Sinai Health System / Mount Sinai Hospital Medical Center
PGY1 Pharmacy Residency
Guidelines
2018

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Mount Sinai Hospital Medical Center / Sinai Health System
PGY1 Pharmacy Residency Manual

Purpose: The PGY1 Pharmacy Residency Manual provides the program requirements and guidelines for the resident over the course of the 12 month residency. This residency program builds on a Pharm.D. education to develop clinical pharmacists who are responsible for medication-related care of patients with a broad range of conditions, eligible for board certification, and eligible for postgraduate year two (PGY2) Pharmacy residency training. The qualifications for the aforementioned roles are based on the competencies attained during the residency:

Competency Areas (ASHP standard)
R1: Patient Care
R2: Advancing Practice and Improving Patient Care
R3: Leadership and Management
R4: Teaching, Education, and Dissemination of Knowledge

Educational Goals (ASHP standard)
Goal R1.1: In collaboration with the health care team, provide safe and effective patient care to critically ill patients following a consistent patient care process
Goal R1.2: Ensure continuity of care during critically ill patient transitions between care settings.
Goal R1.3: Prepare, dispense, and manage medications to support safe and effective drug therapy for critically ill patients.
Goal 2.1: Demonstrate ability to manage formulary and medication-use processes for critically ill patients, as applicable to the organization.
Goal 2.2: Demonstrate ability to evaluate and investigate practice, review data, and assimilate scientific evidence to improve patient care and/or the medication-use system related to care for critically ill patients.
Goal 3.1: Demonstrate leadership skills in the provision of care for critically ill patients
Goal 3.2: Demonstrate management skills in the provision of care for critically ill patients
Goal 4.1: Provide effective medication and practice-related education to critically ill patients, caregivers, health care professionals, students, and the public (individuals and groups).
Goal 4.2: Effectively employ appropriate preceptor roles when engaged in teaching

Please refer to the PGY1 Pharmacy Resident Position Description for additional details about the position. Guidelines ensure that residents adhere to the standardized program requirements for completion of the program consistent with ASHP Standards, while contributing actively to optimization of patient care at Mount Sinai Hospital/Sinai Health System (MSH).

I. Screening, Selection and Ranking Process of Residency Candidates

A. APPLICANT REQUIREMENTS

All applicants must meet the following criteria to be considered a candidate for consideration for the Mount Sinai Hospital PGY1 Pharmacy Residency Program.

- Current Illinois pharmacist license (or ability to obtain Illinois license within the timeframe stipulated in the agreement)
- Graduation from a U.S. accredited school of pharmacy
- Doctor of Pharmacy degree or equivalent background and experience
- Ability to commit to residency program for a twelve-month period
- US citizen or permanent resident (with a green card)

The application process for the Mount Sinai Hospital PGY1 Pharmacy Residency Program requires the submission of a curriculum vitae (CV), a letter of intent to the program director, 3 letters of recommendations / reference (two from clinical preceptors) and the transcript. These documents are submitted via the PhORCAS system.

The CV is expected to include descriptions of clinical rotations performed as a student, as well as presentations and projects completed during pharmacy curriculum and any other projects, publications, or presentations performed as a student or practicing pharmacist. Also, work experience should be detailed in addition to student government and volunteer activities. The letter of intent should provide the rationale for seeking a position in a hospital pharmacy residency, in general, and in specific at Mount Sinai Hospital.

The application materials must be complete is PhORCAS by the deadline specified.

B. Pre-Screening of completed applications

1. The applications are initially screened and evaluated by the RPD and/or preceptor designee. The screener evaluates the completed application and CV. Key data elements are extracted into a spreadsheet, including the following:
    - rotations (rotation strength and alignment of rotations with MSH program – assessment of candidate's preparation for the MSH PGY1 residency),
    - aspects of the letter of intent (e.g., written communication skills and content, specifically alignment of resident interests/career goals with the MSH program strengths)
    - work experience (especially in pharmacy, with highest weight given to those who have worked in a hospital as interns/externs and/or technicians)
    - overview of letters of recommendation and summary recommendation evaluation scores
    - clinical research and/or publications/posters, including
        - medication use evaluations
        - process improvement projects/efforts
        - clinical research weighed higher / more pertinent than bench (lab) research
    - extracurricular involvement in school activities and/or leadership
    - academic achievement, including awards, scholarships or GPA
        - For a non GPA school, awards scholarships, or similar evaluations will be relied upon

2. The pre-screening evaluation is documented for each applicant during the respective application year. Once all applicants have been screened, a Residency Advisory Committee meeting is convened for the purpose of selecting the candidates for interview. The content of the summary spreadsheet is reviewed at the meeting, during which each applicant is discussed by the RAC, with the RPD citing key aspects and referencing the completed application. The complete applicant packet is available to preceptors involved in selection.

During the discussion of each candidate, the list of candidates to be invited for interview is determined. At the meeting, the number of interview slots for the year is confirmed; this number is typically around 24. If, at the conclusion of the meeting, the invite list is not finalized – another meeting will be convened in short order to develop the final list. Minutes of the meeting(s) is(are) retained .

3. Next, candidates are offered interview slots (dates). Availability is based on a first-come-first served basis.

C. The Interview

1. MSH typically runs multiple (4) candidate interviews concurrently on the same day. A primary goal of the interview process is ensuring a 'good fit' of the applicant to the MSH program—i.e., that the applicant's qualifications and career goals are consistent with the residency offered at MSH. Note that the questions are standardized and are designed to assess overall fit with the PGY1 residency program based on personal career goals, ability to discuss questions, including those arising from the applicant's CV, inter-personal skills and verbal skills. The interview day consists of
    - Welcome – introductory meeting with Director of Pharmacy, RPD (or other manager), current resident(s), and other candidates.
    - Candidate presentation (to pharmacists, preceptors and other candidates) – 15 to 20 minutes, with 5 minutes for questions. The candidate is encouraged to use a presentation completed for a class assignment – the only specifications are that the presentation be pertinent to hospital practice and highlight pharmacotherapy.
        - The presentation is evaluated based on the candidate's :
            - Basic pharmacotherapy knowledge
            - Critical thinking skills , in terms of logic, flow of presentation and in terms of response to questions
            - Presentation and communication skills
    - A hospital tour
    - Lunch with current resident(s) and at least one other applicant
    - Formal individual interviews , with standardized behavioral based questions
        - Interview with managers, including a one-on-one interview with RPD
        - Interview with two preceptors (a limited number of core preceptors are targeted for the residency interviews – to assure consistency and standardization).
    - Clinical cases – these written cases relate to general pharmacotherapy issues, as would be encountered on a general medicine rotation.
    - A final group Q&A session, led by the RPD
    - Subsequent to the interview, the candidate is welcome to contact the RPD , residents, and/or preceptors with questions

D. The Interview Evaluations: Match List Determination Meeting

`1. Subsequent to the interview of each residency candidate, the interviewer scores the candidates based on their application packet [rotation strength, work experience, research experience, academic performance, extracurricular activities/leadership], written clinical cases, presentation, interview impression (overall and behavioral based questions), communication skills, compatibility with MSH staff, overall impression, and 'fit' to MSH PGY1 program. A scoring tool is provided to ensure consistency between reviewers. Priority is placed on matching the strengths and goals of the candidate to the MSH program.

2. At the end of the interview period, a Match Determination meeting is convened with the interview participants ; candidates' scores are discussed. Minutes are documented/retained for this meeting; further, the spreadsheet, average interviewer scores are also retained /stored in Residency e-folder.
3. The initial rank score of each applicant going into the match determination meeting is based upon the total of the applicants' screening and interview scores, averaged based on all interviewers' scores.
    - A candidate may move up or down in rank order based on discussion generated after the applicant is presented to the group for discussion and consideration. A focus is 'fit' of the resident to the program and to the staff. The rank score is retained for each year, in addition to the final summative (average) score.
    - Not all candidates are ranked. The number ranked in any year is highly dependent on assessment of fit of the candidates to the MSH PGY1 program.
4. The Match Determination group (preceptors and managers who participated in interviews) finalize a 'rank order' list.
5. The RPD submits the list to the National Matching Services.

E. In the event that not all positions are Matched: Second Match

1. If the program does not match all positions, MSH will participate in the second round of the match.
2. MSH will use resources of the National Matching Service to identify candidates. Analogous to round one, the available candidates will be pre-screened.
3. The selection of candidates for interview and the actual interview process mimics that of round one. In the case of out of state candidates, interview by telephone and/or videoconferencing is considered appropriate, if other options are unavailable.
4. After all second match candidates have been interviewed, the Match Determination Group then ranks the candidates, as in #D, above.

