



Graduate Medical Education Policy Manual

2025-2026

Contents

Annual Review of Manual	4
Policy Update Disclaimer	4
NRMP Agreement	4
Appointment Agreement	5
Guidelines for Use of the GME Manual	13
Glossary	14
Academic Assistance and Remediation	16
Accommodations for Disabilities	27
Appeals	29
Electronic Health Record Documentation and Task Completion	31
Annual Institutional Review Protocol	33
Away and Elective Rotations	34
Benefits	39
Cell Phone	42
Clinical Experience and Educational Hours	44
Code of Conduct	46
Designated Institutional Office Organizational Chart	53
Diversity	54
Drug and Alcohol Abuse	55
Dress Code	62
Employment of Relatives or Significant Others	65
Evaluations	67
Fatigue Mitigation	71
Family and Medical Leave	72
Influenza Vaccination	73
Graduate Medical Education Committee Responsibilities	76
Graduate Medical Education Committee Organizational Chart	77
Grievance and Conflict Resolution	78
Hand Hygiene	80
Hand Hygiene Agreement for Graduate Medical Education	83
Harassment	84
Lactation	87
Locker Agreement	88

Moonlighting 89

Non-Compete..... 91

Non-Discriminatory Work Environment 92

Paid Time off and Leave of Absence 95

Patient Safety and Quality Improvement..... 98

Trainee CVC Procedures 99

Professionalism and Responsibility 111

Promotion/Non-Renewal/Dismissal..... 114

Protocol for Special Review 117

Record Requests..... 119

Research..... 122

Recruitment, Selection and Appointment..... 128

Residency or Fellowship Closure and Reduction..... 131

Safety Variance Reporting 132

Statement of Commitment 134

Substantial Disruptions in Patient Care or Education 136

Supervision 137

Transitions of Care 139

Use of Force 141

Vendor Relation 148

Verbal or Telephone Orders 149

Well-Being 157

Work Restrictions for Health Care Workers with Contagious or Communicable Disease..... 159

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 October 9, 2025. All policy updates were reviewed and approved by the MEC on 12/9/2025.

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-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 2025 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 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
GMCEC - 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. 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.
3. 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.
4. 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.
5. At-home Call – Call taken from outside the assigned institution.
6. 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.
 - a. 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.

- b. Extended family – 1 day off - Residents/fellow’s grandparent-in-law, uncle, aunt, niece, nephew, brother-in-law, and sister-in-law.
7. 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 patientcare, time spent in-house during call activities, all moonlighting activities, research activities, and scheduled academic activities such as conferences.
 8. 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.
 9. 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.
 10. 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).
 11. 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.
 12. Paid Time Off (PTO) – paid time for such absences as personal vacation, holiday time, as well as serious illness of an immediate family member, extended bereavement time off, and other similar occasions.
 13. Personal Time- five days of PTO are allotted as personal time that residents/fellows are not expected to plan in advance like the other 15 days of PTO. This is to be used for personal illness or illness of a family member, wellness days, and appointments that require the absence of a full shift/whole day. Residents and fellows should still schedule these days ahead of time whenever possible and follow program policies to make the Program Director and Program Coordinator aware of requests to use personal time.
 14. Program Director – The director of the specific residency program the residents/fellow is currently enrolled in.
 15. Residents/fellow - Interns, residents/fellow, and subspecialty residents/fellow (fellows) enrolled in a Bayhealth sponsored postgraduate training program.
 16. 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.
 17. 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.
 18. Visiting Residents/fellow – A resident/fellow that is in an approved residency training program other than Bayhealth that is participating in a Bayhealth rotation.

Academic Assistance and Remediation

Purpose Statement: This policy establishes a structured process for academic assistance and remediation to support residents/fellows in the Graduate Medical Education (GME) program in achieving competency in their training, in accordance with Accreditation Council for Graduate Medical Education (ACGME) requirements. Per ACGME requirements, sponsoring institutions must ensure that residents/fellows receive timely feedback on their performance, structured remediation plans are provided when academic or professional deficiencies are identified and that there is a fair and consistent process for assessing progress and determining further actions.

Institutional Requirements: 4.5, 3.1

1. Procedure:
 - 1.1 Academic and professional deficiencies may be identified through the following:
 - 1.1.1 Formal evaluations by faculty, program director(s), or clinical competency committee(s).
 - 1.1.2 Poor performance on in-service or board examinations.
 - 1.1.3 Concerns raised by peers, mentors, or supervising faculty.
 - 1.1.4 Professionalism issues, including ethical concerns or behavioral problems.
 - 1.1.5 Failure of required rotations
 - 1.2 **Early Intervention: Verbal Counseling**
 - 1.2.1 Faculty and/or Program Directors should provide immediate feedback when minor deficiencies are observed.
 - 1.2.2 Mentorship or additional academic support may be offered to address concerns before formal remediation is required.
 - 1.2.3 Programs should document verbal coaching through the Residency Management System (Medhub) by completing the GME Academic Assistance and Remediation Form.
 - 1.2.4 The GME Academic Assistance and Remediation Form should be signed by both the resident/fellow and the Program Director.
 - 1.3 **Informal Remediation: Written Counseling**
 - 1.3.1 If deficiencies continue despite verbal counseling and without desired improvement, or if other action/behavior(s) occur, the Program Director will move to Informal Remediation: Written Counseling
 - 1.3.2 Programs must complete the GME Academic Assistance and Remediation Form with the guidance of the GME office, at least ten (10) business days prior to meeting with the resident/fellow.
 - 1.3.3 This form should provide the resident/fellow with the following information:
 - 1.3.3.1 Area(s) of deficiency/affected competencies
 - 1.3.3.2 Description of Performance Issue
 - 1.3.3.3 Action for Improvement (SMART Goals)
 - 1.3.3.4 Resources

- 1.3.3.5 Monitoring Mechanism(s)
- 1.3.4 The written counseling should not exceed 90 days.
- 1.3.5 The Program Director should meet with the resident/fellow biweekly to monitor the progress of the written counseling.
- 1.3.6 Outcome of the Written Counseling: At the end of the written counseling period the resident/fellow and Program Director should meet to discuss outcomes. Potential Outcomes are as follows:
 - 1.3.6.1 Successfully Remediated
 - 1.3.6.2 Extension of Written Counseling
 - 1.3.6.3 Academic Probation
- 1.4 **Formal Remediation: Academic Probation**
 - 1.4.1 If the deficiencies continue despite formal remediation, the trainee may be placed on academic probation.
 - 1.4.2 The GME office must be notified prior to issuing the formal remediation.
 - 1.4.3 The Program Director must complete the GME Academic Assistance and Remediation form with clear expectations. Program Directors should reference the GME Academic Assistance and Remediation Form instructions prior to filling out the form. HR will use the GME Academic Assistance and Remediation form as a template for writing the Performance Improvement Plan (PIP), both documents will be reviewed and signed by the resident/fellow and Program Director
 - 1.4.4 This form should consist of the following information:
 - 1.4.4.1 Area(s) of deficiency/affected competencies
 - 1.4.4.2 Description of Performance Issue
 - 1.4.4.3 Action for Improvement (SMART Goals)
 - 1.4.4.4 Resources
 - 1.4.4.5 Monitoring Mechanism(s)
 - 1.4.5 A performance improvement plan (PIP) is developed with clear expectations and potential consequences in partnership with the GME Office, Designated Institutional Official, and Human Resources department.
 - 1.4.6 The Program Director will meet with the resident/fellows to initiate the PIP only after approved by Human Resources and GME office.
 - 1.4.7 The formal remediation should not exceed 90 days.
 - 1.4.8 The Program Director must conduct and document a follow-up review of the PIP weekly/biweekly.
 - 1.4.9 Academic Probation is reportable to credentialing agencies and may be reportable to the state medical boards under certain circumstances.

- 1.5 Outcome of the Academic Probation: At the end of the academic probation period the resident/fellow and Program Director should meet to discuss outcomes. Potential Outcomes are as follows:
 - 1.5.1.1 Successfully Remediated
 - 1.5.1.2 Extension of Academic Probation
 - 1.5.1.3 Non-reappointment (allowed to complete current year of training but will not receive a contract to continue in the program)
 - 1.5.1.4 Dismissal (immediate termination of contract due to inability to remediate)

1.6 **Dismissal from Training Program**

- 1.6.1 Dismissal may occur in the event the trainee does not successfully remediate after probation.
- 1.6.2 The Program Director will provide the resident/fellow with the *GME Appeal Process Policy*
- 1.6.3 A Resident/Fellow may be dismissed from the GME program for failure to satisfactorily perform under the PIP or for the following behaviors:
 - 1.6.3.1 Apparent serious violations of ethical, legal or medical practice standards of conduct
 - 1.6.3.2 Significant patient safety concerns
 - 1.6.3.3 Responsible for adverse incidents/issues that endanger patients or staff
- 1.6.4 The appeals process does not apply in the case of certain egregious events such as: falsification of records, material omission of information on application or any official paperwork, violation of Drug and Alcohol Abuse Policy, conviction of a felony, or loss of medical license leading to inability to practice clinical medicine.
- 1.6.5 In the event a trainee is dismissed from a program, and is eligible for appeal, they will be placed on paid administrative leave for up to ten (10) business days.
- 1.6.6 If the trainee decides not to appeal, the dismissal will stand, and the trainee will be terminated on that date.

2. References:

- 2.1 GME Appeal Process Policy
- 2.2 Drug and Alcohol Abuse Policy B9065.14
- 2.3 Accreditation Council of Graduate Medical Education (ACGME) Institutional Requirements

3. Exhibits:

- 3.1 Exhibit A: GME Academic Assistance and Remediation Form
- 3.2 Exhibit B: GME Academic Assistance and Remediation Form Instructions

Exhibit A: GME Academic Assistance and Remediation Form Instructions

Please follow the instructions below when completing the GME Academic Assistance and Remediation Form.

The GME Academic Assistance and Remediation Form is used to appropriately document the program's actions in response to deficiencies in competency areas as they are detected in the learner through existing supervision and assessment mechanisms. The form can be used to document all actions, including verbal and written counseling/coaching (non-disciplinary), probation, non-promotion, extension of training, non-reappointment, and dismissal (disciplinary and reportable).

Fields in the form should be completed as much as necessary and possible, to provide a clear plan for the learner to improve their performance. Counseling or corrective actions that follow should occur as early as possible after the clear identification and documentation of deficiencies to allow the learner enough time to make improvements before resolution of the problems or additional corrective actions are taken.

1. Please complete: the learner's name, Program Director (PD) name, program, PGY level and date of the start of counseling or remediation action.
2. Please choose type of action:
 - **Non-disciplinary actions:** Non-disciplinary actions are not reportable to the board or licensing agencies. Please maintain ALL documentation, emails, evaluations and notes from conversations with peers and faculty within the Residency Management System (Medhub).
 - i. Verbal Counseling
 - ii. Written Counseling
 - **Formal corrective actions:** **Please contact the GME office prior to delivering any formal corrective action.** These actions are reportable to licensing boards when appropriate. Corrective actions that are not appealed, or whose decision is not overturned during the appeal process become part of the learner's permanent record maintained in the GME office. *Please note: Although formal corrective actions generally follows non-disciplinary actions in a stepwise fashion, (1. verbal counseling, 2. written counseling, 3. probation, 4. dismissal) non-disciplinary steps may be omitted depending on the seriousness and nature of the issues at hand.*
Formal action includes:
 1. Academic Probation
 2. Non-promotion (extension of training for competency-related deficiencies)
 3. Non-promotion (non-renewal of contract)
 4. Dismissal

Due to their egregious nature, some actions are NOT appealable, this includes falsification of records, material omission of information on application or any official paperwork, violation of substance abuse policy, conviction of a felony or loss of medical license leading to inability to practice clinical medicine.

3. **Area(s) of Deficiencies and/or Affected Competencies:** Deficiencies should be noted by areas of competency. Multiple competencies may be checked, if necessary. If other is selected, please explain.

4. **Description of Performance Issue:** A thorough description of the performance issue, including specifics of behavior or knowledge deficits, as well as dates of occurrence should be

(Professionalism) Dr. Smith consistently communicates with nursing staff in a condescending manner. This has been noted on several occasions by staff with whom he has worked (Dr. X on Green service 7/1/2021, Dr. Y on Red service 8/1/2021 and Dr. Z on 8/15/2021).

provided to the learner. Please ensure you have appropriate non-anecdotal documentation to back up performance issues. Example provided below.

5. **Action for Improvement:** SMART goals should be developed to ensure timely results-focused remediation. The PD or CCC may set these goals and should work with the learner to develop the remediation plan, which the PD will review and approve as appropriate.

SMART goals are:

- **S**pecific: What are the expectations? What improvement is expected?
- **M**asurable: How will you determine if the goal has been met, what measurement will be used?
- **A**chievable: Is the goal achievable? What resources are provided?
- **R**esults Focused: What will be accomplished if goals are met?
- **T**ime Oriented: What is the time period in which the goal should be achieved? Time period will depend on reason for counseling or remediation.

For example:

Action for Improvement (please add/delete rows as necessary)			
Targeted Area for Improvement/Reason	Expected Improvement Outcomes	Measurement of Improvement	Time Frame
Professionalism: Dr. Smith has been observed using inappropriate language and acting in an unprofessional manner with other caregivers. This was observed by several Faculty members and reported by the nurse manager on several occasions.	Effective immediately, Dr. Smith is expected to behave in a professional manner towards all caregivers at all times. Dr. Smith should act in a respectful manner and use appropriate language in all interactions in the workplace. If the goals are accomplished Dr. Smith will be considered successfully remediated. As this performance issue was not formal in nature it will not be reported to boards or other agencies unless	Feedback regarding professional behavior will be solicited from nursing personnel with whom Dr. Smith works over the next 90 days.	Immediate improvement expected and will be monitored over a 90-day period.

Action for Improvement (please add/delete rows as necessary)

	further issues are noted at a later date.		
Medical Knowledge: Dr. Smith's medical knowledge seems to lag significantly behind that of his peers. This has been noted both in his rotation evaluations recently and his in-service exam scores last year (for which he was counseled previously). Dr. Smith's knowledge in several instances (which we have discussed) could have affected patient care outcomes if not recognized by other team members.	Dr. Smith will be provided with a mentor who can help develop a study plan to increase his knowledge and prepare him for future rotations as well as the next in-service exam. It is expected that they will be prepared for rotations by reading recommended materials. It is also expected that they will discuss cases with his faculty or senior prior to making medical knowledge-based decisions until he reaches an adequate level of competency for his level of training	Feedback from mentor Improved rotation evaluations in regard to medical knowledge Improved in-service exam scores next month	Dr. Smith will meet with his mentor biweekly to discuss progress and with the PD after every rotation to review evaluations over a 90-day period at which time his progress will be assessed for adequate improvement.

6. **Resource(s) Recommended and/or provided to help the learner meet his or her goals:** Please list any resources provided to the learner for improvement. Examples of possible resources include books or journal articles to read, mentorship, or simulation training. Example Provided Below.

Dr. Smith should review the goals and objectives of upcoming rotations to determine appropriate reading materials to build a knowledge base. Dr. Smith should also reference the following materials: 1, 2, 3

7. **Monitoring Mechanism:** Who will monitor progress? How will they do so? How often? It is the ultimate responsibility of the Program Director to monitor the progress of the improvement plan. Example provided below.

The PD will meet with Dr. Smith weekly to review progress using feedback from team members with whom Dr. Smith has worked that week.

8. **Consequences for failure to meet expected improvement in competency areas –** What will happen if the learner fails to meet SMART goals? What will occur if goals are not met in the expected time frame must be clearly delineated.

If further incidents displaying a lack of professionalism when dealing with nursing staff occur within the 90 days of this remediation plan, the next step of corrective action which is

Example provided below.
9. Signature:

the form must be signed and dated by both the PD and the learner. Additional documentation can be attached to substantiate the need for remediation. As noted above, it is recommended that a written record of all steps in the remediation process be maintained by the program. **By signing the form, the learner does not agree**

with the information contained on the form, it merely indicates that they have received, read and understand the performance improvement plan. The learner can appeal any appealable formal corrective actions.

10. **Learner Performance Comments:** Although optional, the learner may comment here.

11. **Outcomes:** At the end of the counseling or remediation period the learner and PD should meet to discuss outcomes. Outcomes of formal corrective actions and consequent steps should be discussed with GME prior to holding meeting with learner.

Potential outcomes are:

- Successfully Remediated
- Written Counseling (if verbal counseling was not successful, or new events have occurred which necessitate further remediation)
- Academic Probation (if written counseling was not successful or new events have occurred which necessitate further remediation)
- Extension of Probation (extension of Probation/training) (if progress was made but was not found to be adequate to discontinue remediation)
- Non-Reappointment (allowed to complete current year of training but will not receive a contract to continue in the program)
- Dismissal (immediate termination of contract due to inability to remediate)

Comments and signature of both PD and learner are required as a part of outcome plan; if learner refuses to sign, the PD should denote and date.

Completed forms should be sent to GME for permanent record if they pertain to formal corrective actions. If additional remediation is required, a new form should be completed.

Exhibit B: GME Academic Assistance and Remediation Form

Please reference the GME Academic Assistance/Remediation Form Instructions (separate document) when completing this form. Contact the GME Office with any questions.

Learner Name:		Program Director:	
Date:	Program:	PGY:	
Non-Disciplinary Actions - Counseling - (Not Reportable, Non-Appealable)			
<input type="checkbox"/> Verbal Counseling		<input type="checkbox"/> Written Counseling	
Formal Disciplinary Actions - (Reportable & Appealable)			
<input type="checkbox"/> Academic Probation (Performance Improvement Plan with HR)		<input type="checkbox"/> Non-Promotion (Extension of Training at current PGY)	
<input type="checkbox"/> Non-Promotion/Non-renewal of contract		<input type="checkbox"/> Dismissal	
Formal Actions Require GME and HR Sign Off Prior to Issuance			
GME Reviewer:		Date:	
HR Reviewer:		Date:	
Area(s) of Deficiency/Affected Competencies (select one or more)			
<input type="checkbox"/> Interpersonal/Communication	<input type="checkbox"/> Practice Based Learning	<input type="checkbox"/> Research	
<input type="checkbox"/> Medical Knowledge	<input type="checkbox"/> Professionalism	<input type="checkbox"/> Systems Based Practice	
<input type="checkbox"/> Patient Care	<input type="checkbox"/> Surgical/Procedural Skills	<input type="checkbox"/> Other	
If Other selected above, please explain:			

Description of Performance Issue (additional documentation may be attached)

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Action for Improvement (please add/delete rows as necessary)

Please provide SMART Goals (Specific, Measurable, Achievable, Results Focused and Timely)

Targeted Area for Improvement	Expected Improvement Outcomes	Measurement of Improvement	Time Frame
1.			
2.			
3.			

Resource(s) Recommended/Provided to help the trainee meet his/her goals:	
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Monitoring Mechanism

Name of faculty member who will be monitoring and frequency of meetings	
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Consequences for failure to meet expected improvement in competency areas:	
--	--

Signatures

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Program Director Signature:	Date:
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- My signature below does not signify that I agree with the information contained herein, it acknowledges that my PD (or his/her designee) has discussed this performance improvement plan with me and that I have read and understand the content and terms of the plan.
- If applicable (formal action), I have been advised that I will need to meet with the GME Designated Institutional Official or designee to discuss my rights to appeal this decision (**formal actions only- appeals do not apply to counseling**).

Learner Signature:	Date:
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Trainee Performance Comments (Optional)

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Outcome of Action Plan

<input type="checkbox"/> Successfully Remediated	<input type="checkbox"/> Written Counseling	<input type="checkbox"/> Academic Probation	<input type="checkbox"/> Extension of Academic Probation	<input type="checkbox"/> non-reappointment	<input type="checkbox"/> Dismissal
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Please comment (required):

Program Director Signature:	Date:
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Learner Signature:	Date:
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Accommodations for Disabilities

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

Institutional Requirements: 4.1, 3.2.g.5.f, 4.9.d

4. Procedure:
 - 4.1 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.
 - 4.2 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.
 - 4.3 Qualified applicants must be able to perform the essential functions of the selected medical specialty and may request reasonable accommodation to perform these functions.
 - 4.4 **Reasonable Accommodation for Resident/Fellow**
 - 4.4.1 Reasonable accommodations will be made to accomplish the following:
 - 4.4.1.1 To ensure equal opportunity to all candidates through the application and interview process.
 - 4.4.1.2 To enable a qualified individual with a disability to perform the essential functions of the position; and
 - 4.4.1.3 To allow a resident/fellow with a disability to enjoy equal benefits of employment in the program.
 - 4.4.2 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.
 - 4.4.3 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.
 - 4.4.3.1 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.
 - 4.4.4 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.
 - 4.5 **Application Process**
 - 4.5.1 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.

