

Policies and Procedures



Oral and Maxillofacial Surgery Residency Program

University of Mississippi Medical Center

2015-2016

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POLICIES AND PROCEDURES

ORAL AND MAXILLOFACIAL SURGERY RESIDENCY PROGRAM UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

This protocol outlines the mission statement of the Department of Oral and Maxillofacial Surgery and its faculty, the goals of the residency program, policies and procedures of the residency program, the responsibilities of the resident, and structure of the training program.

Refer to the House Staff Manual to become familiar with policies and procedures of the University of Mississippi Medical Center and the University Hospitals and Health Systems.
The manual can be found on the UMMC Intranet.

Mission Statement

The Oral and Maxillofacial Surgery Residency Program at the University of Mississippi Medical Center is to be a great program—dedicated to achieving the highest standards of performance in education, research and health care delivery; educating outstanding oral and maxillofacial surgeons in the broad scope of the specialty; being a leader in the development of innovations that will improve human health; recognized nationally for our leadership in innovations; being the preferred deliverer of OMS health care in the state; committed to recruiting and retaining high performing faculty, residents and support staff; embracing diversity yet maintaining a commitment to work as a team; finding solutions to the challenges of health disparities in Mississippi and the nation; promoting the value of professionalism and life-long learning in all our faculty, residents and staff; and enhancing the reputation of our university.

Residency Program Goals

Education

Goal 1: Provide basic science and medicine didactic education that is required to competently practice oral and maxillofacial surgery and communicate with medical colleagues.

Goal 2: Provide an OMS didactic education that is broad scope so that graduates of this program can practice the full scope of the specialty.

Goal 3: Provide a training experience that encourages life-long learning and stimulates resident interest in an academic career.

Research:

Goal 4: Develop a research program that focuses on the development and/or implementation of innovative technologies for clinical practice.

Goal 5: Residents are encouraged to perform research projects in conjunction with OMS and other faculty to gain an appreciation for scientific methodology.

Patient Care:

Goal 6: Our first priority is to deliver excellent care for our patients. We will encourage residents to critically think and continuously assess patient outcomes. We will structure a graduated increase in resident responsibility as he/she matriculates through the residency program.

Goal 7: Provide a clinical education that is broad scope so that graduates of this program can practice the full scope of the specialty.

Goal 8: Deliver patient care in a manner in which residents develop skills and habits that are necessary for establishment of a successful private practice.

Service:

Goal 9: Residents will appreciate and embrace the opportunity they have to serve patients and community now and in the future as oral and maxillofacial surgeons.

Goal 10: Residents will appreciate and embrace the need for an organized voice that represents OMS before the public and that addresses the challenges facing our specialty.

PROGRAM OVERVIEW

The program currently has a 48-month duration certificate program and a 72-month dual degree program and is designed to complete the requirements of the Commission on Dental Accreditation for an approved advanced educational program in Oral and Maxillofacial Surgery. We accept one resident in each program every year.

The program operates out of the University of Mississippi Medical Center Dental School for outpatient care and the University Hospital for inpatient and outpatient hospital-based care. The program offers a full scope training experience including extensive training in maxillofacial trauma, head and neck pathology, facial reconstruction, orthognathic surgery, preprosthetic surgery, temporomandibular joint surgery, craniofacial surgery, exodontia and other surgery as it pertains to the specialty.

PROTOCOL – ORAL AND MAXILLOFACIAL SURGERY

This is not intended in any way to be identified as a rigid format from which no deviation shall be permissible. It is intended to be used as a guide for directing the efforts of all people on the service in the most efficient manner possible. Thereby making the service an effective unit of the dental school and hospital both in delivery of care to the patients and as a teaching institution.

Management of oral and maxillofacial surgery inpatients and outpatients at University Hospital and the dental school will be the responsibility of the service as a group. Staff "private" patients treated will not be exempt from this group care. The Chief Resident/Attending should be constantly advised of the progress of all patients.

The outpatient clinics should always be manned during regularly scheduled hours. During regularly scheduled surgery in the operating room, residents who are not involved in the surgical procedure will be responsible for managing the outpatient clinic. Everyone will aid in the clinic when possible.

Residents/interns will have only those surgical privileges granted by the Chief Resident or Attending staff.

Pathology, orthognathic, reconstructive and trauma cases will be operated by the resident initiating and adequately preparing the case for surgery. Residents/Interns are encouraged to work up cases to the level of their experience and to enlist the help of the Chief Resident/Attending in preparing cases for surgery. The maximum amount of education will result by the sharing of major surgical procedures between the primary resident preparing the case and the Chief Resident. Subsequent to the Chief Resident's approval, the case should be presented to the staff prior to scheduling surgery or admission.

Dentofacial Deformity patients will be evaluated in the DFD clinic. Residents will gather all diagnostic records requested by the attending surgeon covering the case. Meetings for discussion of diagnosis, treatment planning, proposed surgical procedures, and expectations of treatment should occur with the attending. The case should be formally presented in a power point presentation by the resident working up the case the following week at DFD conference.

General Duties

1. Admission notes and admission orders will be written on all patients admitted to the hospital prior to their going to the ward. This may be done as a preadmission or at the beginning of the day to eliminate patients waiting needlessly in the clinic for the residents to finish surgery, etc. This can allow the patient to have his chest radiographs, laboratory work, etc. completed at a convenient time for all departments concerned.
2. Arrangements for beds will be completed on all admitted patients prior to their going to the ward. Admission history and physical examinations will be done at the earliest possible time by the house staff responsible for this service.
3. All cases scheduled for the operating room will be posted by the Attending's nurse, Chief Resident or his appointee in a timely manner to ensure that OMS block time is not lost. Cases requiring special anesthesia consideration or management (e.g., hypotension) will be discussed with the anesthesia staff at the time of posting.
4. No patient will be taken to the operating room at any time for elective or emergency surgery without consultation with the Chief Resident and the scheduled attending staff.

5. No resident will take any major case to the operating room without a second resident or attending staff.
6. All patients scheduled for the operating room will be evaluated prior to surgery. Any contraindications to surgery will be specifically identified and evaluated. This will be the responsibility of the resident on night call who will immediately consult the Chief Resident.
7. The patient's clinic and/or hospital chart with appropriate radiographs, study models, etc. necessary for surgical cases will be present in the operating room at the time of surgery. These same items should be returned to the clinic immediately after surgery by the resident.
8. Details of chart completion will be given by upper level resident to each new intern or first year resident coming on the service.
9. It is the ultimate responsibility of the intern or resident to see that the patient's chart (PE completed, patient NPO, Anesthesia Preop, etc.) is properly completed and the patient prepared for surgery. A Preoperative Note should be written prior to surgery and it should include a review of EKG, chest radiographs, laboratory results, etc. All preop tests/labs should be reviewed by the resident the day before surgery so that action can be taken if needed.
10. Hospital discharge summaries, written or dictated, for the patient's chart will be completed at the time of discharge. The resident discharging the patient will complete the hospital summary including the postoperative period discharge orders, and condition upon discharge. When a faculty member is the surgeon on a case, the assisting resident assumes the responsibility for the charting procedure.
11. All inpatients will be seen and notes written at least twice a day on the ward.
12. All Emergency Room calls will be answered and managed as expediently as possible.
12. All requests for vacation or leave will be submitted on the appropriate *VACATION REQUEST FORM* well in advance of the requested time. No more than one vacation per month will be allowed unless approved by the Dr. Brown. No one is to take off-service vacations except in unusual circumstances.
13. No Chief Residents who are completing the program may leave during the month of June.
14. All interns and residents will contact the Chief Resident prior to leaving the hospital.
15. There will *always* be a functioning camera in the operating room.
16. Before accepting any transfers from other hospitals/offices, contact the chief resident and Attending on call.
17. Residents have in-house call whenever on maxillofacial trauma call. Residents on-call are expected to always be physically in the hospital and available when needed.

18. The Chief resident on the Private Service is responsible for activities related to Attendings' private clinic and patient care. This includes all call and after hours care of these patients. The Chief Resident on the Hospital/Resident Clinic Service is responsible for all activities related to hospital consults, trauma care, and running of the Resident Clinic. Chief Residents can make arrangements amongst themselves on covering for one another's service on the weekends.

Specific Duties for Residents on Hospital

1) Operating room requirements:

- a. A resident will complete a treatment plan in EPIC and alert Peggy Thompson (or other assigned personnel) for insurance carrier verification and financial counseling on any resident case at University Hospital.
- b. All lab work, and if appropriate x-rays, will be presented to staff before the date of service.
- c. All residents participating in the surgery, unless a last minute substitution, will be prepared to discuss the history, diagnoses, treatment options, planned treatment, risks, complications, etc.
- d. A resident will be present from the time the patient enters the OR until extubated, unless trached. It is not the nurse's responsibility to call you. They often do as a courtesy, but not for the first case of the day.
- e. A resident will complete the following tasks after surgery within 24 hours whenever possible: dictate the operative note complete billing entries in EPIC and have Attending approve, add patient sticker to log in clinic, enter case into OMSNIC Resident Surgical Log data base (can be done weekly by close of Friday), complete any research forms.

2) Dental school resident clinic expectations

- a. Clinic operations are from 8-5. All patient care should be complete by 4:30 to allow discharge by 5 PM. We will not tolerate unnecessary delays. Therefore, at least one resident must be in the clinic as of 8 AM prepared to render care promptly once patients are seated.
- b. When behind in clinic and if two or three residents are in the OR and staff is scrubbed, then one resident will be relieved by staff to return to the clinic.
- c. Patient care is priority during working hours. Therefore, other tasks or recreational activities should be done after hours or after patient care is complete. This includes lab work, administrative work, and personal business or computer recreation of any kind. Be aware that computers are university property and "abuse" of them should be avoided.
- d. All sharps and trash must be removed from patient care trays immediately to prevent injuries. When short nursing or assisting staff, assistance with room turn around is appreciated.
- e. Any transfers from another clinic or the ER must follow standard nursing protocol and registration protocol. This includes first seeing the patient directly whenever possible and alerting the clinic front desk of the add on. Transfers should be scheduled as early as possible in the day.

3) Resident clinic sedation clinic expectations

- a. As above, clinic operations are from 8-5. One resident must be available to start at that time.
- b. The goal for the first start time is 8:30am (actually starting surgery).
- c. Add-ons are not acceptable unless emergent.
- d. At least one resident and staff must be in the sedation room while patients are sedated. One of the residents has to be an upper level resident who has had anesthesia training. Three qualified personnel must be present for sedations by OMS standards, and only an RN ancillary staff can be counted in this number.
- e. No medications can be administered without staff being present.

4) Hospital/Resident Clinic call

- a. Residents should see patients directly whenever possible when paged. During business hours, this may mean frequent coordination and teamwork to assure patient care is rendered in both a timely and appropriate venue.
- b. Communicate to the appropriate chiefs/attendings regarding all admissions.

5) Private clinic sedation expectations.

- a. Whenever appropriate numbers of residents are available in the resident clinic, private sedations in the private clinic must have a resident present preferably the private service chief (unless he is doing a private OR case) or a junior level resident who has had anesthesia training.
- b. Communication between the hospital service and private service chiefs is integral to the coverage of all private OR and sedation needs.

Resident Patient Care Logbook

Each resident *must* keep an up-to-date log of all major cases in which they participated. The OMSNIC Resident Surgical Log can be used for this purpose. In addition, there is a logbook in the Resident Clinic that is to be kept up-to-date by the Chief Resident on all major cases performed at University Hospital.