II. DEVELOPMENT of the RESIDENT's CUSTOMIZED RESIDENCY PLAN

A customized training plan is used to individualize the program for each resident based on his/her baseline skills, interests, and career goals. The Residency Program Director (RPD), with input from the Residency Advisory Committee (RAC), develops a customized training plan for each resident at the beginning of the residency. This plan incorporates the information obtained from the resident's initial self-assessment along with the established goals of the residency program; the customized plan is to be agreed upon and signed by both the resident and RPD**.**

A. Initial Resident Self-Assessment

1. Prior to the start of the residency, the resident completes the questionnaire (assigned as a task if PharmAcademic) pertaining to previous experience, interests, and career goals, providing self-evaluation that encompasses both required and elective residency goals and objectives. The questionnaire is assigned as a task in PharmAcademic. PharmAcademic is an integrated software system (McCreadie Group) which facilitates planning, the management of learning experiences /rotations, scheduling, evaluation, and outcomes.

* *PharmAcademic language utilizes the term learning experience; for the purposes of this document, the term rotation is used synonymously with the concept of learning experience.*

2. An RAC meeting is convened to review and analyze the resident's initial self-evaluation, with the goal of optimizing the resident's learning experience and addressing the resident's interests / career goals.

3. At the end of the orientation period, the RPD, with input from RAC, completes a baseline evaluation of the resident's performance using the same required and elective goals and objectives as used by the resident during the initial self-evaluation. A key utility of the baseline evaluation is the initial comparison of the resident self-evaluation with the preceptor evaluation: this comparison is used in honing the self-evaluation skills of the resident.

B. Customized Training Plan

1. **Initial Plan:**

The start of the initial plan is drafted before the start of the residency – upon review of the resident's responses when submitting the entering questionnaire. Key aspects include strengths, weaknesses, knowledge/skill level, interests and career goals. . *Formalization of the initial plan*, however, occurs towards the end of Orientation, after discussion between the resident and RPD. The plan is documented in PharmAcademic only after a meeting between the RPD and resident. (RAC input is key in formulating the initial plan.)

The customized plan may include alterations (additions or deletions) of goals and objectives, changes in structure (required and elective learning experiences * and/or their lengths or sequencing), changes in preceptorship, and/or changes in the assessment strategy

2. **Frequency of Updates:**

The customized training plan is updated on a **quarterly basis;** it evaluates the resident's performance, changes to the resident's schedule, changes to the objectives that are part of the resident's initial plan, and any other information that the RPD deems appropriate.

RAC input is key in developing the updates. RAC meeting is convened prior to the update to address resident progress in attainment of the goals/objectives of the residency. Importantly the meeting focuses on approaches to maximize residency learning – recognizing skills that are already well developed, identifying areas that most need improvement.

Customized Training Plan Updates are preceded by a meeting between the resident and RPD; the plan is not formalized / documented in PharmAcademic until a meeting has occurred between the RPD and resident. Updates occur during the last week of Quarters I, II, and III.

III. ORIENTATION of the RESIDENT

A. Licensure Policy

As stated in the contract, the expectation is that the resident be licensed as soon as possible given that the entire residency is enhanced with early licensure.
Per letter of intent / contract: The resident should obtain testing dates (NAPLEX and MPJE) before the start of the residency; RPD notification is required if a testing date is scheduled after the start of the residency. Expectation for pharmacist licensure: August 1. Per the terms of the Pharmacy Residency Agreement, the resident is **required** to be licensed within 90 days of the residency start. **Failure to obtain pharmacist licensure by 90 days**, approximately 3 months**, after the start of the residency will result in termination from the program**

B. To the PROGRAM

1. First Week
    - The resident completes the health-system orientation during the initial two days of orientation.
    - During the first week, the ASHP Standard is discussed and key PharmAcademic concepts are addressed in meetings with the RPD. (Given that the resident would have completed the survey prior to the start, access has been assured). Also in the first week, importantly, the RPD thoroughly reviews the Guidelines / Policy & Procedures of the residency and the requirements for graduation.

2. Remainder of Orientation

During the orientation rotation, the resident completes new-hire pharmacist orientation with training focused on needs of a new graduate, details below.

2. During Orientation, the resident learns, then performs, the basic operational functions of the pharmacy. Much of the time during orientation is spent shadowing pharmacy staff, specifically limited technician shadowing with predominantly pharmacist shadowing. Shadowing is interspersed with targeted operational topic discussions, led by various experts in the respective areas. Discussions range from IV admixture to automated dispensing cabinets. The objective is to provide opportunity for the resident to gain an overview of the pharmacist staffing role. Shadowing is often a necessity, given licensure status of some residents.
3. Resources. Multiple resources are available to the resident during orientation.
    a. The resident is provided with the Resident Expectation List for Operations, which is discussed in detail during orientation period by the preceptor for pharmacy staffing.
    b. As a component of training for staffing at MSH, the resident must complete the MSH staff pharmacist orientation checklist. Completion of this checklist, by the end of orientation is required prior to beginning the service commitment in August.
    c. The resident is given the Meditech Training Checklist for new hires. Completion of this checklist, by the end of orientation is required prior to beginning the service commitment in August
    d. The resident is provided with the Pharmacy "Tip List" ... a grouping of descriptive information deemed very worthwhile by newly hired pharmacist staff.
4. Non-Operational Major Components of Orientation:
    a. ACLS Training: The resident completes BLS/ACLS training, as soon as feasible. Ideally this occurs during the orientation period. Notably attainment of BLS/ACLS is not a requirement; however, if certification is sought, then attainment of ACLS within the relatively early phase of the residency, orientation, is optimal.
    b. Major Project - Discussions with the residents regarding project possibilities begin during orientation; every effort is made to align the interests and career goals of the resident with a project / preceptor. The goal is to have the project selected before August 1.
    c. Other Learning - Also during the Orientation period, each resident will provide a single topic presentation to the resident group and key preceptors on a major disease impacting MSH patients. A preceptor is assigned to each resident to serve as a mentor to the resident in developing and presenting their first topic discussion.
        - The concept of one pharmacotherapy 'review' is the result of MSH Pharmacy quality improvement effort : this brief pharmacotherapy assignment 'ties' much of the previous academic, didactic work of the student to the future

pharmacotherapy efforts of the resident, during a period of heavy emphasis on operational functions.

- Preceptor introduction: A meeting will be convened to allow each of the preceptors to introduce themselves and provide a brief overview description of their respective rotation(s).

d. Presentation Topics – during Orientation

Core Discussions during Orientation
Operations – multiple presentations !
ADR Overview
Medication Safety
COPD/Asthma
DVT/PE
HTN
Infectious Diseases
Ischemic Stroke
ACLS Review
ACLS Review II & ACS Overview
DM
Heart Failure
"All things Surgery" -- SCIP and beyond
MICU Orders – a Review
Med Hx and beyond
OB / L&D Order Review
ED in a Nutshell

C. To each LEARNING EXPERIENCE

1. Preparation for resident's learning experience:

In order to be best prepared for the learning needs of the resident, the preceptor communicates with the RPD and *prior* preceptor(s) regarding the resident's performance. Such discussion is a component of RAC meetings; however, discussions occur as the resident moves from learning experience to learning experience, to ensure an optimal transition. As described in the Transitions section, below, focused/targeted communication between current and next preceptor is required, in addition to a Quarterly Review Summary of resident progress in key competencies, which is reviewed at the RAC meetings for each resident.

During the week prior to start of the rotation, the resident is expected to contact the preceptor to ascertain start time and expectations for the first day).

2. The Learning Experience

On the first day of each rotation, the preceptor provides the resident with a formal orientation to the learning experience.

A. The preceptor reviews the learning experience description and requirements for that learning experience with the resident.

B. Scheduled meetings and specific responsibilities are outlined for the resident during the first meeting. Topic discussion frequency is stated; a comprehensive list of topic discussions cannot be provided, as topic discussions sometimes arise in an ad hoc manner, based on the patients that the resident is exposed to.

C. The date and expectations for any major rotation-specific assignments or projects are made within the first several days, ideally on the first day.

D. If review of specific content matter is required, a list of readings is provided to the resident. This specification may not be all inclusive, as the need for readings can arise in an ad hoc manner.

