clinical service or be a chief-level Trainee

1.2 Participation in Institutional Committees

- 1.2.1 Trainees are encouraged to participate in departmental and hospital committees to become familiar with the administrative aspects of health care.
- 1.2.2 When trainees sign up to be part of a hospital committee, they should attend as many meetings as allowed based on their schedule

and be an active participant in the committee; expectations include attending at least 50% of the scheduled committee meetings

1.2.2.1 Trainees are expected to share committee updates at Forum quarterly meetings so that information is passed to all trainees, unless information in the meetings is confidential

1.2.3 Trainees must reapply for committee membership each academic year through the GME office

1.2.3.1 An email with information will be sent at the beginning of each academic year

1.2.3.2 Upper-level trainees will have seniority for committee membership

1.2.3.3 Family Medicine trainees are required to be part of a committee

1.2.4 Trainees who are interested in being part of the GMEC subcommittees must be peer selected annually

1.3 Teaching and Supervision

1.3.1 Medical Students

1.3.1.1 Residents/fellows play a critical role in the education of medical students. In the hospital setting, the residents/fellows may be the first point contact, and the immediate supervisor for the student

1.3.1.2 Residents/fellows will teach a substantial amount of what the students learn. Residents/fellows need to be aware of the student's rotation learning objectives and student roles

1.3.1.3 Residents/fellows are expected to role model professionalism, ethics, and humanistic patient care to students

1.3.1.4 Residents/fellows should provide both formative and summative feedback to students they are supervising

1.3.2 Senior residents/fellows are also expected to teach, mentor, and supervise junior residents either directly or indirectly with direct supervision immediately available. If indirect supervision is provided, supervision must be consistent with Review Committee policies and the specific criteria established by the program

1.4 Administrative

1.4.1 Work Hours

- 1.4.1.1 Residents/fellows have the professional responsibility to ensure they can provide services that promote patient safety by ensuring they are well rested and fit for duty
- 1.4.1.2 Trainees must log their work hours into MedHub
- 1.4.1.3 Failure to do so shows a lack of professionalism that may be reviewed at your programs CCC meetings
- 1.4.1.4 In the event of an emergency, your program coordinator may enter hours or submit the time sheet for you
 - 1.4.1.4.1 Emergencies are unexpected time off for illness or personal issues
 - 1.4.1.4.2 All incoming trainees receive education on appropriate procedures associated with logging work hours; these instructions are available for reference on the resources & documents section located on MedHub
 - 1.4.1.4.3 If a violation is being logged the trainee will be required by MedHub to log the reason for violation for program review
 - 1.4.1.4.4 Trainees always have access to the past and current week's timesheets. After entering all hours for the week trainees must hit the submit button to signify the entire week has been recorded
 - 1.4.1.4.5 If a trainee feels a work hour violation may occur, the trainee must contact the Program Director or Coordinator immediately

1.4.2 Emails

- 1.4.2.1 Each trainee is provided with a Bayhealth issued cell phone to easily check emails throughout the workday
- 1.4.2.2 Trainees are expected to check their Bayhealth email address daily, unless they are on PTO or other leave
- 1.4.2.3 This will be considered a professionalism issue if trainees do not check their email daily

1.4.3 Healthstream Modules

- 1.4.3.1 Trainees must complete healthstream modules before the due date
 - 1.4.3.1.1 Healthstreams that are overdue are monitored by the program and the GME office and will be forwarded to the Program Director and DIO

- 1.4.3.1.2 Trainees who do not complete the required modules within five days will lose badge access and will be required to complete the modules before returning to clinical duties

1.4.4 Feedback

- 1.4.4.1 Trainees must provide summative and formative feedback as necessary
- 1.4.4.2 Trainees should provide formative, at the moment feedback to medical students and junior trainees to aid in their development. Feedback should be constructive in nature and helpful to the growth of their junior colleagues
- 1.4.4.3 Trainees should provide summative, end of rotation feedback to medical students
- 1.4.4.4 Trainees should complete peer evaluations of other trainee colleagues in regard to professionalism, teamwork, and interpersonal communication skills
- 1.4.4.5 Trainees will evaluate faculty with whom they have rotated. This feedback is necessary to help faculty improve teaching skills and should acknowledge faculty strengths as well as offer constructive suggestions for improvement
- 1.4.4.6 Trainees will complete internal and external (ACGME) evaluations of programs to aid in program development and improvement

1.5 Personal Development and Growth within Specialty

- 1.5.1 With the assistance of an assigned mentor or the Program Director, Trainees must develop and implement a plan for study, reading and research of selected topics that promote personal and professional growth and be able to demonstrate successful use of the literature in dealing with patients
- 1.5.2 Trainees should have mastery of the information contained in standard tests and be facile in using the literature to solve specific problems

- 1.5.3 Trainees will be responsible for presentations at conferences and for teaching junior trainees and medical students on a routine basis
- 1.5.4 Trainees should begin to understand the role of physicians in an integrated health care delivery system and to be aware of the issues in health care management facing patients and physicians
- 1.5.5 Trainees should be able to give formal presentations at scientific assemblies and assume a leadership role in teaching on the service
- 1.5.6 The morals and values of the profession should be highly developed, including the expected selfless dedication to patient care, a habit of lifelong study and commitment to continuous improvement of self and the practice of medicine
- 1.5.7 Trainees will make every effort to benefit from the education offered, by attending educational conferences as required for each program
- 1.5.8 Trainees should develop a personal program of reading. In addition to general specialty reading, the trainees will complete directed daily reading relating to problems encountered in the care of patients
 - 1.5.8.1 Trainees are responsible for reading in advance of performing or assisting in a procedure for the first time
 - 1.5.8.2 Trainees should research new diseases as presented in patients
- 1.5.9 Trainees must develop the following competencies to the level of a new physician by the completion of training: Patient Care, Medical Knowledge, Practice-based Learning, and Improvement, Interpersonal and Communication Skills, Professionalism, Systems-Based Practice
- 1.6 Required Citi Training and IHI Modules
 - 1.6.1 Trainees are required to complete Citi Training and IHI Modules within six months of the first year of residency
 - 1.6.1.1 Instructions on this will be provided to the trainees during GME orientation

- 1.6.1.2 Trainees who do not complete the Citi Training and IHI Modules within six months will be subject to disciplinary action through the program

Safety Variance Reporting

Institutional Policy: B9000.03, last updated 7/13/22

Purpose Statement: The purpose of this policy is to help obtain information for reporting, documenting, evaluating, responding to, and trending hospital incidents.

