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ACGME

January 13, 2015

Michael E. Mahla, MD
Associate Dean for Graduate Medical Education
University of Florida College of Medicine
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Gainesville, FL 32610-0321

Dear Dr. Mahla:

On behalf of the CLER site visit team, I enclose the written CLER site visit report. We are sending you the report prior to its submission to the CLER Evaluation Committee in order to provide you with an opportunity to review the findings and allow you the option of submitting a response. If you would like to respond, please complete the attached form and submit it to cler@acgme.org by close of business on **02/20/15**. As you will see, there is no formal structure to the response. The only requirement is that you use 11 point font or larger and limit the number of pages to no more than 3 in total. While we are open to receiving all manner of input, we would especially appreciate any information that you feel would provide the Committee with further clarity regarding issues raised within the report. We would also appreciate any early insights you would be willing to share as to how you might use this report to strengthen resident/fellow engagement in the CLER focus areas.

Once again, we emphasize that your response is optional. The report (along with any response) will be shared with the CLER Evaluation Committee at a future meeting. At the conclusion of the first cycle of site visits we also anticipate issuing a report with national data to provide you with some opportunities for comparison. It will likely be the second quarter of 2015 when the final report containing national data is issued.

We thank you for being a part of the beta testing of this new site visit process. If you have any questions, please let me know.

Best regards,

Robin Wagner

Robin Wagner, RN, MHSA
Vice President, CLER

UF Health Shands Hospital
Clinical Learning Environment Review (CLER)
Site Visit Report

Dates: December 2-4, 2014

Sponsoring Institution: University of Florida College of Medicine

Participating Site: UF Health Shands Hospital

CEO Host: Edward Jimenez, MBA

Designated Institutional Official (DIO) Host: Michael Mahla, MD

Site Visitors: Mark Bixby, MD (lead site visitor)
Baretta R. Casey, MD, MPH
Yolanda Wimberly, MD

Overview

The University of Florida (UF) School of Medicine sponsors 69 active ACGME-accredited residency/fellowship programs with approximately 770 residents/fellows. UF Health Shands Hospital is a major participating site for the University of Florida School of Medicine programs. UF Shands Hospital is part of the larger UF Health System, which, in addition to Shands Hospital, is made up of UF Health Shands Cancer Hospital and UF Health Shands Children's Hospital, both on the same campus as the main hospital in Gainesville, Florida. In addition, to these hospitals, the system also includes a rehab hospital, a psychiatric hospital and other community hospitals and ambulatory centers.

The visit began with a meeting with the senior leadership, including Mr. Edward Jimenez, interim CEO and Chief Operating Officer; Dr. Timothy Flynn, Senior Associate Dean for Clinical Affairs, UF College of Medicine, Chief Medical Officer, UF Health Shands; Dr. Irene Alexaitis, Vice President Nursing and Patient Services; Dr. William Lee Titsworth, resident member of the Graduate Medical Education Committee; and Dr. Michael Mahla, Professor and Associate Dean for GME, GMEC Chair and Designated Institutional Official. Additional activities included group meetings with residents/fellows (peer selected), faculty members, program directors, senior management of patient safety and healthcare quality, and a series of one-on-one discussions with individual residents/fellows and other staff (e.g. nursing) that occurred during walking rounds of multiple clinical sites within the hospital. At the end of the visit, the site visitors met for a final debriefing/feedback session with Mr. Jimenez, Dr. Mahla, and other members of the senior leadership team.

Group meetings with the residents/fellows, faculty members and program directors included a combination of open discussion questions and survey questions using an audience response system (ARS) for the purpose of acquiring anonymously reported information. For the ARS portion of the interviews, the residents/fellows, faculty members, and program directors were given transponders and asked to respond to several multiple-choice questions. Many of the

ARS questions were used to encourage discussions on particular topics; walking rounds were then used to expand, clarify, or follow-up some of the topics raised during the group discussions. The CLER team visited numerous clinical locations including medical, perioperative, obstetric, intensive care, radiology, pathology, emergency department and other floors, units and outpatient clinics where residents/fellows have clinical experiences. Resident end-of-shift hand-offs were observed for six programs.