E. The evaluation schedule is also reviewed and includes discussion of the midpoint and final, at minimum.

3. SUBSEQUENT to the *initial* ORIENTATION to Learning Experience
    A. After the period of orientation, the preceptor independently observes and evaluates the performance of the resident to verify the type of instruction needed to ensure achievement of the learning experience goals and objectives. Instruction, with some limited ***direct instruction***, occurs throughout the learning experience and typically involves review of content matter and discussions related to patients that are on service.
    B. Specifically towards the beginning of the rotation and when needed, preceptors provide appropriate ***modeling*** of patient care and practice management skills. These interactions involve one-on-one time or may involve discussion regarding the rationale and logistics (the "how and why") of patient care and practice management project skill.
    C. The preceptor determines when the resident has sufficiently observed preceptor demonstrations, indicating when the resident is ready to practice.
    D. The preceptor observes resident activities and provides ongoing feedback, ***coaching*** as necessary. The schedule for this feedback is to be mutually agreeable to the resident and preceptor. Although the timing of these informal sessions is not specified, a schedule of two to three times weekly is a generalizable goal.
    E. The preceptor determines when the resident is ready for independent practice; subsequently ***facilitating*** opportunities for independent practice to occur. During independent practice, the preceptor must provide appropriate supervision and contact information if issues and/or questions arise. The preceptor must be available by pager/cell phone AND be available on site. Exceptions can be made by RPD or RPC on an individual basis; considered are the type of rotation and, importantly, whether an alternate qualified preceptor is available on site for questions.

IV. ASSESSMENT STRATEGY:

EVALUATIONS and the MONITORING of RESIDENT PROGRESS

A. Overview: Residents (and Preceptors) are evaluated in a manner consistent with ASHP Standards. These evaluative steps are iterated throughout the 12 month period; resident progress and performance are reviewed on a continual basis by the RPD and on an ongoing, quarterly basis by the RAC. Quarterly evaluations are a formalized method to assess resident cumulative knowledge and skill; also, importantly, to provide recommendations to the resident on the best approaches to improvement. Finally, at the end of the residency, the RAC meets to consider the resident's progress and ultimate attainment of the program's educational goals and objectives using all assessments and documentation, by granting consensus to attainment of the program certificate of graduation.

As detailed in Orientation to the Program, above, an initial resident self-assessment is completed at the beginning of the ***residency.*** *This assessment assists in planning learning experiences for the resident and is used in the formulation of an individualized residency plan for the resident.*

B. RAC Functions in Monitoring and Ensuring Resident Progress

1. The Residency Advisory Committee (RAC) is composed of the RPD, managers, and Preceptors; the committee is led by the RPD. This committee is charged with oversight of the residency program, with focus on the educational and operational aspects. Additionally pharmacy leadership provides insight and direction on all aspects of the residency program. The objective of the RAC is to focus on opportunities to improve resident performance and to provide continuity between learning experiences, with the ultimate objective of facilitating the best possible educational and experiential outcome for each resident. Adjustments in teaching strategies or in resident course are discussed and plans to provide modifications are discussed.
2. The RAC meets quarterly, at minimum,
    - To discuss resident progress and overall program effectiveness, so that optimal planning for the experiential needs of the resident occurs.

- Informal conversations occur among the preceptors on an ongoing and frequent basis. If these discussions bring a significant issue to the forefront, a formal meeting is convened by the RPD to systematically address that issue.

- Another important RAC function is the assurance of and improvement in Quality.

3. The first RAC meeting of the residency is convened prior to the initiation of the 12 month residency to evaluate and discuss the incoming resident's initial self-assessment. This meeting initiates the plan for the residency and lays the groundwork for the individualization of the program based upon the resident's needs and goals.

C. Evaluations in Learning Experiences

1. Overview of the Evaluation Strategy and Process

- To ensure a systematic approach to evaluation, with the objective of facilitating the resident's skill development, preceptors provide ongoing, criteria-based feedback through-out each learning experience. In general, the preceptor and resident discuss specific skills pertinent to the learning experience several times weekly on an informal basis.
- Preceptors utilize PharmAcademic, to document the resident's progress and to provide narrative commentary for any goal, with specific focus on those goals for which progress is rated "needs improvement."

- Evaluation discussions occur generally between the preceptor and resident; however, the RPD may also be involved, especially if assessments of the resident by the preceptor and the resident self-evaluation differ and cannot be resolved or if the evaluation contains multiple, i.e., greater than 3, "NI" or Needs Improvement scores. In general, preceptor - resident discussions are based on specific circumstances, but, should include the key areas noted in Transition, in 2a, below.

  - Recognizing those skills that are already well developed as well as skills that have improved appreciably during the rotation. Recognizing what has already been accomplished, including disease states discussed, projects completed, skills attained, etc.
  - Identifying those areas (e.g., skills, knowledgebase) that MOST need improvement. Identifying objectives for skill improvement (activities/projects, increased exposure to certain areas of practice), either for the remainder of that rotation or for the next rotation.
  - Comparing the preceptor's and resident's assessments, with an effort to identify any major discrepancies and resolving with the resident why their perception may or may not be accurate. *Noteworthy is that the capacity for self-evaluation is one of the critical outcomes of residency.*

2. Summative Evaluation Scale

SUMMATIVE SCALE NI/SP/ACH and ACHR		
NI	**Needs Improvement**	The resident is not making progress to the level expected of someone with his/her background and relation in time to the start of the residency – i.e., other residents in similar scenarios. For example, the resident is not consistently demonstrating behaviors or skills or demonstrating knowledge base appropriate for that level.
SP	**Satisfactory Progress**	The resident performs at the level expected, based on background and relation to start of post-graduate learning, i.e., compared to other residents
ACH	**Achieved**	The resident performs at the level of a clinical pharmacist.
ACHR	**Achieved for Residency**	Resident consistently performs the objective(s) at an Achieved level and is deemed ACHR by DOP, as agreed upon by RAC
NA	**Not Applicable**	The situation does not apply to the resident.

3. Learning Experience and Evaluation of the Resident

a. Evaluation of the Resident, Overview

During Rotation

1. Only those competency areas listed in the residency program design and those that may have been added for the individual resident are included in the written summative evaluation. Specifically, for each rotation, only those objectives listed in the description of the rotation are evaluated.
2. Preceptors provide ongoing, criteria-based feedback throughout each learning experience to assist the resident's skill developmental processes. No fixed schedule of informal feedback is required, but, a general expectation is that the informal feedback is provided to the resident two to three times weekly, or more frequently if needed.
    - Midpoint: the preceptor and resident conduct an informal evaluation of resident progress in the attainment of the learning experience's competency areas and objectives. The summative scale, above, is utilized.
        - At approximately the middle of a learning experience lasting 6 weeks or less, a midpoint evaluation is conducted, ***informally***. *Each of the learning experience goals and objectives is discussed*. The preceptor provides an evaluation and the resident a self-evaluation. The primary goal of this meeting is to identify how the preceptor and resident can best work together to expand the resident's experience/skill set in the remaining weeks of the rotation. A focus is identification of areas of potential concern, with the intent of rectifying them.
        - If the resident is noted to be deficient in any area or any other issues/ discrepancies are noted, the RPD may be asked to be included in discussion and follow-up plans, including modifications to the rotation learning activities to enhance the resident's learning experience if necessary. Also, a snapshot should be strongly considered focusing on the area of concern.

            - **Snapshot(s)**
                - If a need is identified, a formal snapshot is performed.
                - The preceptor completes the snapshot evaluation of resident performance, using PharmAcademic, prior to the meeting with the resident.

3. Written formative documentation is encouraged. Documentation of the resident's work, reflective of the skills and accomplishments, provides evidence for criteria-based formative evaluation. Examples of appropriate formative evaluation instruments include any snapshots, patient monitoring forms, monographs, Medication Usage Evaluations (MUEs), projects, etc.
    - Such documents, with the exception of PharmAcademic reports, are printed out to be included in the "Resident's Manual." Significant efforts are also maintained by the RPD, in the RPD's resident on-line folder.

4. Summative evaluations are to be completed by preceptors before or on the last day of the learning experience (or the last day of the quarter for longitudinal learning experiences); summative evaluations are required for traditional rotations. Evaluations are discussed, side-by-side, with the resident, then signed and dated. (The summative scale,in C 2 above, is utilized).
    a. Preceptors rate the resident and provide narrative comments. The narrative comment should relate to criteria developed for achievement of that goal: a focus on the quantitative aspects of the performance is not appropriate, rather, the evaluation of that performance.