Camera for Clinical Documentation

Residents must document preoperative, intraoperative and postoperative care for major and/or unusual cases or whenever requested by faculty. While purchasing a high-quality camera is not mandatory for the training program, residents are encouraged to purchase one for convenience purposes and to have for future use once residency training is completed.

Faculty Coverage at University Hospital

1) Following appropriate work up by the service, the Chief Resident or Senior Resident on call will contact the on-call faculty member for all hospital admissions to discuss management of the patient. This will include all patients, whether on or off service, and whether or not surgical intervention is necessary.

2) Faculty on-call are responsible for all admissions, clinic patients, the operating room and rounds on designated days. Faculty call begins at 7:00 PM the preceding evening, except for Mondays and continues until 7:00 PM the day of call.

Wednesday Grand Rounds Conferences

Wednesday conferences will be held from 7-8:30 am. The format will consist of approximately one hour of lecture or presentation followed by a surgical-radiograph review conference.

The Chief Resident (or his designate) on each service is required to bring and present at least one case from his respective institution. The cases should have complete records including photos, radiographs, laboratory reports, etc., and presented in a power point presentation which will permit the entire house staff to benefit and join in the discussion.

The cases may be presented in a "show and tell" fashion, but the senior residents are encouraged to enlist the help of an intern or a resident to review radiographs or discuss treatment. This is intended to be a learning experience in every sense of the word with contributions coming from both the house and attending staff.

All house staff on oral and maxillofacial surgery rotation are required to attend Wednesday conferences. House staff on off-service rotations have a primary obligation to their current service but they are encouraged to attend the conferences when possible. The weekly Wednesday conference is the only forum for discussion and presentation of unusual or different cases to be shared by all. Everyone has a responsibility and an obligation to insure the success of this conference.

Returning to the Private Service to Complete Orthognathic Surgery Cases

1. If a resident has not completely worked up an orthognathic surgery case to the point where it has been presented to staff and the final treatment plan established prior to completing the private service rotation, the case should be transferred to another resident who will accept full responsibility for the case. The original resident will not return to the private service to assist with the surgery.

2. If, prior to leaving the private service, a resident completely works up an orthognathic surgery patient and a final treatment plan is established, the resident should transfer that case to the Chief Resident coming on the private service. The Chief Resident will assume responsibility for following the case and coordinating the surgery. The original resident will be welcome to return to do part of the surgery, however he will not be considered to be the primary surgeon.

3. Residents will not work up and operate orthognathic surgery cases while on an off-service rotation. However, if the case was worked up while on the OMS privae service rotation, he may return from an off-service rotation, at the discretion of the chief of that service, to do part of the surgery.

University of Mississippi Medical Center Infection Control Policy and Procedures

See attached document.

Agreement for Triage of Maxillofacial Trauma Among Oral and Maxillofacial Surgery, Otolaryngology, Plastic Surgery Services

All facial trauma including mandibular fractures, midface fractures, zygomas, Le Forts, frontal sinus fractures, orbital blowouts, soft tissue lacerations (excepts those involving the eyelid margin which are managed by Ophthalmology), will be managed by the service on maxillofacial call. All three services rotate call evenly on a weekly basis (i.e. each service takes trauma call every third week)

The ED triage of facial trauma and the multisystem trauma patient is as follows:

	ED	Trauma	MF Team*	Eye
Isolated				
Outside	ED/Trauma takes referral calls and accepts if indicated.*	ED/Trauma takes referral calls and accepts if indicated.*	N/A	N/A
In UMHC ED				
Soft tissue	Manages all possible facial lacerations and provides followup. Consults Trauma team for repair and followup as needed.	Manages any laceration that the ED is not able to manage. Consults MF team for any that it cannot repair	MF team manages.	Manages any laceration involving the eyelids.
Bone	Evaluates patient. Consults Trauma to rule out other injuries on all patients that have sustained potential trauma to any other body part. Otherwise, consults MF team.	Screens patient for any other traumatic injuries. Consults the MF team for any remaining bony injuries.	MF team arranges for disposition of patient.	N /A
Multisystem	Patients accepted per UMC protocol.	Admits patient. Consults MF team if necessary.	Consults originating between 10 PM and 7 AM will be seen the next morning unless there are extenuating circumstances.	Manages any laceration involving the eyelids.

Resident Evaluations

Residents on the oral and maxillofacial surgery service will receive personal evaluations by the teaching faculty at least twice each year. This usually occurs in June and December. After the evaluations, a written summary will be given to them to read and sign. They are allowed to write

their disagreement on the summary should they desire. The evaluation summaries will be permanently available in their personnel file. Please see attached Evaluations forms.

Residents rotating on off-service rotations will be evaluated by the attending(s) on that service that have interacted with him/her.

Any resident is free to examine their evaluation forms and summaries.

Oral & Maxillofacial Surgery Training Program's Policy on "Moonlighting"

- 1) The Department of OMS strongly discourages moonlighting.
- 2) Moonlighting is FORBIDDEN while on rotations when residents are being remunerated.
- 3) University of Mississippi Medical Center malpractice does NOT cover moonlighting.
- 4) Violations of this policy will result in immediate disciplinary action.

NOTE: Your primary purpose while here is for education. Anything that jeopardizes your education will not be tolerated.

The State of Mississippi requires anyone who indicates that they are a specialist, whether in writing or by implication, be fully trained in that specialty. This means that a resident cannot imply to anyone that they are an oral and maxillofacial surgeon.

The State of Mississippi requires an anesthesia permit for the administration of any drug beyond local anesthesia

Training in Delivery of Outpatient Anesthesia

Once you have had at least 4 months of training on the anesthesiology rotation, you will be allowed to begin providing outpatient anesthesia to OMS patients in the resident and private clinics to which you will rotate. This will always be done under the direction of an OMS faculty member. The nurses will NOT provide any anesthetic agents to residents when faculty is not available.

Your training in outpatient anesthesia will encompass adults and children, and will be comprised of only ASA I or II patients, unless the faculty member has agreed to taking on a more "unhealthy" patient. You are encouraged to discuss anesthetic management techniques with your faculty and try a broad range of anesthetic agents in keeping with the "comfort level" of your faculty.

Didactic Education in Outpatient Anesthesia and Pain Control

Lectures on anesthesia and pain control will be provided during seminars throughout your training on a recurring basis. Additionally, Journal Clubs will target anesthesia on a recurring basis.

Your anesthesiology rotation will be five months long. During the initial month, you will be exposed to lectures by anesthesia faculty pertaining to basic physiology, and anesthetic techniques. You will also be orientated to the OR and patient management. Besides the periodic grand rounds lectures related to anesthesia, this will be your primary didactic experience.

Resident Research & Publication

You are not required to participate in research, but reimbursement for travel to the national meetings is based upon the resident having a “ready-for-publication” paper that they have done. This provides incentives to residents to participate in research activities. All residents have to put together at least one lecture per year that is presented to the entire OMS group during the Wednesday grand rounds seminar.

OMSITE

You will take the OMSITE exam in your 1st, 3rd, and 4th year. Poor scoring on OMSITE and lack of improvement in your knowledge base is grounds for placement on probation. Refer to Resident Benchmarks.

OMS Resident Eligibility and Selection Policy:

Mandatory requirements for eligibility for the OMS four year certificate program include:

1. The applicant must be a graduate of an accredited U.S. or Canadian Dental School.
2. The applicant must be a U.S. citizen or legal alien.

Screening of applicants is at the discretion of the Program Director. Those who are deemed qualified will be contacted by the program and offered a formal interview. The selection committee is composed of OMS faculty and upper level OMS residents. Each member has an equal vote into the ranking of candidates. Our program participates in the National Dental MATCH Program and adheres to all rules and regulations of this program.

Each applicant is graded by the same criteria independent of his/her sex, race, creed, color, or national origin. Some of the criteria used to assess candidates are class standing, national board scores, grade point averages, personality (interview), research experience, academic interest, extra clinical experience (i.e. externship, military dental service, anesthesiology, etc.), and letters of recommendation. In addition, applicants for the dual-degree program must meet criteria set forth by the School of Medicine Deans Council (copy this link into your internet browser <http://som.umc.edu/admissions.html#OMS-MD>)

This policy is in agreement with the Graduate Medical Education Policy on Recruitment and Appointment of Residents and the School of Medicine Deans Council

**University of Mississippi Medical Center [UMMC]
Oral and Maxillofacial Surgery Advanced Educational Program**

Proposed Description

The Oral and Maxillofacial Surgery [OMS] Advanced Educational Program [AEP] is a six year combined OMS residency/MD degree program designed to fulfill the educational requirements of the Council on Dental Education [CDE] of the American Dental Association [ADA], the American Board of Oral and Maxillofacial Surgery [ABOMS] and the American Medical Association [AMA].

OMS AEP Outline

Program Year	Category	Training Description	Dates
1*	PGY1	OMS Resident	7/1 – 5/31
2	M3	3 rd Year Medical Student	6/1 - 5/31
3**	M4	4 th Year Medical Student (9 months)	6/1 -2/28
		OMS Elective (4 months)	3/1 – 6/30
4***	PGY2	General Surgery Intern (8 months)	7/1 – 2/30
		Anesthesia (4 months)	3/1 – 6/30
5	PGY3	OMS Junior Resident	7/1 - 6/30
6	PGY4	OMS Chief Resident	7/1 - 6/30

*Year 1: PGY 1, OMS Intern

Non-Mississippi residents may participate in year 1 of the OMS AEP; however, acceptance to School of Medicine [SOM] for transfer to advanced standing as third year medical [M3] student in year 2 requires:

1. Successful completion of your PGY1 year of residency.
2. Establishment of Mississippi residency [<http://som.umc.edu/admissions.html#ResidencyClass>]
3. Completion of a UMMC SOM Application for Transfer to Advanced Standing
4. Passage of United States Medical Licensure Examination [USMLE] Step 1.

OMS Intern may audit or enroll as a graduate in selected second year medical school courses and take any Step 1 preparation course offered to M2 students.

**Year 3

Upon successful completion of the medical school curriculum and all other related requirements for the degree, such as passage of USMLE Steps 2CK and 2CS, the MD degree will be awarded.

***Year 4: PGY2, General Surgery Intern/Anesthesia

Must fulfill dual purpose of 1] a year of oral and maxillofacial surgery training required for ADA-approved OMS AEP and 2] AMA-approved year of post-medical school surgical internship training for medical licensure.

Admissions Criteria

- Must be a U.S. citizen or permanent resident
- Must either be a legal resident of Mississippi or establish Mississippi residency as condition for promotion to year 2 and transfer to advanced standing as M3
- Must have earned D.M.D. or D.D.S. degree from a dental school accredited by Council on Dental Education of the American Dental Association.
- Must be ranked academically at or above 75th percentile [top 25%] of dental school graduating class. If class rank is not reported, the applicant must be in top unit reported [for example, quartile or quintile].
- Must have scored in 88th percentile or above on Part I of the National Dental Board Examination or 80th percentile or above on the National Board of Medical Examiners Comprehensive Basic Science Examination. Additional experience beyond dental school [such as general practice residency, anesthesia residency, private practice, graduate school], especially in Mississippi, will make an applicant more competitive

Selection Process

1. Candidates must submit an application and required supporting documentation to the Postdoctoral Application Support Service [PASS] Dental Match program.
2. OMS Residency Program Director [or an appropriate SOD OMS departmental selection committee] will screen applications using admission criteria described above and select qualified applicants to be interviewed.
3. Applicants must be interviewed in December by
 - a. SOD OMS Residency Program Interview Panel and
 - b. Members of the SOM Admissions Committee
4. Based on a discussion of the application and interviews
 - a. The SOM Admissions Committee will indicate those applicants found to be acceptable for entrance to the MD program.
 - b. The SOD OMS Residency Program Director/Selection Committee will select and rank applicants for match to the OMS residency program
5. An offer of acceptance to the OMS AEP will be extended only to those applicants who are accepted by both the SOD OMS Residency Program Director/Selection Committee and SOM Admissions Committee. Acceptance is conditional pending the outcome of a criminal background check [see <http://som.umc.edu/admissions.html#CBCs>].
6. During Year 1, the PGY1/OMS Intern must submit a UMMC SOM Application for Transfer to Advanced Standing to the Associate Dean for Medical School Admissions not later than March 31 to enable registration for USMLE Step 1.
7. Dismissal for cause or withdrawal from either the OMS residency program or MD program simultaneously results in the same action in the other program. This will be stated in the acceptance letter that will be signed by both the OMS Residency Program Director and Associate Dean for Medical School Admissions.