- 4.5.2 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.
- 4.5.3 When a request for accommodation, has been made, the Human Resources designee may meet with the resident/fellow and the Program Director to:
 - 4.5.3.1 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.
 - 4.5.3.2 Identify the potential accommodation and assess the effectiveness each would have in allowing the resident/fellow to perform the essential job functions.
 - 4.5.3.3 Select and implement the accommodation that is the most appropriate for both the resident/fellow and Bayhealth; and,
 - 4.5.3.4 Work with the resident/fellow to obtain technical or other assistance, as needed.
- 4.5.4 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.

5. References:

- 5.1 Americans with disabilities act of 1990, as amended. ADA.gov. (1990).
<https://www.ada.gov/law-and-regs/ada/>
- 5.2 ACGME Institutional Requirements. (2025)

Appeals

Purpose Statement: This policy establishes a structured process for residents/fellows in the Graduate Medical Education (GME) program at Bayhealth to appeal decisions that impact their academic standing, disciplinary actions or program continuation, in accordance with Accreditation Council for Graduate Medical Education (ACGME) requirements.

Institutional Requirements: 4.5, 3.1

1. Procedure:
 - 1.1 This policy applies to all Residents/Fellows enrolled in the GME program and outlines the rights and procedure for appealing Adverse Decisions.
 - 1.2 **Grounds for Appeal:** Resident/Fellows may file an appeal if they believe that an Adverse Decision was made based on the following:
 - 1.2.1 Procedural errors that result in an unfair decision
 - 1.2.2 Arbitrary, capricious, or discriminatory actions
 - 1.2.3 Lack of sufficient evidence to support the decision
 - 1.2.4 New evidence not previously available that could materially impact the outcome
 - 1.3 The failure of the Resident/Fellow to comply with the time limits and other requirements outlined in the below four steps shall void the appeal.
 - 1.4 **Step 1: Appeal Process: Initial Appeal Submission**
 - 1.4.1 The Resident/Fellow must submit a written appeal within seven (7) business days of receiving the Adverse Decision to the GME office via email to GME@bayhealth.org.
 - 1.4.2 The appeal must include: A clear statement of the decision being appealed, the basis for the appeal (stated in 4.2), and supporting documentation (if applicable).
 - 1.5 **Step 2: Review by Program Director (if applicable)**
 - 1.5.1 Upon receipt of the appeal, the Program Director will review the submission and may schedule a meeting with the Resident/Fellow to discuss the appeal.
 - 1.5.2 The Program Director will issue a written decision within ten (10) business days of receiving the appeal.
 - 1.6 **Step 3: Appeal to the Designated Institutional Official or Associate Designated Institutional Official**
 - 1.6.1 If the Resident/Fellow disagrees with the decision of the Program Director and wishes to continue the appeal, the Resident/Fellow must submit a written appeal to the GME office via email (GME@bayhealth.org) for the DIO/ADIO within five (5) business days of receiving the Program Director's written decision.
 - 1.6.2 The DIO/ADIO will review the appeal and issue a written decision within ten (10) business days to the Resident/Fellow and Program Director.
 - 1.6.3 The Program Director has no right to appeal a decision by the DIO/ADIO.
 - 1.7 **Step 4: Formal Appeal to the GME Decision Appeal Committee**
 - 1.7.1 If the Resident/Fellow is dissatisfied with the DIO/ADIO's decision and wishes to continue the appeal, the Resident/Fellow is required to submit a written appeal to the GME office by emailing GME@bayhealth.org within five (5) business days of receiving the DIO/ADIO's written decision.
 - 1.7.2 The GME office will assemble a Decision Appeal Committee for the appeal within ten (10) business days. This will include the following individuals:

- 1.7.2.1 Program Director from another Program (chair);
 - 1.7.2.2 GME Representative (non-voting member);
 - 1.7.2.3 Three faculty members from another program; and
 - 1.7.2.4 A Senior Resident, Chief Resident, or Resident Forum Chair from another program.
 - 1.7.3 The Program Director and Resident/Fellow will have the opportunity to present their case at a hearing before the Decision Appeal Committee.
 - 1.7.4 The Committee may request additional documentation or witness testimony as needed.
 - 1.7.5 The Decision Appeal Committee will deliberate the arguments, evidence and testimony taken from any individuals to render its decision.
 - 1.7.6 The Committee's decision is not required to be unanimous and can be determined by a majority of the voting members. The Panel has the discretion to uphold, reject, or modify the appeal.
 - 1.7.7 The Decision Appeal Committee Chair will issue a written decision within ten (10) business days of the hearing.
 - 1.7.8 The decision of the Decision Appeal Committee is final and binding.
 - 1.8 Non-Retaliation: Residents/Fellows who file an appeal in good faith are protected from retaliation. Any concerns regarding retaliation should be reported to the GME office and Human Resources.
 - 1.9 Confidentiality: All appeal proceedings, documents and deliberations will remain confidential to the extent permitted by institutional policy and applicable laws. Records of all appeals and outcomes will be maintained by the GME office.
2. References:
- 2.1 Accreditation Council of Graduate Medical Education (ACGME) Institutional Requirements

Electronic Health Record Documentation and Task Completion

Purpose Statement: Timely, accurate, and complete documentation of patient care in the Electronic Health Record (EHR) is essential to ensuring continuity of care, facilitating communication among healthcare team members, and meeting the requirements of the Centers for Medicare and Medicaid Services (CMS) and institutional policy. Residents and fellows are expected to complete documentation and address EHR tasks within established timelines for both inpatient and ambulatory settings. Supervising faculty are responsible for ensuring compliance, co-signature, and oversight.

Institutional Requirements: 4.1, 2.6.b

1. Procedure:
 - 1.1 **Outpatient Documentation and Task Requirements—Trainee Responsibilities**
 - 1.1.1 Complete office notes within 48 hours of the visit and send them 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 MyChart 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 requests.
Complete medication renewal requests per clinic policy.
 - 1.2 **Outpatient Documentation and Task Requirements—Trainee Responsibilities—Faculty Responsibilities**
 - 1.2.1 Complete office notes within 48 hours of the visit.
 - 1.2.2 Co-sign precepting notes within 7 business days of the visit.
 - 1.2.3 Review diagnostic and lab test results within 3 business days, documenting actions in the patient chart.
 - 1.2.4 Complete MyChart messages within 48 hours if forwarded for action.
 - 1.2.5 Assist staff with patient care task requests as needed.
 - 1.3 **Inpatient Documentation and Task Requirements—Trainee Responsibilities**
 - 1.3.1 Complete daily progress notes by 6:00 PM each day and send them to faculty for co-signature.
 - 1.3.2 Complete new patient history & physical (H&P) notes, discharge summaries, and initial consult notes within 24 hours and send them to faculty for co-signature.
 - 1.3.3 Respond to all pages as soon as possible, not exceeding 30 minutes.
 - 1.3.4 Review inpatient diagnostic and lab results promptly and document actions taken.
 - 1.3.5 Place admission orders within 30 minutes of ED notification of a new patient; other orders as soon as possible.
 - 1.4 **Inpatient Documentation and Task Requirements—Faculty Responsibilities**
 - 1.4.1 Co-sign trainee daily progress notes by the end of each day.
 - 1.4.2 Co-sign H&Ps, discharge summaries, and consult notes within 24 hours.
 - 1.4.3 Indirectly supervise trainees in completing patient care tasks and responding to pages.
 - 1.4.4 Oversee review of diagnostic studies and lab tests.
 - 1.4.5 Complete MyChart messages within 48 hours if forwarded for action.
 - 1.5 **Non-Compliance**
 - 1.5.1 Trainees: Failure to meet these requirements will be reviewed by the Clinical Competency Committee (CCC) and Program Director. Actions may include coaching, remediation, probation, or other disciplinary measures.

- 1.5.2 Faculty: Non-compliance will be reported to the Program Director. Repeated violations may result in removal from supervisory duties and other disciplinary actions as determined by leadership.

Annual Institutional Review Protocol

Purpose Statement: The purpose of this policy is to describe the process by which the Graduate Medical Education Committee (GMEC) and Designated Institutional Official (DIO) at Bayhealth maintains oversight of the Sponsoring Institution's accreditation through the Annual Institutional Review (AIR)

Institutional Requirements: 4.1, 1.14

1. Procedure:
 - 1.1 At the conclusion of each academic year, the Bayhealth GMEC will convene an AIR Subcommittee to conduct a comprehensive review of institutional performance indicators. At a minimum, this review will include the most recent Accreditation Council for Graduate Medical Education (ACGME) institutional letter of notification, results of ACGME resident/fellow and core faculty surveys, and accreditation information for all Bayhealth-sponsored ACGME-accredited programs, including accreditation status and citations.
 - 1.2 **The AIR Subcommittee Membership** must include: the DIO, GME Director, Institutional Program Manager, Program Directors, one (program director selected) faculty member from each program and one peer-selected resident/fellow. Additional membership can be appointed by the DIO and/or GMEC.
 - 1.3 The following performance indicators will be reviewed by the AIR Subcommittee:
 - 1.3.1 **Accreditation & Institutional Oversight:** ACGME Institutional Letter of Notification, Program Letters of Agreement (PLAS), findings from self-study visits, accreditation information for all ACGME- accredited programs including accreditation status, citations and responses.
 - 1.3.2 **Program Evaluation & Performance:** Annual Program Evaluations (APE), ACGME surveys results for core faculty and resident/fellows.
 - 1.3.3 **Educational Outcomes:** Board passage rates and In-Training examination results.
 - 1.3.4 **Scholarly Activity & Quality Improvement:** Resident/Fellow and Faculty scholarly activities, Resident/Fellow and Faculty participation in safety and quality improvement initiatives.
 - 1.4 The GMEC may appoint additional Subcommittees to conduct additional document review, develop objectives or corrective action plans, review progress on citation corrections, and provide mentoring for any areas of noncompliance. The Subcommittee's recommendations will be submitted to the full GMEC for approval, which may also specify additional monitoring procedures for the resulting action plans. The GMEC is responsible for monitoring any item identified as noncompliant, with the DIO determining the frequency of reporting based on the nature and severity of the noncompliance
 - 1.5 **DIO Executive Summary:** Following the AIR subcommittee meeting, the Designated Institutional Official (DIO) will prepare and submit an annual written executive summary of the AIR to both the GMEC and the Bayhealth Board of Directors
 - 1.5.1 The written executive summary prepared by the DIO must include an overview of institutional performance on AIR indicators, along with any resulting action plans and associated performance monitoring procedures.
2. References:
 - 2.1 ACGME Institutional Requirements (2025)

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.

Institutional Requirements:

1. Forms:
 - 1.1 Away Rotation Request Form
2. Procedure:
 - 2.1 Residents/fellows may request to complete up to one, four-week elective away rotation during the duration of the program
 - 2.1.1 In special circumstances, approval for additional away rotations may be granted, but are subject to Program Director and DIO approval
 - 2.2 The away rotation must be in a specialty area not offered by Bayhealth Medical Center
 - 2.3 Approval of any away rotation is subject to the rules and laws surrounding visa sponsorship when applicable
 - 2.4 Bayhealth does not pay for costs associated with housing, licensing, travel, fees, or other expenses
 - 2.5 Away rotations must be approved by the Program Director and DIO
 - 2.6 **Steps for Applying**
 - 2.6.1 Residents/fellows must first discuss the away rotation with the Program Director or other program designee
 - 2.6.2 Resident must then complete the Elective Approval Form and send it to the Program Director and Program Coordinator to sign
 - 2.6.3 The Program Coordinator will then send the request to the GME office for the DIO to review the request
 - 2.6.4 The GME office will return the request to the Program Coordinator and contact the resident with the response
 - 2.6.5 The Elective Away Rotation form should be completed at ninety days prior to the rotation
 - 2.6.6 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
 - 2.6.6.1 The Program Letter of Agreement must be approved by the Host Institution, Bayhealth's Risk Management department and the DIO
 - 2.6.7 The Program Coordinator will contact Bayhealth's Risk Management department to ensure the resident has malpractice coverage for the rotation
 - 2.6.7.1 Residents/fellows must have the state medical license for medical malpractice to be issued
 - 2.6.7.1.1 The state of New Jersey does not require residents to have a medical license.
 - 2.6.7.2 This must be given to risk management prior to the resident beginning the away rotation
 - 2.6.8 Residents/fellows are responsible for obtaining the state medical or training license, housing, and any other expenses necessary to complete the rotation
 - 2.7 **Risk Management Requires the following**
 - 2.7.1 Program Letter of Agreement between Bayhealth and Program Site
 - 2.7.2 Elective Approval Form signed/approved by Program Director and DIO
 - 2.7.3 Copy of state license

- 2.7.3.1 Risk management will submit the approved elective form and state license to the malpractice carrier for approval
 - 2.7.3.2 Upon approval, risk management will provide a certificate of insurance to the hosting institution
 - 2.7.3.3 Program Coordinator must notify risk management of any changes with the rotation
- 2.8 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.
- 2.9 **Trainees on J-1 Visas**
 - 2.9.1 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 institution's 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](#)
 - 2.9.2 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.
- 2.10 **Trainees on H1B Visas**
 - 2.10.1 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

By signing below, I am in agreement with the terms of this away rotation.

1. I must notify my program director as soon as possible if any of the following events occur;
 - 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.
 - 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

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

Recommends approval

Do not recommend approval

Signature of the Approver

Date

(DIO, ADIO, ADGME)			
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.

Institutional Requirements: 4.1, 2.4, 4.6, 4.7, 3.2.g.5, 3.2.g.5.a

1. Procedure:
 - 1.1 **Health and Disability Insurance:** Residents/fellows who enroll will receive medical, prescription, dental, vision, supplemental life, voluntary AD&D, and flexible spending accounts, effective the first day of the month following orientation.
 - 1.1.1 **Enrollment Responsibility:** Residents/fellows must enroll and submit all required documentation by the deadline to ensure coverage. **Missed Enrollment:** Failure to complete enrollment or submit documentation on time will result in no coverage until the next fall open enrollment period (beginning January 1).
 - 1.1.2 **Interim Coverage:** Residents/fellows may opt for interim coverage between orientation and the start of benefits; details are provided during onboarding.
 - 1.1.3 **Short-Term Disability:** Coverage begins within the first 90 days of employment.
 - 1.1.4 **Optional Benefits:** Medical, prescription, dental, vision, and basic life insurance (self and dependents), Flexible Spending Account, Retirement and savings plan, short-term disability, accidental death and dismemberment (AD&D)
 - 1.1.5 Residents/Fellows on a J1 visa **must** enroll in healthcare insurance through the institution due to ECFMG requirements.
 - 1.1.6 **Additional Information:** Detailed benefit information is available at id.mybenefitexpress.com and through Baynet under Human Resources.
 - 1.2 **Meal Stipends:** Residents and fellows are provided with a \$2,000 meal stipend for the academic year, loaded onto their Bayhealth ID badge for use in hospital campus cafeterias. These funds are intended to cover breakfast, lunch, and dinner while working and should not be used for meals at home or shared with other employees, friends, or family. The account resets at the end of June and is refilled starting July 1 of each academic year.
 - 1.3 **Board Certifications:** Residents/Fellows may use their educational funds in their final academic year to cover board exam fees. To be eligible for reimbursement, residents and fellows must register for board certification during their employment at Bayhealth.
 - 1.4 **Mandatory Exams:** Programs will purchase, schedule, and proctor In-Training Exams. Residents will be reimbursed for one attempt of the USMLE Step 3 or COMLEX Level 3, if applicable, provided the exam is taken during their employment at Bayhealth. Specialty board study materials will be purchased by the program for residents and fellows.
 - 1.5 **CME:** Residents/Fellows will receive five (5) CME days per year in accordance with their individual program's criteria. They may also use their educational funds or request research funds to attend or present at specialty conferences.
 - 1.6 **Visas:** Residents/fellows will be reimbursed for the cost of J-1 Visa fees. Bayhealth will pay for the cost of H1-B sponsorship (when applicable) to highly qualified residents.
 - 1.7 **Professional Memberships:** Programs will pay for resident/fellows' memberships to specific professional associations required by the program
 - 1.8 **Education Funds:** All PGY-1 residents receive \$1,500 in education funds. Residents at PGY-2 and above receive \$2,000, except for those in their final year and fellows, who receive \$3,000 to cover qualifying board exams and board certification fees, when applicable.
 - 1.8.1 **Use of Education Funds:** Education funds may be used for continuing education, professional dues, subscriptions, and association fees not already covered by the program; textbooks not provided by the program; one stethoscope per resident/fellow

during training; educational resources such as study materials; reimbursement for repeated or other exam fees; specialty board certification exams (if registered prior to the end of employment); and travel to professional meetings. These funds do not roll over into the next academic year.

- 1.8.2 **Reimbursements:** Residents/fellows are responsible for saving receipts and sending all needed documentation to the program coordinator/assistant for reimbursement
- 1.8.3 **Education Fund Exclusions:** Educational funds have certain exclusions. Residents and fellows should consult their Program Coordinator regarding any items not listed that they wish to use educational funds for. Excluded items include computers or iPads (laptops and desktops), fellowship credentialing, application and interview fees outside of Bayhealth, handheld ultrasound devices, full medical licensure, and scrubs.
- 1.9 **Research:** Residents/Fellows should reference the Graduate Medical Education Research policy
- 1.10 **Mandatory Training Certifications:** 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/fellow’s educational fund.
- 1.11 **Credentialing Fees:** Programs will pay for or reimburse residents and fellows for their medical training license, DEA registration, and fingerprinting. Full medical licensure is not covered.
- 1.12 **Resident/Fellow Salary:** The GMEC annually reviews and approves resident and fellow stipends and benefits. The current stipend schedule is provided to all applicants and incoming residents/fellows and is also posted online. PGY-3 Chief Residents receive an additional stipend when applicable.
- 1.13 **Apparel:** Residents/fellows should refer to the apparel chart for their program and PGY level. General Surgery residents and Gastroenterology fellows will use the scrub machines provided by Bayhealth for their surgical scrubs.
- 1.14 **Employee Assistance Program:** this confidential service provides residents/fellows with access to mental health assessments, counseling, and treatment. It is available 24/7 for urgent and emergent care needs
- 1.15 **Vital WorkLife:** This comprehensive program offers additional support tailored to the unique needs of medical professionals. Services include confidential counseling, peer coaching, financial and legal services, WorkLife Concierge and more.
- 1.16 **Free Parking:** Residents must park in the employee parking lot or on the top level of the parking garage. Fellows and chief residents are permitted to park in the physician parking lot.

Item Name	FM Residents		IM Residents		EM Residents		GS Residents		Sports Medicine Fellows	Hem/Onc Fellows		Gastro Fellows	
	PGY-1	PGY-2 & 3	PGY-1	PGY-2&3	PGY-1	PGY-2 & 3	PGY-1	PGY-2-5	PGY-4	PGY-4	PGY-5&6	PGY-4	PGY-5 & 6
White Coats	3	1	3	1	3	1	3	1	1	3	1	3	1
Pewter Scrubs (sets)	3	1	3	1						2	1		

Black Scrubs (sets)					4	1							
Navy Scrubs (sets)									3				
Jacket for DSU									1				

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: Bayhealth is committed to providing patient care through healthy, alert, and responsive residents and fellows, while maintaining a balanced environment between clinical responsibilities and graduate medical education. This policy establishes institutional standards for Clinical and Educational Work Hours, consistent with the Accreditation Council for Graduate Medical Education (ACGME) Institutional, Common, and Program-Specific Requirements. The policy supports patient safety, trainee well-being, and adherence to regulatory standards.