1. Each member of the hospital staff is expected to submit a Safety Report in response to any unexpected event constituting harm or potential harm to a patient, visitor, volunteer, physician, student, or instructor in accordance with this policy.
2. The Safety Report shall be entered into the on-line reporting system and will not become part of the medical record.
3. If a patient, visitor, volunteer physician, or student suffers harm that necessitates unexpected care or intervention, the report must, in addition to submitting an online safety variance report, place a call to Risk Management to verbally report the event

Substantial Disruptions in Patient Care or Education

Purpose Statement: This policy addresses Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements IV.N. Substantial Disruptions in Patient Care or Education: The Sponsoring Institution must maintain a policy consistent with ACGME Policies and Procedures that addresses administrative support for each of its ACGME-accredited programs and residents/ fellows in the event of a disaster or interruption in patient care.

1. Procedure:
 - 1.1 Should any disaster or interruption in patient care prevent Bayhealth and/or any of its facilities from supporting a residency program(s), Bayhealth as a Sponsoring Institution will notify ACGME and assist trainees in finding alternative programs to complete their training
 - 1.2 In the event of a significant alteration to the residency experience in one or more residency programs, the Bayhealth Designated Institutional Official (DIO) and/or Graduate Medical Education Committee (GMEC) will follow this procedure:
 - 1.2.1 As soon as possible, the DIO will:
 - 1.2.1.1 Gather data and information from the affected Program Directors to determine the short-term (days/weeks) and long-term (weeks/months) impact on program functions and/or clinical operations at training site affected by the disaster and provide information to the GMEC.
 - 1.2.1.2 If ACGME programs are affected, the DIO will promptly contact the ACGME after the initial GMEC meeting to provide an update on the disaster and initial steps taken by the institution and the GMEC.
 - 1.3 The ACGME may invoke the Extraordinary Circumstances Policy if it is determined that the Sponsoring Institution's ability to support trainees education has been significantly altered.
 - 1.3.1 Within 30 days of the invocation of the Extraordinary Circumstances Policy, the DIO will revise the Sponsoring Institution's educational program to comply with common, specialty-specific, institutional, and program requirements.
 - 1.3.2 Within 10 days of the invocation of the Extraordinary Circumstances Policy, the DIO will contact the ACGME to receive deadlines for the Sponsoring Institution to:
 - 1.3.2.1 Submit program reconfiguration to ACGME; and,
 - 1.3.2.2 Inform each programs trainees of the decision to reconstitute the program and/or transfer the trainees either temporarily or permanently.

- 1.3.3 The DIO will continue to communicate with the ACGME regularly, as needed, to provide updates on any additional program or institutional issues.
- 1.4 The GMEC will meet regularly, as necessary, to continue its assessment of the situation and to make decisions regarding Bayhealth training programs.
 - 1.4.1 Issues to be reviewed, assessed, or acted upon by the GMEC include:
 - 1.4.1.1 Patient Safety
 - 1.4.1.2 Safety of Trainees, Faculty, and Staff
 - 1.4.1.3 Supply of available Faculty and Trainees for clinical and educational duties
 - 1.4.1.4 Extent/impact of damage to clinical technology and clinical information systems
 - 1.4.1.5 Extent/impact of damage to communication technology (e.g. phones, pager, intra/internet)
 - 1.4.1.6 Changes in the volume of patient activity in the short-term and long-term
- 1.5 If the GMEC determines that a program or the institution cannot provide an adequate experience for a trainee because of the disaster, both individual programs and the institution will work toward the following options:
 - 1.5.1 Temporarily relocate a trainee to a site of training within the current local affiliate training sites.
 - 1.5.2 Arrange a temporary transfer for a trainee to another ACGME program until the institution can provide adequate educational experience for the trainee. As best possible at the time of the transfer, the program will inform the trainee being transferred regarding the minimum duration of the transfer and the anticipated total duration of the transfer.
 - 1.5.3 Assist the trainee in a permanent transfer to another program/institution.
 - 1.5.3.1 The preferences of the trainee will be considered by the transferring institution or program whenever possible.
- 1.6 Continuation of financial support in the event of a disaster will be dependent on the short-term and long-term impact on each program and the institution overall. In addition, it will be dependent on current policies related to reimbursement.
 - 1.6.1 For trainees temporarily relocated to a Bayhealth affiliated training site, Bayhealth will continue to pay the trainee's salary and benefits as long as funds are available.
 - 1.6.2 For trainees temporarily assigned to a program at another institution:
 - 1.6.2.1 Bayhealth will continue to pay the trainees salary (according to the Bayhealth stipend schedule) and benefits if funds are available.

- 1.6.2.2 Bayhealth will work with the institution to which the trainee is temporarily assigned to negotiate financial support from that site for trainees temporarily assigned there.
- 1.6.3 For trainees permanently transferring to another institution, Bayhealth will not cover salary and benefits.

Supervision

Purpose Statement: Trainees at Bayhealth Graduate Medical Education must be supervised by faculty physicians in a manner that is consistent with the Accreditation Council for Graduate Medical Education (ACGME) common program requirements and requirements for the applicable residency program. There must be enough institutional oversight to ensure that trainees are appropriately supervised; appropriate supervision meaning that the trainee is supervised by the teaching faculty in such a way that the trainee assumes progressive responsibility according to their level of education, proven ability, and experience

1. Procedure:
 - 1.1 Each program must have a supervision policy that is available to trainees, faculty members, other members of the health care team, and patients.
 - 1.1.1 It is the responsibility of the individual Program Directors to establish detailed written policies describing trainee supervision at each level for their residency programs in accordance with institutional policies and ACGME requirements.
 - 1.1.2 The Program Director will provide explicit written descriptions of lines of responsibility for the care of patients, which will be made clear to all members of the teaching teams.
 - 1.1.3 The program must define when the physical presence of a supervising physician is required.
 - 1.2 Trainees will be given a clear means of identifying supervising physicians who share responsibility for patient care on each rotation.
 - 1.3 The Program Director will use the following levels of supervision and their correlating definitions:
 - 1.3.1 Direct Supervision:
 - 1.3.1.1 The supervising physician is physically present with the trainee during the key portions of the patient interaction.
 - 1.3.1.2 The supervising physician and/or patient is not physically present with the trainee and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.
 - 1.3.2 Indirect Supervision:
 - 1.3.2.1 The supervising physician does not provide physical or concurrent visual or audio supervision but is immediately available to the trainee for guidance and is available to provide appropriate direct supervision.