Selected results from the ARS survey are included as part of this report. The survey includes results from separate group interviews with 56 residents/fellows, 61 faculty members, and 57 program directors from the residency/fellowship programs at UF Health Shands Hospital. While overall there was a very high response rate (>95%) for all questions, for any single question the number of respondents may have varied. Of the resident/fellow cohort, none were PGY1, 21% were PGY2, 27% were PGY3 and the rest were PGY4 or higher. Approximately one-half of the faculty members and three-quarters of the program directors interviewed indicated they had been at UF Health Shands Hospital for six or more years.

Of note, those interviewed did not comprise a random sample. This report includes only point estimates and not estimates of variance (e.g. confidence intervals). Since the CLER program is still in the early phase of implementation, comparative data from other clinical sites are not yet available. Therefore, the ARS survey information is included for purposes of providing general feedback. The following summary terms are used throughout this report: few (<10%), some (10-49%), most (50-90%), and nearly all (>90%).

The site visit explored the six focus areas of the CLER program including patient safety, healthcare quality (with a special focus on healthcare disparities), supervision, transitions in care, duty hours/fatigue management and mitigation, and professionalism.

The focus areas were assessed according to three key questions related to: 1) institutional infrastructure and resources, 2) GME leadership and faculty members' engagement, and 3) resident engagement in using the clinical site's patient safety and quality structures and processes. Future CLER visits will also assess UF Health Shands Hospital's perspective on measures of success in integrating GME into the quality infrastructure and the clinical site's plans for improving the quality and value of the clinical learning environment infrastructure to support engagement with GME in these six focus areas**.**

General Comments

In the meeting with the senior leadership, Mr. Jimenez stated the strategic goal for the hospital is quality care, involving all hospital staff members to achieve this goal. He noted the hospital is focused on four areas to in relation to this goal: 1) to be the best in quality of care, 2) to provide outstanding experience of care, 3) to train the next generation, and 4) to advance science.

The hospital and GME leadership have initiated several efforts to enhance resident/fellow engagement in improving healthcare quality and patient safety. For example:

- A House Staff Quality/Patient Safety Committee has been created to engage residents/fellows in patient safety and quality improvement and to provide a forum for resident/fellow input to the hospital's patient safety and quality improvement strategy.
- The hospital supports a free clinic (CareOne Clinic) to provide services for the local underserved population and to reduce readmissions.
- The GME leadership has a well-established resident-as-teacher program.
- A joint effort between the hospital and the House Staff Quality/Patient Safety Committee has resulted in moving toward standardizing transitions in care using the I-PASS format.
- A simulation lab is used to improve procedural competency.

Leadership indicated most departments have an active staff member, called the physician director for quality (PDQ), who takes an active role in departmental quality initiatives and works with residents/fellows on their quality projects.

The residents/fellows interviewed were positive when speaking about the clinical and educational culture at the hospital.

Patient Safety

Senior leadership stated the hospital's patient safety priorities are advancing all four domains of improvement including reducing harm (mortality), reducing variation in care, enhancing the patient experience, and improving the culture of safety. The patient safety and quality leadership listed the hospital's top priority in patient safety in which they hope to engage all employees, including residents/fellows, is engaging all hospital personnel in patient safety and event reporting. They went on to specifically list the priorities of improving hand-off communication, medication safety, and surgical safety with use of time-out checklists and debriefing; and decreasing hospital-acquired infections, specifically mentioning catheter-associated urinary tract infections (CAUTI) and central line-associated blood stream infections (CLABSI). Eighty-six percent of the residents/fellows, 92% of faculty members, and 89% of the program directors in the group interviews reported they knew UF Health Shands Hospital's priorities for patient safety. All physician groups mentioned reducing readmissions and some elements of improving performance on core measures. The resident/fellows also mentioned educating residents/fellows on how to report and increasing resident/fellow-submitted patient safety event reports; reducing mortality and variability in patient care; improving patient safety indicators; and transforming to a culture of safety. The faculty members also mentioned reducing line sepsis, improving Foley catheter management and hand hygiene; reducing harm and variability in care; and increasing patient satisfaction. The program directors also mentioned decreasing observed to expected mortality and medication errors, improving patient experience and patient satisfaction, and reducing patient falls and line infections such as CAUTI and CLASBI.

All of the residents/fellows in the group interviews indicated they had received formal education or training about patient safety. In discussions with residents/fellows in the group and on walking rounds, some appeared to have a working knowledge of patient safety terminology and

principles (e.g., Swiss cheese model of system failure, root cause analysis, and fishbone diagrams).