Institutional Requirements: 4.1, 4.11, 3.2.e

1. Procedure:
 - 1.1 **Program Specific Policies:** Each GME program must maintain a written Clinical and Educational Work Hours policy consistent with this institutional policy and its ACGME Review Committee (RC) requirements. This policy must:
 - 1.1.1 Be reviewed and updated annually.
 - 1.1.2 Be distributed to all trainees and faculty.
 - 1.1.3 Ensure appropriate balance between education, service, and well-being.
 - 1.1.4 Minimize undue service burdens on trainees.
 - 1.1.5 Acknowledge that clinical responsibilities do not end precisely at shift changes.
 - 1.1.6 Provide consistent faculty or senior-level backup for patient care responsibilities.
 - 1.1.7 Senior resident or faculty support must be immediately available at all times.
 - 1.2 **Required Time Off:** Trainees must have at least 8 hours off between scheduled clinical work periods, at least 14 consecutive hours off after 24 hours of in-house call and one day in seven free from clinical work and education, averaged over four weeks. At-home call must not be assigned on these days.
 - 1.2.1 Trainees may choose to return to or remain in the hospital for compelling reasons (e.g., caring for a critically ill patient or educational value), but such time must still comply with the 80-hour weekly limit, and the one-day-off-in-seven rule.
 - 1.2.2 The maximum clinical and educational work hours must not exceed 80 hours per week, averaged over four weeks.
 - 1.2.3 **Night Float:** Night float shifts are subject to the 80-hour weekly limit and one day off in seven rule, ensuring schedules support rest and education.
 - 1.2.4 **Moonlighting:** Moonlighting hours count toward the 80-hour weekly maximum. Moonlighting must not interfere with education, trainee well-being or patient safety. Reference the institutional and Program specific Moonlighting Policies
 - 1.3 **Work Hour Documentation & Compliance**
 - 1.3.1 Trainees must submit work hours daily using the MedHub platform.
 - 1.3.2 Residents/Fellows have access to the previous and current calendar week in Medhub (the week ends on Sunday at midnight)
 - 1.3.3 Failure to report work hours is considered a professionalism concern, and repeated noncompliance will be reviewed by the Clinical Competency Committee (CCC). Coordinators cannot enter missed work hours for residents/fellows.
 - 1.3.4 Trainees are responsible for:

- 1.3.4.1 Submitting hours even when on Paid Time Off (PTO).
- 1.3.4.2 Logging hours honestly and completely, including work from home and on-call responsibilities.
- 1.3.5 If hours cannot be entered on time **due to leave or emergency:**
 - 1.3.5.1 Trainees must notify their program coordinator via email.
 - 1.3.5.2 Program coordinators may enter missing hours for up to one month in certain circumstances like unscheduled leave or emergency.
 - 1.3.5.3 After one-month, missing hours will be alerted to GME leadership and will trigger a professionalism review.
- 1.4 **Reporting Work Hour Concerns:** Bayhealth supports a culture of open communication and non-retaliation. Trainees may report work hour concerns through any of the following channels:
 - 1.4.1 Directly to the Program Director or Associate Program Director.
 - 1.4.2 Via Resident/Fellow forum leaders, who can escalate concerns to GME leadership.
 - 1.4.3 By contacting the DIO, GME Chair, or GME Director directly.
 - 1.4.4 Anonymously, through the GME Anonymous Feedback Form which is automatically routed to the DIO and GME Director for review.
- 1.5 **Work Performed Remotely:** Trainees should complete clinical responsibilities onsite when possible. However, work performed at home (e.g., documentation in the EMR, patient-related phone calls) must be logged as part of clinical and educational work hours. Trainees who plan to finish clinical documentation from home must obtain prior approval from their program. Activities not counted as duty hours include independent reading or studying and research not involving direct patient care
- 1.6 **Structured Handoffs:** All programs must ensure that transitions of care are conducted using a structured and standardized handoff protocol (e.g., I-PASS) in accordance with **Joint Commission National Patient Safety Goal NPSG.02.05.01.**
 - 1.6.1 Handoffs must: minimize interruptions, allow interactive communication and be documented appropriately in the EMR or designated handoff tool.

Code of Conduct

Institutional Policy CCPlan.02 (Last updated 1/7/2025)

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 criteria 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.

1. Procedure:

1.1 **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 licensure, certification and Condition of Participation laws and regulations.

1.2 **COMPLIANCE WITH ALL HOSPITAL POLICIES AND PROCEDURES**

All of Bayhealth's employees must also scrupulously comply with all policies and procedures.

1.3 **DEALING ETHICALLY AND HONESTLY WITH CUSTOMERS, SUPPLIERS AND CONSULTANTS**

1.3.1 **Quality of Service** Bayhealth is committed to providing services that meet all contractual obligations and quality standards.

1.3.2 **Contract Negotiation**

1.3.2.1 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.

1.3.3 **Admissions, Transfers and Discharges**

1.3.3.1 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.

1.3.4 **Clinical Decision Making**

1.3.4.1 The rights of Bayhealth's professional, medical, nursing and allied health staff to exercise professional judgment in the discharge of their duties will be respected. Clinical decisions are based on identified patient health needs. Decisions will not be compromised by financial incentives, or risk sharing relationships with leaders, managers, clinical staff, independent licensed practitioners or vendors. Procedures designed to protect the integrity of clinical decision making include disclosure and review of conflicts of interest and utilization of fair bidding practices.

1.3.5 **Marketing and Advertising Activities**

1.3.5.1 In conducting all marketing and advertising activities, Bayhealth employees may offer factual information or documented evidence to the general public. Bayhealth employees shall not distort the truth, make false claims, engage in comparative advertising or attack or disparage another provider. Marketing materials will accurately reflect services available and the level of licensure /accreditation. All direct to consumer marketing activities require legal review in advance if they involve giving anything of more than nominal value to a patient.

1.3.6 **Competitive Analysis**

1.3.6.1 Antitrust law prohibits competitors from entering into agreements to fix prices or to reduce price competition. Price fixing has been interpreted broadly to include *any* type of joint action between two competitors which influences the price of products or services that the competitors sell either directly or indirectly. Because it is often difficult to determine what activities may result in price fixing, Bayhealth employees should follow the following principles:

Employees should not provide Bayhealth business information to a competitor, *unless* the provision of this information is necessary to consummate a bona fide customer/supplier relationship or to serve particular customers jointly. Employees may supply published pricing information and fee schedules to customers even though a competitor may obtain this information through the customer. However, employees should not disclose or disseminate any information believed to be confidential or proprietary to Bayhealth.

- 1.3.6.2 Employees should not obtain information about a competitor's business directly from the competitor unless the provision of this information is necessary to consummate a bona fide customer/supplier relationship or to serve particular customers jointly. Employees shall not obtain such information directly from a competitor in order to perform market analysis. However, employees may obtain information about a customer from public sources or from competitors. In conducting market analyses, employees should not accept or use information known to be proprietary to a competitor. Supervisors must ensure that a competitor's proprietary information is not improperly obtained or used in any improper fashion.
- 1.3.7 Antitrust Issues**
- 1.3.7.1 Antitrust laws apply to all commercial and federal domestic (and some foreign) transactions by Bayhealth, and they are designed to ensure that competition exists and to preserve the free enterprise system. As this is a highly complex area, and this policy cannot cover all situations in which antitrust laws may apply, employees should take special care in this area, and promptly refer any questions to a Compliance Officer, who will consult legal counsel as required. Antitrust issues that an employee may encounter are in the areas of pricing, boycotts and trade association activity.
- 1.3.7.2 Examples of actions that violate the antitrust law and that must not be engaged in under any circumstances include entering into or negotiating an agreement with one or more competitors to: (a) fix prices at any level or to fix other terms of service; (b) allocate customers or markets; or (c) boycott a supplier or customer. In addition, employees must refrain from engaging in unfair practices that might restrict competition. For example, employees should refrain from any discussion of pricing schemes or market divisions with competitors to avoid implicating these prohibitions. In addition, employees must refrain from reciprocal agreements and must not require purchasers to buy from Bayhealth under any kind of coercion, express or implied.
- 1.3.8 Anti-kickback and False Claims Issues**
- 1.3.8.1 Federal and state laws prohibit Bayhealth and its employees from offering a kickback to an entity or person to induce that customer or potential customer to purchase services from or to refer a patient to Bayhealth. Moreover, the laws prohibit accepting a kickback. In addition, there are laws that prohibit the filing of false claims. As this is a highly complex area of the law, this policy cannot list all situations in which the anti-kickback or false claims laws may apply. Therefore, employees must take special care in this area, and promptly refer any questions to a Compliance Officer, who may refer the question to legal counsel, if appropriate.
- 1.3.8.2 Examples of the types of actions that could violate the federal Medicare/Medicaid anti-kickback statute and similar state laws include the following:
- 1.3.8.2.1 Offering or paying anything of value to induce someone to refer a patient to Bayhealth;
- 1.3.8.2.1.1 Offering or paying anything of value to anyone (patient or referral source) in marketing Bayhealth;

- 1.3.8.2.1.2 Soliciting or receiving anything of value for the referral of Bayhealth patients to others;
- 1.3.8.2.1.3 Receiving free goods of any kind other than the same good when purchasing products.
- 1.3.9 Bayhealth has adopted various Policies designed to ensure compliance with federal and state anti-kickback laws.
- 1.3.10 Examples of the types of actions that could violate the federal False Claims Act and other federal false billing laws include:
 - 1.3.10.1.1 Filing a claim for services that were not rendered at all or were not rendered as described on the claim form;
 - 1.3.10.1.2 Filing a claim for services that were rendered, but were medically unnecessary;
 - 1.3.10.1.3 Submitting a claim containing information you know to be false; or
 - 1.3.10.1.4 Misusing Social Security or Medicare symbols, emblems or names in marketing.
- 1.3.11 **Charging of Costs/Timekeeping**

Any document submitted to secure reimbursement or payment should be true and correct.

 - 1.3.11.1 The employee's entry into the timekeeping system and/or signature on a timesheet is a representation that the entry/timesheet accurately reflects the number of hours worked. The supervisor's signature on an expense report is a representation that it has been reviewed and that steps have been taken to verify the validity of the hours or expenses reported and the correctness of the allocation of the hours or expenses. Supervisors must avoid placing pressure on subordinates that could lead them to believe that deviations from appropriate time reporting or cost charging practices will be condoned.
- 1.3.12 **Billing and Reimbursement**

Bayhealth is committed to ensuring that its billing and reimbursement practices comply with all federal and state laws, regulations, guidelines and policies and that all bills are accurate and reflect current payment methodologies. Bayhealth is committed further to ensuring that all patients and customers receive timely bills and that all questions regarding billing are answered. Bayhealth shall provide assistance to patients and third party payers seeking to understand the charges associated with patient care. Conflicts regarding billing will be resolved in accordance with the Grievance Management Process.

1.4 **USING HOSPITAL RESOURCES PROPERLY**

- 1.4.1 **Making Political Contributions**

Employees may not contribute or donate Bayhealth funds, products, services or other resources to any political cause, party or candidate without the advance written approval of Administration. However, employees may make voluntary personal contributions to any lawful political causes, parties or candidates as long as the individual does not represent that such contributions come from Bayhealth and as long as the individual does not obtain the money for these contributions from Bayhealth for the sole purpose of making such a contribution.
- 1.4.2 **Providing Business Courtesies to Customers or Sources of Customers**

Bayhealth's success in the marketplace results from providing quality services at competitive prices. Bayhealth does not seek to gain an improper advantage by offering business

courtesies such as entertainment, meals, transportation or lodging to customers, referral sources or purchasers of Bayhealth services. Employees should never offer any type of business courtesy to a referral source or a purchaser for the purpose of obtaining favorable treatment or advantage. To avoid even the appearance of impropriety, employees must not provide any referral source or purchaser with gifts or promotional items of more than nominal value (*e.g.*, pens or calendars).

- 1.4.3 Except for additional restrictions that apply in the federal or state government area and are noted below, employees may pay for reasonable meal, refreshment and/or entertainment expenses for referral sources and purchasers of Bayhealth services which are incurred only occasionally, are not requested or solicited by the recipient, and are not intended to or likely to affect the recipient's business decisions with respect to Bayhealth.
- 1.4.4 **Educational Activities Grants**
Department Heads or those otherwise in a position that represent Bayhealth shall not receive any educational activities grants that create even the appearance of impropriety or conflict with the "Gifts to Physicians from Industry" Guidelines adopted by the American Medical Association's Council on Ethical and Judicial Affairs and the Pharmaceutical Manufacturers Association (now Pharmaceutical Manufacturers and Research Association) in December 1990.
- 1.4.5 **Research Grants**
Bayhealth shall ensure that any funds provided to support health care research or consulting agreements are provided for bona fide purposes and in a manner that clearly separates such payments from any referrals.
- 1.4.6 **Charitable Contributions**
All charitable contributions received from vendors must directly benefit Bayhealth. Under no circumstances may a check be made payable to an individual at Bayhealth. Bayhealth shall not accept any donations that are in conjunction with a marketing effort or sales promotion. Under no circumstances shall donations be accepted that require Bayhealth to use the donation to purchase supplies from the vendor making the contribution. [See the Hospital's Corporate Policy on Charitable Contributions and Research Grants.]
- 1.4.7 **Government Customers**
Bayhealth, on a regular basis, is a party to numerous government contracts and subcontracts with various governmental agencies. Examples are provider contracts wherein Bayhealth supplies services to or on behalf of the Medicare and Medicaid programs, either directly or as a subcontractor to a Medicare contractor. It is essential that all employees are knowledgeable of, and comply with, all of the applicable laws, rules and regulations of all such governmental agencies. Billing Personnel also should comply with Bayhealth's Corporate Policy on Reimbursement and Billing Policies and Procedures. Any employees who may have a concern or question concerning compliance with any governmental contract or subcontract should contact their supervisor or a Compliance Officer.
- 1.4.8 Employees also may not provide or pay for any meal or refreshment (except on Bayhealth premises in the course of business activities), entertainment, travel or lodging expenses for government employees without the prior approval of a Compliance Officer. State, local and foreign governmental bodies may also have restrictions on the provision of business courtesies, including meals and refreshments. Bayhealth's employees doing business with such governmental bodies are expected to know and respect all such restrictions.

1.4.9 **Accurate Books and Accounts**

All of Bayhealth's payments and other transactions must be properly authorized by management and be accurately and completely recorded on Bayhealth books and records in accordance with generally accepted accounting principles and established corporate accounting policies. No false, incomplete or unrecorded corporate entries shall be made. No undisclosed or unrecorded corporate funds shall be established for any purpose, nor shall Bayhealth's funds be placed in any personal or non-corporate account. All corporate assets must be properly protected, and asset records must be regularly compared, with actual assets with proper action taken to reconcile any variances.

1.5 **AVOIDING ABUSES OF TRUST**

Bayhealth expects its employees to avoid engaging in any activity that might interfere or appear to interfere with the independent exercise of the employee's judgment in situations where the employee's personal interests might detract from or conflict with Bayhealth's best interest or the interests of Bayhealth's customers or suppliers.

1.5.1 **Relationship to other health care providers, educational institutions and payors/recognition of conflicts of interest**

1.5.1.1 All relationships between Bayhealth and other health care providers, educational institutions and payors will be guided by our values of integrity and responsibility for our actions. The potential for conflicts of interest exists at all levels of the organization including Board Members, Managers, the Medical Staff and Employees. Bayhealth will consider its contractual and other relationships carefully and maintain effective procedures to identify potential conflicts of interest to ensure that our mission to our patients, the community we serve and our business interests are protected and advanced in our relationships with others, see also B9000.48 Conflict of Interest Policy, and D7300.01 Conflict of Interest, Bayhealth Home Care.

1.5.1.2 All reasonable precautions should be taken to avoid conflicts, and the appearance of conflicts, between private interests and the performance of official duties.

1.5.1.3 Conflicts of interest must be disclosed in order to ensure that decisions are not inappropriately influenced by such conflicts.

1.5.2 **Insider Trading**

No employee of Bayhealth shall trade in the securities of any company, or buy or sell any property or assets, on the basis of non-public information acquired through employment at Bayhealth, whether such information comes from Bayhealth or from another company with which Bayhealth has a confidential relationship.

1.5.3 **Acceptance of Business Courtesies**

1.5.3.1 Never accept anything of value from someone doing business with Bayhealth or someone whose services are subject to Bayhealth's review if the gratuity is offered or appears to be offered in exchange for any type of favorable treatment or advantage. To avoid even the appearance of impropriety, do not accept any gifts or promotional items of more than nominal value. Gifts received which are valued in excess of \$50 must be reported to your Vice President. An employee may accept meals, drinks or entertainment only if such courtesies are unsolicited, infrequently provided and reasonable in amount. Such courtesies must also be directly connected with business discussions, unless an exception is approved by a

supervisor. Do not accept reimbursement for lodging or travel expenses or free lodging or travel without the express written approval of your Vice President.

1.6 **Government Proprietary and Source Selection Information**

1.6.1 Bayhealth does not solicit nor will it receive any sensitive proprietary internal government information, including budgetary, program or source selection information, before it is available through normal processes.

1.7 **LIMITATION ON EFFECT OF CODE OF CONDUCT**

Nothing contained in this Code of Conduct is to be construed or interpreted to create a contract of employment, either express or implied, nor is anything contained in this Code of Conduct intended to alter a person's status of "employment-at-will" with Bayhealth to any other status.

1.8 **RESERVATION OF RIGHTS**

Bayhealth reserves the right to amend the Code of Conduct, in whole or in part, at any time and solely at its discretion.

2. References:

2.1 None

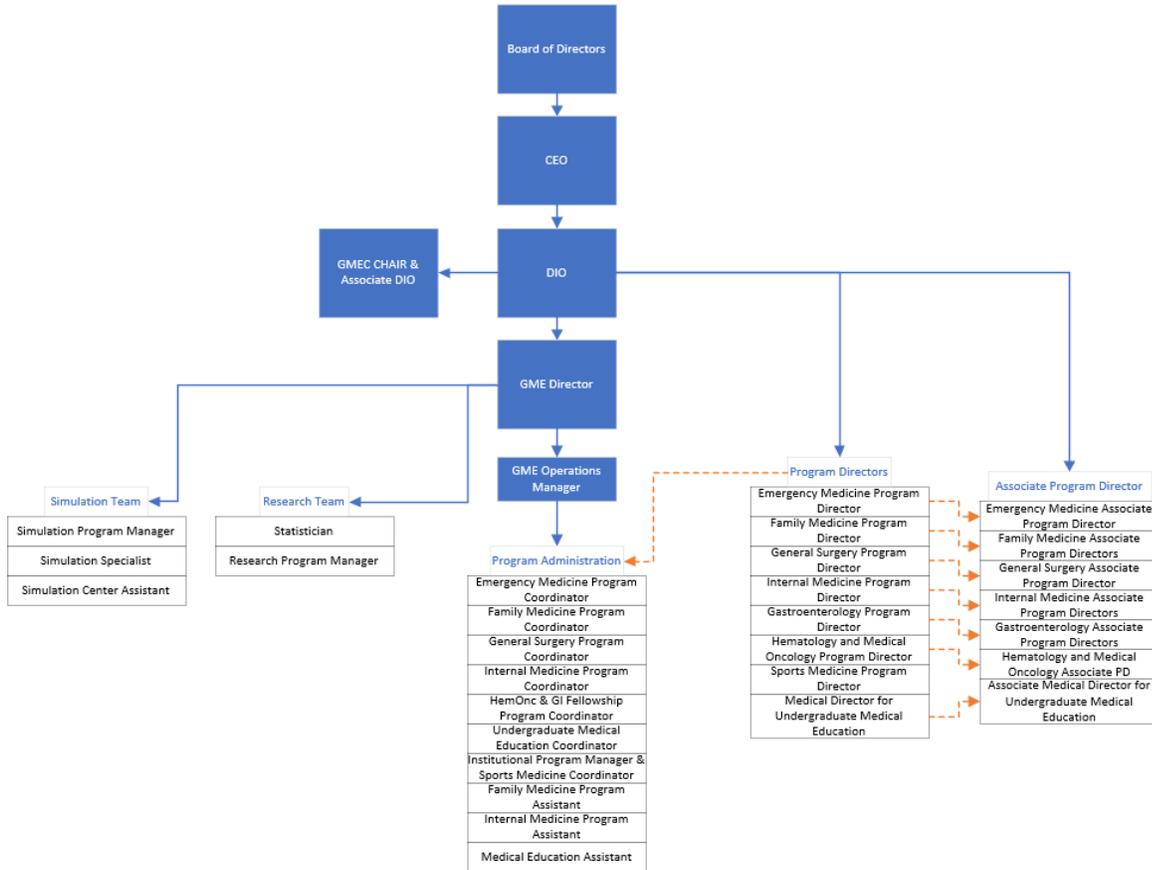
3. Exhibits:

3.1 Statement of Understanding of and Compliance with Bayhealth's Corporate Policy on Code of Conduct

Designated Institutional Office Organizational Chart

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

Institutional Requirement(s): 1.1, 1.2, 1.3, 2.1, 4.1



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.