- 1.3.3 Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.
- 1.4 Each trainee must know the limits of their scope of authority, and the circumstances under which the trainee is permitted to act with conditional independence.
- 1.5 As the trainee’s supervision level evolves, the description of their responsibilities must include identification of the mechanisms by which the participant’s supervisor(s) and Program Director make decisions about each trainee’s progressive involvement and independence in specific patient care activities.
- 1.6 Senior trainees should serve in a supervisory role of junior trainees with appropriate patients, provided the junior trainees have demonstrated progress in the training program.
- 1.7 In each program, there will be circumstances in which trainees must verbally communicate with appropriate supervising faculty, regardless of training level and experience. Programs must identify and put in writing circumstances in which verbal communication with Supervising Faculty is necessary. At a minimum, these circumstances must include:
 - 1.7.1 Emergency admission
 - 1.7.2 Consultation for urgent condition
 - 1.7.3 Transfer of patient to a higher level of care
 - 1.7.4 Code Blue Team activation
 - 1.7.5 Change in DNR status
 - 1.7.6 Patient or family dissatisfaction
 - 1.7.7 Patient requesting discharge AMA
 - 1.7.8 Patient death
- 1.8 Trainees will be assigned a faculty supervisor for each rotation or clinical experience (inpatient or outpatient). The faculty supervisor will provide the Program Director with a written evaluation of each trainee’s performance during the period that the trainee was under their direct supervision. The Program Director will structure faculty supervision assignments of sufficient duration to assess the knowledge and skills of each trainee and delegate the appropriate level of patient care authority and responsibility.
- 1.9 In addition, the Program Director must evaluate each Trainee’s abilities based on specific criteria established by the faculty of the training program. These criteria will be guided by national standards-based criteria when such are available.

- 1.10 The trainee is protected in a manner that is free from reprisal which ensures they can raise concerns and provide feedback in a confidential manner without intimidation or retaliation. If a trainee feels that they are not adequately supervised, they are encouraged to engage the Chief Trainee, Program Director, or Associate Program Director to discuss the matter and obtain appropriate supervision. Occasionally, these issues are unable to be resolved at the program level, in which case the trainee is encouraged to contact the Designated Institutional Official or GME Director for resolution. If a trainee feels that they are not adequately supervised by program faculty, the first contact will be the Program Director or Associate Program Director, when applicable. If these individuals are not available or the trainee does not feel comfortable approaching these individuals, the next contact is the Designated Institutional Official. Finally, if the Designated Institutional Official cannot be reached, the GME Director, and appropriate supervision is arranged.
- 1.10.1 If the issue of inadequate supervision is raised, it will be discussed immediately at an ad hoc Graduate Medical Education Committee (GMEC) meeting. A trend of inadequate supervision may prompt a special review of the program.
- 1.11 Faculty will be held to this policy and program-level supervision policies as part of a contract that they must sign prior to participation in the program. If a faculty fails to provide adequate supervision per these policies, they will face remediation, which could result in removal as program faculty.

Transitions of Care

Purpose Statement: Residents/Fellows and faculty members will receive training on the proper protocol for transitioning care. This is to ensure and monitor effective, structured patient handover processes to facilitate continuity of care and patient safety at all participating sites.

1. Procedure:
 - 1.1 Transitions in care occur regularly under the following conditions:
 - 1.1.1 Change in level of patient care, including inpatient admission from the ambulatory setting, outpatient procedure, or diagnostic area.
 - 1.1.2 Inpatient admission from the Emergency Department
 - 1.1.3 Transfer of a patient to or from a critical care unit
 - 1.1.4 Transfer of patient from the Post Anesthesia Care Unit (PACU) to an inpatient unit when a different physician will be caring for that patient
 - 1.1.5 Transfer of care to other healthcare professionals within procedure or diagnostic areas
 - 1.1.6 Discharge, including discharge to home or another facility such as skilled nursing care
 - 1.1.7 Change in provider or service change, including resident sign-out, inpatient consultation sign-out, and rotation changes for residents.
 - 1.2 Individual Graduate Medical Education (GME) programs must have a policy addressing transitions of care that is consistent with general institutional policies concerning patient safety and quality of healthcare delivery.
 - 1.3 Individual GME programs must design clinical assignments to minimize the number of transitions in patient care.
 - 1.4 Individual GME programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.
 - 1.5 GME programs must ensure that residents/fellows are competent in communicating with team members in the hand-over process.
 - 1.6 Each GME program must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care.

Use of Force

Institutional Policy: D8160.25, last updated 3/30/22

Purpose Statement: This policy establishes guidelines regarding the use of force by an employee while protecting themselves, co-workers, patients, visitors, and the general public.

1. Definitions:

- 1.1 Active Assailant: A person who is using or imminently threatening the use of force against another person, with or without a weapon, in an aggressive manner that poses an imminent danger to an employee or another person.
- 1.2 Active Resistance: A person who is uncooperative and fails to comply with directions from an employee, and instead attempts to avoid physical control and/or arrest by creating distance between themselves and the employee or the employee's reach. This type of resistance includes but is not limited to evasive movement of the arm, flailing arms, and full flight by running.
- 1.3 Chokehold: Sometimes referred to as a Neck or Carotid Restraint, a chokehold is a technique that involves applying direct pressure to a person's trachea (windpipe) or airway (front of the neck) with the intention of reducing the intake of air. A Carotid Restraint is a technique that applies direct pressure to the carotid artery (on the side of the neck) restricting the flow of blood to the brain and causing a temporary loss of consciousness.
- 1.4 Control Instruments: Tools (such as a baton) applied with non- impact pressure to joints and sensitive areas of the body (mainly areas of skin covering bone) in order to elicit and maintain control of a person.
- 1.5 Cooperation: Responsiveness to and compliance with employee requests.
- 1.6 De-escalation (Techniques): Actions taken by an employee meant to stabilize a situation and reduce the need for physical intervention, so that a dangerous situation may be managed through voluntary compliance.
- 1.7 Holding Techniques: Holding techniques include a firm grip or grab of an arm, wristlocks, come along holds (i.e. escort holds that are not elevated to compliance techniques), controlled takedowns, and pins against the ground or objects, as well as any combination of the above.
- 1.8 Handcuffs: A pair of lockable linked rings for securing a person's wrists.
- 1.9 Imminent Danger: Imminent danger describes threatened actions or outcomes that are immediately likely to cause death or serious bodily harm to an employee or another person unless action is taken. In order to be imminent, the person threatening danger must have the means/instruments and opportunity/ability to