In the group interviews, 93% of the residents/fellows indicated they believed the hospital provides a safe, non-punitive environment for reporting errors, near misses, and unsafe conditions. This overall sense of a safe culture for reporting errors was consistent among faculty members, program directors, and nursing staff.

UF Health Shands Hospital uses the Patient Safety Reporting (PSR) system for capturing patient safety events. The PSR system is an online system and reports may be submitted anonymously. The patient safety leadership noted that residents/fellows could also report patient safety events using telephone, in-person, and e-mail communication with the patient safety staff, and those reports are subsequently entered into the online system. They noted that patient safety reports were to be submitted by all members of the team involved in the care of a patient, and that multiple reports of a single patient safety issue are welcome.

The quality and patient safety officers indicated that all patient safety event reports are reviewed by patient safety and risk management leadership and then sent to unit leaders for review and recommendations as to the need for further investigation.

The patient safety leadership reported the hospital received 8,040 entries in academic year 2013 and 9,874 in academic year 2014 via the patient safety event reporting system and estimated that 10 to 15 percent of the reports are filed anonymously. The patient safety office tracks the number of patient safety reports submitted by residents/fellows, and reported that residents/fellows submitted 346 patient safety event reports in calendar year 2013. Thus far, in calendar year 2014, residents have submitted 527 patient safety event reports.

Eighty-five percent of the residents/fellows in the group interviews reported they had experienced an adverse event or near miss at UF Health Shands Hospital. Of those, 62% (52% of the total) indicated they had reported the event themselves, 27% indicated they relied on a physician supervisor to submit the report, 6% indicated they relied on a nurse to report the event and 4% indicated they chose not to submit a report. In a separate query, 29% of the residents/fellows responded they had reported a near miss event.

Seventy-two percent of the faculty members and 86% of the program directors interviewed indicated that they believed less than half of the residents/fellows have reported a patient safety event using the hospital's reporting system. When faculty members were asked to indicate what process they believed residents/fellows would most frequently follow when reporting a patient safety event, two-thirds believed the residents/fellows would report the event themselves, 5% believed the residents/fellows would rely on nurses to report the event, 20% believed the residents/fellows would rely on their supervisor to report the event, and 8% believed the residents/fellows would care for the patient but choose not to submit a report. In response to this same question, 73% of the program directors believed the residents/fellows would report the event themselves, 9% believed the residents/fellows would rely on nursing staff, 9% believed the residents/fellows would rely on their supervisors to report the event and 9% believed the residents/fellows would choose not to submit a report.

According to patient safety leadership, nurses submit the majority of patient safety event reports. Of the nurses interviewed, many indicated that the patient safety reporting system was not burdensome; a few indicated it could take up to 30 minutes to complete a report if the incident was complex. When asked for a demonstration, nurses were able to easily identify and access the intranet site used for patient safety event reporting. While most indicated they had used the system, a few had not submitted a report in months. Among the nurses interviewed, events that did not result in patient harm or unexpected patient deteriorations were not consistently viewed as reportable events. Some of the nursing staff, residents, and fellows interviewed appeared to have a limited understanding of the range of reportable events.

The faculty members, program directors, and nurses interviewed were consistent in their observation that residents/fellows are increasing in the number of patient safety event reports they file.

Of those residents/fellows in the group interviews who reported submitting a patient safety event by any means (self-report, nurse or supervisor), 44% indicated they received feedback. The format of the feedback varied from automated e-mail recognition of the report, to conversations with a nurse manager, safety officer or physician supervisor, to participating in an RCA investigation or case presentations at Morbidity and Mortality (M&M) conferences.

The patient safety leadership reported that the hospital conducted 50 root cause analyses (RCAs) in academic year 2014, and of those, 33 involved residents/fellows. In the group interviews, 80% of the faculty members and 60% of the program directors reported they had the opportunity to participate in a patient safety investigation such as an RCA.

Of the residents/fellows in the group interviews who were PGY3 and above, 43% reported they had participated in a patient safety investigation such as an RCA. As there are more residents/fellows at UF Health Shands Hospital than RCAs performed at this site, residents/fellows reportedly learn how to analyze patient safety issues through other forums. In the group interviews, M&M conferences were identified as one means for residents/fellows to learn these skills. In discussions about the use of M&M conferences as a mechanism for analyzing patient safety events, it was unclear if all of the patient safety events presented in the conferences, or those not selected for presentation, were also routinely entered into the hospital's patient safety reporting system. Discussion of near misses appears to be a part of M&M conference activities across most programs. When queried as to the format of M&M conferences, some residents/fellows and faculty members described them as case presentations with peer discussions, and others described them as inter-professional discussions that included consideration of systems factors, analysis of root cause, and action planning. Some M&M conferences appear to be limited to physician attendance with invited nurse participation, while others were described as inter-professional discussions.