Institutional Requirements: 4.1, 3.2.g.6

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.

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.

Institutional Requirements:

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 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 employee's or affiliate member's professional licensure, certification, or registration are permitted

1.3 **Safety and PPE:** 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

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 and constructive feedback is essential to support trainee development by identifying areas for improvement and reinforcing behaviors that meet or exceed performance expectations. This policy ensures that evaluations are conducted by all ACGME-accredited residency and fellowship programs at Bayhealth, maintaining institutional compliance with ACGME requirements and promoting a culture of continuous improvement in graduate medical education.

Institutional Requirements:

1. Procedure:
 - 1.1 All evaluations must be in the Bayhealth Residency Management System, Medhub. Evaluations are maintained by the Residency/Fellowship Program Director and Coordinator.
 - 1.2 All programs must adhere to the regulations and requirements outlined in this policy to remain in compliance with institutional and ACGME standards.
 - 1.3 The following evaluations are required by each ACGME accredited Residency/Fellowship program at Bayhealth:
 - 1.3.1 Faculty of Resident/Fellow (not anonymous)
 - 1.3.2 Faculty of Program (anonymous)
 - 1.3.3 Resident/Fellow of Faculty (anonymous)
 - 1.3.4 Resident/Fellow Self Evaluations
 - 1.3.5 Resident/Fellow 360 Evaluation (anonymous)
 - 1.3.6 Resident/Fellow of another Resident/Fellow (anonymous)
 - 1.3.7 Resident/Fellow of Program (anonymous)
 - 1.3.8 Resident/Fellow of Conference (anonymous)
 - 1.3.9 Resident/Fellow of Rotation/Clinic (anonymous)
 - 1.3.10 Resident/Fellow Semi-Annual & Summative (not anonymous)
 - 1.3.11 Patient of Resident/Fellow (anonymous)
 - 1.3.12 Program Director Evaluation of Core Faculty (not anonymous)
 - 1.4 **Faculty of Resident/Fellow Evaluations:** Faculty play a critical role in assessing and supporting trainee development. Faculty are strongly encouraged to include narrative comments in evaluations, which are valuable for trainee development and CCC milestone reviews. The following standards apply:
 - 1.4.1 Evaluations must be professional, respectful, and growth oriented. While not anonymous, they should be treated as if feedback is being delivered directly to the trainee.
 - 1.4.2 Faculty are expected to directly observe and provide ongoing, constructive feedback—both verbal and written—throughout each rotation or comparable assignment.
 - 1.4.3 Real-time verbal feedback is highly encouraged, focusing on both strengths and areas for improvement to support timely reflection and behavior change.

- 1.5 Formal evaluations must be completed in MedHub by supervising faculty within three weeks of the rotation's end. These evaluations:
 - 1.5.1 Must be mapped to ACGME specialty-specific Milestones.
 - 1.5.2 Will be made available to the trainee in MedHub.
 - 1.5.3 Can be discussed with the trainee upon request, either by faculty or the Program Director.
 - 1.5.4 **Evaluation Volume:** The number of evaluations required from each faculty member varies based on their clinical service assignment and the number of trainees they supervise.
- 1.6 **Resident/Fellow of Faculty Evaluations:** Residents and fellows are expected to provide open and honest feedback on faculty performance without fear of retaliation. These evaluations are essential to improving the quality of teaching and the learning environment.
 - 1.6.1 Participation in the faculty evaluation process is required for all residents and fellows.
 - 1.6.2 Evaluations are anonymous and must be completed through MedHub.
 - 1.6.3 All evaluations should be submitted within three weeks of completing the rotation or as specified by program.
- 1.7 **Resident/Fellow of other Resident/Fellow Evaluation**
 - 1.7.1 Residents and fellows must complete peer-to-peer evaluations of other learners within the program. These evaluations are submitted anonymously via MedHub and serve as a valuable tool to provide insight into professionalism, communication, teamwork, and other core competencies that may not be fully observed by faculty.
 - 1.7.2 Peer feedback supports well-rounded trainee development and contributes to the Clinical Competency Committee's (CCC) assessment of milestone progression.
- 1.8 **Resident/Fellow Self Evaluations:** Self-evaluations are a valuable tool that allow residents and fellows to reflect on their performance, recognize strengths, identify areas for improvement, and take an active role in their professional growth. This process promotes self-awareness and supports lifelong learning, both of which are essential components of physician competency.
 - 1.8.1 Residents and fellows are expected to complete at least two self-evaluations per academic year. These evaluations will be used by the Program Director to help develop Individualized Learning Plans (ILPs) and will be reviewed as part of the Clinical Competency Committee (CCC) evaluation process.
- 1.9 **Resident/Fellow of Clinic/Rotation Evaluations:** Residents/fellows are expected to complete an evaluation of clinic/rotation at the end of each rotation. For longitudinal experiences, such as continuity clinic, this should be evaluated at least quarterly.
- 1.10 **Resident/Fellow of Continuity Clinic**
 - 1.10.1 Resident/Fellows should follow the program specific policies on continuity clinic evaluations
 - 1.10.2 For programs that require this type of evaluation this should be completed at least quarterly.

- 1.11 **Resident/Fellow of Conference Evaluations:** The purpose of resident/fellow conference evaluations is to provide anonymous feedback on the quality, relevance, and effectiveness of didactic sessions and other educational activities. This feedback helps program leadership improve content, ensure alignment with learning objectives, and enhance the overall educational experience. Evaluation data will be used to inform the planning of future didactics and educational conferences. Most programs will also review this feedback during Program Evaluation Committee (PEC) meetings to identify best practices and determine necessary improvements.
- 1.12 **Resident/Fellow 360 Evaluations:** 360-degree evaluations provide valuable input to the Clinical Competence Committee (CCC) by incorporating feedback from a diverse group of stakeholders involved in the trainee’s education and clinical work.
 - 1.12.1 These evaluations are anonymous and completed by various Bayhealth staff members, ensuring a comprehensive assessment of the resident’s or fellow’s competencies, professionalism, and teamwork.
- 1.13 **Resident/Fellow & Faculty of Program Evaluations**
 - 1.13.1 Residents, fellows, and faculty are required to complete anonymous program evaluations in MedHub to assess the program’s strengths and identify areas for improvement.
 - 1.13.2 These evaluations must be completed twice annually by at least 70% of the residents/fellows and faculty, with at least one conducted prior to the Program Evaluation Committee (PEC) meeting.
 - 1.13.3 Feedback from these evaluations is reviewed by the PEC and used to inform program improvement plans and meet ACGME Annual Program Evaluation (APE) requirements.
- 1.14 **Summative Evaluation of Resident/Fellow**
 - 1.14.1 Summative evaluations provide a comprehensive assessment of trainee progress, skills, and milestone achievement every six months.
 - 1.14.2 Programs must consider all evaluation data, including faculty assessments, 360-degree feedback, and self-evaluations when determining overall performance.
 - 1.14.3 The Program Director completes the official summative evaluation in MedHub or using a program developed scorecard that is then saved in MedHub Forms/Files. The Program Director, or a designated faculty member reviews the evaluation with the trainee, and documents whether they meet level-appropriate milestones and are ready to advance or graduate.
 - 1.14.4 Evaluations must be included in the trainee’s permanent record at least twice annually.
 - 1.14.5 The Clinical Competency Committee (CCC) reviews all data to advise the Program Director on trainee progression.
 - 1.14.6 Program Directors review CCC recommendations, make final competency determinations, and submit milestone assessments to the ACGME every six months.
 - 1.14.7 Program Directors or designees are expected to meet with trainees to discuss summative evaluations. Trainees should review and sign the evaluation to confirm understanding, supporting timely progress toward graduation.

- 1.15 **Summative Final Evaluation of Resident/Fellow:** At the completion of residency or fellowship training, each resident or fellow must receive a final summative evaluation from the Program Director. This evaluation must:
- 1.15.1 Document the trainee’s performance during the entire training period.
 - 1.15.2 Confirm whether the trainee has demonstrated sufficient competence to enter unsupervised practice in their specialty.
 - 1.15.3 Be based on ACGME Milestones, incorporating all relevant evaluation data collected throughout training.
 - 1.15.4 Be shared with and signed by the trainee and placed in the permanent educational record (Medhub).
 - 1.15.5 This final evaluation is an ACGME requirement and serves as an official record of the trainee’s readiness for independent practice.
- 1.16 If residents, fellows, or faculty have concerns regarding the adequacy of feedback, the anonymity of evaluations, or overall evaluation compliance, they are encouraged to contact the Program Director or the Graduate Medical Education (GME) Office. These concerns should be addressed by following the established process outlined in the institution’s grievance procedure.

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.

Institutional Requirements: 4.1, 3.2.g.5.b, 3.2.g.5.c

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: B9065.07, last updated 4/19/2025

Please see the Bayhealth Medical Center Institutional Policy on Leave of Absence for details regarding Family and Medical Leave.

Influenza Vaccination

Institutional Policy: B9806-9807.16, last updated 10/23/24

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 define the responsibilities of the Graduate Medical Education Committee (GMEC) in alignment with the Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements and Bayhealth Medical Center policies.

Institutional Requirements: 1.9, 1.11, 1.12

1. Procedure:

- 1.1 The Graduate Medical Education Committee (GMEC) at Bayhealth oversees the following:
 - 1.1.1 ACGME accreditation and recognition status of the institution and its programs.
 - 1.1.2 The quality of the learning and working environment across all programs and participating sites.
 - 1.1.3 Educational experiences and achievement of outcomes per ACGME Common and specialty-specific Program Requirements.
 - 1.1.4 Annual program evaluations and self-studies.
 - 1.1.5 Institutional policies for vacation and leaves, including medical, parental, and caregiver leave.
 - 1.1.6 Processes related to reductions or closures of programs, major sites, or the institution.
 - 1.1.7 Provision of patient safety summaries to residents, faculty, and clinical staff.
- 1.2 **The GMEC reviews and approves:**
 - 1.2.1 Institutional GME policies and procedures.
 - 1.2.2 Annual recommendations for resident stipends and benefits.
 - 1.2.3 New program applications, major program or site changes, and resident complement changes.
 - 1.2.4 Appointment of new program directors.
 - 1.2.5 Responses to ACGME progress reports, exceptions to work hours, voluntary withdrawals, and appeals.
 - 1.2.6 Exceptionally qualified resident appointments outside standard eligibility.
- 1.3 **Performance Oversight**
 - 1.3.1 GMEC conducts an Annual Institutional Review (AIR) according to the AIR policy.
 - 1.3.2 Underperforming programs are monitored through a Special Review process.
- 1.4 **GMEC Membership**
 - 1.4.1 Designated Institutional Official (DIO)
 - 1.4.2 A minimum of two program directors
 - 1.4.3 A minimum of two peer-selected residents
 - 1.4.4 A quality improvement or patient safety officer/designee
 - 1.4.5 Additional members may be included as needed

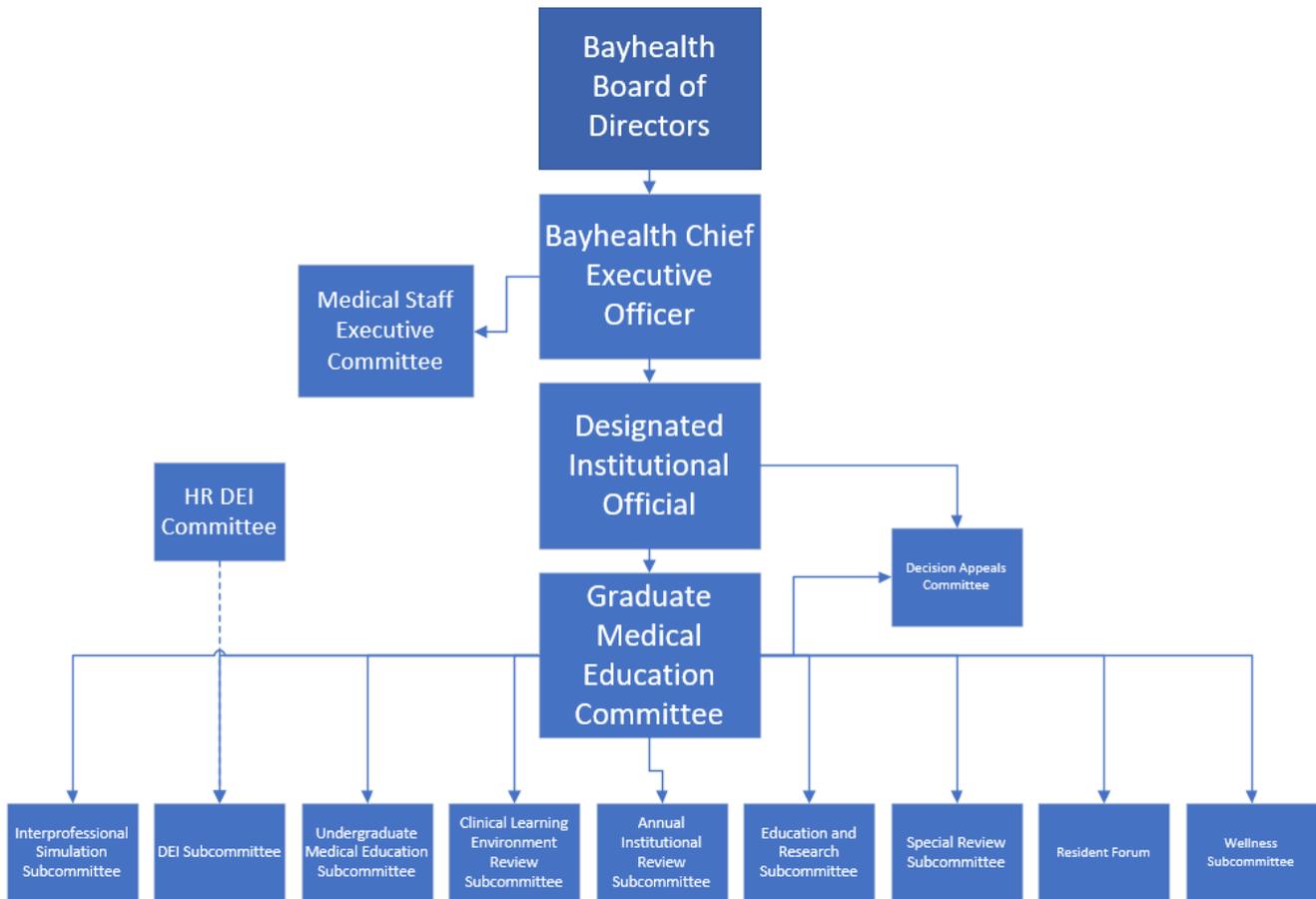
2. References:

- 2.1 ACGME Institutional Requirements (2025)

Graduate Medical Education Committee Organizational Chart

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

Institutional Requirement(s): 2.3, 1.10



Grievance and Conflict Resolution

Purpose Statement: At Bayhealth Medical Center, all Residents, Fellows, and Faculty members are encouraged to address and resolve concerns through appropriate and timely communication. This process ensures a supportive and professional learning and working environment and aligns with the ACGME's Institutional Requirements for addressing concerns related to training, the clinical learning environment, mistreatment, and professionalism. This grievance policy includes an explicit mechanism for reporting mistreatment or harassment, discrimination, or abuse by faculty, staff, residents, or others.

Institutional Requirements: 4.1, 3.1, 4.5

1. Procedure:
 - 1.1 This grievance policy includes an explicit mechanism for reporting mistreatment or harassment, discrimination, or abuse by faculty, staff, residents, or others.
 - 1.2 Trainees may file grievances related to perceived non-compliance with ACGME standards or requirements through this process
 - 1.3 For adverse academic or appointment actions residents/fellows will be entitled to due process under the institution's separate policies: *Academic Probation and Remediation Policy*, *Appeals Policy*, *Promotion, Non-Renewal and Dismissal Policy*.
 - 1.4 All grievance and appeal proceedings will be conducted by individuals without a conflict of interest. Review bodies will be selected to provide impartial adjudication.
 - 1.5 **Step 1: Informal Resolution**
 - 1.5.1 Whenever possible, individuals should first attempt to resolve concerns **informally** through direct communication. The following options are available: Discuss the issue with the appropriate faculty member, Program Director, or Chief Resident and/or bring the concern to the Resident Forum or Wellness Committee for peer support or informal guidance.
 - 1.6 **Step 2: Formal Concern Submission to the Program Director**
 - 1.6.1 If a Resident, Fellow, or Faculty member does not feel comfortable using informal channels; or believes the concern is too sensitive or complex for informal resolution; or has already attempted informal resolution without success, they may formally submit the concern in writing to the Program Director.
 - 1.6.2 The written concern should include: a clear description of the issue(s), relevant dates and facts, the outcome or resolution being sought.
 - 1.6.3 Upon receipt of the written concerns, the program director will schedule a meeting with the individual within seven (7) business days, if feasible. After meeting and any necessary follow-up, the Program Director will issue a written response including the decision and any action steps. A copy of this written response will be shared with the designated Institutional Official (DIO).
 - 1.7 **Step 3: Escalation to the DIO**
 - 1.7.1 If the concern directly involved the Program Director or the individual is not satisfied with the Program Director's decision, they may submit the concerns in writing to the DIO within five (5) business days of receiving the Program Director's response.
 - 1.7.2 The DIO will review the concern and schedule a meeting with the individual within seven (7) business days of receipt. After reviewing the concern and meeting with the individual, the DIO will issue a written decision outlining any resolution or next steps. When appropriate the DIO will issue a written decision to the Program Director. The DIO's decision is final for concerns of this nature.
 - 1.8 **Step 4: Institutional Level Options**

1.8.1 If previous steps have not led to satisfactory resolution, or if the individual prefers to escalate the concern beyond the GME office, the trainee may contact the Corporate Compliance Hotline: 800-932-5373

1.9 At any time, if the Program Director or DIO determines that a concern may involve a violation of ACGME requirements, a compliance issue, a potential breach of institutional policy, professionalism standards or resident/faculty well-being guidelines, they will consult with the appropriate Bayhealth compliance, legal or human resources personnel to ensure proper review and follow-up.

1.10 Bayhealth strictly prohibits retaliation, mistreatment, or recommendation against any individual who in good faith raises concern or participates in a grievance process. All matters will be handled confidentially and professionally in accordance with ACGME and institutional policy.

2. References:

2.1 ACGME Institutional Requirements (2025)

2.2 GME Policy: Academic, Probation and Remediation

2.3 GME Policy: Appeals

2.4 GME Policy: Promotion, Non-Renewal and Dismissal

Hand Hygiene

Institutional Policy: B6030.03, last updated 7/31/2024

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 requirements for other units such as the Operating Room (OR), Special Care Nursery, Pharmacy with additional requirements, follow specific policies.
- 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, Color Street, Jamberry's, poly gel, press on nails, tip extensions, bonding, sculpting products, nail wraps, fake nails, crackles, vinyls, stencils, decals, stickers, stamps, polish strips, plates, silks, jewels, and overlays to name a few.

1.7.2 Natural nail tips should be short and not extend beyond the end of the fingertip. Monitoring is completed by requesting employees to hold up their hands with palms facing inward. If nail tip is over the end of the fingertip, nails are too long. Nail polish is in good repair without chips.

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 1/13/2025

Purpose Statement: This policy addresses Bayhealth’s commitment to providing work environments free from sexual harassment for all Bayhealth team members 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 team members and/or affiliate staff members.

Team members 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 a team member making a report of sexual harassment is strictly prohibited. Team members 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 team members will be provided with a Delaware Sexual Harassment Notice at the time of hire. Annual Sexual Harassment Training will be mandatory for all Bayhealth team members, included as part of team members’ annual mandatory education.

1. Procedure:

- FILING A COMPLAINT
- Any team member who reasonably believes that a supervisor, non-supervisory team member, Bayhealth affiliate member (physicians, volunteers, student interns), or other non-team members (vendors or contractors), has engaged in sexually harassing conduct, towards themselves or another team member 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,
 - Senior Vice President of Human Resources, or HR Director of Operations
 - 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 team member who complains about sexual harassment, helps someone else complain about sexual harassment, or provides information regarding a complaint.
- Any team member 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 team member’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.
- A team member, who intentionally brings forth a false complaint, knowingly helps another team member 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.

2. 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.*)

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.