cause death or serious bodily harm. The threatened harm does not have to be instantaneous. The period of time involved is dependent on the circumstances and facts of each situation and is not the same in various situations.

- 1.10 N.A.P.P.I: Also known as Non-abusive Psychological and Physical Intervention training designed to be non-abusive effective protection for self and others. It focuses on creating a culture of cooperation between staff, visitors, and patients. Also creates a common language for staff that provides clear communication when reporting an issue, determining the most appropriate response, and documenting the escalating behavior.
- 1.11 Oleoresin Capsicum Spray: Also known as OC Spray or Pepper Spray, this is an inflammatory chemical agent that causes an intense burning sensation of the skin, eyes, and mucous membranes. Direct exposure to a person's eyes will likely result in the eyes closing, tearing, and swelling. When inhaled, a person experiences choking, gagging, gasping for breath, or, on rare occasion, unconsciousness. As a result of these symptoms, a person may experience nausea or temporarily impaired thought processes or may become disoriented or lose his or her balance.
- 1.12 Passive Resistance: A person who is not cooperative, in that the person fails to comply (in a non-movement way) with verbal or other direction from an employee.
- 1.13 Physical Contact: Routine or procedural contact necessary to effectively accomplish a legitimate objective. Examples include, guiding a subject into a bed, holding the subject's arm while transporting, handcuffing a subject.
- 1.14 Physical Force: Forceful, concentrated striking movements such as punching and kicking, or focused pressure strikes and pressures. These techniques can be combined with take-downs or pins against the ground or other objects.
- 1.15 Proportionate Force: Actions, including de-escalation and force, which correspond appropriately with the particular circumstances confronting the employee.
- 1.16 Substantial Risk: A substantial risk is one that is foreseeably likely to occur. That is, the risk is one that a reasonable employee in the same circumstances may anticipate as the likely outcome.
- 1.17 Tactical Communication: Verbal communications techniques that are designed to avoid or minimize the use of force. Such techniques include attempts to exercise persuasion, advice, instruction, and warning prior to the use of physical force.
- 1.18 Tactical Positioning: Making advantageous use of positioning, distance, and cover to isolate and contain a person and avoid the need to resort to force.
- 1.19 Time as a Tactic: Establishing a zone of safety around a person that creates an opportunity for an assessment and action, when feasible, thereby decreasing the need to resort to force.

- 1.20 Uniform Presence: Public Safety in Bayhealth Medical Center issued and approved uniform presence established through identification of authority and proximity to the person.
 - 1.21 Verbal Control Techniques: Consists of persuasion, advice, instruction, and warning in the form of verbal statements or commands that may result in compliant behavior.
2. Procedure:
- 2.1 General Principles**
 - 2.1.1 This policy complements the N.A.P.P.I. (Non-abusive Psychological and Physical Intervention) model that is the fundamental standard of Bayhealth Medical Center’s use of force training.
 - 2.1.2 This policy recognizes constitutional principles but aspires to go beyond them.
 - 2.1.3 The Fourth Amendment requires that an employee’s use of force be “objectively reasonable.” *Graham v. Connor*, 490 U.S. 386 (1989). Under this standard, an employee may only use force that a reasonable person would utilize when facing similar circumstances.
 - 2.1.4 The objectively reasonable standard acknowledges the difficult decisions that employees are forced to make under rapidly evolving and often unpredictable circumstances, but it does not provide specific guidance on what to do in any given situation.
 - 2.1.5 In situations where employees are justified in using force, the utmost restraint will be exercised.
 - 2.1.6 Use of force will never be considered routine.
 - 2.1.7 Employees are to respect the sanctity of human life
 - 2.1.8 Everything possible will be done to avoid unnecessary uses of force
 - 2.1.9 The least amount of force necessary is to be used, employees must only use the amount of force that is appropriate to the circumstance
 - 2.1.10 Employees may use force only to accomplish specific lawful duties and objectives
 - 2.1.11 Employees are encouraged to use de-escalation and use of force training techniques that have been provided during Bayhealth sponsored events absent emergent circumstance that are within reason.
 - 2.1.12 Sound judgment and the appropriate exercise of discretion will be the foundation of employee decision making.
 - 2.1.13 It is not possible to entirely replace judgment and discretion with detailed policy provisions.
 - 2.1.14 This policy is intended to make sure that de-escalation techniques are used whenever feasible, that force is only used

when necessary, and that the amount of force used is proportionate to the situation that an employee encounters.

2.1.15 Safety of the Individual

- 2.1.15.1 After gaining control of a person, employees will position the person in a manner to allow the person to breathe unobstructed.
- 2.1.15.2 Employees will not sit, kneel, or apply pressure or stand on a person's chest or back or neck, and whenever feasible will not force the person to lie on his or her stomach.
 - 2.1.15.2.1 Chokeholds are not to be utilized.
- 2.1.15.3 Employees are to promptly provide or request medical aid
 - 2.1.15.3.1 Employees have a duty to provide prompt medical care. Whenever a person is injured, complains of an injury, or requests medical attention as soon as it is safe and practical.
 - 2.1.15.3.2 Employees have a duty to continuously monitor individuals for potential medical intervention after a use of force. Employees will closely monitor persons against whom force was used for signs that they require medical assistance.