Nurses, residents and fellows interviewed on walking rounds indicated that residents and fellows usually conduct time-outs prior to performing patient procedures throughout the floors and units of the hospital.

In the resident/fellow, faculty member, and program director group interviews, the participants were asked for recommendations to improve resident and fellow engagement in the hospital's patient safety efforts. Suggestions included:

- Providing more feedback than the automated message with more detail on outcome.
- Simplifying & streamlining the PSR entry process.
- Receiving better information on the outcomes of RCAs.
- Improving identification of who was involved in a case and who should attend an RCA.
- Scheduling RCAs at times when residents/fellows are able to attend.
- Organizing data around patient safety reports and making it more specific to resident/fellow activity.
- Having more interdisciplinary meetings on patient safety.
- Assuring all residents/fellows complete the IHI modules.
- Conducting simulations on units and floors where care is provided and with full team participation.
- Having more collaboration among the teaching faculty.
- Giving the faculty protected time to teach quality and patient safety.
- Including residents/fellows in the annual patient safety/quality improvement retreat.
- Making more grants available to residents and fellows for quality work.
- Facilitating more interdisciplinary patient safety work.
- Involving quality improvement and patient safety staff as active participants in departmental and institutional quality & safety activities.

Healthcare Quality

The senior leadership stated the hospital's priorities for healthcare quality improvement (QI) were the same as their patient safety priorities. The patient safety and quality leadership team stated the hospital's top priorities for healthcare QI are decreasing mortality by decreasing complications & harm, improving the patient experience, adhering to core measures, and decreasing readmissions.

Eighty-two percent of the faculty members and 59% of the program directors interviewed believed their residents/fellows (PGY2 and above) knew UF Health Shands Hospital's priorities for healthcare quality improvement. Eighty-eight percent of the residents/fellows in the group interview reported they knew the hospital's priorities for healthcare QI and listed using NSQIP risk calculators prior to operative procedures; improving hand-off tools (I-PASS & SBAR); involving all residents/fellows in quality projects; using professional interpreters consistently; reducing readmissions; and improving mortality rates, performance on core measures, hand-offs, and patient experience. Ninety percent of the faculty members in the group interview reported they themselves knew the hospital's priorities for healthcare quality improvement and cited reducing readmissions and venous thromboembolism (VTE); decreasing door to balloon time and mortality rates; improving transitions of care and performance on Surgical Care

Improvement Project (SCIP) measures; increasing surgical safety using time-outs; and improving vaccination rates. Eighty-two percent of the program directors in the group interview reported they knew the hospital's priorities for quality improvement and listed making patient management more consistent; reducing harm such as medication errors and VTE; improving patient satisfaction, performance on core measures, immunization rates, and the safety culture by improving teamwork; decreasing readmissions and mortality; and increasing breast screening rates.

Twenty-four percent of the residents/fellows in the group interviews reported they were engaged with the hospital's leadership in developing and advancing UF Health Shands Hospital's quality strategy and, 39% reported they had participated in a QI activity directed by the hospital's administration.

Nearly all of the residents/fellows in the group interviews (PGY2 and above) reported they had participated in QI project of their own design or one designed by their program or department. Of these, two-thirds reported their project in some way linked to the hospital's goals; 11% reported they did not know if their project linked to the hospital's goals. Sixty-eight percent of residents/fellows in the group interview reported being engaged in inter-professional QI teams working on performance improvement projects. Nurses, residents and fellows interviewed on walking rounds described joint quality improvement projects on some units.

The residents/fellows interviewed appeared to have a limited knowledge of QI terminology and methods (for example PDSA cycles). When residents and fellows were asked to describe their projects, most described personal QI activities centered on care of their own patients, data reviews, planning or implementing a process change, or conformance to patient care guidelines, and not projects that involved engaging in one or more complete quality improvement cycles.