Institutional Requirements: 3.2.g.5.d

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:

Moonlighting

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

Institutional Requirements: 4.11.a

1. Procedure:
 - 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 fellows can moonlight based on Program Director discretion
 - 1.5 Gastroenterology fellows can moonlight based on Program Director discretion
 - 1.6 Sports Medicine fellows are not permitted to moonlight
 - 1.7 Moonlighting is prohibited internally (at Bayhealth) due to liability insurance and other restrictions
 - 1.8 Moonlighting is prohibited unless specifically approved in advance by the Program Director and DIO
 - 1.8.1 Such approval must be submitted through MedHub annually
 - 1.9 Residents will not be required to engage in moonlighting.
 - 1.10 The hospital does not provide professional liability coverage for duties assumed outside of the hospital
 - 1.11 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
 - 1.12 Time spent by residents in Moonlighting must be counted towards the 80-hour maximum weekly hour limit
 - 1.13 The individual programs will be responsible for monitoring clinical and education work hours through the residency management software system (Medhub) to ensure compliance
 - 1.14 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
 - 1.15 Approval may be withdrawn if moonlighting activities are associated with a decline in the resident's/fellow's performance
 - 1.16 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
 - 1.17 Residents/Fellows on visas are not permitted to moonlight
 - 1.17.1 Physicians sponsored by ECFMG for J-1 status are participants in the U.S. Department of State's (DoS') Exchange Visitor Program. The J-1 classification is explicitly reserved for educational and cultural exchange. It is not a work visa and, therefore, J-1 physician participants are not permitted to engage in any work outside of their approved program of graduate medical education (as reflected on Form DS-2019).
 - 1.17.2 Residents/Fellows can reference the ECFMG document "Employment Outside of the Approved Training Program" found here [evspemot.pdf \(ecfm.org\)](#)

1.17.3 The H1B visa is an employer sponsored visa. Residents/Fellows can only work at the site listed on their visa (Bayhealth) and therefore are unable to participate in Moonlighting.

Non-Compete

Purpose Statement: In accordance with the **ACGME Institutional Requirements (2025)**, Bayhealth is committed to ensuring that no resident or fellow in an ACGME-accredited program sponsored by Bayhealth is subject to non-competition guarantees or restrictive covenants as a condition of training. This policy protects the career mobility of trainees and supports institutional compliance with national graduate medical education standards.

Institutional Requirements: 4.13

1. Procedure:
 - 1.1 **Prohibition of Non-Competition Agreements**
 - 1.1.1 The Sponsoring Institution (Bayhealth), and all ACGME-accredited residency and fellowship programs under its sponsorship, **must not and will not** require residents or fellows to sign any form of non-competition guarantee, restrictive covenant, or similar agreement as a condition of appointment, reappointment, or completion of training.
 - 1.2 This prohibition applies regardless of the trainee’s employment classification, including but not limited to:
 - 1.2.1 GME training contracts
 - 1.2.2 Addenda or letters of agreement
 - 1.2.3 Affiliate institutional agreements
 - 1.2.4 Bayhealth Physician Employment Handbook or employment contracts
 - 1.3 **Oversight and Compliance:** The Designated Institutional Official (DIO) is responsible for ensuring that all GME-related contracts, policies, and documents are reviewed for compliance with ACGME requirements regarding restrictive covenants.
 - 1.4 The Graduate Medical Education Committee (GMEC) shall review this policy at least annually, or sooner if institutional, legal, or regulatory requirements change.
 - 1.5 Any reports of non-compliant language or contracts will be promptly investigated by the DIO and corrected in collaboration with Bayhealth Legal and Human Resources.
 - 1.6 **Resident/Fellow Rights:** Residents and fellows may not be penalized, threatened, or coerced into accepting a non-competition agreement as part of their training.
 - 1.7 If a resident or fellow believes they have been presented with or affected by a non-compete clause related to their training, they may report this to: Their Program Director, The GME Office, The Designated Institutional Official (DIO), The GME Anonymous Feedback Form
2. References:
 - 2.1 ACGME Institutional Requirements (2025) Section: 4.13

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.

Paid Time off and Leave of Absence

Purpose Statement: This policy establishes standardized procedures for residents and fellows to take approved leave while maintaining compliance with ACGME institutional requirements, supporting trainee well-being and ensuring continuity of patient care and program requirements.

Institutional Requirements: 4.1,4.8

1. Procedure:
 - 1.1 Orientation: Residents and Fellows will receive information regarding PTO, FMLA, and all leave policies during GME orientation.
 - 1.2 **Scheduled Paid Time Off (PTO)**
 - 1.2.1 Allocation for Residents and Fellows: 120 hours (15 days) of PTO per academic year. 40 hours of personal time (5 days) per academic year.
 - 1.2.2 PTO must be approved by the Program Director considering program needs. Programs may restrict PTO during specific rotations unless FMLA applies.
 - 1.2.3 At least one scheduled one-week PTO per academic year is required.
 - 1.2.4 PTO does not accrue or roll over into the next academic year. PTO is not paid out at graduation.
 - 1.3 **Unscheduled Paid Time Off (PTO)**
 - 1.3.1 Residents and Fellows should reference the program specific policies on procedure for unscheduled time off.
 - 1.3.2 Coverage for missed clinical duties must be arranged; if FMLA applies, coverage may not be required.
 - 1.3.3 After sick leave that is over five (5) days of length, residents and fellows must have a fit for duty clearance from their primary care provider or walk-in clinic before returning to work. This must be submitted to the Bayhealth's Occupational Health department before being able to return to work.
 - 1.4 **Family and Medical Leave (FMLA)**
 - 1.4.1 Eligibility: Must be employed for twelve (12) months and over 1,250 hours worked
 - 1.4.2 Duration: Up to 12 weeks of unpaid, job-protected leave for qualifying events
 - 1.4.3 Coordination: Runs concurrently with PTO, disability leave or worker compensation.
 - 1.4.4 Impact: FMLA leave does not result in dismissal but may extend training. Board exam eligibility may be affected if leave exceeds program limits.
 - 1.4.5 All residents/fellows must apply for FMLA regardless of 12-month eligibility to allow HR to track leave.
 - 1.4.6 FMLA Application Process: Apply via the Matrix System: Call: 877-202-0055 or download the Matrix App
 - 1.5 **Medical, Parental and Caregiver Leave**
 - 1.5.1 Paid Leave: 100% salary for first six (6) weeks of approved leave, one additional week of paid time off (up to 120 hours) may be applied after PTO is exhausted.
 - 1.5.2 Notification: Submit leave requests 30 days prior to foreseeable events; as soon as possible for emergencies
 - 1.5.3 Oversight: Program Director coordinates with benefits department and GME Director as needed.
 - 1.6 **Bereavement Leave**

- 1.6.1 Immediate Family: Up to three (3) scheduled shifts off with pay.
- 1.6.2 Extended Family: One (1) scheduled shift off with pay.
- 1.6.3 Additional Time: PTO may be used if additional days are needed.
- 1.6.4 Documentation: Proof of death may be obituary, funeral statement, death certificate or similar.
- 1.7 **CME**
 - 1.7.1 Allocation: Five (5) CME days per academic year
 - 1.7.2 Use: For conferences, board preparation, licensing, professional dues, subscriptions or educational resources
- 1.8 **Parental Leave**
 - 1.8.1 Residents and fellows are required to notify their Program Director as soon as they become aware of the need for parental leave. This ensures adequate time for planning, approval, and coordination.
 - 1.8.2 Upon Notification the Program Director will review applicable board requirements and meet with the residents/fellows to determine the amount of parental leave permitted, identify any training time that must be made up, outline the leave process, including required documentation and approvals.
 - 1.8.3 The Program Director must refer to the applicable board-specific policies when evaluating training time and leave impact.

Internal Medicine, Gastroenterology and Hematology/Oncology (ABIM)	Up to 35 days per year of training may be missed without extension An additional 35 days may be granted under the Deficits in Required Training Time policy with appropriate FasTrack documentation.
Family Medicine (ABFM)	Up to 20 weeks away from training over three years is allowed without a required extension This includes institutional leave allowances (PTO, Family Leave, Personal Time, Admin Leave, etc.)
Emergency Medicine (ABEM)	An extension is required for leave exceeding 6 weeks, unless covered under the ABEM Parental, Caregiver and Medical Leave Policy
General Surgery (ABS)	Acceptable training time without extension: <ul style="list-style-type: none"> • Years 1-3: 140 weeks total

	<ul style="list-style-type: none"> • Years 4-5 92 weeks total <p>This includes the institutional leave allowances (PTO, Family Leave, Personal Time, Admin Leave, etc.)</p>
Sports Medicine	
*Subject to change based on board requirements. Last updated in November 2024.	

- 1.8.3.1 The program must document parental leave in Medhub as a Leave of Absence (Maternity/Paternity), including any extension to the training period.
- 1.8.3.2 The following individuals need to be notified of any planned parental leave: GME Office: GME@bayhealth.org, Human Resources
- 1.8.3.3 Residents and Fellows should use the process in 4.9 for parental leave.

1.9 Paid Time Off (PTO) & ACGME Leave

- 1.9.1 Residents/fellows must use all but 40 hours of available PTO prior to accessing ACGME-mandated pay
- 1.9.2 Remaining ACGME-paid leave will then be applied and must also be documented in Medhub as a leave of absence, including any training extensions. Coordinators must enter PTO in both Medhub and Infor (under physician PTO). Coordinators should put a comment in Infor that says “paid leave per ACGME”
- 1.9.3 Exhaustion of Leave and Unpaid Time: If all PTO and ACGME mandated leave are exhausted: the saved 40 hours of PTO will be applied. If no PTO remains, unpaid leave may be taken, subject to eligibility for short-term disability. All unpaid leave must be documented in Medhub (leave of absence unpaid) and Infor (Leave of absence unpaid)
- 1.9.4 Failure to follow the outlined process, including timely documentation and notification, may result in delays to board eligibility or completion of training.

2. References:

- 2.1 Bayhealth Family and Medical Leave Policy B9065.27
- 2.2 Military Leave of Absence Policy B9065.50

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.

Institutional Requirements: 3.2

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.

- 1.1 **Trainee:** Any postgraduate trainee in the institution, including residents, fellows, and students.
- 1.2 **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)
- 1.3 **Clinical Supervisor: Supervising Attending** or all trainees who have reached **Teaching Competency** for CVC insertion.
- 1.4 **Direct Supervision:** Supervision of the procedure with the clinical supervisor in the room with the trainee.
- 1.5 **Indirect Supervision:** Supervision of the procedure with the clinical supervisor not present but available to assist if required.
- 1.6 **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.
- 1.7 **CVC sites:** Subclavian, Internal Jugular, Femoral.
- 1.8 **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:

- 1.9 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
- 1.10 **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)
- 1.11 **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.
- 1.12 **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 and Responsibilities

Purpose Statement: Residents and fellows are physicians in training who gradually assume increasing responsibility in clinical care, education, and scholarship. This policy defines expectations for professional conduct, accountability, and responsibility in patient care, education, administrative duties, and professional growth. It aligns with ACGME Institutional and Common Program Requirements and supports a safe, respectful, and ethical learning environment.

Institutional Requirements: 4.1, 3.2.f

1. Procedure:
 - 1.1 **Core Professionalism Expectations:** Trainees must demonstrate a commitment to professional responsibilities and adhere to ethical principles, including but not limited to:
 - 1.1.1 **Compassion, Integrity & Respect:** Treat patients, families, colleagues, and staff with dignity, courtesy, and sensitivity.
 - 1.1.2 **Patient-Centered Responsiveness:** Prioritize patient needs above self-interest; when fatigue, conflict, or other factors impair safe care, transition that care to a qualified, rested provider.
 - 1.1.3 **Respect for Privacy & Autonomy:** Honor confidentiality and informed consent.
 - 1.1.4 **Accountability:** Be responsible to patients, society, the profession, and the institution for actions, decisions, documentation, and professional behavior.
 - 1.1.5 **Cultural Sensitivity & Equity:** Exhibit awareness, respect, and responsiveness to diversity (e.g. age, culture, race, religion, gender, sexuality, disability).
 - 1.1.6 **Fitness for Duty:** Ensure physical and mental readiness to perform assigned work. Recognize and address impairment in oneself or others.
 - 1.1.7 **Honesty & Integrity:** Provide accurate, truthful documentation (notes, time logs, procedure logs) and communications.
 - 1.1.8 **Appropriate Professional Behavior:** Maintain boundaries, refrain from public or physical expressions of anger, avoid harassment or discrimination, and adhere to institutional policies.
 - 1.1.9 **Appearance & Deportment:** Abide by Bayhealth's dress code and present a professional demeanor in all settings.
 - 1.2 **Responsibilities & Domains of Behavior**
 - 1.2.1 **Patient Care & Clinical Responsibilities**
 - 1.2.1.1 Participate in direct patient care with graduated responsibility consistent with training level, supervision requirements, and program policy.
 - 1.2.1.2 Responsibly perform tasks including, but not limited to history & physicals, daily rounds, progress notes, test ordering and interpretation, procedures (as permitted), disposition planning, patient/family communication, and care coordination.
 - 1.2.1.3 Recognize limitations: when patient safety or care quality may suffer (e.g. due to fatigue or complexity), transfer responsibility to an appropriate provider.
 - 1.2.1.4 Engage in consultations, either receiving or providing them under supervision, with increasing autonomy over time.
 - 1.2.1.5 Aim by training end to be capable of independent practice or chief/tracking-level responsibilities, as applicable in your specialty.
 - 1.2.2 **Teaching, Mentoring & Supervision**

- 1.2.2.1 Serve as educators and role models to medical students and junior trainees, demonstrating professionalism, ethics, and humanistic care.
- 1.2.2.2 Know the learning objectives for students and align teaching accordingly.
- 1.2.2.3 Provide timely formative and summative feedback to students.
- 1.2.2.4 For senior trainees: supervise juniors either directly or indirectly (per program policy and ACGME supervision standards).
- 1.2.3 **Administrative & Operational Duties**
 - 1.2.3.1 Track and report work hours accurately (e.g., via MedHub). Failure to do so is a professionalism concern.
 - 1.2.3.2 Comply with institutional modules/mandates (e.g. HealthStream, CITI training, IHI modules) by deadlines; failure to complete may have clinical implications (e.g. badge access suspension).
 - 1.2.3.3 Check Bayhealth email daily (unless on leave) and respond timely to program and institutional communications.
 - 1.2.3.4 Provide evaluations of faculty, peers, programs, and services in internal or external evaluation systems (including ACGME).
 - 1.2.3.5 Participate in departmental or hospital committees when selected. Trainees must attend at least 50% of meetings, share updates in resident forums (unless confidentiality applies), and reapply annually. Those on remediation or contract extension may be ineligible.
- 1.2.4 **Professional Growth, Scholarship & Lifelong Learning**
 - 1.2.4.1 In collaboration with mentors or Program Directors, create and execute a personal plan for study, research, reading, and professional development.
 - 1.2.4.2 Use evidence, literature, and quality improvement methods to inform patient care decisions.
 - 1.2.4.3 Present at conferences, journal clubs, and teaching sessions.
 - 1.2.4.4 Develop leadership, educational, and service capabilities appropriate to your stage of training.
 - 1.2.4.5 Uphold the moral values of professionalism: committed patient care, continuous self-improvement, dedication to service.
- 1.3 **Unprofessional Conduct & Consequences:** Examples (not exhaustive) of behavior that may constitute unprofessional conduct include:
 - 1.3.1 Falsification or dishonesty (in documentation, evaluation, time logs)
 - 1.3.2 Violations of laws, institutional policies, or ethical standards
 - 1.3.3 Repeated tardiness, absenteeism, or failure to complete assigned duties
 - 1.3.4 Disrespect toward patients, staff, peers, or authority figures
 - 1.3.5 Inappropriate patient interactions or boundary violations
 - 1.3.6 Harassment, discrimination, abuse of power
 - 1.3.7 Improper use of social media or electronic communications
 - 1.3.8 Failure to comply with mandatory training or institutional requirements
 - 1.3.9 When unprofessional behavior is observed or reported, the following process will apply:
 - 1.3.10 Initial Review & Inquiry by Program Director (or designee)
 - 1.3.11 Remediation Plan: tailored corrective actions, mentorship, counseling, and monitoring
 - 1.3.12 Evaluation by CCC: if issues persist, the Clinical Competency Committee will review and recommend further action

1.3.13 Escalation: persistent unprofessional conduct, non-remediation, or serious violations may be referred to the Designated Institutional Official (DIO) or the Graduate Medical Education Committee (GMEC) for disciplinary action (e.g. probation, non-renewal)

1.3.14 All processes will follow due process and avenues for grievance or appeal per institutional and GME policies.

1.3.15 Trainees have the right to report concerns (their own or others') without retaliation, via Program Director, DIO, GME Office, or confidential institutional reporting systems.

1.4 **Evaluation, Remediation & Oversight:** Programs must regularly assess professionalism in trainees, referencing ACGME Milestones and internal evaluation tools. Documentation of concerns, remediation plans, progress, and resolutions must be maintained in the trainee's MedHub/permanent GME file. The DIO and GMEC ensure consistent application of professionalism standards across programs and monitor outcomes.

2. References:

2.1 Sexual Harassment Policy (B9065.36)

2.2 Discrimination Policy (B9090.05)

2.3 Personal Appearance and Dress (B9065.11)

2.4 GME Grievance Policy (GME Policy Manual)

2.5 GME Dress Code Policy (GME Policy Manual)

2.6 ACGME Institutional Requirements (2025)

Promotion/Non-Renewal/Dismissal

Purpose Statement: This policy establishes the criteria for the promotion of residents and fellows and outlines the procedures and actions to be taken in cases of non-promotion, non-renewal of a contract, or dismissal from a residency or fellowship program at Bayhealth.

Institutional Requirement(s): 4.1, 4.4

1. Procedure:

1.1 Promotion Criteria

- 1.1.1 Following the satisfactory completion of each year of graduate medical education (GME), and with attestation by the Program Director, a resident or fellow in good standing may be promoted to the next level of training. Promotion is subject to the terms, limitations, and conditions outlined in this policy and the Resident/Fellow Agreement.

1.2 Promotion Process

- 1.2.1 Promotion is based on a combination of periodic clinical evaluations and other assessment methods, as determined appropriate by the program. Recommendations for promotion are made by the program's Clinical Competency Committee (CCC) and the Program Director. To be eligible for promotion, residents and fellows must meet the following criteria:
- 1.2.1.1 Satisfactory completion of all assigned training requirements
 - 1.2.1.2 Consistently acceptable clinical and academic performance
 - 1.2.1.3 Demonstrated competence appropriate to their level of training
 - 1.2.1.4 Residents and fellows must be in full compliance with all terms of the Resident/Fellow Appointment Agreement
 - 1.2.1.5 Continued promotion is contingent upon the continued accreditation of both the Sponsoring Institution and the respective program by the Accreditation Council for Graduate Medical Education (ACGME).
 - 1.2.1.6 Additional promotion criteria may be defined by the Clinical Competency Committee (CCC) and Program Director, in alignment with program-specific requirements.
 - 1.2.1.7 Each program utilizes specialty-specific milestones to track progression through the clinical skills acquisition model (novice, advanced beginner, competent, proficient, expert).
 - 1.2.1.8 While progression through milestones may vary by individual, residents or fellows are expected to meet the recommended milestone levels for their current training year in the majority of their specialty-specific competencies prior to promotion or graduation.
- 1.2.2 Final approval of promotion decisions is subject to oversight by the Graduate Medical Education Committee (GMEC), in accordance with the ACGME institutional requirements.

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

1.3 Additional Promotion Requirements

- 1.3.1 **Examination Requirement for Promotion from PGY-1 to PGY-2:** Residents must pass USMLE Step 3 or COMLEX Level 3 during their PGY-1 year to be eligible for promotion to PGY-2
 - 1.3.1.1 Residents who do not pass USMLE Step 3 or COMLEX Level 3 by the end of PGY-1 will be extended as a PGY-1 for up to 90 days and are expected to retake and pass the exam within that period.
 - 1.3.1.2 Residents are advised to schedule the exam as early as possible, as testing dates fill quickly and score reporting may take up to four weeks.
 - 1.3.1.3 Residents will not be promoted to PGY-2 until official transcripts of a passing score are received, which may result in an off-cycle graduation.
 - 1.3.1.4 If a resident fails the exam a second time, they may be granted one additional 90-day extension, subject to program approval.
 - 1.3.1.5 Failure to pass USMLE Step 3 or COMLEX Level 3 after three attempts will result in dismissal from the program and Bayhealth Medical Center.