*Approved by the School of Medicine Deans Council November 16, 2009
Amended by the School of Medicine Deans Council February 22, 2012*

**University of Mississippi Medical Center
GMEC Policy on Leave**

Leave will be accrued in accordance with UMC policy, and as permitted by the VA. Leave must be reported and may be granted in accordance with the requirements of the individual residency programs, and in addition, in accordance with the requirements of the VA for those residents assigned to the VA. A resident must not take leave without first obtaining approval from the program director.

Approved GMEC 5/22/2003

Medical Leave for Houseofficers
Graduate Medical Education
University of Mississippi Medical Center

Houseofficers enrolled in graduate medical education programs at the University of Mississippi Medical Center are unique in their dual roles as both student and employee. Each UMMC houseofficer is enrolled in an American Board of Medical Specialties and Accreditation Council of Graduate Medical Education (ACGME/ABMS) defined, time-limited, training program. Advancement in the program and annual contract renewal are performance dependent. Benefits including medical insurance and medical leave are prescribed by the national accrediting agencies. To maintain compliance with accreditation regulations, insure consistency and fairness across individual programs and the institution, and meet state and federal regulatory requirements, the following guidelines are provided for administering Medical Leave:

- Houseofficers will accumulate leave at the same rates as any state employee.
- Houseofficers will accumulate 12 days medical leave annually in the first three years of training.
- Houseofficers will accumulate 18 days personal leave annually in the first three years of training.
- The first day of any leave taken for medical reasons will be subtracted from personal leave time
- Extended medical leave requires documentation from a treating physician
- Paid leave for medical purposes, in any year of GME training, may not exceed the anticipated 30 days (6 weeks) to be accumulated in the current active 12 month employee contract PLUS any time accumulated and not yet used from previous years of UMC employment MINUS any personal or medical leave time already used in the current year of training.
- Medical leave beyond 6 weeks in duration in the first year of training at UMMC will be taken as unpaid leave
- Up to 12 weeks leave may be taken in accordance with FMLA guidelines; leave time beyond the anticipated annual 30 days and previously accumulated medical and personal leave time will be unpaid.
- Any house officer failing to complete their twelve month contracted training and employment time, will repay to UMMC any unearned medical or personal leave they have received.

UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

RESIDENT PROFESSIONAL LIABILITY PROGRAM

The Mississippi Supreme Court has ruled that physicians and dentists, who are residents, interns or fellows (hereinafter "House Officers") at the University of Mississippi Medical Center, are employees of the State of Mississippi and are entitled to the protection and immunity from liability under the terms of the Mississippi Tort Claims Act. Pursuant to the Act, the University will provide a defense and indemnity to all House Officers against claims for actions or omissions occurring within the course and scope of their employment while at UMMC and/or on official rotation at other Mississippi hospitals or clinics. The same protection is afforded to former house officers for such claims made after their employment, if the claims relate to conduct during the term of their internship, residency, or fellowship.

*University of Mississippi Medical Center
Office of Risk Management
2500 North State Street
Jackson, Mississippi 39216-4505
Telephone: (601) 984-1980*

GRADUATE MEDICAL EDUCATION

Salaries and Benefits

2014-2015 Salaries	
Postgraduate Year 1	\$46,738
Postgraduate Year 2	\$48,347
Postgraduate Year 3	\$49,670
Postgraduate Year 4	\$51,791
Postgraduate Year 5	\$53,814
Postgraduate Year 6	\$55,187
Postgraduate Year 7	\$57,009
Postgraduate Year 8	\$58,331

- **Health insurance**

Insurance is provided to the resident at no cost; family coverage is available at additional cost.

- **Professional liability**

Residents are provided professional liability coverage at no charge for activities for or on behalf of the hospital within the scope of the residency training programs.

- **Parking**

Covered parking is provided at no charge.

- For other benefits, see UMMC Human Resources.

OMS Policy on Evaluation and Promotion and Dismissal of Residents

Residents will be evaluated bi-annually by all faculty. A 360 Global Evaluation is utilized for outcome measures in patient care, medical knowledge, interpersonal communications and skills, professionalism, systems based practice and practice-based learning and improvement.

Residents who receive a satisfactory evaluation will be promoted. Unsatisfactory resident performance may result in probation or dismissal from the program. As outlined in the Academic Performance Policy. In addition, gross negligence or professional misconduct is grounds for dismissal.

Residents may contest the decision for probation or termination from the training program through the formal process outlined in the Graduate Medical Education Due Process Policies and Procedures for Adjudication of Academic and Disciplinary Complaints. You can use your internet browser to copy link for full policy. (<http://gme.umc.edu/administration/policies.html>)

OMS Academic Performance Policy

Residents will be classified as one of the following:

1. Good Academic Standing
2. Academic Assistance
3. Academic Probation
4. Academic Remediation

Medical knowledge is one of the six competencies assessed on a regular basis as part of resident education. The OMSITE exam is a key part of this assessment. Residents must take this exam every year that they are on service. In addition residents must participate in scheduled lectures and take assigned quizzes. The only excused absences are for sick leave, vacation, critical OR coverage, educational conferences and off-service rotations.

Good Academic Standing:

A resident will be considered in good standing if he/she:

1. Scores at or above 25th percentile on all but 2 sections for equivalent year on the OMSITE
2. Has a 75 or above quiz average on all departmental related lectures
3. Has a satisfactory or superior rating on the Medical Knowledge competency domain of the semi-annual resident review by the majority of faculty
4. Scores 2.5 or higher on clinical competency exams

Academic Assistance:

A resident will be placed on academic assistance for any one of the following:

1. Scores below the 25th percentile for the equivalent year on more than 2 sections of the OMSITE
2. Has below a 75 quiz average on all departmental related lectures for a six month period
3. Receives an unsatisfactory rating on the Medical Knowledge competency domain of the semi-annual resident review by two or more of the faculty for a six month period
4. Scores below 2.5 on a clinical competency exam

A resident on academic assistance will be required to:

1. Meet with the Program Director to review examination results and discuss issues contributing to a sub-optimal academic performance including knowledge base deficits, time utilization, test-taking skills, and extenuating circumstances.
2. Meet with Dr. Natalie Gaughf, Director, Office of Academic Support. Ongoing counseling to enhance proficiency is left to the discretion of Dr. Gaughf and the resident.
3. Develop a written personal study program with input from the Program Director and Dr. Gaughf.

Academic Probation:

A resident on academic assistance will be placed on probation if he/she has failed to improve academic performance as evidenced by any one of the following:

1. Has not adequately performed the requirements listed above for academic assistance.
2. Has below a 75 quiz average on all departmental related lectures for a 12 month period
3. Receives an unsatisfactory rating on the Medical Knowledge competency domain of the semi-annual resident review by two or more of the faculty for a 12 month period
4. Scores below 2.5 on consecutive clinical competency exams

A resident on probation will be required to:

1. Meet with the Program Director to review examination results and discuss issues contributing to a sub-optimal academic performance including knowledge base deficits, time utilization, test-taking skills, and extenuating circumstances.
2. Meet with Dr Natalie Gaughf, Director, Office of Academic Support. Ongoing counseling to enhance proficiency is left to the discretion of Dr. Gaughf and the resident.
3. Develop a written personal study program with input from the Program Director and Dr. Gaughf.

Academic Remediation:

A resident may be placed on academic remediation and be required to repeat a year of residency training on OMS and/or other services if he/she:

1. Score below the 25th percentile for the equivalent year on more than 2 sections of the OMSITE for a second time
2. Has below a 75 quiz average on all departmental related lectures for a 12 month period
3. Receives an unsatisfactory rating on the Medical Knowledge competency domain of the semi-annual resident review by two or more of the faculty for a 12 month period
4. Scores below 2.5 on consecutive competency exams

The resident remediating will be required to meet with the Program Director, Director of the Office of Academic Support and the Associate Dean for GME for counseling and determination if continuing in training is appropriate. A first year resident who has performed poorly may be required to remediate (without a probationary period) if he/she is deemed unprepared to rotate off service on medical/surgical services in the second year of the four year track.

Dismissal:

At anytime during remediation that a resident is failing to progress appropriately, he/she may be dismissed from the program. This will be at the discretion of the Program Director and Associate Dean for GME. It will be done as per HR procedure and policy.

For residents in the dual degree track, dismissal from one program automatically dismisses you from the other program.

Reevaluation:

Residents that are not in good academic standing will be re-evaluated to be taken off probation at the end of each semester.

University of Mississippi Medical Center
Policy on Evaluation and Promotion and Dismissal of Residents

All residency programs are required to provide regular evaluations to the residents. Programs will provide formal written evaluations from the program director, program residency committee, department chair, or designee at least two times per year or more often if required by the accrediting body for that program. Residents whose performance is below an acceptable standard must be notified of deficiencies in their performance.

Each program must establish criteria for promotion for each level of training and completion of the program. Unsatisfactory trainee performance may result in the dismissal from the program of the House Officer. This decision will be made by the Program Director in consultation with Chairman of the Department. If a House Officer wishes to contest the Program Director's decision for termination from the training program, appeal for review can be addressed to a constituted Departmental Grievance Committee composed of selected peers and faculty.

Reappointment for additional years of training shall be based upon evaluation of the resident physician's performance and availability of positions. If the resident physician does not commence the training program upon the first day of the regular academic year of UMMC, viz., July 1, and the resident physician does not exhibit sufficient competency to advance to the following year of residency, then UMMC may terminate this contract at the end of the academic year of the training program even if this contract states a later termination date. UMMC shall give the resident physician at least four (4) months written notice of an intent not to reappoint the resident physician to the next year of training, unless the event or events giving rise to such non-reappointment occur during the last four months of the academic year, in which case UMMC shall give the resident physician as much notice of non-reappointment as is reasonably allowable.

GMEC 12/16/04

Guidelines for Academic Remediation

**Office of Graduate Medical Education
University of Mississippi Medical Center**

Background: Trainees are expected to sustain reasonable progression of learning and performance throughout their training program. Occasionally, there may be a need for additional efforts to assist residents or fellows in satisfactorily meeting all competency requirements for graduation and/or to be prepared to pass their applicable board examination.

Process: Several triggers may be utilized to capture those trainees who may need remediation, including but not limited to: 1) results of the specialty-specific In-Training Exam (ITE), 2) a specific level not attained in any of the ACGME six competencies on any or multiple rotation evaluations, 3) failure to meet level-appropriate milestone targets, 4) sentinel or egregious event(s), or 5) other aspects of performance or behavior.

It is recommended that all trainees in programs that have ITEs should take the exam on an annual basis. Suggested scores that may cause a resident to enter remediation may include:

- Upper-level trainees answering less than 30-40% of questions correctly (determined by PGY year)
- First-year trainees scoring at or below the 20th percentile

Each program should set their own thresholds based on timing of the exam, national benchmarks and predictive values within their specialty area.