2.2 Use of Force

- 2.2.1 Employees may use force for the following legitimate lawful duties and objectives:
 - 2.2.1.1 To overcome resistance directed at the employee or others
 - 2.2.1.2 To prevent physical harm to the employee or to another person, including intervening in a suicide or other attempt to self-inflict injury
 - 2.2.1.3 To protect the employee, or a third party, from unlawful force; or to prevent significant property damage or loss.
 - 2.2.1.4 For Public Safety employees to affect a lawful seizure (an arrest or detention) or to carry out a lawful search.
- 2.2.2 Employees may not use or threaten to use force for the following reasons:
 - To resolve a situation more quickly, unless the extended delay would risk the safety of the person involved, employees, or others, or would significantly interfere with other legitimate

lawful duties and objectives

- To punish a person or to retaliate against them for past conduct or to impose punishment
- To prevent a person from resisting or fleeing in the future
- To force compliance with an employee's request, unless that request is necessary to serve employee or public safety, or
- Based on bias against a person's race, ethnicity, nationality, religion, disability, gender, gender identity, sexual orientation, or any other protected characteristic.

2.2.3 Employees are to evaluate the circumstances facing them in the field to determine whether force is appropriate and what amount is proportionate. When force cannot be avoided through de-escalation or other techniques, employees are to use no more force than is proportionate to the circumstances. In general, the greater the threat and the more likely that the threat will result in injury or death, the greater the level of force that may be immediately necessary to overcome it. Consistent with training, some of the factors that employees will consider when determining how much force to use include:

2.2.4 The risk of harm presented by the person

2.2.5 The risk of harm to the employee or innocent bystanders by using force

2.2.6 The seriousness of the lawful duties and objective

2.2.7 Whether further de-escalation techniques are feasible, including the time available to an employee to decide, and whether additional time could be gained through tactical means

2.2.8 If there is a practical, less harmful alternative available to the employee

2.2.9 Mental or physical disability, medical condition, and other physical and mental. Note: The presence of physical or mental disability does not preclude the use of force but should be considered when determining the appropriateness of a use of force.

2.2.10 Whether there are other exigent/emergency circumstances.

2.2.11 As a situation changes, employees will reevaluate the circumstances and continue to respond proportionately. Over the course of an encounter, the circumstances and threats an employee face may change.

2.3 Employees, based on role, receive training on the following range of force options:

- Uniformed or physical presence (least)
- N.A.P.P.I. (Non-abusive Psychological and Physical Intervention)
- Verbal Control Techniques
- Physical Contact
- Holding Techniques
- Physical Compliance (Pressure Point Control Hold, Public Safety Only)
- Restraint Tools
- Physical Force *Public Safety Involvement and led when present*
- Control Instruments: Handcuffs, Batons (greatest) * Public Safety Only*

2.4 The force options available to an employee fall along a continuum.

- Employees are not required to exhaust one type of force before moving to a greater force.
- Sound judgment and the appropriate exercise of discretion will be the foundation of employee decision making in the broad range of possible use of force situations

2.5 The level of resistance that an employee encounter is a key factor in determining the proportionate amount of force. The types of resistance employees may encounter fall along a continuum, from a cooperative person to an active assailant. Consistent with training, the following general options apply when employees are exercising judgment in determining what level of force is necessary and proportionate:

| | Force Options | | | | | | | | |
|---------------------|---------------------|-----------|----------------|------------------|--------------------|---------------------|-----------------|----------------|---------------------|
| Level of resistance | Uniformed /Physical | N.A.P.P.I | Verbal Control | Physical Contact | Holding Techniques | Physical Compliance | Restraint Tools | Physical Force | Control Instruments |
| Cooperative | x | x | x | | | | | | |
| Passive Resistance | x | x | x | x | x | x | x | | |
| Threatening | x | x | x | x | x | x | x | x | |
| Active Assailant | x | x | x | x | x | x | x | x | x |

2.6 Employees will attempt to de-escalate confrontations with the goal of resolving encounters without force.

- Employees may only use force that is objectively reasonable, necessary,

and as a last resort.

- Increased levels of force will not be utilized when a safe alternative would achieve the same objective.
- Employees will use de-escalation and force-mitigation tactics and techniques learned through Bayhealth sponsored training.
- Public Safety department is authorized to use additional techniques in accordance with training programs approved by the department.

2.7 Employees will provide clear instructions and warnings before and during the use of force.

- Provide clear instructions and warnings
- Seek to communicate in non-verbal ways when a verbal warning would be inadequate
- Indicate the consequences of refusing to comply with a mandatory order, including that force will be used unless the person complies; and
- Give the person a reasonable amount of time to comply.

2.8 Employees will consider an individual's mental, physical, or other incapacities. Employees will consider whether a person's failure to comply with an employee's command is due to a medical condition, mental impairment, physical limitation, developmental disability, language barrier, drug interaction, behavioral crisis, or other factors beyond the individual's control.

- In these situations, employees will consider whether specific techniques or resources would help resolve the situation without force.

2.9 Use of force reporting

- Employees will immediately notify Bayhealth Medical Center's Public Safety Department of use of force incidents and document appropriately.
- Employees will complete their reports accurately and completely, articulating specific facts to explain an employee's own decision to use force.
- Use of force by an employee that results in death or serious bodily injury of any degree, will immediately be reported to the Senior Director of Emergency Management and Public Safety.
- This notification will occur before any investigation of the incident is undertaken, other than to secure the scene and to render medical assistance as required.

- In case of lethal force, the Local Law Enforcement Agency will conduct the subsequent investigation into the use of force.

2.10 Employee Accountability

- Employees will be held accountable for violations of this policy in accordance with the Corrective Action Policy and

Delaware Code.