    The preceptor selects the appropriate rating (from the Summative Scale, above) to indicate progress during the learning experience. Especially for any goal for which 'needs improvement' is selected, narrative comments are required; additionally, narrative comments are encouraged for 'satisfactory progress' selections – in that the resident can benefit from recommendations on how to / what steps to take in order to improve performance.

b. Both the resident and the preceptor complete each of the evaluation instruments for resident performance in the learning experience, respectively The resident's evaluation is termed a self-evaluation. Each party should have completed their respective evaluation prior to the discussion of the evaluations in a face-to-face meeting to resolve any differences in the evaluations and to identify a plan of action to facilitate improvement.
    - Discussion: During the learning experience's summative evaluation, the preceptor reviews the evaluation of the resident and compares it to the resident's self-evaluation. Conversely, the resident's self-evaluation is reviewed and discussed with the preceptor. Discussion of any issues or discrepancies should take place at that time; discrepancies are to be resolved. If discrepancies cannot be resolved, the RPD is involved in the discussion. Thereafter, the evaluation should be signed by the resident and preceptor.
    - The RPD reviews all evaluations; if not optimally completed, the evaluation may be 'sent back' for revision / comment.
        - Once appropriately completed, the RPD signs all evaluations.

c. The PharmAcademic evaluation is completed, each by the resident and the preceptor, then forwarded to the RPD for signature. All evaluations are reviewed and then cosigned by the RPD in PharmAcademic. If the evaluation is not optimally completed, the RPD may first comment on the evaluation and send it back for re-review and editing by the evaluator. Thereafter, the RPD co-signs the evaluation.

d. f a non-PharmAcademic evaluation is used, documentation of the evaluation is manually signed by the preceptor, resident, and RPD.

b. EVALUATIONs, based on Learning Experience Type

i. <u>Traditional (Concentrated) Learning Experiences (Rotations)</u>

The above description applies to traditional, concentrated rotations which are typically four weeks, but, may have durations of up to six weeks.

ii. <u>Longitudinal Learning Experiences</u>

The concepts of the above description applies to longitudinal learning experiences. Exception:

- At regularly scheduled increments, longitudinal learning experience evaluations are completed by the rotation preceptor.
    - At minimum, summative evaluations are completed every 3 months.
    - The number of summative evaluations conducted is dependent on the duration of the learning experience.
    - For example, the major residency project has 3 summative evaluations during the project, with the 4th evaluation being the final evaluation.

- Other aspects of learning experience evaluations are identical to concentrated learning experiences, as detailed above.

4. Evaluation of the Preceptor by the Resident, for the Learning Experience

- At the end of each learning experience, the resident completes an evaluation of the preceptor's performance by the last day of each learning experience (or quarterly for longitudinal learning experiences). The resident reviews the evaluation with the preceptor.
- The RPD also reviews the evaluation and comments; then signs off on its completion.
    - Further, the resident has another opportunity to provide feedback about the preceptor -- as it is again solicited during the resident's exit interview

Significance of the preceptor's evaluation

- *Bidirectional feedback : although preceptors routinely evaluate residents, residents experiences are key to enhancing the program through positive change.*
- The preceptor evaluation is used as a tool in evaluating the quality of the preceptor's instruction effectiveness / performance. The RPD addresses any deficiencies or issues to improve the quality of the preceptor's instruction.
- Improvement in preceptor instruction is a topic of RAC discussion, an area of focus on quality improvement of the program. The RPD brings forward to the RAC discussion on quality issues: the intent of this focus is improving the effectiveness of the preceptor's teaching skills and techniques.
- Notably, at the end of the residency, the residents have further input in that they are given the opportunity to select one preceptor to receive the "Preceptor of the Year" Award.

5. Evaluation of the Learning Experience, by the Resident

- At the end of each learning experience, the resident completes an evaluation of the learning experience. This is done using PharmAcademic. The resident reviews the evaluation with the preceptor.
- The RPD also reviews the evaluation and comments, then signs off on its completion.
    - Further, the resident has another opportunity to provide feedback about the learning experience -- as it is again solicited during the resident's exit interview

Significance of evaluation of the learning experience by the resident

- *Bidirectional feedback : although preceptors routinely evaluate residents, residents experiences are key to enhancing the program through positive change.*
    - Improvement in the quality of the learning experiences is a topic of RAC discussion, an area of focus on quality improvement. The RPD brings forward to the RAC a discussion on learning experience optimization: the intent of this focus is ensuring the best possible, optimal learning experience.

6. TRANSITION *between Learning Experiences*

To ensure an optimal and efficient transition from one learning experience to the next learning experience, a combination of two steps are used:

1. **During the last week of the learning experience**, performance of the resident during the rotation is discussed with the next preceptor to assure continuity of progress towards the residency goals, competency areas and objectives. The RPD is optionally included; however if there are three (3) or more evaluations scored as NI or there is deemed to be a significant deficiency of any type, the RPD is included. Discussion topics must include:
    - Recognizing those skills that are already well developed as well as skills that have improved appreciably during the rotation.
        - Recognizing what has already been accomplished, including disease states discussed, projects completed, skills attained, etc.
    - Identifying those areas (e.g., skills, knowledgebase) that MOST need improvement. Identifying objectives for skill improvement (activities/projects, increased exposure to certain areas of practice), either for the remainder of that rotation or for the next rotation.
    - Addressing any issues of critical or significant need in resident development:
        - competencies/objectives or areas seeking to identify any major discrepancies between resident self-evaluation and preceptor evaluation and resolve with the resident cause for the discrepancy
        - Professional behaviors
    - *Resident capacity for self-evaluation, which is one of the critical outcomes of residency, is evaluated*

2. The **quarterly performance of each resident (for key competencies) is addressed at RAC Meetings**. Firstly, the RPD maintains the table of key objectives AND quarterly resident performance, *Attachment. Next, this information is shared at the quarterly meeting – to apprise all preceptors of resident strengths, areas for improvement in an overview format.*

D. Evaluation of the Resident, toward Attainment of PGY1 Residency Goals, Competencies & Objectives and Attainment of the Certificate of Graduation

1. Quarterly
   A. RAC reviews Quarterly progress of resident, updating the Goal / Objective Milestone Tracker. The critical goals/objectives for attainment of the certificate of graduation are the focus of the resident progress discussion.

      Goals/Objectives which must be "ACHR" to attain a Certificate of Graduation

Competency Area R1: Patient Care, ALL goals
GOAL R1.1 In collaboration with the health care team, provide safe and effective patient care to a diverse range of patients…following a consistent patient care process.
GOAL R1.2 Ensure continuity of care during patient transitions between care settings.
GOAL R1.3 Prepare, dispense, and manage medications to support safe and effective drug therapy for patients.
GOAL R1.2 Ensure continuity of care during patient transitions between care settings.
Competency Area R2: Advancing Practice and Improving Patient Care, the objective
Objective 2.1.4: (Applying) Participate in medication event reporting and monitoring.
Competency Area 3: Leadership. GOAL R3.1 Demonstrate leadership skills.
Objective R3.1.1: (Applying) Demonstrate personal, interpersonal, and teamwork skills critical for effective leadership.
Objective R3.1.2: (Applying) Apply a process of on-going self-evaluation and personal performance improvement.
GOAL R4.1 Provide effective medication and practice-related education to patients, caregivers, health care professionals, students, and the public – specifically, objectives:
Objective R4.1.1: (Applying) Design effective educational activities.
Objective R4.1.2: (Applying) Use effective presentation and teaching skills to deliver education.
Objective R4.1.3: (Applying) Use effective written communication to disseminate knowledge.
Objective R4.1.4: (Applying) Appropriately assess effectiveness of education.

      - The RPD convenes an RAC meeting at which the Quarterly Milestone achievement of each resident is discussed.

   B. RPD meets one on one with each resident to discuss quarterly progress AND plan for the following quarter. The RPD completes the Quarterly Evaluation subsequent to the discussion with resident and uploads to PharmAcademic for sharing.

2. Final
   A. Resident Evaluation
      The RPD completes an End-of-Residency evaluation of the resident's progress towards the residency program goals; this evaluation is brought to the RAC for discussion and review. The RAC must have consensus on attainment of ACHR on the critical goals and objectives for the MSH Residency.
   B. Final Resident Self-Evaluation
      The resident completes an End-of-Residency evaluation of the progress towards the residency program goals. The resident is provided with a list of the educational goals and objectives for the course of the residency and asked to self-rate adjustment. The evaluation is reviewed by the RPD, then brought to the RAC for discussion.

E. Evaluation of the PGY1 Residency Program by the Resident

1. Ongoing Evaluations : Quarterly "Rehydration" Meetings
   - On a quarterly basis, residents meet with RPD and pharmacy managers to discuss the degree to which the residency program is meeting their needs and goals. The residents are directly posed questions: 'what is going well and what needs to be improved?'
   - On a quarterly basis, RPD and residents (+/- other managers and core preceptors) have a group dinner on Taylor St.
2. Final Evaluation: Final "Rehydration" or End of Residency Meeting
   - Focus of this meeting is whether or not the program has met the residents' goals.