If more than 50% of the trainees in a program are below flagged thresholds, curriculum changes for the program are likely warranted as opposed to individual resident remediation processes.

Suggested activities for remediating trainees include:

- The Program Director must specifically identify areas for remediation: knowledge base deficits, specific competency areas, time management, test-taking skills, or other extenuating personal circumstances.
- The trainee should meet with the program director (PD) or an associate program director (APD) to discuss issues contributing to a sub-optimal performance and participate in formulating a remediation plan. This meeting should be documented in writing.
- The PD, an APD, mentor, or dedicated faculty member should supervise the resident's participation in and completion of tasks in the remediation plan.
- The trainee may benefit from meeting with an academic resources counselor for an academic assessment. (Available through UMC learning resources; contact GME Office for referral.) Ongoing counseling to enhance proficiency may be left to the discretion of the counselor or the supervising PD/APD.
- Increased attendance requirements for conferences may improve knowledge deficits.
- The trainee may develop a written personal study program. Once a plan is in place, the trainee should provide periodic reports to the supervising PD/APD, which outlines material covered. This plan may include things such as review of textbooks, work in on-

line modules, reviews of cases, completion of board preparation courses, or completion of sample board question sets, as examples.

- Trainees should meet with their supervising PD/APD periodically and often enough to show progress in their participation in the plan.
- Extra required simulation training or expanded rotation exposure for certain skills may help improve any identified procedural problems in some trainees.
- In some cases, adjustment of a trainee's rotation schedule may be needed or helpful.
- Evaluation through student-employee health may be beneficial, especially for residents who appear disengaged or dysphoric.
- Complete or submit other additionally-required activities at the discretion of the PD.

Remediation is NOT punitive. All activities assigned as part of a remediation plan should have clear and apparent educational value and assist the trainee in meeting specified goals.

Conclusion: Usually remediation is undertaken before probation is considered. However, in some circumstances, the deficiencies may be so significant as to warrant more definitive action, including probation, when first recognized. Particularly when misconduct is involved, a single event may be the trigger for action, without prior warning or a history of any previous negative feedback. Any behaviors which could significantly compromise patient care and safety or create a hostile work environment may be grounds for immediate action, up to and including dismissal. Academic Probation is always at the discretion of the PD.

Trainees who fail to meet any of the stipulated requirements for their individual remediation plan may be required to extend training time to achieve certifying examination eligibility or may not be approved to sit for their boards after residency completion. Trainees may be considered to have completed the remediation protocol at the discretion of the supervising PD/APD, when all steps in their individual plan have been completed, including activities such as any assigned scholarly projects, specific numbers or types of patient encounters or procedures, or when a satisfactory score has been achieved on the next ITE.

Trainees undergoing academic remediation should not be allowed to engage in moonlighting activities.

Academic remediation is NOT considered a reportable event for future credentialing purposes, unlike formal academic probation, which usually will be.

Academic Remediation Protocol Checklist

Resident Name: _____

Assigned PD/APD supervisor: _____

Specific competency areas to be remediated: _____

Completion Date

Initial meeting with PD/APD to review plan	
Meet with academic counselor, if needed.	
Evaluation by student-employee health, if needed.	
Meeting with Associate/Assistant Dean for GME, if needed	
Rotation / Schedule adjustments, if needed	
Submitted written personal study or corrective action plan	
Simulation assignments	
Conference Attendance goal	
Meet with PD/APD periodically (review study / action plan) Date: _____ Achievement: _____ Date: _____ Achievement: _____ Date: _____ Achievement: _____ Date: _____ Achievement: _____	

Resident Signature

PD/APD Signature

PROFESSIONAL ISSUES

DUTY HOURS POLICY

The University of Mississippi Medical Center and its affiliated hospitals are committed to providing excellent patient care and outstanding education for physicians in training. Compliance with all Accreditation Council for Graduate Medical Education policies is expected. Effective July 1, 2011, the work hours of resident physicians enrolled in programs not granted a work-hours extension are as follows:

I. Duty Hours

- Duty hours are defined as all scheduled clinical and academic activities related to the residency program, *i.e.*, patient care (both inpatient and out-patient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.
- Scheduled duty hours are limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.
- Residents are to be provided with one day in seven free from responsibilities to the program, averaged over a four week period, inclusive of call and free from all clinical, educational, and administrative activities. One day is defined as one calendar day.
- Residents should have 10 hours free of duty, and must have 8 hours off between Scheduled Duty Periods.

II. On-Call Activities

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. Inhouse call is defined as those duty hours beyond the normal work day when residents are required to be immediately available in the assigned institution.

- Interns (PGY-1's) are limited to a maximum of 16 hours of continuous duty in hospital.
- PGY-2 residents and above must be scheduled for In-house call no more frequently than every third night (when averaged over a four-week period).
- Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. PGY-2's must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty. In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for severely ill or unstable patients and must be documented as defined in section VI.G.4.b of Specialty and Subspecialty Program Requirements.
- All trainees are limited to no more than 28 hours continuous duty in the hospital (24 hours in house call, plus 4 hours to complete post call patient care responsibilities).
- No new patients, as defined in Specialty and Subspecialty Program Requirements, may be accepted after 24 hours of continuous duty.
- At-home call (pager call) is defined as call taken from outside the assigned institution.
- Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven completely free from all educational and clinical responsibilities of duty, when averaged over four weeks. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

- At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
- Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”.
- The Program Director and the faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

Oversight

- Each residency program must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours and the working environment. These policies must be distributed to the residents and the faculty. Monitoring of scheduled duty hours is required with frequency sufficient to ensure an appropriate balance between education and service.
- Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.
- To monitor compliance with applicable institutional and specialty/ subspecialty duty hours policies and requirements, The GMEC will assess each UMMC residency program at least annually. The extent and frequency of monitoring for each program will be determined by the GMEC based upon the program's duty hour history, data collected by the GMEC from the program and its residents, and other data sources identified by the GMEC. Duty hours assessment will also be a standard component of each GMEC-RRSC internal program review and report.

Work Hours Extension

The work hours of resident physicians enrolled in programs which have been granted an extension are limited to the amount in that extension up to a maximum of 88 hours per week. Except for an extension of total work hours all other aspects discussed in section 1 a-d of this policy apply to those programs receiving the extension.

The UMMC considers the participation in program or institutional work hours monitoring processes to be a part of the resident physician's professional responsibilities.

Department of Oral and Maxillofacial Surgery
Duty Hour Log for PGY-1 Residents
 2014-15

Resident Name: _____

Service (Brown, Caloss, Chandran, Qaisi): _____

Service Hand Off:

1. Did Head and Neck service check out to you appropriately?
 (yes,no,comments)_____
2. Did Resident/Intern on call check out to you appropriately?
 (yes,no,comments)_____

Notes:

1. If not in full hours, record in quarter units, e.g. 8.25, 7.5, 9.75.
2. Include all clinical and educational activities related to the residency occurring on one of our sites.
3. Do not include any reading or preparation time off-site.
4. Do not include travel time between home and work. You may include travel time between work sites, if applicable.
5. Do not include any time on or off site in non-educational or non-clinical duties even if they occur during the day, e.g. going to the bank, working out.

Day and Date	Regular Hours	In-House On Call Hours	Total Hours	Was the longest shift you worked 16 hours or less?		Did you have at least 10 hours off between duty periods?	
				Yes	No	Yes	No
TOTAL							

Department of Oral and Maxillofacial Surgery
Duty Hour Log for PGY2-PGY4 Residents
 2014-15

Resident Name: _____

Service (Brown, Caloss, Chandran, Qaisi): _____

Service Hand Off:

3. Did Head and Neck service check out to you appropriately?
 (yes,no,comments)_____
4. Did Resident/Intern on call check out to you appropriately?
 (yes,no,comments)_____

Notes:

6. If not in full hours, record in quarter units, e.g. 8.25, 7.5, 9.75.
7. Include all clinical and educational activities related to the residency occurring on one of our sites.
8. Do not include any reading or preparation time off-site.
9. Do not include travel time between home and work. You may include travel time between work sites, if applicable.
10. Do not include any time on or off site in non-educational or non-clinical duties even if they occur during the day, e.g. going to the bank, working out.

Day and Date	Regular Hours	In-House On Call Hours	Total Hours	Did you have at least 8 hours off between duty periods?	
				Yes	No
TOTAL					

Evaluation Policy and Grievance Algorithm

All trainees at the University of Mississippi Medical Center will receive both formative and summative evaluation on a periodic basis. Attending physicians are expected to provide feedback and constructive criticism on all aspects of the trainee's performance, including but not limited to, clinical judgment, medical knowledge base, data gathering skills (history taking, physical exam, old record review, lab follow-up), procedural skills, humanistic attributes, professionalism, over-all patient care skills as well as all behaviors defined within the six ACGME descriptive areas of competency. *Trainees should expect direct constructive criticism and suggestions for improvement.* The Training Program Director or his/her designee will meet individually at least semiannually to review each house officer's overall performance and progress in the training program.

The details of the process of resident evaluation and grievance will vary appropriate to the requirements of the RRC or other accrediting agency for the resident's specialty or subspecialty. The process will typically include the elements described below.

ATTENDING PHYSICIAN:

If the trainee is performing at a low satisfactory or unsatisfactory level, the substandard performance should be brought to the trainee's attention as soon as possible. Performance problems should be documented with clear suggestions regarding appropriate conduct for such situations in the future. In addition to discussing the problem directly with the trainee, the attending physician should notify the program director (preferably in writing) of the nature of the problem as soon as possible. In some cases, changes in routine supervision on patient care services may be warranted. If a trainee is unhappy with an evaluation or feels it is unfair, he/she is encouraged to discuss the evaluation in detail with the attending physician. It is advisable that the resident initial and date all documentation to signify his/her awareness of the opinions and actions recorded.

PROGRAM DIRECTOR:

If after additional discussion, the trainee feels the evaluation is unjustified, he is asked to put his complaint in writing and discuss the evaluation in detail with the program director, who will serve as a mediator. In most cases, after seeking input from all involved parties and reviewing the situation in detail with both the attending physician and the trainee, the program director will dictate a report to be included in the trainee's file along with the original evaluation and the trainee's rebuttal and explanation. In some cases, the attending physician may wish to file an amended evaluation. In all cases, the trainee is asked to define specific ways in which the behavior can be changed or improved. In the setting of continued marginal or unsatisfactory performance, a house officer may have clinical privileges revoked by the program director, and be asked to function in a remedial role in which all aspects of patient care must be immediately supervised by another physician including countersignature of all patient orders and notes. In

general, a remedial program will be established which includes reading assignments and didactic conference attendance, (and in some cases language classes) in an effort to improve performance. A specific probationary period will be defined.

DEPARTMENT CHAIRMAN: _____

Unsatisfactory trainee performance may result in the dismissal from the program of the House Officer. This decision will be made by the Program Director in consultation with the Chairman of the Department. If a House Officer wishes to contest the Program Director's decision for termination from the training program, appeal for review can be addressed to a constituted Departmental Grievance Committee composed of selected peers and faculty.