Fifty-five percent of residents/fellows in the group interviews reported they have access to organized systems for collecting and analyzing data for the purpose of quality improvement. When asked the same question, 70% of faculty members and 61% of program directors interviewed reported their residents/fellows have access to data for quality improvement. It appears that the primary source of data is from departmental, hospital and national databases and the electronic health record (EHR). Residents/fellows, faculty and program directors indicated the hospital's information technology department and departmental staff members are available to assist residents/fellows with quality projects.

When asked for recommendations to improve resident/fellow engagement in healthcare quality improvement at UF Health Shands Hospital, physicians in the group interviews suggested:

- Providing better access to data.
- Having statisticians available to analyze data.
- Providing resources to make changes based on QI project recommendations.
- Improving resident education as to the hospital's priorities.
- Making sure the residents/fellows know the hospital's goals.
- Improving resident/fellow participation in committees.

Healthcare Disparities

UF Health Shands Hospital seeks to provide equal access to care for their community, providing care for uninsured and underinsured patients. Access to care is one of the hospital's priorities and appears to be supported by the GME community. The senior leadership reported that UF Health Shands Hospital's priorities in addressing healthcare disparities are in development. They noted they are currently in the process of assessing their vulnerable populations including the rural community, patients of lower socioeconomic status and patients with dual diagnoses, primarily psychiatric and medical conditions. The leaders also indicated the hospital is addressing patient needs when limited English proficiency is an issue and providing professional and certified interpreter services for those patients. When queried, 44% of the residents/fellows, 64% of the faculty members and 47% of the program directors in the group interviews reported they knew the hospital's priorities with regard to addressing healthcare disparities, mentioning placing a limited health literacy notice on the front of the patient's chart when appropriate, and use of interpreters for patients with limited English proficiency; use of sign language interpreters; ensuring patients receive discharge instructions in their preferred language, follow-up with needed specialty care, and a medical home upon discharge; caring for all patients once they enter the hospital system; serving the un-insured and under-insured; identifying service areas with high readmission rates; maximizing use of the interpreter phone system; providing a charity care program for medications and care; improving access to care by opening clinics in under-served areas; and providing ambulatory and tertiary care for patients.

UF Health Shands Hospital does not appear to have a systematic approach to identifying variability in the care provided to or clinical outcomes of their known vulnerable patient populations. Leadership, residents and faculty suggested that there are some population-specific data collection activities related to health care disparities beginning in some areas, including some clinical research projects.

Cultural competency training for residents/fellows and faculty members appears to be largely generic and not tailored to the specific populations served by UF Health Shands Hospital.

Transitions in Care

The senior leadership stated their priority for improving transitions in care is focused on all hand-offs. During the group interviews, 84% of the residents/fellows, 89% of the faculty members, and 86% of the program directors believed they knew the hospital's priorities for improving transitions of care. All the physician groups mentioned using I-PASS for handoffs. The residents/fellows further mentioned standardizing hand-offs, reducing the number of hand-offs, using a formatted hand-off template, performing hand-offs in a standard place, having faculty members and senior residents monitor hand-offs, and performing face-to-face hand-offs to be priorities. Faculty members mentioned improving transitions from surgery to the intensive care units by having real-time electronic access to the patient chart, decreasing boarding times, performing face-to-face hand-offs with the use of a template, improving transitions from inpatient to outpatient care, face-to-face attending level hand-offs especially in some intensive care units,

and using SBAR for service to service hand-offs. Program directors listed inter-professional involvement in hand-offs, appropriate supervision of all hand-offs, accurate transition documentation; improving the hospital discharge process, medication reconciliation for all transitions, and transfers from ICU to the floor; reducing the number of transitions in care, standardizing hand-offs through SBAR, assuring resident continuity for patients, combining hand-off processes in some intensive units, and improving follow-up continuity in the ambulatory setting.

Residents, fellows and nurses interviewed on walking rounds, and physicians in the group interviews noted that UF Health Shands Hospital is developing a common approach to managing resident/fellow patient care hand-offs across programs and service areas. Currently, the care transition processes described by the residents/fellows vary from specialty to specialty. Of the residents/fellows in the group interviews, 89% indicated they use a standardized process for sign-off and transfer of patient care during change of duty. Of those who indicated they use a standardized process, 83% indicated they use written templates of patient information to facilitate the hand-off process. Most residents/fellows indicated they use standardized processes for transfer of patients between hospital floors and units and for transfers from inpatient to outpatient care. Inter-professional rounding was reported to occur in some service areas. During the walking rounds, the several hand-off sessions observed varied in use of templates, style of template, and level of detail relayed. Of the observed hand-offs, some occurred in quiet non-patient care areas without interruption.