- Emphasis is on the responsibility of the residents to make any comments or suggestions to guide the enhancement of the current program for the future residents.

3. Exit Interview

RPD and Director of Pharmacy, or designee, meet with each resident individually at the time of graduation.

V. Formal Project

A. The resident is required to complete one formal major project relating to a specific aspect of pharmacy practice. The major project spans most of residency; it is set up as a longitudinal learning experience. Scientific research principles are utilized by the resident to complete and present project under guidance of the preceptor. This project is intended to give the resident an organized exposure to scientific research techniques, prepare the resident for future pharmacy practice research activities, and give the resident experience in preparing and presenting a paper/project.

B. Procedure:

1. Annually, potential projects are identified by the RPD, management and preceptors prior to the start of the residency. These topics are expected to be timely, feasible, and of benefit to both the hospital and the resident. Discussions with the residents regarding project topics begin during orientation. Selection of the project ideally occurs during orientation, by August 1. The resident is given the opportunity to review potential topics and choose one that is of interest and mutually beneficial to the resident and department. Every effort is made to align the project with the resident's interests and/or career goals.
2. The RPD, in conjunction with the Director of Pharmacy, provide final approval for the topic.
3. The project preceptor facilitates the project and mentors the resident.
4. The resident plans, coordinates, and completes the project over the course of the residency, with preceptor oversight. Completion of an Institutional Review Board (IRB) application is a necessary component of this process.

C. Requirements:

1. The resident completes a project on a specific aspect of pharmacy practice. This may be in the form of original research, a problem-solving exercise, or process improvement or enhancement/expansion of some aspect of pharmacy services.
2. A presentation of the project status (typically *during* the project) is made in December at ASHP MCM.
3. A presentation of the finalized project is made at the Great Lakes Pharmacy Residency Conference (GLPRC) in April.
4. A final summary, as a Word document, must be submitted in a form consistent for submission to the P&T Committee.

D. Typical Timeline of the Major Project

Step	Anticipated Deadline
Select major project topic	Mid July. August 1 – deadline
Lead discussion of project (with preceptor as secondary) at a meeting of preceptors: delineate objective and methods	Mid August
IRB Completion → Approval	September
Complete written proposal for project : objective, methods	Mid September
Present DRAFT ABSTRACT for ASHP	Mid September
Submit Abstract to ASHP: Deadline Oct 1	**October 1**
Present DRAFT POSTER for ASHP MCM to meeting of preceptors	Mid November
Present POSTER to Department	Last week November
Present POSTER @ MCM	**First Week December**
Intense data collection / intervention	December
Continued data collection	January - March
Present DRAFT ABSTRACT for GLRC	Mid January
Submit Abstract to GLRC: Deadline Feb 1	**Feb1**
PPT review at meeting of preceptors	Mid – late March
Oral presentation of PPT to Department	Mid April
Present Final Project @ GLRC (PPT)	**Last Week of April**
Presentation (Word Document) at Hospital Committee Meeting, e.g., P&T	Spring

VI. Pharmacy SERVICE / STAFFING

ASHP has established standards regarding the time residents spend performing patient care duties and other activities related to their program. Clearly, providing residents with a comprehensive didactic and clinical education must be carefully planned and balanced with concerns for both safety and resident well-being / balance.

The MSH Residency program is structured so that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill staffing and that didactic and clinical education have priority in the allocation of resident time and energy.

Residents staff four (4) shifts monthly; those shifts are either weekday PMs or weekends (AMs or PMs). Also, residents work one holiday over the course of the entire residency.

- The resident works any combination of weekday PMs and weekends during the month

A. DUTY HOUR POLICY

DUTY-HOUR REQUIREMENTS (directly from the ASHP document: https://www.ashp.org/-/media/assets/professional-development/residencies/docs/duty-hour-requirements.pdf)

Residents, program directors, and preceptors have the professional responsibility to ensure they are fit to provide services that promote patient safety. The residency program director (RPD) must ensure that there is not excessive reliance on residents to fulfill service obligations that do not contribute to the educational value of the residency program or that may compromise their fitness for duty and endanger patient safety. Providing residents with a sound training program must be planned, scheduled and balanced with concerns for patients' safety and residents' well-being. Therefore, programs must comply with the following duty-hour requirements:

I. Personal and Professional Responsibility for Patient Safety
   A. Residency program directors must educate residents and preceptors about their professional responsibilities to be appropriately rested and fit for duty to provide services required by patients.
   B. Residency program directors must educate residents and preceptors to recognize signs of fatigue and sleep deprivation, and adopt processes to manage negative effects of fatigue and sleep deprivation to ensure safe patient care and successful learning.
   C. Residents and preceptors must accept personal and professional responsibility for patient care that supersedes self-interest. At times, it may be in the best interest of patients to transition care to another qualified, rested provider.
   D. If the program implements any type of on-call program, there must be a written description that includes:
      - the level of supervision a resident will be provided based on the level of training and competency of the resident and the learning experiences expected during the on-call period; and,
      - identification of a backup system if the resident needs assistance to complete the responsibilities required of the on-call program.
   E. The residency program director must ensure that residents participate in structured handoff processes when they complete their duty hours to facilitate information exchange to maintain continuity-of-care and patient safety.

II. Maximum Hours of Work per Week and Duty-Free Times
   A. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all inhouse call activities and all moonlighting.
   B. Moonlighting (internal or external) must not interfere with the ability of the resident to achieve the educational goals and objectives of the residency program. (Mount Sinai Hospital does NOT have internal moonlighting)
      1. All moonlighting hours must be counted towards the 80-hour maximum weekly hour limit.
      2. Programs that allow moonlighting must have a documented structured process to monitor moonlighting that includes at a minimum:
         a. The type and number of moonlighting hours allowed by the program.
         b. A reporting mechanism for residents to inform the residency

program directors of their moonlighting hours.

c. A mechanism for evaluating residents' overall performance or residents' judgment while on scheduled duty periods and affect their ability to achieve the educational goals and objectives of their residency program and provide safe patient care.

d. A plan for what to do if residents' participation in moonlighting affects their judgment while on scheduled duty hours.

C. Mandatory time free of duty: residents must have a minimum of one day in seven days free of duty (when averaged over four weeks). At-home call cannot be assigned on these free days. (Mount Sinai Hospital does NOT utilize 'at-home' call)

D. Residents should have 10 hours free of duty between scheduled duty, and must have at a minimum 8 hours between scheduled duty periods. ASHP Duty-Hour Requirements

E. If a program has a 24-hour in-house call program, residents must have at least 14 hours free of duty after the 24 hours of in-house duty. (Mount Sinai Hospital does NOT have a 24-hour in-house call program)

III. Maximum Duty-Period Length

A. Continuous duty periods of residents should not exceed 16 hours. The maximum allowable duty assignment must not exceed 24 hours even with built in strategic napping or other strategies to reduce fatigue and sleep deprivation, with an additional period of up to two hours permitted for transitions of care or educational activities.

B. In-House Call Programs (Mount Sinai Hospital does NOT have a 24-hour in-house call program)

1. Residents must not be scheduled for in-house call more frequently than every third night (when averaged over a four-week period).
2. Programs that have in-house call programs with continuous duty hours beyond 16 hours and up to 24 hours must have a well-documented structured process to oversee these programs to ensure patients' safety and residents' well-being, and to provide a supportive, educational environment. The well-documented, structured process must include at a minimum:
    a. How the program will support strategic napping or other strategies for fatigue and sleep deprivation management for continuous duty beyond 16 hours.
    b. A plan for monitoring and resolving issues that may arise with residents' performance due to sleep deprivation or fatigue to ensure patient care and learning are not affected negatively.

C. At-Home or other Call Programs (Mount Sinai Hospital does NOT utilize 'at-home' call)

1. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
2. Program directors must have a method for evaluating the impact on residents of the at-home or other call program to ensure there is not a negative effect on patient care or residents' learning due to sleep deprivation or serious fatigue.
3. Program directors must define the level of supervision provided to residents during at-home or other call.
4. At-home or other call hours are not included in the 80 hours a week duty-hour calculation, unless the resident is called into the hospital/organization.
5. If a resident is called into the hospital/organization from at-home or other call program, the time spent in the hospital/organization by the resident must count towards the 80-hour maximum weekly hour limit.
6. The frequency of at-home call must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks. No at-home call can occur on the day free of duty.

Approved by the ASHP Commission on Credentialing on March 4, 2012 and the ASHP Board of Directors on April 13, 2012. Updated with new ASHP logo, title, and minor editing on March 4, 2015.