APPEAL FROM DEPARTMENTAL CHAIR:

House Officers may appeal grievable matters by petitioning in writing to the Vice Chancellor for Health Affairs. Upon receipt of a formal written request from a resident for review of a Department Chair's / *Program Director's* action, the Vice-Chancellor will select a faculty member of the Graduate Medical Education Committee to chair an appeals committee. The appeals committee chair will appoint an appeals committee of four (4) additional GMEC *or* RRSC members, including at least 1 (one) member of the House Staff. The appeals committee chair will promptly convene the committee to hear the appeal, generally within ten (10) business days of the Vice-Chancellor's appointment of the appeals committee chair. The decision of the appeals committee will be submitted to the Vice Chancellor. The decision of the Vice Chancellor shall be final in accordance with the by-laws and policies of the Board of Trustees of State Institutions of Higher Learning.

Per the University of Mississippi Medical Center*, the following issues are considered "grievable":

- Complaints against faculty;
- Disciplinary actions, including dismissals, demotions and suspensions;
- Application of personnel policies, procedures, rules and regulations, ordinances and statutes;
- Acts of reprisal against employees using the grievance procedure;
- Complaints of discrimination on the basis of race, color, creed, political affiliation, religion; age, disability, national origin, sex, marital status, veteran status; or
- Any matter of concern or dissatisfaction to an employee if the matter is subject to the control of institutional management.

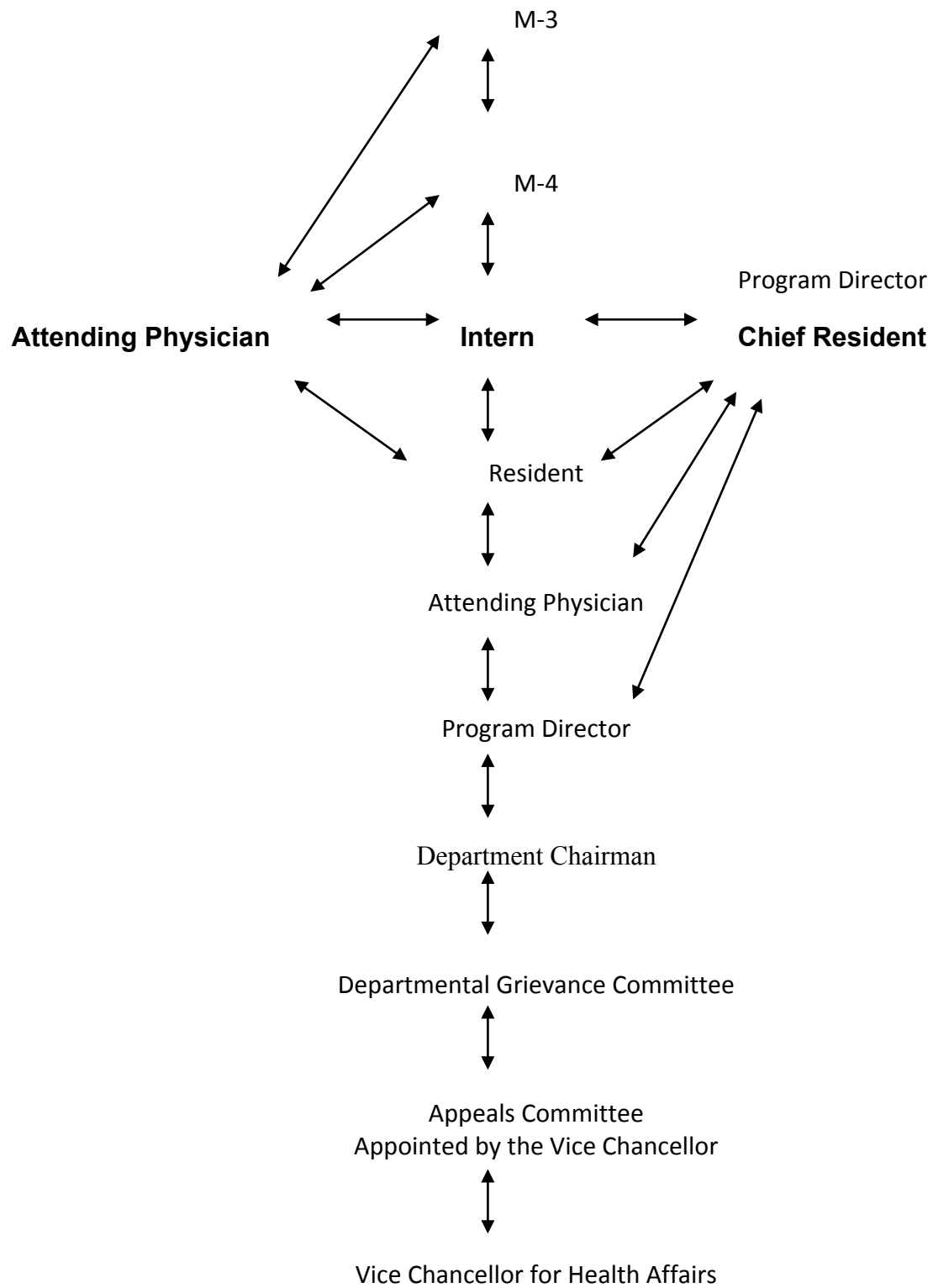
Likewise, the following issues are considered "nongrievable":

- Scheduling and staffing requirements;
- Issues which are pending or have been concluded by direct appeal through an administrative or judicial procedure;
- Temporary work assignments which do not exceed 90 calendar days;
- Budget and organizational structure, including the number of assignment of employees or positions in any organizational unit;
- The measurement and assessment of work through performance appraisal, except where the employee can show that the evaluation was discriminatory, capricious, or not job related;

- The selection of an individual by a department head or designee to fill a position through promotion, transfer, demotion, or appointment unless it is a violation of UMC or Board of Trustees policy;
- Internal security practices established by the institution, department head or designee;
- Termination or layoff from duties because of lack of work, reduction of the work force, or job elimination;
- Voluntary resignation by an employee bars action under the grievance procedures;
- Any matter not within jurisdiction or control of the institution;
- Content of published UMC policies or procedures;
- An action by the institution pursuant to federal or state law or directions from the Board of Trustees of State Institutions of Higher Learning; or
- Establishment and revision of wages and salaries, position classification and general benefits.

*(Employee Handbook, The University of Mississippi Medical Center)

TRAINEE GRIEVANCE ALGORITHM



Resident Competency Exam Schedule and Benchmarks									
Competencies									
Year	Semester	H and P	Third Molar	Implant	Trauma	Anesthesia	Pathology	TMJ / Pain	Orthognathic
PGY 1	Summer/Fall	X	X						
	Spring/Winter								
PGY 2	Summer/Fall								
	Spring/Winter								
PGY 3	Summer/Fall			X	X				
	Spring/Winter					X	X	X	X
PGY 4	Summer/Fall						X	X	X
	Spring/Winter								
Benchmarks									
PGY 1			PGY 2/Med School			PGY 3			PGY 4
Attain proficiency in performing and documenting an H and P			Attain an adequate medical knowledge base off service			Broaden critical thinking skills			Attain proficiency in making independent decisions
Learn how to function efficiently as a house officer			Attain an adequate surgical knowledge base off service			Broaden independent patient management skills			Attain competency in performing core OMS procedures independently in head and neck pathology, TMD, and dentofacial deformities
Attain proficiency in basic dentoalveolar skills			Learn how to interact effectively with other medical professionals			Attain competency in advanced dentoalveolar skills			Learn how to manage services efficiently and effectively
Gain basic understanding of the full scope of OMS procedures			Attain proficiency in delivering general anesthesia and sedation			Attain competency in management of basic facial trauma			Learn important leadership skills for a successful OMS practice
Broaden knowledge base in order to attain 70 on CBSE (6yr program)			Attain proficiency in managing medically compromised patients			Attain competency in ambulatory anesthesia/sedation skills			Broaden OMS knowledge base in preparation for ABOMS exams
Pass USMLE Step 1 (6 yr program)						Effectively teach students and lower level residents			Score at or above 25th percentile on all but 2 sections for equivalent year on OMSITE
Score at or above 25th percentile on all but 2 sections for equivalent year on OMSITE						Broaden OMS knowledge based needed to operate at level of chief			
						Score at or above 25th percentile on all but 2 sections for equivalent year on OMSITE			

ATTENDING FACULTY EVALUATION
Department of Oral and Maxillofacial Surgery
University of Mississippi Medical Center

Attending:	Date:
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Directions: Circle the number corresponding to the scale below

1 = *Strongly Agree* 2 = *Agree* 3 = *Disagree* 4 = *Strongly Disagree* 0 = *Not Applicable*

ATTENDING AS PHYSICIAN					
<i>Attending establishes effective working relationships with:</i>					
1. Nurses	1	2	3	4	0
2. Residents	1	2	3	4	0
3. Fellows	1	2	3	4	0
4. Other Attendings	1	2	3	4	0
<i>Attending:</i>					
5. Relates well to patients	1	2	3	4	0
6. Demonstrates competence in technical surgical skills	1	2	3	4	0
7. Demonstrates competent surgical judgement	1	2	3	4	0
8. Demonstrates knowledge of current literature	1	2	3	4	0
ATTENDING AS EDUCATOR					
<i>Attending:</i>					
9. Is approachable/available	1	2	3	4	0
10. Is interested about resident education	1	2	3	4	0
11. Clearly communicates his expectations regarding resident responsibilities	1	2	3	4	0
12. Clearly explains/demonstrates skills/procedures to be learned	1	2	3	4	0
13. Allows resident to assume <u>patient responsibilities</u> up to their abilities	1	2	3	4	0
14. Allows resident to assume <u>surgical responsibilities</u> up to their abilities	1	2	3	4	0
15. Provides timely, constructive feedback	1	2	3	4	0
16. Takes advantage of teaching opportunities (i.e. clinic, intraop, rounds)	1	2	3	4	0
17. Supports resident in critical clinical situation	1	2	3	4	0
18. Balances teaching of surgically relevant, technical, and judgement skills	1	2	3	4	0
OVERALL RATING: Based on your evaluation of the attending as both a <u>physician</u> and <u>educator</u> , rate the attending's overall teaching effectiveness using the scale below: <i>1 = Outstanding 2 = Very Good 3 = Acceptable 4 = Marginal 5 = Unsatisfactory</i>					
19. Overall Teaching Effectiveness of attending	1	2	3	4	5

COMMENTS:

University of Mississippi Medical Center
Trainee Self-Assessment

Name: _____ PGY: _____ Date: _____

Long-term career plans:

I feel my strengths are (as it pertains to OMS):

I feel my weaknesses are (as it relates to OMS):

Are you satisfied with your performance in this residency program? If not, what steps do you plan to take to improve your performance?

What is your perception of how you are viewed by your peers (team player, easy to get along with, works well with others)?

Do you feel you perform adequately on off-service rotations and your medical knowledge is sufficient?

