QEII Resident Escalation Plan

PART 1: Principles

Preamble: It is acknowledged that in order to provide adequate clinical coverage during the COVID-19 pandemic, residents will sometimes be required to provide care outside of their usual area of practice. It will also require that we redeploy our resident resource in a fair, transparent and reasonable manner.

Residents may be asked to help with care outside of the QEII site, specifically in other hospitals in the NSHA and within other health authorities in the Maritimes. This document addresses internal QEII reallocation. This document will respect the existing PGME "Guidelines for Public Health Emergencies and Mass Casualty Events" and the "Principles for Redeployment of Residents and University Fellows in Times of Exceptional Health System Need" and decisions made using this document must also align with the MarDocs contract. In the event of a conflict, the Public Health Emergency Guidelines; Principles for Redeployment, and MarDocs contract will be respected first.

This plan includes all resident physicians who practice within the QEII on a full or significant part time capacity

We acknowledge that residents are learners, and under the terms of their license, require supervision. We acknowledge that we will work to minimize disruption to planned educational programs and curriculum delivery.

We expect that the highest need areas for redeployment will be in the ICU, the Emergency Department, COVID Secondary Assessment Centers and inpatient COVID-19 units. Non-COVID medical and surgical inpatient units may also need redeployment support.

Principles

1. All departments will be required to continue current service delivery which may be reduced, unchanged, or increased **AND** help with COVID-19 care plan in QEII.
2. Given variable increases and decreases in workload by departments, the numbers (or percentage) of residents available for redeployment will vary widely between departments.
3. Every resident has the ability to contribute to our combined effort to implement a COVID-19 disaster plan.
4. Each Program Director or designate will assign residents to a "work category" which indicates what level of care this resident can provide. (See Part 2 for work categories).
5. Each Program Director or designate should consider the individual professional circumstances of each resident, including such things as progress in the program, remediation status and existing educational accommodations in assigning a category.

No one is fully exempt from redeploying in some manner. The process of assigning a category of work will take place at the level of the Program Director (in consultation with Resident Affairs in cases of educational accommodation).

6. Residents will not ordinarily work in a work category above their assigned work category, but can work at a lower level.
7. Residents will be provided with appropriate PPE, as dictated by NSHA infection control policy, for any new work environment to which they are reassigned.
8. We will attempt to reassign work between departments in a fair and equitable manner. (see section 3 for reallocation process). This will be a dynamic iterative process to meet evolving care needs.
9. When residents are quarantined or otherwise unable to deliver face-to-face care, they may still be able to contribute to virtual care, COVID-19 planning, and other educational, administrative and research related activities as their personal health permits.

Part 2: Categories of Work

Each resident should be placed in one category.

Please note that all hospital-based work will have some increased risk for COVID-19 exposure when compared to home isolation.

Educational accommodations must be respected.

1. **Should not be redeployed from current rotation except in exceptional circumstances.**

   We would consider deployment of these residents only as a last resort.

   We would expect the Program Director to place a resident in this category based upon consideration of progress in the program, remediation status and educational accommodations, or lack of clinical patient care skills to care for or directly assess ill or potentially ill patients. Program Directors may be contacted about residents placed in this category who are not on enhanced learning plans or who do not have educational accommodation that precludes seeing patients.

   This group can and will contribute to non-face-to-face care (as appropriate), or participate in education or contact tracing and in any other not specified non-face-to-face clinical manner.

2. **Able to function clinically in a lower acuity patient unit with some supervision/support from an expert**.

   We would expect most residents who see patients clinically in **any environment** to fit in this category or higher.

   Examples of this work may include an inpatient unit where goals of a care are for no escalation to ICU, or assisting under physician resourced areas as supervised doctors lead by a consultant in that area.

   Examples may include IM/ Hospitalist/rehabilitation units, or in lower acuity areas within an ED. This is NOT an exhaustive list.

3. **Able to function clinically to care for or assess acutely ill patients, either with or without direct supervision.**

   We would expect most residents who routinely provide **inpatient** medical or surgical services to be in this category.

   This category would include the Secondary Assessment Centers (SAC's) currently under the administrative lead of the Department of Emergency Medicine. Additional areas may include selected IMCU's. This is NOT an exhaustive list.

4. **ICU able resident physicians.**

   This is the most limited resource, but experienced residents in ICU, anesthesia, medicine, Emergency Medicine and specific surgical specialties may possess this skill.

   Prior to being deployed in this area, the ICU department would vet potential acceptable residents.

Part 3: Reallocation Process

We would expect residents to be first asked to fill positions and roles done by residents.

Residents cannot work as unsupervised staff, without credentialing and locum privileges. In specific situations this could be explored by a resident and PD to meet departmental or provincial specialty care needs.

1. Departments will maximize the internal reallocation of staff, Clinical Associates and residents before requesting residents from other departments to assist in essential departmental activities.
2. Departments at maximal capacity with essential work would not be asked to provide residents to help in other areas of need.
3. Departments exceeding maximal capacity with essential work (Recipient departments) would ask for help via process as outlined in steps 6 and 7.
4. Department(s) currently performing less than usual levels of work (Donor departments) would be asked to provide assistance first via process outlined in steps 6 and 7.
5. We are aware that some residency programs have modified resident services during COVID-19. This process, where significant numbers of residents are not providing clinical work (i.e. creating of two teams of residents each working at half of usual capacity) will be addressed when requests to receive or donate residents are made. This manner of scheduling is likely not sustainable. Departments with this plan in place will be considered donor departments.
6. RECIPIENT Department Head (or delegate) will make a request for additional resident physician resources to the CZ Medical Lead (ZMED). The requesting DH will identify the type of resident or skill set required or preferred. The CZ Medical Lead will facilitate the reallocation process between departments in accordance with our principles and best available critical mass data.
7. The DONOR Department Head (or delegate) in discussion with the Program Director would identify residents for redeployment, by category of work that is required. The Department Head would forward the names the CZ Medical Lead and the requesting RECIPIENT Department Head.
8. Residents would be expected to ordinarily work only in assigned category or lower.
9. We acknowledge that the Zone Medical Executive Director can mandate resident redeployment if this collaborative process fails.