The faculty members appear to vary by specialty as to the degree and manner in which they monitor resident/fellow skills in conducting change of shift hand-offs.

Supervision

When queried as to potential vulnerabilities in the supervision of residents/fellows, the hospital's senior leadership identified possible vulnerabilities in procedural areas. Residents/fellows, faculty members and program directors reported a culture of close supervision. In the group discussions, faculty members and program directors believed there were vulnerabilities with regard to supervision related to times of high volume patient care needs, the availability of attending coverage in some services, over-supervision potentially impeding the transition to autonomy, and noted that the ability to supervise from afar may lead to an attending physician not being available for hands-on training.

Nearly all of the residents/fellows in the group interviews reported they nearly always knew what they were allowed to do with and without direct supervision. All faculty members and program directors interviewed were confident residents/fellows knew what they were allowed to do with and without direct supervision. In a query via the audience response system, 30% of the residents/fellows reported that, while in training at UF Health Shands Hospital, they had been placed in a situation or witnessed one of their peers placed in a situation where they believed there was inadequate supervision (e.g. the attending wasn't available).

Physicians in the group interviews indicated the hospital uses both New Innovations and the ACGME Case Logs to document numbers of procedures performed by residents/fellows. These systems are on-line and one or the other is used depending on specialty. For each procedure, residents/fellows are deemed competent after performing a specified number of observed procedures. Some programs use simulation training of procedures before the resident/fellow are allowed to perform procedures on patients.

Seventy-nine percent of the faculty members and 94% of the program directors in the group interviews felt they have an objective way of knowing which procedures a particular resident/fellow was allowed to perform with or without direct supervision. Fourteen percent of the residents/fellows in the group interviews reported they have an objective way of knowing whether another resident/fellow is able to perform a specific procedure with or without direct supervision.

Fourteen percent of the program directors in the group interviews reported that, in the past year, they had to manage an issue of resident/fellow supervision that resulted in a patient safety event. When queried, the quality and patient safety leadership could not recall any patient safety events related to supervision.

The hospital does not appear to have a system by which nurses and others can identify an individual resident's competency to perform a clinical procedure. The nursing staff members who were interviewed appeared to principally rely on familiarity, trust, year of training, or the presence of attending physicians during resident/fellow performance of procedures.

When queried as to their perception of patients' awareness of the different roles of residents/fellows and attending physicians, 31% of faculty members and 42% of the program directors in the group interview thought the majority of patients would know the different roles. Twenty-seven percent of the residents/fellows thought the majority of patients would be able to successfully identify the differences in roles.

Duty Hours, Fatigue Management, and Mitigation

In discussions about the ACGME policies on duty hours, the faculty members and program directors in the group interview expressed concerns including decreased continuity of care, fragmented education, increased numbers of transitions in care, reduced depth of knowledge about individual patients, lack of professionalism of junior faculty, decreased clinical exposure, increased requirements for EHR charting reducing available clinical time. They also noted the rules don't impact some disciplines but all programs have to complete the required documentation, and the duty hours result in reduced time off due to shorter but more frequent duty segments.

Nearly all of the residents/fellows in the group interviews reported they received education on fatigue management and mitigation and two-thirds reported that this education consisted of an initial session at orientation with other program-specific required sessions throughout their training. Most faculty members and program directors in the group interviews reported they had

received education on fatigue management and mitigation. When queried as to resources available for fatigue management, the residents/fellows identified training about fatigue management and mitigation, call rooms and rooms available for napping, cab fare when too fatigued to drive home (with a subsequent return to the hospital), caffeinated beverages and food available in the resident lounge, and a serenity room.

In the group interviews, the residents/fellows were presented with a scenario describing a maximally fatigued resident two hours before the end of his/her shift. When asked what they would do in this circumstance, 35% of the residents/fellows interviewed indicated they would simply power through to sign-off, 41% indicated they would notify a supervisor and expect to be taken off duty, 12% indicated they would approach another resident and hope they would take over their responsibilities, 8% responded they would report their tiredness to a supervisor and expect to be asked to stay until the end of the shift, and 4% indicated they would take some other action.