1.4 Board Certification Requirement for Fellow Promotion

- 1.4.1 Fellows enrolled in an Internal Medicine subspecialty must pass the American Board of Internal Medicine (ABIM) Certification examination in Internal Medicine as a prerequisite for promotion to the PGY-6 level
- 1.4.2 Fellows who do not achieve board certification in Internal Medicine by the end of the PGY-5 year may face one or more of the following outcomes, based on individual circumstances and institutional policy:
 - 1.4.2.1 Promotion may be delayed, with a corresponding extension of the fellowship program
 - 1.4.2.2 Placement on academic probation
 - 1.4.2.3 Non-renewal of the fellowship appointment
- 1.4.3 Fellows are required to submit proof of successful board certification to the Program Director by June 30th of the PGY-5 year to ensure timely verification for advancement.

1.5 Resident/Fellow Non-Renewal, Non-Promotion, or Dismissal

- 1.5.1 Grounds for disciplinary action, including non-renewal of contract, non-promotion, or dismissal from the residency or fellowship program, include but are not limited to the following:
 - 1.5.1.1 Unsatisfactory academic performance including failure of a rotation or examination scores below program-defined thresholds
 - 1.5.1.2 marginal or unsatisfactory performance in any of the following areas as documented by faculty evaluations: clinical diagnosis and judgement, medical knowledge, technical skills, data interpretation and patient management, communication and interpersonal skills, professionalism, initiative and motivation
 - 1.5.1.3 Unprofessional or unethical conduct, including, behavior that disrupts operations at Bayhealth or its affiliated training sites, and disregard for the rights, safety, or welfare of patients, staff, visitors or colleagues.
 - 1.5.1.4 Violation of institutional or programmatic policies, including failure to comply with Bayhealth policies and bylaws, affiliate hospital or departmental rules, medical staff regulations, terms of the resident/fellow agreement.
 - 1.5.1.5 Legal or criminal misconduct including, commission of an offense under federal, state, or local law that adversely impacts the residents/fellow's ability to fulfill training responsibilities.

1.5.1.6 Loss of eligibility for continued training include failure to maintain licensure, visa status, immunizations, extended absence or unavailability that interferes with the ability to meet training obligations or failure to comply with other institutional requirements.

1.5.2 Residents/fellows should reference the GME Academic Probation and Remediation policy as well as the GME Appeal Policy.

1.6 In cases of non-promotion, non-renewal of contract, or dismissal, the resident or fellow will receive a written notice of intent at least 120 days prior to the end of the current contract year.

1.6.1 This notice will include information about the resident/fellows right to due process, including access to the institution's GME Appeals policy, which outlines procedures for appealing actions such as non-promotion, non-renewal or dismissal.

1.6.2 The 120-day notice requirement does not apply to residents/fellows currently on probation or undergoing remediation.

1.6.3 Academic Leave

1.6.3.1 Residents/fellows may request academic leave in some circumstances. Please refer to GME Paid Time Off and Leave of Absence Policy

2. References : [ACGME Milestones](#)

Protocol for Special Review

Purpose Statement: This policy outlines the process by which the Sponsoring Institution (Bayhealth), through the Designated Institutional Official (DIO) and the Graduate Medical Education Committee (GMEC), provides effective oversight of underperforming ACGME-accredited Residency and Fellowship Programs. The policy defines criteria for identifying underperformance, describes the Special Review process, and ensures alignment with the ACGME Institutional Requirements (effective July 1, 2025).

Institutional Requirements: 4.1, 1.15

1. Areas Involved:
 - 1.1 Graduate Medical Education
2. Forms:
 - 2.1 None
3. Procedure:
 - 3.1 **Identification of Underperforming Programs:** programs may be designated as underperforming based on the following criteria:
 - 3.1.1 **Adverse Accreditation Status** (e.g., Initial/Continued Accreditation with Warning, Probation)
 - 3.1.2 **Quantitative Metrics:** Board Passage Rates below RRC thresholds, recruitment issues (unmatched/unfilled >3 years), high attrition of residents/fellows/faculty, clinical experience deficiencies (e.g., case logs).
 - 3.1.3 **Survey Data:**
 - 3.1.3.1 Mean scores less than three in two or more of the eight categories for the resident/fellow survey
 - 3.1.3.2 Mean scores less than three in two or more of the six categories for the faculty survey
 - 3.1.3.3 Two responses with less than 50% compliance and significantly below the national norm in any of the identified categories
 - 3.1.3.4 A pattern of significant downward trends since the last survey
 - 3.1.3.5 Survey completion rate below the 70% (Resident/Fellow) or 60% (Faculty) required by the ACGME
 - 3.1.3.6 ACGME requests for progress report related to concerns identified by resident, fellow or faculty survey.
 - 3.1.4 **Program Operations:** Failure to submit required ACGME data, organizational disruptions or major changes, repeated noncompliance or complaints, scholarly activity below expectations.
 - 3.1.4.1.1 Programs may also ask for special review via the Program Director
 - 3.2 **Special Review Process: Review Initiation & Timeline**
 - 3.2.1 If a residency/fellowship program meets criteria for designation as an underperforming program, the Designated Institutional Official (DIO) will schedule a Special Review. The DIO and GMEC will determine if the Special Review will be a focused (limited scope) or full (comprehensive) review.
 - 3.2.2 A Special Review must be scheduled within 30 to 60 days of a program's designation as underperforming.
 - 3.2.3 **Members of the Review Panel:** DIO, GMEC Chair, one faculty member and one resident/fellow from different programs, GME Director and additional reviewers at DIO discretion.

- 3.2.4 **Review Content:** ACGME Program and Institutional Requirements, accreditation letters and progress reports, APEs, case logs, scholarly activity, survey results, and any other relevant documentation requested by the DIO/designee.
- 3.2.5 **Interviews:** Interviews will be conducted with the Program Director, faculty, residents/fellows from each PGY level, program coordinator and others as needed.
- 3.3 **Reporting and Action Planning:** A written report from the DIO will be prepared within 2 weeks, based on Special Review Panel feedback.
 - 3.3.1 The report will include findings, recommendations, and the due date for the action plan.
 - 3.3.2 The Program Director has 30 days to submit an action plan that will be reported and reviewed at the next GMEC meeting.
 - 3.3.3 The GMEC may, at its discretion, choose to modify the Special Review Report before accepting a final version.
 - 3.3.4 The final report and action plan are subject to GMEC approval and will be documented in official GMEC minutes.
 - 3.3.5 The GMEC may require regular progress reports (e.g. Quarterly) until issues are resolved.
- 3.4 **Monitoring and Resolution:** The GMEC and DIO will monitor outcomes of the Special Review process, including actions taken by the Program and/or by the institution.
- 3.5 Once all findings are resolved, the DIO will issue a closure letter to the Program Director and file documentation in the program's permanent GME record.
- 4. References:
 - 4.1.1 ACGME Institutional Requirements (2025)

Record Requests

Purpose Statement: This policy establishes the process for requesting records related to Graduate Medical Education (GME) training, including verification of training, procedural logs, performance evaluations, and copies of diplomas. It applies to all former Residents and Fellows, including those who completed training and those who left before completion. This policy applies to all Residency and Fellowship Programs under the institution's GME Office and governs requests from former trainees for access to their training records.

1. Procedure:
 - 1.1 Request Submission: Former Residents/Fellows must submit an email request to the GME office (GME@bayhealth.org) that includes their full name, training program, dates of participation, specific documents requested, contact information (email, phone, address), and the completed GME Authorization to Release form.
 - 1.2 Verification of Identity
 - 1.2.1 The institution will verify the identity of the requester before processing the request. A government issued ID will be required.
 - 1.2.2 If requesting records on behalf of a former Resident, an authorization form signed by the former Resident must be provided.
 - 1.3 Types of Records Provided
 - 1.3.1 Residents/Fellows who completed training can obtain the following records:
 - 1.3.1.1 Verification of Training: A formal letter confirming program completion.
 - 1.3.1.2 Diploma Copies: One copy of the diploma may be provided at no charge. Additional copies may require a processing fee.
 - 1.3.1.3 Procedural Logs: Available if maintained by the program.
 - 1.3.2 Residents/Fellows who did not complete training can obtain the following records:
 - 1.3.2.1 Verification of Training: a letter stating dates of participation without the completion date.
 - 1.3.2.2 Procedural Logs: available if maintained by the program.
 - 1.3.2.3 Performance Evaluations and Disciplinary Records: May be disclosed only if legally permitted and in accordance with institutional policy.
 - 1.4 Processing Timeframe
 - 1.4.1 Standard requests will be processed within 30-45 business days of receipt of a complete request.
 - 1.4.2 Expedited requests will be considered on a case-by-case basis and will be processed as soon as practicable.

- 1.5 Fees: Copies of records may be subject to an administrative fee. Shipping fees may apply for physical copies. All fees in this section shall be determined at Bayhealth's sole discretion.

Authorization to Release Information

By Bayhealth Medical Center Graduate Medical Education

Resident/Former Resident Name _____

Program(s) Enrolled in/Completed _____

Dates of training _____

Last 4 numbers of SSN _____

I, _____, hereby give consent and authority to Bayhealth Medical Center, Inc., and its representatives to release information and documentation as outlined below. As an applicant for medical licensing, or credentialing, it is my responsibility to provide sufficient information upon which a proper evaluation can be undertaken of my relevant training, current competence, character, ethics, and any other criteria adopted by state licensing board(s) or verification service companies requesting such information. I release Bayhealth Medical Center, Inc., and its agents and/or representatives from any liability from any and all of their activities conducted in association with this authorization. I hereby authorize Bayhealth Medical Center Graduate Medical Education to release to:

Organization Name _____

Organization Street Address _____

Organization contact _____

Contact email/phone _____

- Confirmation of training dates
- Procedure Information
- Continuity clinic patient counts
- Milestones
- List of completed rotations
- Completed Evaluation
- Information regarding my professional qualifications, credentials, clinical competence, ethics, character, and other information reasonably having a bearing on my qualification for medical licensure/credentialing

Signature _____

Printed Name _____

Date _____

Research

Purpose Statement: The purpose of this policy is to describe the process to be followed for the completion of case reports and research studies within the Graduate Medical Education Program.

1. Forms:
 - 1.1 [Research form](#)
 - 1.2 [Poster Request Form](#)
 - 1.3 B9065.72 Extended Travel for Seminar/Event and Expense Reimbursement Policy Attachments
 - 1.3.1 Request to Attend Seminar/Event with Travel
 - 1.3.2 Seminar Check Request
 - 1.3.3 Extended Travel Expense Report
 - 1.3.4 Bayhealth Per Diem Rates for Meals during Extended Travel
 - 1.3.5 Bayhealth Mileage Rate and Campus-to-Campus Mileage Chart
2. Procedure:
 - 2.1 GME-Level Oversight
 - 2.1.1 Research page on Baynet can be found under Baynet>Departments>Graduate Medical Education>Research Resources.
 - 2.1.2 The GME Department oversees completion of IHI and Citi Training Modules within 6 months of the program start date for all residents and fellows.
 - 2.1.2.1 Residents cannot begin to work on any research projects without completion of required CITI courses/modules
 - 2.1.3 The GME Department oversees delivery of a Research Curriculum within the first year of the program start date for all residents and fellows, regardless of program.
 - 2.2 Program-Level Oversight
 - 2.2.1 The GME Research Program Manager and the ERSC will retain oversight of resident and faculty scholarly activity.
 - 2.2.1.1 All residents must complete scholarly activity prior to graduation in accordance with section 4.15 of applicable program requirements.
 - 2.2.1.2 The Research Program Manager will collect and retain a repository of cases appropriate for case reports from different fields of medicine.
 - 2.2.1.3 The Research Program Manager will track any research studies that involve residents.
 - 2.2.2 Database

- 2.2.2.1 The GME Research Program Manager will create and maintain a database to track resident scholarly activity (active and completed projects) and prevent multiple submission overlap of cases submitted by residents and faculty.
- 2.2.2.2 A list of national conferences within relevant specialties, inclusive of abstract deadlines and conference dates, will be maintained by the Research Program Manager on the shared drive for resident access. Residents will be notified of all deadlines in a timely manner
- 2.2.3 Mentorship
 - 2.2.3.1 A designated member of faculty will provide oversight and mentorship for resident scholarly activity.
 - 2.2.3.2 Faculty mentors will work with residents to ensure clinical relevance and feasibility, with the support of the Research Program Manager
 - 2.2.3.3 Faculty mentors will maintain oversight of resident scholarly activity, providing guidance as needed and appropriate.
 - 2.2.3.3.1 Each faculty mentor will meet with residents within the first 2 months of the academic year to discuss research goals for the year.
 - 2.2.3.3.2 Each resident will have opportunities to check in with faculty mentor and Research Program Manager as needed to provide progress updates on active projects
 - 2.2.3.4 Residents needing assistance with identifying a mentor may contact Research Program Manager or their program director or coordinator.
- 2.3 Scholarly Activity Requirements
 - 2.3.1 All residents are highly encouraged to participate in at least one presentation per academic year including local or national conference presentations, QI symposium, etc.
 - 2.3.2 Resident-led QI projects will be done every year. All residents are encouraged to be part of these QI projects.
 - 2.3.3 All scholarly activity must be updated in real time in MedHub portfolio under the Portfolio Entries tab.
 - 2.3.3.1 Entries must indicate the date the presentation occurred, the date of publication, or the date a project was accepted and started depending on the type of activity.
 - 2.3.3.2 Residents must select the appropriate entry type (i.e. Internal Presentation: Noon Conference or Case Presentation/Report; Local Presentation: Presentation to Bayhealth other than residency program; Regional/National Presentation: Presentation outside of Bayhealth or at a regional conference hosted by Bayhealth; Ethics Case; Evidence Based

Medicine Review; Grant; Quality Improvement Project; Safety Improvement Project; Research Project Publication)

- 2.4 Review with Faculty Mentor and Research Program Manager
 - 2.4.1 Residents should submit information via the research form as soon as they have an interesting patient case, QI project, or study.
 - 2.4.1.1 Case reports will be reviewed to confirm more than one resident is not working on a case report for one patient.
 - 2.4.1.2 Clinical studies (i.e. retrospective chart review studies) should be submitted via the research form for discussion with faculty mentor and Research Program Manager to ensure that it is F.I.N.E.R. (Feasible, Interesting, Novel, Ethical, and Relevant) and to prepare for IRB submission, if required.
 - 2.4.2 Detailed workflow for scholarly activities can be found on Baynet (Departments > GME > GME Research Resources).
- 2.5 Submission and Acceptance to a Conference
 - 2.5.1 The program will only support presenting research conducted at Bayhealth Medical Center that is presented under the Bayhealth Medical Center and/or program name.
 - 2.5.1.1 Research conducted prior to employment at Bayhealth will not be covered by this policy. If costs are incurred for research conducted prior to employment at Bayhealth by a resident during their employment at Bayhealth, reimbursement may be reviewed on a case-by-case basis by the Program Director. Full or partial reimbursement is not guaranteed.
 - 2.5.1.2 Residents may present research conducted outside of Bayhealth. The resident may use PTO to cover time required. The resident may not request reimbursement for any costs associated with the presentation. The resident is responsible for finding their own schedule coverage if coverage is required.
 - 2.5.2 Submission
 - 2.5.2.1 Collaboration with other residents and fellows on submissions is encouraged.
 - 2.5.2.2 Include all faculty involved in the submission.
 - 2.5.2.3 All submissions MUST be reviewed by an attending prior to submission.
 - 2.5.2.3.1 Plan accordingly- Attendings will have edits for all submissions. Submit to an attending for review at least 2 weeks prior to the submission deadline.

- 2.5.2.3.2 After edits, attendings need to approve the final version before submission.
- 2.5.2.3.3 If unable to discuss with your attending, contact other attendings on the case. If still unable to find an attending, please contact Research Program Manager.
 - 2.5.2.3.3.1 Reviewers take time to work with you on these submissions. Therefore, all reviewers must be included in the case submission.
- 2.5.2.4 Notify the Research Manager at ERSC@bayhealth.org, faculty mentor/attendings and Research Subcommittee members at the time of submission to a conference via email.
- 2.5.3 Acceptance
 - 2.5.3.1 Residents must notify ERSC@bayhealth.org, chief residents, research subcommittee members, and faculty mentor via email following submission acceptance.
 - 2.5.3.1.1 Notify within seven calendar days for national conference acceptance.
 - 2.5.3.1.2 Notify within two calendar days for local conference acceptance.
 - 2.5.3.1.3 Forward acceptance email, including title of case, authors/coauthors, attendings, and the date of presentation (not the conference dates).
 - 2.5.3.1.4 Failure to comply with notification requirements could jeopardize reimbursement and coverage for clinical responsibilities.
 - 2.5.3.2 Complete and submit the “Request to Attend Seminar” form.
 - 2.5.3.2.1 Use cost estimates if actual costs not yet available.
 - 2.5.3.2.2 Most expenses are accepted based on the guidelines below if delineated and approved in the request form.
- 2.5.4 Reimbursement
 - 2.5.4.1 Reimbursement requests MUST be made according to Bayhealth Policy B906572 Extended Travel for Seminar/Event and Expenses Reimbursement.
 - 2.5.4.2 Reimbursement requests for expenses incurred in advance of the event, such as registration fees and travel costs, must be submitted in accordance with policy B906572.

- 2.5.4.3 Reimbursement requests for expenses incurred during the event must be submitted in accordance with policy B906572.
 - 2.5.4.3.1 If multiple residents are going to a conference for their own projects, encourage rooming/traveling together.
 - 2.5.4.3.2 **Reimbursement and approval are not guaranteed. Each submission will be reviewed on a submission-by-submission basis.**
- 2.5.4.4 Criteria for review include, but are not limited to, number of presenters, number of presentations, total number of presentations previously attended, available budget, requested budget, and patient coverage requirements.
- 2.5.4.5 Cost caps
 - 2.5.4.5.1 Local Conferences
 - 2.5.4.5.1.1 Each resident may be reimbursed for cost of the poster and registration fees only
 - 2.5.4.5.1.2 Residents may request posters be printed through the GME office by completing the poster request form. Requests must be made at least 30 days prior to the poster due date.
 - 2.5.4.5.2 Reimbursement for national conferences will be as per GME reimbursement policy.
- 2.5.5 Poster/Presentation
 - 2.5.5.1 For all conferences, residents must use the official Bayhealth poster template unless otherwise required by the conference.
 - 2.5.5.2 The faculty mentor must approve all posters/presentations before the conference day.
 - 2.5.5.3 Mock Presentations
 - 2.5.5.3.1 Residents are required to complete a mock presentation for any national conference presentations.
 - 2.5.5.3.1.1 Exceptions may be made on a case-by-case basis.
 - 2.5.5.3.2 Following submission of presentation and acceptance, the Research Program Manager, program's Chief Resident Faculty Mentor will work together to schedule a mock presentation date and notify the resident.

2.5.5.3.3 The presentation/poster must be finalized and approved by the mentor prior to the mock presentation. Posters must be printed and available at the time of the mock presentation.

2.5.5.3.4 All mock presentations need to be completed within 2 weeks of the conference.

2.6 Failure to Comply

2.6.1 A resident who does not meet the requirements for submission, communication, or mock presentations (even if previously approved) may lose privileges to receive research reimbursement or program-directed patient coverage.

2.7 The subcommittee may make exceptions on a case-by-case basis.

Recruitment, Selection and Appointment

Purpose Statement: This policy outlines Bayhealth’s guidelines for the recruitment and selection of residents and fellows. It is designed to ensure that all recruitment and section processes for Bayhealth’s Graduate Medical Education (GME) programs are conducted in a valid, fair, effective and ethical manner, in alignment with institutional values and accreditation standards.