Definitions – from ASHP document

Duty Hours: Duty hours are defined as all scheduled clinical and academic activities related to the pharmacy residency program. This includes inpatient and outpatient care; in-house call; administrative duties; and scheduled and assigned activities, such as conferences, committee meetings, and health fairs that are required to meet the goals and objectives of the residency program. Duty hours must be addressed by a well-documented, structured process. Duty hours do not include: reading, studying, and academic preparation time for presentations and journal clubs; travel time to and from conferences; and hours that are not scheduled by the residency program director or a preceptor. Scheduled duty periods: Assigned duties, regardless of setting, which are required to meet the educational goals and objectives of the residency program. These duty periods are usually assigned by the residency program director or preceptor and may encompass hours which may be within the normal work day, beyond the normal work day, or a combination of both.

Moonlighting: Voluntary, compensated, pharmacy-related work performed outside the organization (external), or within the organization where the resident is in training (internal), or at any of its related participating sites. These are compensated hours beyond the resident's salary and are not part of the scheduled duty periods of the residency program.

Continuous Duty: Assigned duty periods without breaks for strategic napping or resting to reduce fatigue or sleep deprivation.

Strategic napping: Short sleep periods, taken as a component of fatigue management, which can mitigate the adverse effects of sleep loss.

B. EXTERNAL EMPLOYMENT POLICY (aka MOONLIGHTING)

External Employment (aka Moonlighting) is highly discouraged by the MSH program. Successful completion of the residency program leading to certification is a function of the successful completion of all the program's requirements, which determine the primary role, thus schedule, of the resident. It must be understood that the responsibilities of the resident may not correspond to a consistent day to day schedule and at times, extra hours of effort may be necessary to complete residency requirements. Patient-care rotations, teaching, and service requirements take precedence over scheduling for external employment and therefore, the residency program must be considered the primary priority of each resident,

- External employment, if determined a necessity by the resident, may not interfere with the resident's responsibilities or requirements. All additional shifts picked up by the resident off-site MUST NOT INTERFERE with the activities of the residency program – conflicts with the Duty Hours, as reference. It is the resident's responsibility to identify if they have external employment.
- Residents are expected to inform RPD of any external employment situation; then, must inform the RPD of work schedule (such that duty hours are not exceeded). Notably, however, the schedule devised by MSH must take priority over any other work situation and if duty hours are exceeded, then MSH duties take precedence over any other employment.

VII. Resident Logistics

A. Resident Duties & Responsibilities

The Resident agrees to comply with all applicable policies, procedures, rules and regulations described in the SINAI HEALTH SYSTEM, Pharmacy Department, and the Pharmacy Residency Guidelines.

The Resident agrees to perform the duties and responsibilities required within the regular hours of duty, as specified by the Accreditation Council for Graduate Medical Education, in Common Program Requirements.
http://www.acgme.org/acWebsite/dutyHours/dh_ComProgrRequirmentsDutyHours0707.pdf

The Resident staffs four (4) shifts monthly. Also, the residents each work one holiday over the course of the entire residency.

The Resident agrees to perform stated duties and responsibilities to the best of his/her abilities at a satisfactory level of competence as determined by the Residency Program Director ("RPD") and the Director of Pharmacy through a continuous evaluation of the Resident's performance.

The Resident agrees to provide patient care commensurate with his/her level of knowledge and skill under a combination of direct supervision and progressive independence based upon demonstrated competence and abilities. The Resident agrees to provide safe, effective care based on the best evidence available. The Resident develops an understanding of ethical socioeconomic/cultural and medical-legal issues that affect patient care and will learn to apply appropriate cost-containment measures in the provision of care.

The Resident agrees to participate in any institutional committees or councils to which the Resident is appointed, assigned, or selected. The Resident agrees to participate in teaching and supervising pharmacy students and in teaching other pharmacy Residents and medical Residents and, when called upon, render an evaluation of the performance of these individuals.

- **COMMUNICATION ETIQUETTE**
  - PAGER
    - The resident is assigned a pager
    - Response to pages should essentially be immediate
  - Email: Sinai Outlook
    - Sinai email (Outlook) is to be checked twice daily, at minimum:
      - Prior to starting the residency shift
      - At the time of completion of work duties, prior to departure for home
      - Any number of times in between
      - A 24 hour response to emails is the general expectation
    - Urgent emails (emails flagged as 'urgent' or 'stat') : as quickly as possible / appropriate
    - Email that states an expectation or a request – from Director, RPD, RPC or Ops Manger OR current Preceptor: a prompt response is expected.
    - Response within 24 hours expected: unless the resident is on PTO,
      - Even if the resident has not obtained the desired/endpoint to the request, receipt of the email must be acknowledged
        - The situation must be stated and the expected timeframe of completion provided, if appropriate.

B. Mount Sinai Hospital Medical Center Responsibilities

Mount Sinai Hospital's PGY1 Pharmacy Residency Program agrees to provide, through its facilities and affiliated facilities, an education and training program that is in compliance with the American Society of Health Systems Standards for PGY1 Pharmacy Residency Programs.

- The education and training will occur in facilities that are approved by The Joint Commission on the Accreditation of Healthcare Organizations or other recognized healthcare accrediting agencies.

Mount Sinai Hospital's PGY1 Pharmacy Residency Program agrees to provide policies and procedures whereby complaints of sexual harassment or other forms of discriminatory practices may be addressed in a manner consistent with Title VII of the Civil Rights Acts. Training in the areas of sexual harassment and cultural diversity is provided during the new caregiver orientations.

Mount Sinai Hospital's PGY1 Pharmacy Residency Program agrees to provide the Resident with due process where actions are contemplated which could result in dismissal from the program or could adversely affect a Resident's intended career development.

Mount Sinai Hospital's PGY1 Pharmacy Residency Program agrees to provide the Resident the following:

a. Personal protective equipment including gloves, face protection (masks and goggles) and gowns as required under OSHA and CDC guidelines
b. Office space and computer
c. On-site library services
d. Lab coat
e. Pager (and/or) phone

INSURANCE COVERAGE

Insurance Coverage is available to the Resident through SINAI HEALTH SYSTEM caregiver benefits.

NON-DISCRIMINATION

Mount Sinai Hospital complies with all applicable federal, state and local laws and regulations relating to non-discrimination in employment. Mount Sinai Hospital does not and will not discriminate on the basis of race, color, age, sex, sexual orientation, religion, ancestry, citizenship, national origin, marital, familial or disability status or veteran status, or any other characteristic protected by applicable law with respect to any aspect of employment.

C. TRAVEL

- ASHP Midyear Clinical Meeting
- Great Lakes Pharmacy Conference

Travel Expense Reimbursement:

Midyear Clinical Meeting and Great Lakes Conferences expenses are reimbursed

Receipts must be itemized and only for one person (Itemized checks are required for group meals.)

- Receipts for all of the following expenses while attending a conference must be submitted:
  - Transportation (to/from airport) – share transportation if possible
  - Meals (up to 3 meals/day) – Meals must be reasonably priced, nothing extravagant or overtly expensive. Alcohol is not covered.
  - Parking or car rental
  - Conference registration
  - Poster printing
  - Airfare
  - Hotel

The form (check request form on Sinai Net) and itemized receipts for each documented expense must be submitted to the Director of Pharmacy after completion of the conference for review and approval.

D. VACATION (PTO)

The Resident is entitled to 184 hours of Paid Time Off (PTO). The hours are front-loaded. Any unused PTO at the end of residency is voided.

Paid Time Off (PTO) Hours include:
1. Sick, holiday, vacation days
2. All conferences including but not limited to ASHP Midyear Clinical Meeting and Great Lakes Pharmacy Resident Conference must be taken as PTO
3. Time off for job interviews and board exams must be taken as PTO

PTO leave is granted at the discretion of the Residency Program Director and must be approved, in advance, by the Residency Program Director. PTO can be scheduled pending approval from the RPD, and the manager where the resident is scheduled to work, and the preceptor whose rotation the vacation impacts*. It is imperative that the resident request time off well in advance of schedule preparation by the managers.*

E. EXTENDED LEAVE

The Resident complies with the Human Resource Policies and Procedures.

Absences of less than 8 weeks may be addressed at the end of the scheduled duration of the PGY1 12 month residency learning period, at the discretion of the Residency Program Director and Director of Pharmacy. Reasonable accommodations are made to facilitate completion of PGY1 program based on the availability of the staff to precept the Resident past the expected graduation date. Absence of greater than 8 weeks will result in the automatic termination of the Agreement between the site and the Resident, and the Resident will not be permitted to continue to graduation and time spent in the program will be forfeited.

Upon return to work after the leave, the Resident will continue with PGY1 Pharmacy Residency Program and learning experiences as arranged with the RPD. Some electives may not be available at this time. Salary will resume on return and be extended to the end of employment at the previous rate. Benefits will be extended as HR policy.