- This policy is not intended to create or impose any legal obligations or bases for legal liability.
 - This applies to the employee's own conduct, as well as observation or knowledge of the conduct by other employees.
 - Employees are responsible to take steps to prevent or stop illegal or inappropriate uses of force by other employees.
 - Allegations of inappropriate or excessive use of force.
- 2.11 Allegations of inappropriate use of force incidents will be reported to the Senior Director of Emergency Management and Public Safety.
- 2.12 Senior Director of Emergency Management and Public Safety will inform Risk Management of the allegation and collaboratively determine next steps within 24 hours. Follow-up options include:
- Collaborative follow-up with representatives from Public Safety, Human Resources and Risk Management.
 - Public Safety Lead Investigation
 - Risk Management Lead Investigation
 - Use of Force Committee Review
 - Investigation updates will be provided by the investigator within 72 hours.
 - During investigations employees will be removed from duty or assigned a non-public facing administrative duty based on departmental needs.
- 2.13 Use of Force Committee
- Used to evaluate the use of force by a team member only when the investigation produces unclear results.
 - The Committee consists of the VP of Corporate Support Services, VP of Human Resources, Senior Director of Emergency Management and Public Safety, Senior Director of Risk Management, and an Ad hoc Subject Matter Expert
- 2.13.1 Facts of the incident and subsequent investigation will be provided to the committee, including any material evidence.
- 2.13.2 Committee is tasked with determining whether or not the use of force was reasonable and appropriate.
- Inappropriate use of force will be subject to corrective action.
 - Committee may also determine the need to report the incident to local authorities.

- 2.14 Leaders are responsible for reviewing and monitoring the appropriateness of use of force in their areas.
- 2.15 Training
- 2.16 Employees will be issued this policy and educated on use of force during de-escalation training.
- 2.17 Mandatory training is required in certain departments.
 - 2.17.1 Training topics include:
 - When and how to use de-escalation
 - Force- mitigation techniques
 - Tactical communication, positioning, and time as a tactic
 - Self-defense techniques
 - Techniques for physical intervention

Vendor Relation

Purpose Statement: To set forth guidelines for appropriate vendor access and solicitation within Bayhealth.

1. Procedure:
 - 1.1 Residents/fellows will follow the Vendor policy and procedures of Bayhealth that is found on BayNet.
 - 1.2 It is the responsibility of the Graduate Medical Education Office to provide proper education to all residents/fellows about vendor interactions during orientation.
 - 1.3 It is the responsibility of the resident/fellows to address any concerns about a vendor with their supervising physician.

Verbal or Telephone Orders

Institutional Policy: B9085.48, last updated 4/29/22

Purpose Statement: To establish safe and clear communication of verbal and telephone orders.

1. Procedure:
 - 1.1 Verbal orders are limited to urgent or emergency situations when immediate written or electronic communication is not feasible, for example when a physician is performing a procedure.
 - 1.2 Telephone orders may be accepted for patient treatment by a nurse, pharmacist, physical/occupational therapist, registered dietitian, licensed speech pathologist and respiratory therapist as appropriate to their scope of practice. The physician is also to participate in the read back process.
 - 1.2.1 When communicating telephone orders, the physician is to remain on the phone while the caregiver enters the orders in the electronic order entry system to address any safety prompts that may arise.
 - 1.2.2 When STAT orders are entered, the provider will notify the nursing staff in a timely and appropriate fashion.
 - 1.2.3 Paper Physician Order Sheets
 - 1.2.4 May be used during the event of electronic downtime.
 - 1.2.5 Telephone orders will be transcribed immediately to the paper Physician Order Sheet. The entire written order will be read back to the physician verifying the details of the order and the patient for whom the order is being given. The physician will then confirm the read back.
 - 1.2.6 The transcriber will sign the order with their full name, credentials, date, and time along with the full name of the physician giving the order. The transcriber will document the read back.
 - 1.3 Telephone orders documented in the patient's medical record are to be reviewed and countersigned by the physician consistent with the Rules and Regulations of the Medical Staff and Joint Commission.
 - 1.4 Verbal or telephone orders for antineoplastic agents are not permitted under any circumstances. These medications are not administered in urgent or emergent situations and have a narrow margin of safety.
 - 1.4.1 It is recognized that certain agents classified as antineoplastic are used for indications other than oncologic related conditions. In emergent situations some agents may be prescribed as a telephone order (examples include

methotrexate and hydroxyurea).

- 1.5 Discrepancies or questions concerning verbal or telephone orders are to be resolved before the preparation, dispensing or administration of the medication.
 - 1.5.1 The following elements will be included in a verbal or telephone medication order:
 - 1.5.1.1 Name of the patient
 - 1.5.1.2 Medication name
 - 1.5.1.3 Dosage form (e.g., tablets, capsules, injection)
 - 1.5.1.4 Exact strength or concentration
 - 1.5.1.5 Quantity and/or duration
 - 1.5.1.6 Route of administration
 - 1.5.1.7 Specific instructions for use
 - 1.5.1.8 Name of the prescriber
 - 1.5.2 The name of the medication will be confirmed by any of the following:
 - 1.5.2.1 Spelling
 - 1.5.2.2 Providing both the brand and the generic names of the medication
 - 1.5.2.3 Providing the indication for use
 - 1.5.3 To avoid confusion with the dose of the medication (spoken numbers), the numbers will be confirmed by the physician dictating a dose of 50mg (fifty milligrams) as five zero milligrams.
 - 1.5.4 The instructions or directions will not contain abbreviations. For example 1-tab TID will be communicated as take or give one tablet three times daily.

Weather (Severe Weather Emergency)

Institutional Policy: B9000.19, last updated 1/4/24

Purpose Statement: Policy provides for the management and planning required before and during weather events to ensure essential services and operations continue to the extent possible with little to no interruption.

1. Procedure:

- 1.1 Responsibilities

- 1.1.1 Severe Weather Conditions

- 1.1.1.1 During severe weather or related emergency conditions, personnel in certain designated positions are required to be on-site to ensure continuity of care for our patients as well as to ensure that our emergency medical facilities remain accessible. Each department director is tasked with determining which positions and subsets thereof are essential and nonessential for their respective department. It is understood that directors retain the right to alter the designation of a given position from nonessential to essential or vice versa in response to the changing conditions of a specific event. (refer to Section 4.3 Staffing/Compensation for additional information).

- 1.1.2 State of Emergency

- 1.1.2.1 In the event that a State of Emergency is declared by the State of Delaware, Bayhealth staff can check the Bayhealth website (www.bayhealth.org) for general information regarding operational status. Department directors or their designees will contact staff with specific instructions related to their respective department's operations. Directors establish communication procedures for adverse weather conditions and other emergencies for

their department, and inform employees of those procedures. In the event that the Emergency Operations Plan is activated, staff will respond as directed in that plan.

1.2 Weather Event Planning

1.2.1 Weather Event Coordinator

1.2.1.1 Bayhealth's Senior Director of Emergency Management, Public Safety, and Transportation Services in consultation with the Administrator On- Call (AOC) coordinates and facilitates weather event planning.