Institutional Requirement(s): 4.1, 4.2, 4.3

1. Procedure:
 - 1.1 **Resident/Fellow Recruitment:** Resident/fellow eligibility must align with the ACGME Institutional Requirements, Common Program Requirements, and applicable specialty- or subspecialty-specific requirements.
 - 1.2 At the time an interview is offered, candidates will receive a sample written agreement of appointment (contract) outlining the terms, conditions, and responsibilities of training at Bayhealth Medical Center. This document will include information on stipend, benefits, professional liability coverage, disability insurance, health insurance, and institutional policies on vacation and leaves of absence (including medical, parental, and caregiver leave). This process ensures compliance with all ACGME Institutional Requirements and Bayhealth policies.
 - 1.3 Bayhealth Medical Center does not discriminate on the basis of age, gender, race, religion, color, creed, national origin, disability, sexual orientation, or veteran status in determining resident or fellow eligibility and appointment. Selection is based on compliance with eligibility requirements, as well as assessment of the applicant’s interpersonal and communication skills, professionalism, integrity, medical knowledge, and preparedness for graduate medical education.
 - 1.4 **Eligibility Requirements for Appointment:** To be eligible for appointment to a Bayhealth Graduate Medical Education (GME) program, applicants must meet at least one of the following qualifications:
 - 1.4.1 Graduation from a medical school in the United States or Canada accredited by the Liaison Committee on Medical Education (LCME), or graduation from an osteopathic medical school accredited by the Commission on Osteopathic College Accreditation (COCA).
 - 1.4.2 Graduation from a medical school outside the United States or Canada with valid certification from the Educational Commission for Foreign Medical Graduates (ECFMG), or possession of a full and unrestricted license to practice medicine in a U.S. licensing jurisdiction in the applicant’s current ACGME specialty or subspecialty program.
 - 1.1 Resident/Fellow Selection: Resident and fellow selection at Bayhealth requires the following:
 - 1.1.1 Submission of a copy of the applicant’s medical school diploma and a letter from the medical school dean verifying graduation.
 - 1.1.2 Submission of at least three (3) letters of recommendation from physicians who have directly supervised or worked with the applicant.
 - 1.1.3 Completion of a personal interview, conducted either in person or via video conference.
 - 1.1.4 Demonstrated eligibility for medical licensure in the State of Delaware.
 - 1.1.5 Successful completion of the required licensing examinations, as applicable:

- 1.1.6 Graduates of osteopathic medical schools (COCA-accredited) must pass COMLEX Level 1 and COMLEX Level 2-CE.
- 1.1.7 Graduates of allopathic medical schools (LCME-accredited) must pass USMLE Step 1 and Step 2 CK.
- 1.1.8 Graduates of international medical schools must pass USMLE Step 1 and Step 2 CK and hold valid ECFMG certification.
- 1.1.9 Fellowship applicants must have passed USMLE Step 3 or COMLEX Level 3 prior to the start of the program and must be board eligible in their specialty.
- 1.2 **Visa Criteria:** International medical graduates (IMGs) seeking J-1 visa sponsorship must meet the eligibility criteria outlined in the Educational Commission for Foreign Medical Graduates (ECFMG) Exchange Visitor Sponsorship Program. Bayhealth Medical Center, in collaboration with ECFMG, will facilitate J-1 visa sponsorship.
- 1.3 All J-1 visa applications will be coordinated through the Graduate Medical Education (GME) Office, with the designated Training Program Liaison (TPL) serving as the primary contact for applicants throughout the process.
- 1.4 Residents/fellows who have previously used five (5) or more years of J-1 visa status will not be eligible for interview or consideration for fellowship positions at Bayhealth Medical Center.
- 1.5 In limited circumstances, Bayhealth Medical Center may consider H-1B visa sponsorship. These requests will be reviewed on a case-by-case basis and require prior approval. All H-1B visa applications will be handled by legal counsel designated by Bayhealth Medical Center. To qualify for H-1B sponsorship, residents or fellows must have successfully passed USMLE Step 3 prior to their start date.
- 1.6 All visa holders are responsible for maintaining valid immigration status throughout their training at Bayhealth Medical Center.
- 1.7 **Requirements for Appointment**
 - 1.7.1 **Temporary Training License**
 - 1.7.1.1 All residents/fellows must obtain a temporary training license from the State of Delaware and submit a copy to the GME Office prior to appointment.
 - 1.7.1.2 Bayhealth will reimburse the cost of the training license.
 - 1.7.1.3 Bayhealth will not reimburse costs associated with obtaining a full medical license or a license for moonlighting activities.
 - 1.7.2 **Health and Immunization Requirements:** Failure to provide required health or immunization records may result in a delayed start date or placement on unpaid leave until requirements are met.
 - 1.7.2.1 Residents and fellows must provide documentation to Bayhealth Medical Center's Occupational Health, including Proof of immunizations/vaccinations for MMR, Varicella, Hepatitis B, and Tdap or Td (within the last 10 years). If titers are negative, the appropriate vaccines must be administered. Tuberculosis (TB) testing within 12 weeks prior to the start of training; annual TB screening is also required.
 - 1.7.2.2 **Compliance with drug testing requirements:** A positive drug test will result in denial of employment unless the result is due to legally prescribed medication that does not impair the applicant's ability to perform essential duties safely. The Bayhealth Medical Review Officer will evaluate all positive results and consult with the prescribing physician if necessary.

Compliance with the Bayhealth Drug and Alcohol Abuse Policy (Policy #B9065.14).

- 1.8 Residents and fellows must upload the following documents to MedHub, Bayhealth's Residency Management System, prior to the start of training: Photo Identification (driver's license, passport, or government-issued ID), Demographic Information, Delaware Temporary Training Medical License, ECFMG Certification (if applicable), Certified Medical School Diploma and Visa Documentation (if applicable)
 - 1.9 **Pre-Employment and Background Screening (Human Resources):** All newly hired residents and fellows must successfully complete the following screenings prior to appointment at Bayhealth: Criminal background check, Drug screening and Sex offender registry check
 - 1.10 Residents/fellows must also pass all required Human Resources and Occupational Health screenings prior to appointment. The GME Office will be notified by Human Resources if a candidate fails any required pre-employment screening.
 - 1.11 **After Match Appointment:** All residents and fellows will receive a written contract/offer letter that outlines appointment terms, conditions, responsibilities, and institutional policies, in compliance with ACGME Institutional Requirements.
2. References:
- 2.1 Bayhealth Drug and Alcohol Abuse Policy, B9065.14

Residency or Fellowship 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.

Institutional Requirements: 4.1, 4.15

1. Procedure:
 - 1.1 **General Expectations:** Bayhealth senior leadership, Program Directors, DIO, and GMEC will make every effort to avoid program closure or reduction. If a decision becomes necessary, actions will prioritize resident/fellow welfare, educational continuity, and compliance with ACGME requirements.
 - 1.2 **Notification Requirements:** Bayhealth notify the GMEC, DIO and all affected residents/fellows within five (5) business days of any decision regarding program reduction or closure, including institutional closure.
 - 1.2.1 DIO must notify the ACGME of the program reduction or closure and maintain communication with the ACGME throughout the process.
 - 1.3 **Reduction in Program Size:** If a decision is made to decrease the size of the program the Program Director must notify the DIO, GMEC and residents/fellows within five (5) business days of the decision. Whenever possible, reductions will be accomplished by decreasing the number of incoming positions rather than affecting currently enrolled residents/fellows.
 - 1.3.1 If a reduction affects currently enrolled residents/fellows, the PD and DIO will work with affected trainees to identify placement in other ACGME-accredited programs.
 - 1.3.2 The DIO and GMEC will monitor the reduction process to ensure fairness, transparency and compliance.
 - 1.4 **Program Closure:** If a decision is made to close a program the Program Director must notify the DIO, GMEC, and residents/fellows within five (5) business days of the decision. Bayhealth will make every effort to allow currently enrolled residents/fellows to complete their training prior to closure.
 - 1.4.1 If closure occurs before residents/fellows are able to complete training, the Program Director and DIO will assist them in securing placement in other ACGME-accredited programs. The DIO and GMEC will monitor the closure process to ensure appropriate support and compliance.
 - 1.5 **ACGME Compliance:** The DIO must ensure that all notifications, documentation, and actions taken regarding program reduction or closure comply with ACGME policies and procedures.
2. **References:** ACGME Institutional Requirements (2025)

Safety Variance Reporting

Institutional Policy: B9000.03, last updated 1/7/2025

Purpose Statement:

To provide a policy and procedure for reporting, documenting, evaluating, responding to and trending hospital incidents that will:

- Promote reporting that focuses on hospital systems and what caused the incident, not who caused it;
- Promote prevention of similar incidents through heightened awareness of the causes,
- Provided for analysis and follow-up that will reduce the risk of further incidents,
- To meet the Joint Commission and Center for Medicare and Medicaid (CMS) expectations for a system of Safety Variance Reporting.

1. Definitions:

- 1.1 Variance - Any incident or event that is not consistent with expected hospital operations, with the care of patients or is contrary to or a breach in policy and procedures. There may or may not be personal injury or damage.

2. Areas Involved:

- 2.1 All Bayhealth Departments & Facilities

3. Forms:

- 3.1 Safety Variance Report (#N7154) is for use during on-line down- time only.

4. Procedure:

- 4.1 Each member of the hospital staff is expected to submit a Safety Variance Report in response to any unexpected event constituting harm or potential harm to a patient, visitor, volunteer, employee, physician, student or instructor in accordance with this policy.
- 4.2 The Safety Variance Report shall be entered into the on-line reporting system and will not become part of the medical record.
- 4.3 Within five (5) working days from receipt of the Safety Variance Report, managers/designees must review the report, evaluate/investigate the issues involved, take actions as necessary and enter the completed follow-up in the on-line Safety Variance Reporting system.

- 4.4 Managers/Designees should routinely share unit/department Safety Variance Report trends/patterns and changes needed with their staff at Huddles and team meetings to reduce the risk of recurrence and improve patient/staff safety. This information should also include feedback on Safety Variance Reports that their staff have entered concerning events involving other units/departments.
 - 4.5 If a patient, visitor, volunteer, employee, physician, student or instructor suffers harm that necessitates unexpected care or intervention, the reporter must, in addition to submitting an online Safety Variance Report, place a call to Risk Management to verbally report the event.
 - 4.6 Safety Variance Reports are permanently housed in the designated on-line repository and this system is backed up every 24 hours by Information Technology (IT). (FSSC-4.14)
5. References:
 - 5.1 Joint Commission: LD.03.09.01 EPs 3, 4; CMS: §482.21(c)(2) TAG: A-0286 12-11-24, 2025 Joint Commission Standards

Statement of Commitment

Purpose Statement: At Bayhealth Medical Center (Bayhealth), our mission is to strengthen the health of our community, one life at a time. To accomplish this mission, Bayhealth must provide premiere educational experience to its trainees in which they learn to provide optimal care to the community. Therefore, Bayhealth will support strong Graduate Medical Education (GME) programs through the provision of the necessary administrative, educational, financial, human, and clinical resources for all of its Accreditation Council for Graduate Medical Education (ACGME)-accredited programs.

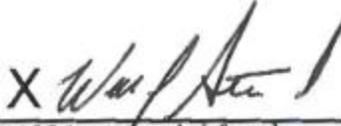
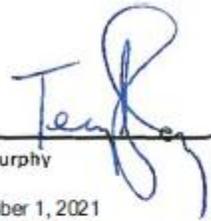
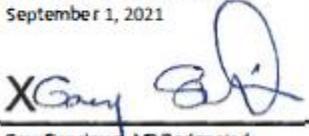
Institutional Requirements: 1.4

1. Procedure:
 - 1.1 Mission: At Bayhealth Medical Center (Bayhealth), our mission is to strengthen the health of our community, one life at a time. To accomplish this mission, Bayhealth must provide premiere educational experience to its trainees in which they learn to provide optimal care to the community. Therefore, Bayhealth will support strong Graduate Medical Education (GME) programs through the provision of the necessary administrative, educational, financial, human, and clinical resources for all of its Accreditation Council for Graduate Medical Education (ACGME)-accredited programs.
 - 1.2 Bayhealth is committed to providing the necessary financial support for administrative, educational, and clinical resources including personnel, necessary to assure excellence in its graduate medical education programs.
 - 1.3 Bayhealth will be responsible for the following considerations to ensure this commitment is enacted within the residency/fellowship program operations:
 - 1.3.1 Provide adequate clinical sites for resident/fellow education within the Bayhealth system and through agreements with approved patient care facilities as necessary
 - 1.3.2 Provide appropriate guidance and supervision to ensure that the patient care provided by residents/fellows is safe and appropriate for the patient, the resident, and their colleagues
 - 1.3.3 Provide access to appropriate educational resources for residents/fellows and faculty (such as library, facilities, teaching space and equipment, and information systems), as well as availability of specialty/subspecialty-specific and other appropriate reference material in print or electronic format (e.g. electronic medical literature databases with search capabilities).
 - 1.3.4 Ensure that the DIO and Program Directors have sufficient dedicated support and time to effectively carry out their educational, administrative, and leadership responsibilities, per the ACGME requirements
 - 1.3.5 Organize staff and support GMEC and a Graduate Medical Education Office to provide support and oversight as stated in the ACGME Institutional Requirements
 - 1.3.6 Support other program faculty who contribute to resident/fellow teaching and administration of the GME programs
 - 1.3.7 Ensure that residents/fellows can communicate any concerns, without intimidation or fear of retribution
 - 1.3.8 Coordinate the fair implementation of personnel policies and procedures for residents/fellows
 - 1.3.9 Provide appropriate on-call rooms, food services, security, and related services for ACGME requirements
 - 1.3.10 Ensure that resident/fellow clinical experience and education hours comply with ACGME requirements and hospital policies.
 - 1.4 The executive leadership of Bayhealth, GMEC, DIO, the Program Director(s), and the Bayhealth Board of Directors will monitor and ensure compliance with requirements and adherence to the established standards.

1.5 This statement of commitment will be reviewed, dated, and signed at least once every five years by the DIO, a representative of Bayhealth's senior administration, and a representative of Bayhealth's Board of Directors.

2. References:

2.1 ACGME Institutional Requirements (2025)

 X _____ William Strickland Executive Board Member September 1, 2021	 X _____ Terry Murphy CEO September 1, 2021
 X _____ Gary Seelman, MD Designated Institutional Official September 1, 2021	

Substantial Disruptions in Patient Care or Education

Purpose Statement: This policy establishes procedures for Bayhealth GME programs in the event of a substantial disruption in patient care or education. This policy ensures administrative support, continuity of resident/fellow assignments, and compliance with ACGME Institutional Requirements, including processes for notification, relocation, or transfer of trainees if necessary.

Institutional Requirements: 4.1 4.14, 1.7, 1.8

1. Procedure:
 - 1.1 **Notification and Initial Assessment:** In the event of a disaster or interruption that impacts on a residency/fellowship program the DIO will assess the short-term (days/weeks) and long-term (weeks/months) impact on program functions and clinical operations.
 - 1.1.1 Program Directors will provide data on affected rotations, patient care, responsibilities, and trainee schedules.
 - 1.1.2 The GMEC will review findings and provide guidance on immediate steps.
 - 1.1.3 The DIO will notify the ACGME promptly after the initial GMEC review.
 - 1.2 **Extraordinary Circumstances Policy:** If the ACGME invokes its Extraordinary Circumstances Policy, within ten (10) days the DIO contacts ACGME for deadlines to submit program reconfiguration and inform trainees of temporary or permanent transfers. Within thirty (30) days the DIO revises educational programs to ensure compliance with ACGME common, specialty-specific, institutional and program requirements. DIO maintains ongoing communication with the ACGME until the situation is resolved.
 - 1.3 **GMEC Oversight:** The GMEC will meet as necessary to assess the situation and make decision regarding affected programs. The key issues reviewed include patient safety, safety of trainees, faculty and staff, availability of faculty and trainees or clinical and educational duties, impact on clinical technology and information systems, impact on communication systems (phones, pagers, IT), changes in patient volume (short-term and long-term)
 - 1.4 **Trainee Relocation and Transfer Options:** If a trainee's educational experience is compromised one of the following relocation or transfer options will be used:
 - 1.4.1 **Temporary Relocation within Bayhealth:** Trainees may be reassigned to another Bayhealth training site. Bayhealth will continue salary and benefits as long as funds are available.
 - 1.4.2 **Temporary External Transfer to Another ACGME program:** Trainees will be temporarily assigned to another ACGME-accredited program outside Bayhealth. Bayhealth will attempt to continue salary and benefits; financial arrangements may be negotiated with the host institution. Trainees will be informed of the expected duration of the transfer.
 - 1.4.3 **Permanent Transfer:** If relocation is not feasible, Bayhealth will assist the trainee in a permanent transfer to another program/institution. Trainee preferences will be considered whenever possible. Bayhealth will not continue salary or benefits after permanent transfer.
 - 1.5 **Communication and Support:** The DIO and GMEC will ensure that trainees are informed promptly about changes in assignments. Program Directors will provide guidance on continuity of education and support for affected trainees.
 - 1.6 **Financial Considerations:** Continuation of salary and benefits depends on short-term and long-term impact of the disruption, availability of funds, policies related to reimbursement and institutional agreements.

Supervision

Purpose Statement: Residents and fellows in Bayhealth’s Graduate Medical Education (GME) programs must be supervised by faculty physicians in a manner consistent with the ACGME Common Program Requirements and the specific requirements of each accredited residency or fellowship program. The institution is committed to ensuring a level of supervision that supports both patient safety and resident/fellow education, while allowing for the progressive development of autonomy based on the resident’s/fellow’s level of training, demonstrated competence, and experience. Institutional oversight will ensure that all residents and fellows receive appropriate supervision by teaching faculty. Supervision must foster professional growth, enabling residents and fellows to assume increasing levels of responsibility as they progress through training.

Institutional Requirements: 4.1, 3.2.d, 3.2.d.1, 4.10

1. Procedure:
 - 1.1 **Institutional Oversight:** The GME office, under oversight of the DIO and GMEC, shall monitor compliance with supervision policies across all programs and intervene if deficiencies are identified.
 - 1.2 Each residency and fellowship program must maintain a supervision policy that is available to residents/fellows, faculty, patients and other care team members.
 - 1.3 **Faculty Accountability:** Faculty are required to comply with this policy and program-level supervision policies. It is recommended that each program have faculty sign an acknowledgement prior to program participation. Failure to provide adequate supervision may result in remediation or removal from the program faculty.
 - 1.4 **Resident/Fellow Protection:** Trainees may raise supervision concerns confidentially and without retaliation. Reports may be made to the chief resident, Program Director, Associate Program Director, DIO, or GME Director. Concerns not resolved at the program level will be addressed by the DIO. Issues of inadequate supervision will be reviewed promptly, and patterns of concern may trigger a GMEC special review.
 - 1.5 **Program Responsibilities:** Program Directors must establish detailed written policies describing resident/fellow supervision at each level, in accordance with institutional policies and ACGME requirements.
 - 1.5.1 Program Directors must provide explicit written descriptions of lines of responsibility for patient care, which will be communicated to all members of the teaching teams.
 - 1.5.2 Programs must define when the physical presence of a supervising physician is required.
 - 1.5.3 Faculty supervisors must be assigned for each rotation or clinical experience (inpatient and outpatient). Supervisors must provide evaluations of trainee performance via Medhub. Assignments must be sufficient duration to allow meaningful evaluation of competence.
 - 1.5.4 Programs must define and disseminate the process by which Program Directors and faculty determine a trainee’s progressive involvement and independence in patient care activities.
 - 1.6 **Levels of Supervision:** The following levels of supervision apply to all programs
 - 1.6.1 **Direct Supervision:** The supervising physician is physically present with the trainee and patient during key portions of the patient interaction **OR** the supervising physician is not physically present but concurrently monitors patient care through appropriate telecommunication technology (video, audio)

- 1.6.2 **Indirect Supervision:** The Supervising physician is not physically present but is immediately available to provide direct supervision.
- 1.6.3 **Oversight:** The supervising physician provides feedback after reviewing patient care, procedures or encounters.
- 1.7 **Trainee Responsibilities:** Trainees must understand the limits of their scope of authority and act within defined levels of supervision.
 - 1.7.1 Senior trainees may supervise junior trainees when appropriate, provided the junior trainees have demonstrated progress in the training program.
 - 1.7.2 Trainees must escalate to supervising faculty in specific situations, regardless of training level, including at minimum:
 - 1.7.2.1 Emergency Admission
 - 1.7.2.2 Consultation for Urgent Condition
 - 1.7.2.3 Transfer of Patient to High Level of Care
 - 1.7.2.4 Code Blue Team Activation
 - 1.7.2.5 Change in DNR status
 - 1.7.2.6 Patient or Family Dissatisfaction
 - 1.7.2.7 Patient Requesting Discharge AMA
 - 1.7.2.8 Patient Death
- 1.8 Enforcement
 - 1.8.1 **Faculty Non-Compliance:** Faculty who fail to provide adequate supervision will face remediation, up to and including removal from program faculty
 - 1.8.2 **Trainee Non-Compliance:** Trainees who provide care outside their scope of authority or fail to escalate appropriately may be subject to remediation under program disciplinary policies.