Resident Evaluations by Faculty

Subject:

Evaluator:

Site:

Period:

Dates of Activity:

Activity:

Evaluation Type:

Patient Care: *(Question 1 of 21 - Mandatory)*

Incomplete, inaccurate medical interviews, physical examinations, and review of other data; incompetent performance of essential procedures; fails to analyze clinical data and consider patient preferences when making medical decisions					Superb, accurate, comprehensive medical interviews, Physical examinations, review of other data, and procedural Skills; always makes diagnostic and therapeutic decisions Based on available evidence, sound judgment, and patient preferences			
Insufficient Contact to Judge	Unsatisfactory				Satisfactory			Superior
0	1	2	3		4	5	6	7 8 9

Patient Care - Performance needs attention: *(Question 2 of 21)*

☐ Performance needs attention

Medical Knowledge: *(Question 4 of 21 - Mandatory)*

Limited knowledge of basic and clinical sciences; minimal interest in learning; does not understand complex relations, mechanisms of disease					Exceptional knowledge of basic and clinical sciences; highly resourceful development of knowledge; comprehensive understanding of complex relationships, mechanisms of disease			
Insufficient Contact to Judge	Unsatisfactory				Satisfactory			Superior
0	1	2	3		4	5	6	7 8 9

Resident Evaluations by Faculty

Medical Knowledge - Performance needs attention: *(Question 5 of 21)*

☐ Performance needs attention

Medical Knowledge - Comments: *(Question 6 of 21)*

Practice-Based Learning Improvement: *(Question 7 of 21 - Mandatory)*

Fails to perform self- evaluation; lacks insight, initiative; resists or ignores feedback; fails to use information technology to enhance patient care or pursue self- improvement					Constantly evaluates own performance, incorporates feedback into improvement activities; effectively uses technology to manage information for patient care and self-improvement							
Insufficient Contact to Judge		Unsatisfactory				Satisfactory				Superior		
0		1	2	3		4	5	6		7	8	9

Practice-Based Learning Improvement - Performance needs attention *(Question 8 of 21)*

☐ Performance needs attention

Practice-Based Learning Improvement - Comments: *(Question 9 of 21)*

Interpersonal / Communication Skills: *(Question 10 of 21 - Mandatory)*

Resident Evaluations by Faculty

Does not establish even minimally effective therapeutic relationships with patients and families; does not demonstrate ability to build relationships through listening, narrative or nonverbal skills; does not provide education or counseling to patients, families, or colleagues				Establishes a highly effective therapeutic relationship with patients and families; demonstrates excellent relationship building through listening, narrative and nonverbal skills; excellent education and counseling of patients, families, and colleagues; always “interpersonally” engaged								
Insufficient Contact to Judge		Unsatisfactory			Satisfactory				Superior			
0		1	2	3		4	5	6		7	8	9

Interpersonal / Communication Skills - Performance needs attention: *(Question 11 of 21)*

☐ Performance needs attention

Interpersonal / Communication Skills - Comments: *(Question 12 of 21)*

Professionalism: *(Question 13 of 21 - Mandatory)*

Lacks respect, compassion, integrity, honesty; disregards need for self-assessment; fails to acknowledge errors; does not consider needs of patients, families, colleagues; does not display responsible behavior					Effectively accesses/utilizes outside resources; effectively uses systematic approaches to reduce errors and improve patient care; enthusiastically assists in developing systems' improvement							
Insufficient Contact to Judge		Unsatisfactory				Satisfactory				Superior		
0		1	2	3		4	5	6		7	8	9

System-Based Learning - Performance needs attention *(Question 17 of 21)*

☐ Performance needs attention

System-Based Learning - Comments: *(Question 18 of 21)*

Resident Evaluations by Faculty

Overall Clinical Competence (Question 19 of 21 - Mandatory)

Insufficient Contact to Judge	Unsatisfactory				Satisfactory				Superior		
0	1	2	3		4	5	6		7	8	9

Overall Clinical Competence - Performance needs attention (Question 20 of 21)

☐ Performance needs attention

Overall Clinical Competence - Comments: (Question 21 of 21)

EVALUATION OF RESIDENT'S CLINICAL PROFICIENCY
University of Mississippi Medical Center

Resident:	Date:			
DIRECTIONS: Rate your perception of the resident's competence for each operative procedure/technical skill listed below using the following scale: <i>1 = Competent to do independently</i> <i>2 = Competent to do with minimal supervision</i> <i>3 = Competent to do with moderate supervision</i> <i>4 = Competent only to assist on procedure</i> Note: If you have not had any experience with a given resident, or their performance on any of the above procedures, leave the procedure entry blank.				
1. Routine removal of teeth	1	2	3	4
2. Removal of impacted teeth	1	2	3	4
3. ORIF Le Fort I fractures	1	2	3	4
4. ORIF Le Fort II fractures	1	2	3	4
5. ORIF Le Fort III fractures	1	2	3	4
6. ORIF Mandibular angle fractures	1	2	3	4
7. ORIF Mandib body & symphysis fractures	1	2	3	4
8. ORIF Mandibular condyle fractures	1	2	3	4
9. ORIF ZMC fractures	1	2	3	4
10. ORIF NOE fractures	1	2	3	4
11. Frontal Sinus Fractures	1	2	3	4
12. Repair of facial lacerations	1	2	3	4
13. Maxillary sinus procedures	1	2	3	4
14. Cystectomies of soft and hard tissue	1	2	3	4
15. Management of malignant skin neoplasms	1	2	3	4
16. Management of benign neoplasms	1	2	3	4
17. Management of TMJ diseases	1	2	3	4
18. Sialolithotomy	1	2	3	4
19. Sialadenectomy	1	2	3	4
20. Management of maxillofacial infections	1	2	3	4
21. Microneurosurgery	1	2	3	4
22. Vestibuloplasty with STSG	1	2	3	4
23. Preprosth hard tissue augmentation procedures	1	2	3	4

24. Osseointegrated implants	1	2	3	4
25. Hard tissue reconstructive procedures	1	2	3	4
26. Soft tissue reconstructive procedures	1	2	3	4
27. Alloplastic onlay reconstructive procedures	1	2	3	4
28. Cheilorrhaphy	1	2	3	4
29. Palatorrhaphy	1	2	3	4
30. Alveolar cleft bone graft	1	2	3	4
31. Sagittal ramus osteotomy	1	2	3	4
32. Vertical ramus osteotomy	1	2	3	4
33. Mandibular subapical osteotomy	1	2	3	4
34. Genioplasty	1	2	3	4
35. Le Fort I osteotomy	1	2	3	4
36. Le Fort II osteotomy	1	2	3	4
37. Le Fort III osteotomy	1	2	3	4
38. Other craniofacial surgery	1	2	3	4
39. Septo/Rhinoplasty	1	2	3	4
40. Blepharoplasty	1	2	3	4
41. Rhytidectomy	1	2	3	4
42. Lipectomy/Lipolysis Procedures	1	2	3	4
43. Coronal flap	1	2	3	4
44. Harvest iliac crest bone graft	1	2	3	4
45. Harvest rib graft	1	2	3	4
46. Harvest cranial bone graft	1	2	3	4
47. History and physical examinations	1	2	3	4
48. Medical management of patients	1	2	3	4
49. Outpatient anesthesia	1	2	3	4
50. Laser Surgery	1	2	3	4

Other Comments:

Faculty Signature: _____ **Date:** _____

PATIENT QUESTIONNAIRE

FELLOW NAME: _____ DATE: _____

PERSON COMPLETING THE SURVEY (optional): _____

During your most recent interaction with Dr. _____, did he/she:

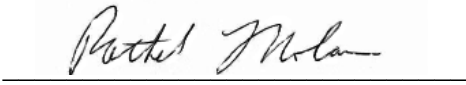
- | | | |
|---|---|---|
| 1) Introduce themselves? | Y | N |
| 2) Behave in a polite and professional manner? | Y | N |
| 3) Give you adequate time to outline your problems? | Y | N |
| 4) Make you feel comfortable during your exam? | Y | N |
| 5) Explain the proposed plan of care to you? | Y | N |
| 6) Outline other options for your care? | Y | N |
| 7) Give you adequate time to ask questions? | Y | N |
| 8) Answer all your questions to your satisfaction? | Y | N |

Please feel free to add additional comments.

Rev 5/2009

ATTENDING ASSIGNMENTS

	Caloss	Brown	Chandran	Qaisi
Monday AM	Admin	Suite B Faculty Julie, MML &! Leah Ann!	Suite A Resident Mary, Stacy & Tasha!	Cancer Clinic Sarah & Cameron!
Monday PM	Admin (June & July Day Surgery OR) !	Suite B Faculty Julie, MML &! Leah Ann!	Suite A Resident Mary, Stacy & Tasha!	Cancer Clinic Sarah & Cameron!
Tuesday AM	Suite A Resident/Student (June & July Batson OR)!	Suite B Faculty IVS ! Julie, Sarah, & Leah Ann !	OR Batson/Admin	OR Main
Tuesday PM	Suite B Faculty ! (June & July Batson OR)!	Suite A Resident/Student Julie & Leah Ann !	OR Batson/Admin	OR Main
Wednesday AM	Caloss (June & July Clinic C)	OR Main	Craniofacial (1st, 3rd) Suite A IVS (2nd, 4th) Marilyn, Stacy & Tasha !	Cancer Clinic Sarah & Cameron!
Wednesday PM	OR Main (June & July Clinic C)	OR Main	Suite B Faculty Julie, Stacy & Tasha!	Cancer Clinic Sarah & Cameron!
Thursday AM	Suite C Faculty Marilyn & Tiffany!	Admin	Suite A Res IVS Stacy, Mary, & Tasha	Suite B Faculty IVS Julie, Sarah & Cameron !
Thursday PM	Suite C Faculty Julie & Tiffany!	Admin	Suite B Faculty Stacy & Tasha! !	Suite A Resident MML, Sarah & ! Cameron!
Friday AM	Suite B Faculty IVS Stacy, MML & Tiffany!	Suite A Faculty IVS Julie, Mary & ! Leah Ann !	OR main	Admin
Friday PM	Admin	Med Mall Resident MML	OR Main	Admin

The University Hospitals and Clinics The University of Mississippi Medical Center Jackson, Mississippi	INFECTION CONTROL POLICY AND PROCEDURE MANUAL	MANUAL CODE: IC/E-5
SUBJECT: EMPLOYEE HEALTH		
Effective Date: 11/79	Review/Revision Date: 10/80, 3/82, 8/83, 9/86, 4/87, 10/88, 4/90, 9/92, 1/96, 6/98, 7/99, 7/01, 7/02, 7/05, 12/06, 5/08	PAGE <u>1</u> OF <u>14</u>
PREPARED BY: Infection Control Committee		APPROVED BY: Rathel L. Nolan, MD Professor, School of Medicine 

I. Purpose:

- A. To assure good health and maximum effectiveness of employees while at work.
- B. To protect employees from risks associated with employment.
- C. To provide health information.
- D. To assist and coordinate administrative functions in matters that relate to employee health.

II. Policies:

- A. Each employee should have a private physician; the Employee Health Service is not a substitute for a personal physician nor does it provide routine medical care for employees.
- B. The benefits are available to all UMC employees.
- C. The Employee Health Service will provide:
 - 1. Emergency care for mild to moderate injuries incurred on duty. Such injuries will be care for, stabilized, and the employee will be referred to his or her personal physician for appropriate follow up if necessary. A major injury should be carried directly to the emergency room for stabilization, then Employee Health should be notified.
 - 2. Pre-employment physical examination for new employees. Each new employee will report to Employee Health for a medical appointment immediately after being processed by Human Resources. If the new prospective employee is disqualified, both the Director of Human Resources and the respective departmental head are notified.

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II. Policies: (cont'd)

3. Fitness for duty examination to determine an employee's ability to continue work will be performed when appropriate. The employee's supervision would initiate referral.
4. Administration of medication furnished by the employee and prescribed in writing by his/her personal physician, upon approval by the Employee Health physician.
5. Surveillance studies as indicated involving special personnel such as food handlers, those possibly exposed to radiation, and others with an exposure to communicable disease or toxic materials.
6. Immunizations and tuberculin skin testing of employees.

D. Employee Health Clinic hours and location:

1. The Clinic is located in Room N-128.
2. Emergency care for simple injuries or illnesses will be available in the clinic from 7:30 a.m. to 4:00 p.m., Monday through Friday (except holidays). During other work hours, care will be provided in the emergency room.