F. COMPENSATION AND BENEFITS

The Resident receives a salary at the annual rate of documented in the residency contract (less applicable taxes and deductions) paid in bi-weekly installments in accordance with the SINAI HEALTH SYSTEM's regularly scheduled pay periods.

For more specific details about each benefit, access the Human Resource webpage on SinaiNet.

G. RESIDENT DISMISSAL POLICY

Residents are expected to conduct themselves in a professional manner and to follow all pertinent medical center and departmental policy and procedures.

A resident may be dismissed from the residency if he/she:

- Breaches any terms or conditions of the contract
- Fails to present themselves in a professional manner
- Fails to follow MSH hospital, pharmacy department, PGY1 Residency policy and procedures
- Fails to get licensed by 90 days, approximately 3 months, after the start of residency.
- Fails to perform at a level consistent with residency program expectations (i.e. consistent, poor evaluations without evidence of improvement over several rotations)

- If the pharmacy Resident does not demonstrate satisfactory progress towards the Goals & Objectives stipulated in the Residency Learning Experience, as determined by the RPD/pharmacy director and preceptors; OR the Resident receives greater than 50% "needs improvement" on a PharmAcademic final rotation evaluation for two (2) rotations

All matters pertaining to the Resident's performance under the terms of the Agreement will be handled by the Residency Program Director, in collaboration with the Director of Pharmacy. Employment during the period of this Agreement is expressly conditioned upon satisfactory performance by the Resident during the entire term of the Agreement presently in effect at the time the Agreement is executed for a period of 12 months, in accordance with the PGY1 Pharmacy Residency Guidelines.

If termination occurs, SINAI HEALTH SYSTEM human resource policies will determine the termination of health insurance and other benefits.

SINAI HEALTH SYSTEM will not terminate this Agreement without providing the Resident with written notice, corrective action plan and an opportunity to discuss the reason for the termination with the RPD and the Director of Pharmacy. The Resident has recourse through Human Resources to appeal this action.

If any of the above performance issues occur, the appropriate disciplinary actions will be taken. The normal steps in a disciplinary action process are as follows:

1. Residents will be given verbal counseling by their primary preceptor or RPD if they fail to meet the above requirements for the first time. They will be counseled on the actions necessary to rectify the situation involved. The remedy or disciplinary actions will be decided solely by the involved residency advisor, primary preceptor or RPD. This verbal counseling will also be documented in their personnel file by the involved residency advisor, primary preceptor or RPD. The Director of Pharmacy must be informed of the action if they are not directly involved.

2. If a resident fails to correct his/her behavior, the RPD, human resources and pharmacy management team will meet together and jointly decide an appropriate disciplinary action against the resident (such as an additional project, removing from certain activities or working after normal hours, etc.) This action will be documented again in the personnel file and will be immediately communicated to the Director of Pharmacy.
3. If a resident still fails to correct his/her behavior or meet the specific disciplinary action requirement, the RPD, Human Resources and pharmacy management team can jointly recommend the resident be withdrawn from the program. This action will require the approval of the Director of Pharmacy and Human Resources. The Residency Preceptors will also review the recommendation. No action of dismissal will be taken against the resident until the final approval of the Director of Pharmacy and Human Resources.
4. If the RPD believes that the action recommended by the Director of Pharmacy, Human Resources, and approved by the Residency Preceptors, is appropriate, then the disciplinary action of dismissal will be taken by the Director of Pharmacy and RPD.

**Residency "advisor" could be resident's mentor, main project preceptor, or other individual who has established a positive relationship with the resident.*

H. ELIGIBILITY

The Resident must meet the qualifications for Resident eligibility as determined by the American Society of Health System Pharmacists (ASHP).

Offers of employment with Mount Sinai Hospital Medical Center are contingent upon the completion of the following:

1. Graduation from accredited Pharmacy College.
2. Applicant background check

3. Pre-placement physical examination including a urine drug screening, compliance with immunization, tuberculosis skin testing
4. Form I-9 documenting the verification of identity, schooling and prior employment authorization, prior to initiating employment
5. Licensure: at minimum, a valid, active Illinois technician license. Alternately, if already licensed as a pharmacist, a valid, active Illinois pharmacist license

I. Residency Binder

Residents will each be given 2 binders which the resident will fill with their work over the course of the residency. The 2 binders are duplicates of each other. One binder will be kept by the RPD after the resident leaves / completes the PGY program and one binder will serve as a portfolio of the resident's activities over the period of the residency for the resident to keep.

The binder should be divided into sections , by rotation) that include, but are not limited to:

- Each rotation completed
- Project information, including
    - IRB
    - Milestones
    - Mid Presentations, e.g., MCM and/or Great Lakes, Lecture to Family Practice physicians
    - Final Presentations
    - Final document, in Word, suitable for presentation at the P&T or other hospital committee
- All P&T committee work
- Summary of meetings
- Lectures (including CE presentations) given and the Power Point presentation
- Key Evaluations
    - Resident Self-Assessment
    - Resident Customized Plan
    - Quarterly Reports
- Monthly / rotation Calendar (which includes daily log of all activities)
    - Major rotation accomplishments
        - Direct Patient Care (DPC) rotation – case or journal club handout
        - Non-DPC rotation – primary project(s) of rotation , e.g., monograph, guideline, cost analysis
        - Copies of journal articles formally reviewed Journal articles, maintained for self-edification and/or future teaching opportunities, are to be kept in a separate binder
        - Policies & Procedures updated by the resident
- Evaluations, including rotation evaluations, self-evaluations, quarterly evaluations, midpoint evaluations, and exit interview

VIII. REQUIREMENTs for the ATTAINMENT of Certificate of Graduation

Requirement	Achieved	Date
1. Complete Orientation Checklist	☐	
2. Successful completion of all learning experiences **a. Orientation and 10 concentrated learning experiences** **b. Longitudinal learning experiences (** Pharmacy Staffing, Residency Project Management)	☐ ☐	
3. The resident must complete a major research or quality improvement project		
a. The resident must submit project to the IRB (unless it is a project deemed exempt from IRB).	☐	
b. The resident must present a poster at ASHP Mid Year Clinical Meeting, or other meeting deemed appropriate by the RPD	☐	
c. The resident must present at the Great Lakes Pharmacy Residency Conference. In case of extenuating circumstances the resident may present at an alternative conference with approval of the RPD	☐	
c. The resident must present the residency project to the pharmacy staff	☐	
d. The resident must present the residency project to the appropriate hospital meeting, e.g., P&T Committee	☐	
4. Achieve the residency goals and objectives, identified as critical, below, as ACHR: must attain a final evaluation of ACHR.	☐	
5. All PharmAcademic Evaluations must have been completed. a. All evaluations are completed and signed b. All related files have been attached, as requested	☐ ☐	
6. Residency Binder completed a. Organized by rotations **b.** Documents included are projects, key patient cases and journal clubs, drug information questions	☐	
7. Completion of the Annual Residency Document	☐	
8. Completion of any other assignments _____	☐	
9. Optional : Completion of teaching certificate program through RUCOP	☐	
10. RAC consensus that the resident has successfully completed the requirements for graduation.	☐	

Competency Area R1: Patient Care, ALL goals
GOAL R1.1 In collaboration with the health care team, provide safe and effective patient care to a diverse range of patients…following a consistent patient care process.
GOAL R1.2 Ensure continuity of care during patient transitions between care settings.
GOAL R1.3 Prepare, dispense, and manage medications to support safe and effective drug therapy for patients.
GOAL R1.2 Ensure continuity of care during patient transitions between care settings.
Competency Area R2: Advancing Practice and Improving Patient Care, the objective
Objective 2.1.4: (Applying) Participate in medication event reporting and monitoring.
Competency Area 3: Leadership. GOAL R3.1 Demonstrate leadership skills.
Objective R3.1.1: (Applying) Demonstrate personal, interpersonal, and teamwork skills critical for effective leadership.
Objective R3.1.2: (Applying) Apply a process of on-going self-evaluation and personal performance improvement.
GOAL R4.1 Provide effective medication and practice-related education to patients, caregivers, health care professionals, students, and the public – specifically, objectives:
Objective R4.1.1: (Applying) Design effective educational activities.
Objective R4.1.2: (Applying) Use effective presentation and teaching skills to deliver education.
Objective R4.1.3: (Applying) Use effective written communication to disseminate knowledge.
Objective R4.1.4: (Applying) Appropriately assess effectiveness of education.