When faculty members and program directors were given the same scenario, 20% of the faculty members and 18% of the program directors felt the resident would power through to sign-off; whereas 53% of the faculty members and 62% program directors believed the resident would report to their supervisor and expect to be taken off duty immediately.

When queried as to their beliefs as to how residents/fellows are reporting their moonlighting time, 23% of the program directors believed residents/fellows might be under-reporting these hours.

In response to a query about patient safety events, 9% of the program directors recalled a patient safety event related to resident/fellow fatigue. The patient safety leadership did not recall any patient safety events in which fatigue was a factor.

Professionalism

When senior leadership were queried as to whether or not there had been any GME-related incidents concerning professionalism and integrity in the past year, they noted that there had been at least one incident resulting in a faculty member being referred to an outside agency to address an issue of professionalism.

Nearly all of the residents/fellows in the group interviews reported receiving education on various professionalism topics during their orientation. In addition, 81% reported participating in required program-specific sessions throughout residency.

In the group interviews, 89% of residents/fellows reported that they believed the hospital provides a supportive, non-punitive environment for bringing forward concerns regarding honesty in reporting. Five percent of the residents/fellows in the group interviews reported that, while at UF Health Shands Hospital, there had been at least one occasion where they felt pressured to compromise their integrity to satisfy an authority figure.

Fifty-two percent of the residents/fellows in the group interviews reported that, while at UF Health Shands Hospital, they have documented a history or physical finding in a patient chart they did not personally elicit (e.g. cutting and pasting from another note). Approximately one-half of the faculty members and program directors interviewed reported they believed the majority of residents/fellows have engaged in this practice.

In each of the group meetings with residents/fellows, faculty members, and program directors, there was at least one person in each session who responded via the ARS that they believe there are residency programs at UF Health Shands Hospital that assist their residents/fellows with exam prep by sharing in-training or board exam questions not available in the public domain.

The residents/fellows in the group interviews were presented with a scenario describing an attending physician's mistreatment of a colleague, and asked how they would advise the colleague. The residents/fellows were varied in their responses. The most common response (59%) was to advise the colleague to discuss the incident with their chief resident or program director. In a follow-up question, the residents/fellows were presented with a continuation of the scenario in which the issues of mistreatment persist and the resident felt that GME chain of command had failed to resolve the issues. When presented with choices of what to do next, the residents/fellows were varied in their responses. Fifty-six percent of the residents/fellows responded that they would advise the colleague to contact the Human Resources (HR) Department or the Equal Employment Opportunity Commission (EEOC), 20% opted for the response of advising the colleague to register a concern with the ACGME, and 15% indicated they would advise the colleague to submit an incident report.

The faculty members and program directors in the group interviews were presented with the same scenario described above and asked what they believed would be the resident's course of action. For the first question, 77% of the faculty members and program directors responded they believed the resident would contact their chief resident or program director. For the follow-up question, the responses were varied; 38% of the faculty members and 39% of the program directors believed the resident would register a concern with the ACGME, 31% of the faculty members and 35% of the program directors believed the resident would contact the HR Department or the EEOC. Fourteen percent of the faculty members and 18% of the program directors responded "other" some adding returning to the program director, or going to the department chair as possibilities others indicated they believed it would not happen at UF Shands Hospital.

Although nearly all residents, fellows, and nurses interviewed reported a safe and respectful work environment, individuals across several units noted that, at times, the behavior of a few attending physicians and nurses has been perceived as being disruptive or disrespectful.

Thank you

In closing, the CLER site visit program would like to thank UF Health Shands Hospital for its hospitality in facilitating the CLER site visit. It is the CLER program's vision that the site visit process be a learning opportunity for all involved. We invite your comments on the CLER program and we look forward to hearing how your institution has responded to the visit and report of the CLER site visit team.

Note: The Clinical Learning Environment Review (CLER) program is designed to broadly inform the Next Accreditation System (NAS). CLER visits do not result in citations or directly lead to programmatic or institutional accreditation decisions. For the first cycle of CLER visits, CLER staff/volunteers may share CLER-derived data/information with the IRC, the RRCs or the public only in de-identified or aggregate form, unless written permission is obtained from the DIO of the Sponsoring Institution.

ACGME will re-visit the site visit protocol and procedures prior to starting the second cycle of CLER visits and any changes will be communicated to Sponsoring Institutions prior to implementation.