Challenges in Continuity of Care: The Role of Fatigue and Importance of Handover

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Disclosure

Dr. Melanie Adams

I do not have an affiliation (financial or otherwise) with a pharmaceutical, medical device or communications organization.

Relationship with Commercial Interest:

- Received Grant/Research Support: none
- Member of a Speaker Bureau/ Advisory Board: none
- Received Honoraria/Consulting fees: none
- Holds investment with pharmaceutical, medical or communication company: none
- Participated in clinical trails within past two years: none
- Holds a patent for a product referenced in this presentation: none

Declaration: My expenses relating to my participation at this event (registration, hotel, travel and incidentals) have been paid by FMRAC.

A Brief Timeline

1984:
- Death of Libby Zion – role of fatigue and supervision highlighted

1989:
- Bell Commission recommendations – limiting residents in NY to 80 hours per week

2003:
- ACGME instituted similar requirements across the US

2011:

-New ACGME guidelines limiting interns (PGY-1's) to 16 hours

-Quebec Arbitration decision limiting all residents to 16 hours of uninterrupted in house call

2012:

- CAIR Position Paper approved with multiple recommendations
- National Steering Committee (NSC) on Resident Duty Hours struck

2013:

- NSC Produces a report with multiple recommendations and re-frames the issue as one of **Fatigue Risk Management**

The Canadian Landscape

1. Residents have **inter-related roles** as learners and care providers
2. Residents are vital providers in a health care system that is collectively responsible for **24/7 patient care coverage**
3. **Duty periods of ≥ 24 hours without restorative sleep should be avoided**
4. Efforts to **minimize risk and enhance safety** are necessary and cannot be undertaken by addressing resident duty hours alone
5. A tailored and rigorous **model** for resident duty hours and the provision of after hour care is needed

NSC: Recommendations

1. Residency programs should implement **a comprehensive approach to minimize resident fatigue**
2. **Residency education should be re-designed** to accommodate changes in duty hours
3. **Accreditation standards** should include specific requirements for the development and implementation of proper **fatigue risk management plans**
4. Continuing **research** into the changes of duty hours on **patient care** should be done
5. A **consortium** committed to the continued evaluation and implementation of resident duty hours should be created

RDoC: Position Paper on Duty Hours

1. Provinces should work towards a system that limits continuous uninterrupted duty hours to **≤ 16 hours**
2. **Duty hours should not interfere with educational experience**
3. Residents should receive **formal training in handover** skills
4. Duty hours should be **flexible**
5. Duty hours should **parallel changes in the culture of medicine**

The Importance of Handover Education

In a 2013 survey of residents, half of respondents (49%) had either witnessed (33%) or been directly involved (16%) in an adverse event that could have been prevented with improved handover.

Formalized handover education is needed in order to avoid any potential negative impact that modified duty hours and an increased number of handovers may have on continuity of patient care.

The Importance of Handover Education

Resident Doctors of Canada has taken a leadership role by examining and evaluating handover methods with an emphasis on **key components and barriers to teaching effective handover** to residents:

- Conducted extensive literature reviews (2010-14)
- Surveyed our membership (2013 and 2015)
- Developed the *CAIR Policy Statement on Handover Education in Canadian Residency Programs* (2014)

RDoC: Recommendations for Handover Education

1. Each patient handover should incorporate **direct verbal and written communication**.
2. Handover should take place in **a quiet area** with **sufficient time allotted**.
3. The **handover process** should employ evidence- based tools and be **standardized** for **each clinical setting**.
4. A formal handover curriculum **should be an accreditation standard** for medical education.
5. Physicians require both **didactic** and **interactive training** in handover. Residents should be **supervised** by faculty/senior residents and receive formal feedback.

The Role of Resiliency Training in Fatigue Management

In conjunction with a number of well being experts, **Resident Doctors of Canada** has collaborated with the **Fédération des médecins résidents du Québec** (FMRQ), the **College of Family Physicians of Canada** (CFPC) Section of Residents and the Section of Medical Students (SoR and SoMS), the **Canadian Federation of Medical Students** (CFMS), and the F**édération médicale étudiante du Québec** (FMEQ) to develop a tailored curriculum that aims to improve mental resiliency in resident doctors.

RDoC: Resiliency Curriculum

Through **skills-based resiliency training** residents will be able to:

- **Identify early signs of distress** and relevant early interventions
- **Apply evidence based skills** to improve performance and thrive in challenging work environment
- **Recognize when and how to seek support**

For More Information, Please Visit:

www.residentdoctors.ca

www.residentdutyhours.ca

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