E. Illness and Injuries:

1. All employees absent from work due to illness or injury for 96 hours or longer must present a statement to their supervisor from their personal physician stating the cause of the absence and the fitness of the employee to return to duty. The return to work statement will then be forwarded to Employee Health where it will be reviewed and filed. Employee Health will notify Infection Control of any employee returning to work with a potentially contagious disease.
2. To identify employees seen in the emergency room who may have a potentially contagious illness, the emergency room billing clerk will forward copies of the employee's emergency room record to Employee Health. Infection Control will be notified of any employee who has a potentially contagious illness.
3. Injury reports will be reviewed by the Employee Health Service.

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III. Procedure:

- A. Medical assessment of new employees will include:
1. Completion of medical history form.
 2. Physical examination
 3. A 2-step TB skin test is required of all new employees. A pulmonary history form must be completed for those with a previously positive skin test.
 4. Rubella screen. Rubella screens will be performed on all new employees. Other employees will be tested upon request. Those employees with negative titers will be referred to the Health Department for counseling and vaccination. Within two weeks of referral, the employee must bring proof of vaccination from the Health Department to Student Employee Health. If an employee refuses the vaccination due to medical reasons, documentation from the personal physician must be brought to Employee Health. This is a requirement of employment. Failure to comply may result in disciplinary action. An employee who refuses the vaccine and comes in contact with a suspected case of Rubella may be dismissed from work without pay or may use personal/medical time. The employee may return to work when the Employee Health Physician ascertains the employee is not contagious.
 5. Varicella-Zoster Screening. Varicella-Zoster screens will be performed on all new employees with a negative medical history of chicken pox. Varicella-Zoster is the cause of chicken pox and is highly contagious. Employees are encouraged to get the vaccine which is offered in Student-Employee Health, at no charge. Employees with negative titers who come into contact with active cases of chicken pox or disseminated Zoster may be dismissed from work until the Employee Health Physician ascertains the employee is not infectious. (See Section 2E and Section 4J). The employee may use personal/medical leave, if available.
 6. TB mask fit testing should be arranged for all new patient care workers and repeated annually. This test is done by appointment. Managers are responsible for determining which workers should be fit tested and for making the appointment in Student Employee Health. Initial fit testing is recommended to be completed within the first two weeks of employment or prior to assignment to a TB Isolation area.

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III. Procedure: (cont'd)

B. Immunization of employees:

1. Diphtheria & Tetanus. Booster doses are available upon request according to the recommendations of the U.S.P.H.S. Advisory Committee on Immunization Practices i.e. every 10 years. Tdap vaccine is available for employees working with children.
2. Measles-Mumps-Rubella. All employees born after 1956 who have direct patient contact are urged to undergo vaccination with MMR. If the employee was vaccinated prior to entering school or has had an episode of measles in the past, a single dose is recommended. If there is no prior history of vaccination or illness, a second dose is recommended. If there is no prior history of vaccination or illness, a second dose is recommended six months later. (Episodes of vaccine failures are occurring in this age group resulting in outbreaks of measles, mumps, and rubella in hospitals, with employees partially responsible for disease spread).
3. Hepatitis B immunization is recommended for all high risk employees.
4. Influenza vaccine will be offered to all employees in the fall of each year. Vaccination is recommended for all health care workers.
5. Varicella zoster screening and vaccination.
Varicella zoster screens will be performed on all new employees with a negative history of chicken pox. Varicella zoster virus is the cause of chicken pox and is highly contagious. All employees who are identified as varicella antibody negative will be offered the vaccination free of charge.
 - a. Employees with negative antibody screens (either with or without vaccination) who come in contact with active cases of chicken pox or disseminated zoster may be dismissed from duties until the Employee Health physician ascertains that the employee is not infectious (see section 4J).

C. Tuberculin skin testing:

1. An annual skin test (PPD) will be offered to all employees who have been tested, or whose previous skin test have been negative. A special effort will be made to encourage employees who have frequent, direct contact with patients to avail themselves of this service.

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III. Procedure: (cont'd)

2. All skin test converters (negative to positive) will receive a chest x-ray. Skin Test Conversion is defined in the size of the induration from less than 10mm with an increase of at least 6mm. Recent converters will be evaluated individually regarding the advisability of chemoprophylaxis with (INH). This is done in consultation with the Health Department.
3. Susceptible (PPD negative) employees who have close contact with a patient with active pulmonary disease, e.g., positive AFB stain or culture of sputum, will be retested promptly after the exposure.

D. Exposure of Employees to Communicable Diseases:

1. Cytomegalovirus (CMV Infection). Women employees in the early stages of pregnancy should avoid contact with patients with CMV infection, e.g., infants with congenital CMV infection, patients with AIDS and disseminated CMV disease or, on rare occasions, post-transplant patients. CMV serology may be useful in documenting exposure during pregnancy. They can reduce the risk of transmission to patients or other personnel by careful hand washing and exercising care to prevent their body fluids from contacting other persons.
2. Diphtheria. Diphtheria toxoid (Td) should be made available to susceptible hospital personnel who have respiratory exposure to a patient with diphtheria. Nose and throat cultures should be performed on such personnel. Personnel with cultures positive for Corynebacterium diphtheria should be removed from patient care duties, treated, and allowed to return to work when culture negative.
3. Herpesvirus infection. Personnel who develop acute herpetic lesions on their hands should refrain from caring for patients at high risk of becoming ill from herpesvirus infection, e.g., neonates or immunocompromised patients. Personnel with vesicular lesions on their hands who continue to work outside high-risk patient areas should use gloves while caring for patients. Personnel with oral herpes infections should either wear a mask or cover the area with a dressing when caring for patients and should also practice good hand washing. Personnel with genital herpes infections should practice good handwashing. Pregnant personnel should avoid unnecessary exposure to patients with suspected herpes infections.

III. Procedure: (cont'd)

4. Measles (rubeola). Known susceptible personnel exposed to measles may be

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afforded some protection by live measles vaccine given shortly after exposure or by immune serum globulin (ISG) .025 ml/kg body weight given within six days after exposure. Exposed susceptible employees should minimize their contact with immunocompromised patients from eight days after exposure through 4-5 days after the rash appears. Live measles vaccine should not be given to pregnant women.

5. Meningococcal infections (meningitis). Personnel with intimate contact, e.g., mouth-to-mouth resuscitation with a patient with meningococcal disease are candidates for prophylaxis (Rifampin 600 mgs. q 12 hr p.o. x 4 doses). If the meningococcal organism involved is known to be sensitive to sulfonamides, a sulfonamide drug would be the prophylactic agent of choice.
6. Mumps. Mumps seldom occur in hospital employees. However, when an employee who is presumed to be susceptible is exposed to a patient with mumps, the Employee Health Service may explain the degree of risk and consider mumps vaccine.
7. Pertussis. Pertussis immunization is not recommended for hospital employees. Asymptomatic employees exposed to a patient with pertussis may be observed and treated if symptoms develop within the incubation period (21 days).
8. Rubella. Susceptible pregnant employees should minimize their chances of having contact with children with rubella or infants with congenital rubella syndrome. Vaccination of susceptible personnel is optional. (See Section 1.d under Procedures). Pregnant women must not be vaccinated, and a vaccine should prevent pregnancy for three months after immunization. Employees with confirmed or suspected exposure to rubella should promptly report the incident to the Employee Health Service. A hem agglutination inhibition (HI) test for rubella antibodies should be performed on such employees. Susceptible persons should be removed from duties ten days after the putative exposure and may return to work 7 days after onset of rash, or the maximum incubation period (21 days) has elapsed since the exposure. Any employee with signs or symptoms suggestive of rubella should be immediately excused from duties
9. Varicella zoster (V-Z) virus infection. Varicella Zoster (V-Z) virus causes chicken pox and herpes zoster infections.

Health susceptible antibody-negative personnel with known exposure who may be incubating V-Z virus infection should be removed from duties ten days after the putative exposure and may return to work after clinical varicella has subsided (all vesicles have crusted over), or the maximum incubation period (21 days) has elapsed since the exposure. Should a varicella antibody negative employee decline vaccination, they will be required to take either accumulated medical leave or leave without pay if they are exposed to active chicken pox or

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disseminated zoster.

10. Acute Viral Conjunctivitis. Acute viral conjunctivitis or “pink eye” is a very common infection, especially in the winter months. This illness is highly contagious and easily spread on the hands of health care workers. All employees who suspect they have contracted this illness should be seen by the Employee Health Service. If the diagnosis is confirmed, the employee may be reassigned to non-patient care areas; or sent home until the illness resolves. Frequent hand washing is essential to prevent spread of this infection.
11. Hepatitis A. Personnel who have had intimate exposure, i.e., close contact with patient’s excrement or accidental parenteral inoculation with infective blood components, to hepatitis A should be offered ISG (0.02 ml/kg body wt) within two weeks of exposure. Employees should be relieved of duty as soon as hepatitis is suspected (elevated SGOT or SGPT) or upon onset of jaundice when it is the first sign of the disease. Employees may return to work seven days after onset of jaundice if released by their private physician.
12. Hepatitis B. See Needlestick Injury Section.
13. Staphylococcus aureus infections. Employee with acute S. aureus skin infections should refrain from performing surgical or obstetrical procedures or caring for high-risk patients such as premature infants. They may resume the above duties at the discretion of the Employee Health Service in conjunction with the appropriate department head of their service.
14. Streptococcal infection. Personnel with S. pyogenes pharyngitis should be treated by their private physician, with penicillin VK, benzathine PCN, or erythromycin. Culture surveys (for streptococcal carriage) of personnel are not indicated unless an outbreak of streptococcal infection occurs among personnel or patient.
15. Scabies. Scabies is a disease caused by infestation with the mite Sarcoptes scabiei. It is transmitted in hospital primarily through intimate direct contact with an infested person, even when high levels of personal hygiene are maintained. Using appropriate precautions when taking care of infested patients will decrease the risk of transmission to personnel. If personnel are infested with the mite, transmission can be prevented by removing them from work until they are treated.
16. Acute Diarrhea
 - a. Personnel with severe acute diarrhea illness accompanied by fever, abdominal cramps, or bloody stools lasting longer than 24 hours should be excluded from direct patient contact pending evaluation.
 - b. Personnel infected by enteric pathogens other than Salmonella may

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return to work after symptoms resolve, and after they recognize the importance of hand washing.

- c. Personnel with non-typhoidal Salmonella infection should be excluded from the direct care of high risk patients until stool cultures are Salmonella free on two consecutive specimens collected not less than 24 hours apart.

- 17. Human Immunodeficiency Virus – See Needlestick Injury Section.
- 18. The Employee Health Service will coordinate care of contagious employee illnesses with the hospital epidemiologist. Any employee or supervisor aware of any contagious disease mentioned in this policy should contact Employee Health immediately.

IV. Needlestick Injury or Mucous Membrane Exposure to Blood and Body Fluids

A. Purpose:

To outline policy, procedures and responsibilities for reporting, investigating, and handling injuries involving exposure to blood and body fluids for any UMMC employee, student or staff.

B. Policy:

An online Employee Injury Report must be completed for any exposure to blood or body fluids incurred by a UMMC employee or staff. UMMC students do not complete an online report. Students must complete the Report of Employee's Injury form #HR-BE-10 in Student Employee Health.