Transitions of Care

Purpose Statement: To promote continuity of care and patient safety, all residents, fellows, and faculty will receive training in structured, standardized patient handoff protocols. This policy ensures consistent implementation and monitoring of effective transitions of care across all participating sites. It will be reviewed annually by the Graduate Medical Education Committee (GMEC) and the Designated Institutional Official (DIO) to ensure ongoing compliance with ACGME requirements, Joint Commission standards, and institutional best practices.

Institutional Requirements: 3.2.c, 3.2.c.1

1. Procedure
 - 1.1 **Institutional Oversight:** The GMEC and DIO will monitor program compliance with handoff procedures, review outcomes related to transitions of care, and implement improvements as needed.
 - 1.2 **Environment for Handoffs:** Transitions of care must occur in settings that minimize interruptions and provider fatigue. Programs must identify designated spaces and times to conduct safe and effective handoffs.
 - 1.3 **Standardized Tools and Documentation:** Programs are encouraged to use standardized handoff tools (e.g., I-PASS, SBAR) and ensure handoffs are appropriately documented in the electronic medical record or other designated systems.
 - 1.4 **Common Handoff Scenarios:** Transitions of care typically occur under the following circumstances:
 - 1.4.1 Change in level of care (e.g., from ambulatory to inpatient, or after a procedure or diagnostic test)
 - 1.4.2 Admission from the Emergency Department
 - 1.4.3 Transfer to or from a critical care unit
 - 1.4.4 Transfer from Post-Anesthesia Care Unit (PACU) to an inpatient unit with a new physician
 - 1.4.5 Transfer of care within procedural or diagnostic areas
 - 1.4.6 Discharge to home or another facility (e.g., skilled nursing facility)
 - 1.5.1 Change in provider or service (e.g., resident sign-out, inpatient consults, rotation changes)
 - 1.6 **Program-Level Policies:** Each ACGME accredited GME program at Bayhealth must maintain a written transitions of care policy aligned with institutional standards for patient safety and quality of care.
 - 1.7 **Minimizing Transitions:** Clinical assignments should be structured to reduce the frequency of handoffs whenever possible.
 - 1.8 **Monitoring of Handoffs:** Programs must ensure and routinely monitor the effectiveness of their structured handoff processes to support continuity and safety.
 - 1.9 **Communication Competency:** Programs must verify that residents and fellows demonstrate competence in communicating during handoffs.
 - 1.10 **Care Team Awareness:** Each program must maintain accurate schedules to identify the attending physician and resident responsible for each patient.
 - 1.11 **Quality Improvement:** Programs are encouraged to review handoff-related issues during morbidity and mortality (M&M) conferences or quality improvement meetings.
 - 1.12 **Training Participation Tracking:** Resident, fellow, and faculty participation in handoff training must be tracked as part of annual professional development requirements.
 - 1.13 **Joint Commission Compliance:** All GME programs must ensure that handoffs adhere to the institution's standardized communication processes, in accordance with Joint Commission

National Patient Safety Goal NPSG.02.05.01. This includes use of approved tools (e.g., SBAR, I-PASS), provision for interactive questioning, and minimizing interruptions.

2.

References

2.1 ACGME Institutional Requirements (2025)

2.2 Joint Commission National Patient Safety Goal (NPSG.02.05.01.)

Use of Force

Institutional Policy: B8160.25, last updated 9/17/2025

Purpose Statement:

This policy establishes guidelines regarding the use of force by a team members while protecting themselves, team members, patients, visitors, and the general public.

1. Procedure:

1.1 General Principles

1.1.1 This policy complements the Workplace Violence De-Escalation Training that is the fundamental standard of Bayhealth Medical Center's use of force training.

1.1.2 This policy recognizes constitutional principles but aspires to go beyond them.

1.1.2.1 The Fourth Amendment requires that a team members use of force be "objectively reasonable." *Graham v. Connor*, 490 U.S. 386 (1989).

1.1.2.2 Under this standard, a team members may only use force that a reasonable person would utilize when facing similar circumstances.

1.1.2.2.1 The objectively reasonable standard acknowledges the difficult decisions that team members 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.

1.1.3 In situations where team members are justified in using force, the utmost restraint will be exercised.

1.1.3.1 Use of force will never be considered routine.

1.1.3.2 Team members are to respect the sanctity of human life.

1.1.3.3 Everything possible will be done to avoid unnecessary uses of force.

1.1.3.4 The least amount of force necessary is to be used.

1.1.3.4.1 Team members are to use only the amount of force that is proportionate to the circumstances.

1.1.3.5 Team members may use force only to accomplish specific lawful duties and objectives.

1.1.3.6 Team members 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.

- 1.1.4 Sound judgment and the appropriate exercise of discretion will be the foundation of team member's decision making.
 - 1.1.4.1 It is not possible to entirely replace judgment and discretion with detailed policy provisions.
 - 1.1.4.2 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 team members encounters.
- 1.1.5 Safety of the individual.
 - 1.1.5.1 After gaining control of a person, team members will position the person in a manner to allow the person to breath unobstructed.
 - 1.1.5.2 Team members 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.
 - 1.1.5.2.1 Chokeholds are not to be utilized.
 - 1.1.5.3 Team members are to promptly provide or request medical aid:
 - 1.1.5.3.1 Team members 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.
 - 1.1.5.3.2 Team members have a duty to continuously monitor individuals for potential medical intervention after a use of force. Team members will closely monitor persons against whom force was used for signs that they require medical assistance.
- 1.2 Use of Force
 - 1.2.1 Team members may use force for the following legitimate lawful duties and objectives:
 - 1.2.1.1 To overcome resistance directed at the team members or others;
 - 1.2.1.2 To prevent physical harm to the team members or to another person, including intervening in a suicide or other attempt to self-inflict injury;
 - 1.2.1.3 To protect the team members, or a third party, from unlawful force; or to prevent significant property damage or loss.
 - 1.2.1.4 For Public Safety team members to affect a lawful seizure (an arrest or detention) or to carry out a lawful search.
 - 1.2.2 Team members may not use or threaten to use force for the following reasons:

- 1.2.2.1 To resolve a situation more quickly, unless the extended delay would risk the safety of the person involved, team members, or others, or would significantly interfere with other legitimate lawful duties and objectives;
- 1.2.2.2 To punish a person or to retaliate against them for past conduct or to impose punishment;
- 1.2.2.3 To prevent a person from resisting or fleeing in the future;
- 1.2.2.4 To force compliance with an team members request, unless that request is necessary to serve team members or public safety, or
- 1.2.2.5 Based on bias against a person’s race, ethnicity, nationality, religion, disability, gender, gender identity, sexual orientation, or any other protected characteristic.
- 1.2.3 Team members 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, team members 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 team members will consider when determining how much force to use include:
 - 1.2.4 The risk of harm presented by the person;
 - 1.2.5 The risk of harm to the team members or innocent bystanders by using force;
 - 1.2.6 The seriousness of the lawful duties and objective;
 - 1.2.7 Whether further de-escalation techniques are feasible, including the time available to an team members to make a decision, and whether additional time could be gained through tactical means;
 - 1.2.8 If there is a practical, less harmful alternative available to the team members;
 - 1.2.9 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.
 - 1.2.10 Whether there are other exigent/emergency circumstances.
 - 1.2.11 As a situation changes, team members will reevaluate the circumstances and continue to respond proportionately. Over the course of an encounter, the circumstances and threats and team member’s faces may change.
- 1.3 Team members, based on role, receive training on the following range of force options:
 - 4.3.1.1 Uniformed or physical presence (least)
 - 4.3.1.2 Workplace Violence De-Escalation Training Series
 - 4.3.1.2.1 Verbal Control Techniques
 - 4.3.1.2.2 Physical Contact
 - 4.3.1.2.3 Holding Techniques
 - 4.3.1.3 Physical Compliance (Pressure Point Control Hold, Public Safety Only)

- 4.3.1.4 Restraint Tools
- 4.3.1.5 Physical Force *Public Safety Involvement and led when present*
- 4.3.1.6 Control Instruments: Handcuffs, Batons (greatest) * Public Safety Only*
- 1.4 The force options available to a team members fall along a continuum.
 - 1.4.1 Team members are not required to exhaust one type of force before moving to a greater force.
 - 1.4.2 Sound judgment and the appropriate exercise of discretion will be the foundation of team members decision making in the broad range of possible use of force situations
- 1.5 The level of resistance that and team members encounters is a key factor in determining the proportionate amount of force. The types of resistance team members may encounter fall along a continuum, from a cooperative person to an active assailant. Consistent with training, the following general options apply when team members are exercising judgment in determining what level of force is necessary and proportionate:

Level of Resistance	Force Options								
	Uniformed /Physical Presence	WPVDe-Escalation Training	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

- 1.6 Team members will attempt to de-escalate confrontations with the goal of resolving encounters without force.
 - 1.6.1 Team members may only use force that is objectively reasonable, necessary, and as a last resort.
 - 1.6.2 Increased levels of force will not be utilized when a safe alternative would achieve the same objective.
 - 1.6.3 Team members will use de-escalation and force-mitigation tactics and techniques learned through Bayhealth sponsored training.
 - 1.6.4 Public Safety department is authorized to use additional techniques in accordance with training programs approved by the department.
- 1.7 Team members will provide clear instructions and warnings before and during the use of force.
 - 1.7.1 Provide clear instructions and warnings;
 - 1.7.2 Seek to communicate in non-verbal ways when a verbal warning would be inadequate
 - 1.7.3 Indicate the consequences of refusing to comply with a mandatory order, including that force will be used unless the person complies; and
 - 1.7.4 Give the person a reasonable amount of time to comply.
- 1.8 Team members will consider an individual’s mental, physical, or other incapacities. Team members will consider whether a person’s failure to comply with an team members 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.
- 1.8.1 In these situations, team members will consider whether specific techniques or resources would help resolve the situation without force.
 - 1.9 Use of force reporting
 - 1.9.1 Team members will immediately notify Bayhealth Medical Center's Public Safety Department of use of force incidents and document appropriately.
 - 1.9.1.1 Team members will complete their reports accurately and completely, articulating specific facts to explain an team members own decision to use force.
 - 1.9.2 Use of force by a team members 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.
 - 1.9.2.1 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.
 - 1.9.2.2 In case of lethal force, the Local Law Enforcement Agency will conduct the subsequent investigation into the use of force.
 - 1.10 Team members Accountability
 - 1.10.1 Team members will be held accountable for violations of this policy in accordance with the Corrective Action Policy and Delaware Code.
 - 1.10.1.1 This policy is not intended to create or impose any legal obligations or bases for legal liability.
 - 1.10.1.2 This applies to the team members own conduct, as well as observation or knowledge of the conduct by other team members.
 - 1.10.2 Team members are responsible to take steps to prevent or stop illegal or inappropriate uses of force by other team members.
 - 1.10.3 Allegations of inappropriate or excessive use of force.
 - 1.10.3.1 Allegations of inappropriate use of force incidents will be reported to the Senior Director of Emergency Management, Public Safety and Transportation Services.
 - 1.10.3.1.1 Senior Director of Emergency Management, Public Safety and Transportation Services will inform Risk Management of the allegation and collaboratively determine next steps within 24 hours. Follow-up options include:
 - 1.10.3.1.1.1 Collaborative follow-up with representatives from Public Safety, Human Resources, and Risk Management.
 - 1.10.3.1.1.2 Public Safety lead investigation.
 - 1.10.3.1.1.3 Risk Management lead investigation.
 - 1.10.3.1.1.4 Use of Force Committee review.
 - 1.10.3.1.2 Investigation updates will be provided by the investigator within 72 hours.

- 1.10.3.1.3 During investigations team members will be removed from duty or assigned a non-public facing administrative duty based on departmental needs.
- 1.10.3.2 Use of Force Committee
 - 1.10.3.2.1 Used to evaluate the use of force by a team member only when the investigation produces unclear results.
 - 1.10.3.2.2 Committee consists of:
 - 1.10.3.2.2.1 VP of Corporate Support Services
 - 4.10.3.2.2.2 VP of Human Resources
 - 4.10.3.2.2.3 Senior Director of Emergency Management, Public Safety and Transportation Services
 - 4.10.3.2.2.4 Sr. Director of Risk Management
 - 4.10.3.2.2.5 Ad hoc Subject Matter Expert
 - 1.10.3.2.3 Facts of the incident and subsequent investigation will be provided to the committee, including any material evidence.
 - 1.10.3.2.4 Committee is tasked with determining whether or not the use of force was reasonable and appropriate.
 - 1.10.3.2.4.1 Inappropriate use of force will be subject to corrective action.
 - 1.10.3.2.4.2 Committee may also determine the need to report the incident to local authorities.
- 1.10.4 Leaders are responsible for reviewing and monitoring the appropriateness of use of force in their areas.
- 1.11 Training
 - 1.11.1 Team members will be issued this policy and educated on use of force during de-escalation training.
 - 1.11.1.1 Mandatory training is required in certain departments.
 - 1.11.2 Training topics include:
 - 1.11.2.1 When and how to use de-escalation
 - 1.11.2.2 Force- mitigation techniques
 - 1.11.2.2.1 Tactical communication, positioning, and time as a tactic.
 - 1.11.2.3 Self-defense techniques
 - 1.11.2.4 Techniques for physical intervention.
- 2. References:
 - 2.1 IASHH Healthcare Security Industry Guideline 05.02, Security Role in Patient Management
 - 2.2 Graham v. Conner 490 U.S.386 104 L. Ed. 2d 443, 190 S. Ct. 1865 (1898)
 - 2.3 International Association of Chiefs of Police National Law Enforcement Policy Center USE OF FORCE Model Policy, August 2001.

2.4 Journal of Healthcare Protection Management,
IAHSS 2007 Volume 22, No. 2, Page 15, Use of
Force in Private Security: A Primer.

Vendor Relation

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

Institutional Requirements: 4.12

1. Procedure:
 - 1.1 Residents/fellows will follow the Vendor Management 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.
2. References:
 - 2.1 Vendor Management B9034.04

Verbal or Telephone Orders

Institutional Policy: B9085.48, last updated 12/2/2024

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, respiratory therapist, diagnostic imaging technicians, and echocardiographers as appropriate to their scope of practice. The physician is also to participate in the read back process.

1.2.1 CPOE

1.2.1.1 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.

1.2.1.2 When STAT orders are entered, the provider will notify the nursing staff in a timely and appropriate fashion.

1.2.2 Paper Physician Order Sheets

1.2.2.1 May be used during the event of electronic downtime.

1.2.2.2 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.

1.2.2.3 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.

1.2.2.4 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.

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 **Severe Weather Conditions:** 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).
 - 1.2 **State of Emergency:** 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.
 - 1.3 **Weather Event Planning: Weather Event Coordinator:** 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.
 - 1.3.1 Weather Event Task Force is made up of the Director of Emergency Management and Public Safety (Weather Event Coordinator & Call Cahir), Administrator On-Call, Administrator, Bayhealth Sussex Campus, VP – Corporate Support Services, VP – Marketing & Communications, VP of Physician Services/BMG, VP of Supply Chain, SVP Patient Care Services and Chief Nurse Executive, SVP and Chief Human Resources Officer, Senior Director, Ambulatory Service Line, Site Director, Facility Services, Senior Director, Facility Management, Executive Team (invited to calls to participate at their discretion), Other individuals may be invited to participate in the call from time to time based on the specifics of the weather event.
 - 1.3.2 **Initial Conference Call:** 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.

1.3.3 05:00 am Conference Call: 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:

1.3.3.1.1 Normal operations: Facilities are open and operating as normal.

1.3.3.1.2 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).

1.3.3.1.3 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.

1.3.3.1.4 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.

1.4 Staffing/Compensation

1.4.1 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.

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

1.4.2 Essential Employees

1.4.2.1 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.

- 1.4.2.2 Use of PTO will not be available to anyone designated as essential during a severe weather or emergency event.
- 1.4.2.3 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.
- 1.4.2.4 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.

1.4.3 Non-Essential Employees

- 1.4.3.1 Those employees considered "non-essential" contact their supervisor for instructions relative to coming to or remaining at work
- 1.4.3.2 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.
- 1.4.3.3 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.

1.4.3.4 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.

1.4.3.5 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.

1.4.3.6 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

1.5 Staff Amenities During Weather Emergencies

1.5.1 Staff Rest Areas

1.5.1.1 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.

1.5.2 Meals

1.5.2.1 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.

1.5.3 Linens and Essentials

1.5.3.1 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.

Institutional Requirements: 4.1, 3.2.g

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.
 - 1.1.2 Residents/fellows and faculty will be educated on strategies to maintain a healthy work-life balance, including stress management techniques, time management, and the importance of taking time for personal recovery.
 - 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 The Bayhealth Critical Incident Stress Management (CISM) Team provides confidential peer support for residents/fellows, faculty, and staff who have experienced stressful and/or traumatic events. Requests for assistance from the CISM team can be made by filling out the confidential request form on Baynet: [Critical Incident Stress Management \(CISM\) | Bayhealth Intranet](#)
 - 1.5 Residents/fellows and faculty will have access to VITAL Work Life. This comprehensive program offers additional support tailored to the unique needs of medical professionals. Services include confidential counseling, peer coaching, financial and legal services, WorkLife Concierge and more.
 - 1.6 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.
 - 1.6.1 Counseling and In-the-moment behavioral Health Support 24 hours a day, 7 days per week by phone at

877-731-3949 or 952-230-5109 or online at
www.vitalworklife.com Username: Bayhealth,
Welcome Code: vitalworklife

Work Restrictions for Health Care Workers with Contagious or Communicable Disease

Institutional Policy: B9806-9807.25, last updated 10/2/2024

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 Healthcare 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 notify 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 (HR) Workers' Compensation Program Coordinator 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 practice.
- 1.4 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 Coordinator and Third-party Administrator communicates claim information to the employee.

- 1.5 Bayhealth follows respiratory virus guidance per CDC recommendations.
- 1.6 Human Resources Workers' Compensation Program Coordinator notifies Infection Prevention (IP) in the event of exposure to patients or other employees.
- 1.7 If a Bayhealth employee is exposed to Meningococcal Disease the workflow in Exhibit B for exposure to staff is followed.
 - 1.7.1 The Bayhealth employee is considered exposed if:
 - 1.7.1.1 Unprotected exposure to the case patient's oral secretions (e.g., intubation, endotracheal tube management, suctioning, mouth to mouth resuscitation).
 - 1.7.1.2 Contamination from a laboratory specimen sent for diagnosis of a suspected case.
 - 1.7.1.3 Close inspection of the patient's oropharynx, provision of oral care, or mucosal contamination from a case specimen
 - 1.7.1.4 Any individual who has been in the room of a patient with meningococcal disease multiple times (greater than 2) while not wearing a surgical mask over an 8-hour period.
 - 1.7.2 Close contact is defined as a person who has had direct contact with the respiratory, oral, or nasal secretions of a case greater than 7 days before onset of meningococcal disease until the case has had 24 hours of effective antimicrobial therapy.
 - 1.7.3 Prophylaxis is given as soon as possible after exposure (within 24-48 hours) and may be given up to 14 days after a confirmed diagnosis.
 - 1.7.4 Completed PEP forms (P10300) for prophylaxis is sent to Occupational Health mail code 3050.
- 1.8 If a Bayhealth employee is exposed to Human Rabies, Bayhealth follows the Delaware Health and Social Services protocol and workflow (Exhibit C &

D)

- 1.9 Occupational Health maintains documentation of employee exposure or presence of a contagious or communicable disease.
- 1.10 Unresolved or equivocal situations are referred to the Occupational Health Medical Director or outside healthcare licensed practitioner for further evaluation and recommendation.
- 1.11 Bayhealth may require a return to work examination at Occupational Health before allowing employees to resume their job duties.

2. References:

- 2.1 *CDC Healthcare Workers Exposure Recommendations:
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html> - Retrieved 01/13/2023
- 2.2 <https://www.cdc.gov/infectioncontrol/guidelines/healthcare-personnel/exposures.html#print> – Retrieved 01/13/2023
- 2.3 <https://www.cdc.gov/infectioncontrol/pdf/guidelines/infection-control-HCP-H.pdf> - Retrieved 01/13/2023

3. Exhibits:

- 3.1 Exhibit A: Active Disease, Work Restrictions and Duration
- 3.2 Exhibit B: Workflow for Communicable disease
- 3.3 Exhibit C & D: Human Rabies post-exposure PEP protocol