IX. CONTINUOUS QUALITY IMPROVEMENT of the RESIDENCY PROGRAM

1. PRECEPTOR

a. Preceptor Selection Criteria

1. ASHP standards for eligibility are used.
    a. Pharmacist preceptors must be licensed pharmacists who:
        - have completed an ASHP-accredited PGY1 residency followed by a minimum of one year of pharmacy practice experience; or
        - have completed an ASHP-accredited PGY1 residency followed by an ASHP-accredited PGY2 residency and a minimum of six months of pharmacy practice experience; or
        - without completion of an ASHP-accredited residency, have three or more years of pharmacy practice experience.
2. In addition, the ASHP-provided preceptor qualifications must be demonstrated by meeting one or more qualifying characteristics in all of the following six areas cited by ASHP:
    a. demonstrating the ability to precept residents' learning experiences by use of clinical teaching roles (i.e., instructing, modeling, coaching, facilitating) at the level required by residents;
    b. the ability to assess residents' performance;
    c. recognition in the area of pharmacy practice for which they serve as preceptors;
    d. an established, active practice in the area for which they serve as preceptor;
    e. maintenance of continuity of practice during the time of residents' learning experiences; and,
    f. ongoing professionalism, including a personal commitment to advancing the profession.

3. New preceptors must
    a. Complete Preceptor Letter's "*Orientation for Pharmacy Residency Preceptors*"
    b. Demonstrate competence in the area of pharmacy practice for which they serve
        i. Function with competence, confidence and independently, based on performance evaluations and/or observations of managers (including the RPD) .
    c. Demonstrate a desire and aptitude for teaching (including competency in the four preceptor roles, i.e., instructing, modeling, coaching, and facilitating.

        i. Prior to designating the pharmacist as a residency preceptor, the preceptor must have been a preceptor of pharmacy students, with positive feedback and good student outcomes.
            - The preceptor demonstrates that he/she is effectively able to blend preceptor requirements with assigned pharmacist responsibilities, as determined by minimization of Over Time hours and timely completion of student evaluations.
        ii. If the resident came from another institution (without a record of student preceptorship on-site), the record of preceptor effectiveness is reaffirmed with previous employer.

b. Development Plan

1. The RPD evaluates the qualifications of potential preceptors and re-evaluates current preceptors annually based on the ASHP accreditation Standard for PGY1 Pharmacy Residencies. Teaching Certificate is desirable, though not a requirement.
2. RPD ensure that the preceptor serves as a role model for the learning experiences that he/she precepts:
    a. contribute to the success of residents and the program
    b. provide learning experiences aligned with ASHP expectations
    c. participate actively in the residency program's continuous quality improvement processes;
    d. demonstrate practice expertise, preceptor skills, and strive to continuously improve;

e. adhere to residency program and department policies pertaining to residents and services; and
f. demonstrate commitment to advancing the residency program and pharmacy services.

3. RPD ensures minimum participation of individual preceptors in preceptor Curriculum : a minimum of two preceptor continuing education encounters annually, including
   a. Seminars, e.g., the Chicago-metro area residency preceptor conferences or other conferences
   b. Specialized Preceptor Learning Modules
   c. Electronic media, e.g., *Pharmacist's Letter Preceptor Home: http://www.pharmacistsletter.com* or ASHP (www.ashp.org) electronic library material.
      - *If a minimum of 2hours Preceptor learning is not completed in the year, then at least two modules in the Preceptor Home archives are to be completed.*
4. RPD promotes ongoing individual preceptor development,
   a. The RPD will review and provide feedback on the preceptor's rotation learning experience evaluations, in addition to preceptor evaluations.
   b. The resident will again be prompted for feedback about preceptors, learning experiences, (and the program overall) during the exit interview at graduation.

2. The RPD, in conjunction with the RAC and pharmacy leadership, routinely evaluates the quality of the residency program, encompassing multiple aspects of the program. Both short-term, i.e., for the current residency, or long-term, i.e., for year-to-year modifications, are addressed. Residency program graduates are also tracked, in order to determine program outcomes. Also addressed are preceptor development criteria and issues. A plan is put in place to provide for adjustments to the program based on the feedback provided by preceptors, residents, and other pharmacy and non-pharmacy staff members, including physicians, nurses, and pharmacy administration.

A. Plan for Improvement in Preceptor Quality
   1. Annually, or more frequently, **a needs assessment is conducted for preceptors**
      a. Evaluate tools and resources available to preceptors
         - Conduct a preceptor survey.
      b. Assess the outcomes of previous plans to determine the outcomes of the changes made to the residency program
      c. Revise plan based on the assessment of plan
      d. Evaluate potential candidates to determine whether the candidate in question is qualified to serve as a preceptor. Refer to Selection criteria, above in VIII) 1.
      e. Plan for annual group dinner / outing – after the residency's end.

B. Evaluate Program Outcomes
   1. *Learning Experiences:* RPD and RAC review learning experience evaluations and regularly review the resident's progress towards achieving the program outcomes. The RAC meets quarterly, at minimum, to discuss the resident progress. If an issue is evident before the quarterly meeting date, a RAC meeting is convened on short notice.
   2. *Resident Outcomes:*
      a. The graduate resident is contacted 2 - 3 years subsequent to graduation to ascertain, again, if the residency met their needs and the resident's perception of preparation for their role in the workplace. Also the graduate resident is asked if, upon time and reflection, they could identify possible areas of improvement of the program. The RAC then evaluates those comments and the need for program modification.
      b. The RPD also maintains a graduate tracking table, updating career moves, as possible.
   3. *The Program*

Review and discuss at the RAC the evaluations of the program by the resident. This is done at the end of the residency.

4. *The Practice of Pharmacy within the institution*
   Evaluate the impact of the PGY1 Pharmacy residency on the provision of patient care within the institution. This is done annually, at the end of the residency.

X. GLOBAL OVERSIGHT of RESIDENCY PROGRAM and ACCREDITATION

II. Pharmacy leadership meets on an ongoing basis for the determination of strategies in planning and general oversight of the residency program. The leadership group ensures that the residency program has a positive impact on patient care at MSH, while advancing the profession of pharmacy by providing post-graduate pharmacists with the experience and mentoring needed to perform as competent, pro-active clinicians in tomorrow's challenging healthcare environment.

III. The leadership group consists of the RPD, RPC, Pharmacy Director, and Pharmacy Managers.

GLOSSARY

MSH Mount Sinai Hospital (Medical Center) / Sinai Health System

ACLS – Advanced Cardiac Life Support

BLS – Basic (Cardiac) Life Support

Certification. A voluntary process by which a nongovernmental agency or an association grants recognition to an individual who has met certain predetermined qualifications specified by that organization. This formal recognition is granted to designate to the public that the individual has attained the requisite level of knowledge, skill, or experience in a well defined, often specialized, area of the total discipline. Certification usually requires initial assessment and periodic reassessments of the individual's qualifications.

Customization. The process by which a residency's generic plan for training (program outcomes; educational goals; educational objectives; structure; learning activities; extent of modeling, coaching, and facilitation; and, assessment strategy for preceptor and self-evaluation) are modified to account for the strengths, weaknesses, and interests of the resident to help ensure that each resident's training is optimal.

Director of Pharmacy. The person who has ultimate responsibility for the residency practice site/pharmacy in which the residency program is conducted.

Interdisciplinary team. A team composed of members from different professions and occupations with varied and specialized knowledge, skills, and methods. The team members integrate their observations, bodies of expertise, and spheres of decision making to coordinate, collaborate, and communicate with one another in order to optimize care for a patient or group of patients. (Institute of Medicine. Health professions education: a bridge to quality. Washington, DC: The National Academy Press; 2001.)

***GLRC* – Great Lakes Residency Conference**

MCM – Midyear Clinical Meeting
PGY1 – Post Graduate Year 1

Preceptor. An expert pharmacist who gives practical experience and training to a pharmacy resident. A clinical preceptor meets the ASHP criteria.

Residency Advisory Council (RAC). *A group consisting of the RPD and the preceptors. At this time, given the relatively small size of the program, all preceptors are members of the RAC group.*

Residency program director (RPD). The pharmacist responsible for direction, conduct, and oversight of the residency program.

Residency program coordinator (RPC)

Service commitments. Clinical and operational practice activities. May be defined in terms of the number of hours, types of activities, or a set of educational goals and objectives.

Site. The actual practice location where the residency experience occurs.

References

1. Residency Learning System – www.ashp.org
2. PharmAcademic – PharmAcademic page, as found on the ASHP Website

Attachments

A. Mount Sinai Hospital / Sinai Health System PGY1 Pharmacy Resident Position Description
B. Glossary of Terms

These guidelines should be cross-referenced with the resident job description and with ASHP standards.