1.2.2 Weather Event Task Force is made up of the following:

- 1.2.2.1 Director of Emergency Management and Public Safety (Weather Event Coordinator & Call Cahir)
- 1.2.2.2 Administrator On-Call
- 1.2.2.3 Administrator, Bayhealth Sussex Campus
- 1.2.2.4 VP – Corporate Support Services
- 1.2.2.5 VP – Marketing & Communications
- 1.2.2.6 VP of Physician Services/BMG
- 1.2.2.7 VP of Supply Chain
- 1.2.2.8 SVP Patient Care Services and Chief Nurse Executive
- 1.2.2.9 SVP and Chief Human Resources Officer
- 1.2.2.10 Senior Director, Ambulatory Service Line
- 1.2.2.11 Site Director, Facility Services
- 1.2.2.12 Senior Director, Facility Management
- 1.2.2.13 Executive Team (invited to calls to participate at their discretion)
- 1.2.2.14 Other individuals may be invited to participate in the call from time to time based on the specifics of the weather event.

1.2.3 Initial Conference Call

1.2.3.1 When possible, twenty-four (24) hours before a predicted significant weather event a conference call with the Bayhealth Weather Event Task Force will be initiated to review weather predictions and begin to make plans based upon those predictions.

1.2.4 05:00 am Conference Call

1.2.4.1 When storms are predicted to begin during the overnight hours, a call will be scheduled at 05:00 AM to review where we stand relative to conditions and make decisions regarding operating status. The operational status options are as follows:

1.2.4.1.1 Normal operations:

Facilities are open and operating as normal.

1.2.4.1.2 Delayed Operations:

Outpatient facilities and some identified hospital-based services will be opening at a time specified by the Task Force. Essential staff will report as usual. Non-essential staff will report as directed by their respective leadership as dictated by the delay in operations (refer to Section 4.3 Staffing/Compensation for additional information).

1.2.4.1.3 Special Circumstances:

There may be times when specific sites or hospital-based services need to alter their operating times due to particular circumstances unique to that operation. This decision is discussed with and approved by the executive overseeing that facility in consultation with

the AOC.

- 1.2.4.1.4 Closed: Outpatient facilities and identified hospital-based services will remain closed due to the weather. Essential staff report as required. Non-essential staff will use PTO and remain at home unless otherwise directed by their leadership. The AOC will make this decision in consultation with the Weather Event Task Force (refer to Section 4.3 Staffing/Compensation for additional information).

4.2.5 Follow-up Conference Calls

- 4.2.5.1 Additional conference calls will be held as conditions dictate. The AOC in consultation with the weather Event Task Force will return Bayhealth to normal operations hours as soon as safely possible.

4.2.6 Communication

- 4.2.6.1 The VP-Marketing and Communication will communicate changes in operational status and related information to staff via the Bayhealth website (www.bayhealth.org). This information will also be emailed to the Pillars leadership group as changes are made. The individual managers that make up the Pillars group are responsible for informing their staff regarding expectations based upon operational status and their department's particular plans.

1.3 Staffing/Compensation

- 1.3.1 A department's director is responsible for

notifying personnel of the staffing plan for their department based on the conditions brought about by a specific weather event. During delayed or closed operations, employees, exempt and non-exempt, are designated as essential or non-essential. This designation may change per event. It is understood that directors retain the right to alter the designation of a given position from non-essential to essential or vice versa in response to the changing conditions of a specific event. Under declared normal operations, staff work according to their regularly scheduled shifts, following normal procedures and policies.

1.3.1.1 Employees are responsible to know what their designation is through communications with their department head.

1.3.2 Essential Employees

1.3.2.1 Personnel designated as essential are required to be on site per the instructions provided by their supervisor. If a staff member is directed to report to work just before, during or after a weather or other form of emergency, they are obligated to comply. This is a condition of employment.

1.3.2.2 Use of PTO will not be available to anyone designated as essential during a severe weather or emergency event.

1.3.2.3 Personnel are reminded that if they are deemed by their department director as essential, they are to plan to be onsite as assigned to meet their work obligations, and if required to be at work, are to arrive at work before a Level 3 Driving Ban is issued.

1.3.2.4 Failure to report to work will be classified as insubordination and the employee will be subject to corrective action under

Bayhealth's Corrective Action Policy.

1.3.3 Non-Essential Employees

- 1.3.3.1 Those employees considered "non-essential" contact their supervisor for instructions relative to coming to or remaining at work
- 1.3.3.2 A non-essential, non-exempt employee reaching Bayhealth within the first hour of their regularly scheduled shift are paid for all actual hours worked but will not have tardiness points added if not arriving by actual scheduled start time to allow for safe travel to the work site. A non-essential employee who fails to reach Bayhealth within the first hour of the regularly scheduled shift are paid for the hours actually worked and tardiness points may be added for being late. Employees are encouraged to allow ample travel time to arrive safely to the worksite.
- 1.3.3.3 Non-exempt non-essential employees have the option to use available PTO to be paid for missed time during reduced or closed operations. Those electing not to use PTO will not receive absence plan accruals for this time. Available PTO is used

for other days that Bayhealth was under normal operations. PTO used during weather emergency events will be considered scheduled. Adjusting work time to make up for missed time is to be approved by the department Director in advance.

- 1.3.3.4 Non-essential exempt employees are to report to work at some time during their scheduled work time. Exempt employees are to use PTO if they cannot safely reach Bayhealth for any part of that day.
- 1.3.3.5 Non-essential employees may be

dismissed from work early when a weather event begins or during the weather event. Dismissal is dependent upon the needs of the department. Non-exempt employees are to use available PTO to be paid for the remainder of their shift. PTO used for this purpose will be considered scheduled. Any early release of employees is coordinated through the Administrator On-Call.