C. Procedure:

- 1. When an exposure to human blood and body fluids has occurred:
 - a. The exposed employee will complete an online Employee Injury Report. The exposed student will complete the Report of Employee's Injury form (UMC Form #HR-BE-10) in Student Employee Health. The injury should be reported during the shift that the injury occurred.
 - b. The employee's supervisor will review the details of the data submitted.
 - c. The employee should report to Student Employee Health as soon as possible after the exposure has occurred. If exposure occurs after clinic hours, the employee should report to the Adult Emergency Room. The following must be documented in the injury report:

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- 1) date and time of exposure
 - 2) job duty being performed by employee at time of exposure
 - 3) details of exposure, including amount of fluid or material, type of fluid or material, and severity of exposure (e.g. for a percutaneous exposure, depth of injury and whether fluid was injected; for a skin or mucous membrane exposure, the extent and duration of contact and the condition of the skin, i.e. chapped, abraded, intact).
 - 4) identification of exposure source – including name, medical record number, whether the exposure source is positive for blood-borne pathogens, or has a high risk lifestyle, i.e. drug use, or has a history of multiple blood transfusions.
 - 5) A care plan with details about counseling, post-exposure management, and follow-up, will be added by Student Employee Health.
2. Baseline lab work will be done on the day of the exposure:
- a. The exposed individual and the source individual have the following baseline lab work done per guidelines set forth by the Infection Control Committee:

Hepatitis B surface antibody
Hepatitis B core IGM antibody
Hepatitis B surface antigen
Hepatitis A IGM antibody
Hepatitis C antibody
Human Immunodeficiency Virus antibody
RPR
 - b. If the exposed individual is put on HIV post-exposure antiviral medication, in addition to the above lab work, a CBC, liver panel, and a Chem 8 are also done at the time of injury. If the individual stays on the antiviral medication for 4 weeks of treatment, the CBC, liver panel, and Chem 8 are repeated after being on the medications for 2 weeks (per CDC guidelines). Additional lab work may be ordered at the discretion of the Student-Employee Health physician.
 - c. The exposed individual will receive counseling by Student-Employee Health about the risks of infection and recommendations for preventing transmission of blood-borne diseases. A discharge instruction sheet with follow-up schedule

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will be given to the employee. The exposed person will be advised to report for medical evaluation for any acute febrile illness within 12 weeks of exposure.

- d. When baseline lab results are complete, the exposed individual will be notified of the results and instructed that all results are strictly confidential.
3. Treatment is based on evidence of contagious disease of the source individual. If test results indicate the source individual has a communicable disease, Student/Employee Health will notify the source individual's primary physician and report the result to the State Board of Health. If the source individual is:
 - a. HIV positive – Post exposure prophylaxis with retroviral drugs will be offered free of charge to all exposed individuals based on recommendations by the USPHS guidelines (MMWR June 29, 2001, 50/RR11; 1-42). Recommendations for HIV Post Exposure Prophylaxis (PEP) consists of either a 4-week treatment of two drugs (basic regimen) or of three drugs (expanded regimen) which includes the addition of a third drug for HIV exposures that pose an increased risk for transmission.
 - b. HIV status unknown – Generally no PEP is warranted; however, the basic 2 drug therapy may be started pending lab results. If PEP is offered and taken and the source is later determined to be HIV negative, PEP should be discontinued.
 - c. Hepatitis B surface antigen positive – (exposed person is unvaccinated or a previous known nonresponder to hepatitis B vaccine) Give HBIG (0.06 ml/kg) and give hepatitis B vaccine.

When HBIG is indicated, it should be administered as soon as possible after exposure (preferably within 24 hours). The effectiveness of HBIG when administered >7 days after exposure is unknown. When hepatitis B vaccine is indicated, it should also be administered as soon as possible (preferably within 24 hours) and can be administered simultaneously with HBIG at a separate site (The hepatitis B vaccine should always be administered in the deltoid muscle.)

- d. Hepatitis B surface antigen positive – (exposed person is vaccinated but antibody response unknown) Test exposed person for HbsAb – if inadequate, administer HBIG (0.06 ml/kg) and hepatitis B vaccine booster.
- e. Hepatitis B surface antigen positive – (exposed person is vaccinated and is known responder) No treatment is necessary.
- f. Hepatitis C virus positive – There is no recommended prophylactic treatment.
- g. Hepatitis A IGM positive – administer immune globulin .02 ml/kg IM as soon as possible after exposure.

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h. Syphilis exposure - administer penicillin G benzathine 2.4 million units IM or if PCN-allergic, give Doxycycline 100 mg PO BID for 14 days.

4. Follow-up lab work is offered per CDC guidelines and is dependent on lab results from the source individual. If unable to obtain blood from the source individual, the exposed individual will be followed as for an unknown source.
5.
 - a. HIV antibody testing – done on all exposed individuals.
 - b. Hepatitis C virus antibody testing – done if exposed to hepatitis C or if source is unknown.
 - c. ALT (liver enzyme test) - done if exposed to hepatitis C or if source is unknown.
 - d. RPR – done if source is unknown.
 - e. Hepatitis B surface antibody – done if HBIG or a hepatitis B vaccine was administered (checked after the appropriate interval to demonstrate active immunity)

Additional lab work may be ordered at the discretion of the Student-Employee Health physician.

V. Precautions for Health Care Personnel Testing Positive for Blood-Borne Pathogens:

Personnel should be counseled about precautions to minimize their risk of infecting others. Removal from the clinical care setting will be at the discretion of the Student-Employee Health physician.

VI. Exclusions

1. The services of Student Employee Health do not extend to contract workers. These individuals are advised to contact their employer regarding health care for work related injuries. Contract workers may wish to receive care from the UMHC Adult Emergency Department at the usual and customary fee. TB skin testing and a variety of vaccinations are available through the Mississippi State Department of Health at the Jackson Medical Mall. Usual and customary fees apply. Round trip shuttle bus service to and from campus is provided at no charge.
2. The services of Student Employee Health do not extend to visiting students. These students should consult their home school, clinical instructor, or private insurance carrier for additional information. See also “Exclusion: A., Contract Worker”.

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VII. Pregnant Health Care Workers

Pregnant healthcare workers have particular concerns regarding coming into contact with an infectious agent that may cause serious illness to the mother or may cause some congenital illness or some adverse pregnancy outcome. Overall this risk appears to be very low, but some risk does exist. Pregnancy does not increase the risk of acquiring infections. Most infections acquired in pregnancy are no more severe than in the non-pregnant woman. Following Standard Precautions will protect pregnant healthcare workers against most infectious agents to which they may be exposed. If Standard Precautions are followed it is rarely necessary to restrict a pregnant healthcare workers patient care responsibilities. Women considering becoming pregnant should assure that they have been immunized against vaccine-preventable diseases prior to conception. The following are diseases of particular concern to pregnant healthcare workers:

Cytomegalovirus (CMV): CMV is the most common congenital and perinatally acquired viral illness in humans. Although rare, it is the single most important infectious cause of mental retardation and congenital deafness in the United States. Evidence of infection can be found in over 50% of women of reproductive years. CMV is most often transmitted by sexual contact or by direct contact with infected urine, saliva, semen, vaginal secretions or breast milk. Many individuals, both sick and well, asymptotically excrete the virus. As such, it is very difficult to avoid both in and out of the healthcare environment. We do not routinely recommend removing pregnant healthcare workers from care of people known to have CMV. This is because many pregnant healthcare workers have already been exposed, and also because there is no guarantee that other patients are not also excreting the virus, although it may not be recognized. No vaccine is available. **Standard Precautions is the only preventive measure. *Being a healthcare worker does not increase the risk of CMV infection.***

Hepatitis A (HAV): HAV is now rare in the United States. Transmission is primarily due to exposure to contaminated feces. Exposures during pregnancy can be safely and effectively managed by administration of immunoglobulin and HAV vaccine.

Hepatitis B (HBV): Infection with HBV during pregnancy can result in severe disease for the mother, fetal loss, or chronic infection of the neonate. Vaccination against HBV is offered free of charge through the Student Employee Health Service to all healthcare workers with primary patient care responsibilities. Vaccination against HBV is strongly recommended.

Hepatitis C Virus (HCV): Risk of acquisition of HCV is not known to be increased by pregnancy. There is no vaccine. **Standard Precautions** is the only preventive measure.

Herpes Simplex Virus (HSV): No vaccine is currently available. Prevention is by **Standard Precautions**. Most healthcare associated infections are local skin infections on

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the hands called herpetic whitlow. It is unlikely to affect the genital tract or the fetus. This is prevented by use of gloves for contact with mucous membranes.

Human Immunodeficiency Virus (HIV): No vaccine is currently available, although medications (chemoprophylaxis) are available through Student Employee Health Service or the Emergency Department that lessen the risk of acquiring the infection following an occupational exposure. **Standard Precautions**, use of needleless systems and other safety needles decreases the risk of exposures.

Influenza: Influenza occurs as seasonal epidemics October through March. It is transmitted by respiratory secretions (i.e. coughing and sneezing). Patients known to have influenza are managed under **Droplet Precautions**. Influenza vaccination is the best method of preventing influenza and its complications. The vaccine is safe and effective in pregnancy and is offered free of charge by the Student Employee Health Service.

Measles (Rubeola): A highly effective vaccine exists and all healthcare workers should be immunized prior to having patient contact.

Parvovirus B19: This is the causative agent of a common childhood illness, erythema infectiosum (a.k.a. Fifth Disease). The disease in healthy children is usually mild, and characterized by a fever and a characteristic rash. It is spread by respiratory secretions and as such can be managed by **Droplet Precautions**. Once the diagnostic rash occurs, however, patients are no longer infectious, making isolation of such patients problematic. In immunocompromised patients the virus may persist for a prolonged period of time and duration of infectivity is unknown. The infection is of concern to the pregnant healthcare worker because it can cause infection of fetal red blood cell precursors leading to the possibility of severe anemia and high-output cardiac failure in the fetus, hydrops fetalis and fetal death. Pregnant healthcare providers should avoid caring for immunocompromised chronically infected individuals. These patients are rarely seen at our institution.

Respiratory Syncytial Virus (RSV): This disease is not known to more severely affect pregnant women or the fetus. The major concern is in regards the nebulized medication, ribavirin that is used to treat RSV. There is concern that fetuses of women exposed to ribavirin during pregnancy could have higher rates of birth defects. As such, pregnant healthcare workers should avoid caring for patients receiving ribavirin.

Rubella (German Measles): This is a mild viral infection that predominately affects children. There are virtually no complications unless the disease is acquired during pregnancy where it can produce the congenital Rubella Syndrome. All women considering pregnancy should assure they have been immunized against rubella. Employees are screened for immunity to rubella at the time of employment and referred for vaccination if non-immune. This is important since infected healthcare workers can potentially infect pregnant patients.

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Syphilis: Although a sexually transmitted disease, syphilis may rarely be transmitted by direct contact with infected skin lesions or mucous membranes. Proper use of **Standard Precautions** makes the possibility of acquiring disease in this fashion very small. Infections during pregnancy can affect the fetus but can be successfully treated with antibiotics.

Tuberculosis: Tuberculosis is spread by infectious particles that may remain suspended in the air for prolonged periods in poorly ventilated areas. Pregnant healthcare workers should abide by all guidelines required for **Airborne Infection Precautions** in patients known or suspected of having tuberculosis. Pregnant women are not at increased risk of development of active disease following exposure compared to non-pregnant women.

Varicella – Zoster Virus (VZV): This virus causes both chickenpox and Herpes zoster (shingles). It can be transmitted by a respiratory route and by contact with the vesicular skin rash. The infection is highly contagious such that most individuals acquire it in childhood or are vaccinated against it. Infection acquired during pregnancy can be particularly severe and result in fetal death. At the time of employment employees are screened for VZV and offered vaccination. Women contemplating pregnancy should assure they are immune to VZV.

Adapted from Association for Professionals in Infection Control and Epidemiology Text of Infection Control and Epidemiology. 2005; pp 111-1 to 111-13