- 1.3.3.6 Bayhealth does not have a telework policy. Any ability to telework is at the discretion of the department leadership in consultation with their VP or SVP. Roles permitting telework should be predetermined and would be approved for the day only if appropriate work can be conducted and the role/position is formally approved for telework. Any exceptions are to be pre-approved by the SVP & Chief Human Resources Officer

1.4 Staff Amenities During Weather Emergencies

1.4.1 Staff Rest Areas

- 1.4.1.1 Bayhealth will provide, as the situation allows, rest areas for staff who remain onsite because of adverse weather conditions. The assignment of rest space will be managed by Patient Care Services through the respective hospital's Nursing House Supervisor. Rest/sleep periods greater than 20 minutes are not included in approved hours worked.

1.4.2 Meals

- 1.4.2.1 Th AOC, when the Governor has declared a state of emergency including a Level 2 or 3 Driving Ban, has the authority to issue meal tickets for staff remaining on site to attend to our patients. Meal tickets

are distributed by the respective hospital Nursing House Supervisor. Uninterrupted meal periods of 20 minutes or longer will not be included in approved hours worked.

1.4.3 Linens and Essentials

- 1.4.3.1 Because of the continued need to provide for our patients, staff is encouraged to bring with them linens and toiletries to meet their personal needs while they remain onsite during the emergency.

Well-Being

Purpose Statement: Bayhealth as the Sponsoring Institution, in partnership with its Accreditation Council for Graduate Medical Education (ACGME)-accredited programs will provide education to all faculty members, residents and fellows to help identify and preempt signs and symptoms of burnout, depression and substance abuse, including how to recognize these symptoms in oneself.

1. Procedure:

- 1.1 Residents, fellows, and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician. The institution, in addition to each training program, has the same responsibility to address well-being as they do to evaluate other aspects of resident/fellow competence.
 - 1.1.1 Each program will provide education to all faculty members and residents/fellows to identify signs and symptoms of burnout, depression, and substance abuse, including how to recognize these symptoms in oneself.
- 1.2 If any resident/fellow or faculty member is concerned about another resident, fellow, faculty member, or themselves displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence, they are encouraged to alert the program director, Designated Institutional Official (DIO), GME Director or other program-specific designated personnel.
- 1.3 Bayhealth will provide access to appropriate tools for self-screening as well as access to Employee Assistance as outlined in Employee Benefits.
- 1.4 Bayhealth residents/fellows and faculty members will have access to confidential, affordable, mental health assessment, counseling, and treatment, including access to urgent and emergent care 24-hours a day, seven days a week.
- 1.5 Residents/fellows will have access to VITAL Work Life. This program offers immediate counseling, peer coaching, financial consulting services, legal services, and other online resources.

Work Restrictions for Health Care Workers with Contagious or Communicable Disease

Institutional Policy: B9806-9807.25, last updated 3/1/23

Purpose Statement: To prevent the spread of contagious or communicable disease to patients, employees, and visitors.

1. Procedure
 - 1.1 Occupational Health follows the Work Restrictions for Health Care Workers with Contagious and/or Communicable Diseases guidelines established by the Center for Disease Control (CDC) when recommending work restrictions for employees with these conditions.
 - 1.2 Employees with suspected or diagnosed contagious/communicable disease are to report to their supervisor prior to performing job duties.
 - 1.2.1 The supervisor refers the employee to Occupational Health for evaluation.
 - 1.2.2 The employee or supervisor then initiates a Safety Variance report.
 - 1.2.3 Occupational Health notifies Human Resources upon confirmation of any communicable disease.
 - 1.3 Work restrictions are determined by CDC guidelines (see Exhibit A), and Control of Communicable Diseases Manual, American Public Health Association (APA).
 - 1.3.1 Work restrictions for personal medical conditions falls under the provisions of Bayhealth's paid time off (PTO), medical leave, extended sick leave, or short-term disability (STD) pay practices.
 - 1.3.2 If the employee develops the contagious/communicable disease secondary to exposure at work, Occupational Health follows the Delaware Workers' Compensation Law regarding medical treatment and lost work time as applicable, and the Workers' Compensation Program Manager and Third-party Administrator communicates claim information to the employee (see policy P9065.35).
 - 1.4 Bayhealth follows the CDC guidance for exposures, symptoms, and travel related to Covid-19. (See appendix B).
 - 1.4.1 Bayhealth employees who are experiencing symptoms do not report to work. The Bayhealth employee contacts Occupational Health through the designated Covid lines: Dover 302-672-2312 M-F from 8am – 5pm, Milford 302-725-3555 M-F from 8am – 5pm and Weekends 9am-5pm
 - 1.4.2 Bayhealth employees who have had direct, unprotected exposure to a lab confirmed Covid-19 positive individual with their household or community contacts Occupational Health through the designated Covid lines. See above.

- 1.4.3 Employees in patient care areas are considered Low Risk per CDC. Employees are not contacted unless they report unprotected exposure to a lab positive individual to Occupational Health.
- 1.4.4 Patient to Employee Exposures
 - 1.4.4.1 Infection Prevention is notified of the lab positive COVID-19 results on Bayhealth patients. Concerns for employee's exposure due to employee not wearing their personal protective equipment are reported to Occupational Health for follow-up
 - 1.4.4.2 IP provides Occupational Health with patient name, location, and audit trail.
 - 1.4.4.3 Occupational Health screens employees via phone based on their specific interactions with the patient and PPE worn.
 - 1.4.4.4 Occupational Health contacts the manager of employee to determine any additional employee exposures.
 - 1.4.4.5 Employees screened are given a risk level and emailed exposure instructions including a symptom log to complete.
 - 1.4.4.6 Employees are instructed to notify their manager of the exposure.
 - 1.4.4.7 Occupational Health updates the manager on the employee work status via email.
- 1.4.5 Employee to Employee exposures
 - 1.4.5.1 Infection prevention notifies Occupational Health of COVID-19 lab positive Bayhealth employees
 - 1.4.5.2 Occupational Health creates a list of close contacts from the lab positive employee and department manager based on dates the employee was working in the department.
 - 1.4.5.3 Occupational Health contacts the close contact list to determine if they are exposed.
- 1.5 Human Resources notifies IP in the event of exposure to patients or other employees.
- 1.6 Occupational Health maintains documentation of employee exposure or presence of a contagious or communicable disease.
- 1.7 Unresolved or equivocal situations are referred to the Occupational Health Medical Director or outside healthcare provider for further evaluation and recommendation.
- 1.8 Bayhealth may require a return-to-work examination at Occupational Health before allowing employees to resume their job duties.