PROGRAM DOCUMENTATION for SITE VISIT

Documents for site visitor:

1. Overall educational goals for the program [*CPR IV.A.1*]

2. Competency-based goals and objectives for each experience at each educational level [*CPR IV.A.2*]

3. Policy on supervision of residents/fellows [*CPR IV.A.4*]

4. Policy and procedures for residents/fellows’ duty hours and work environment [*CPR II.A.4.j.*]

5. Moonlighting policy [*CPR II.A.4.j. and CPR VI.F.*]

6. Evaluations:
   
   a. Formative evaluations of residents- completion of each rotation [*CPR V.A.1.a*]
   
   b. Evaluations showing multiple evaluators: faculty, peers, patients, nurses, and other professionals. [*CPR V.A.1.b(2)*]
   
   c. Documentation of competency-based semi-annual evaluations with feedback [*CPR II.A.4.g*]
   
   d. Final summative evaluation- ‘verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision’. Effective July 1, 2007 [*CPR V.A.2*]
   
   e. Annual written confidential evaluations of faculty by residents [*CPR V.B.3*]
   
   f. Annual written confidential evaluations of program by residents [*CPR V.C.1.d.(1)*]
   
   g. Annual written evaluations of program by faculty [*CPR V.C.1.d.(1)*]

7. Documentation of program evaluation [ex. minutes from meeting] and written improvement plan [*CPR V.C*]

8. Documentation of residents/fellows duty hours [*CPR II.A.4.j;VI.D.1-3*]

9. Residents/fellows files – current and most recent graduates

10. Files of residents/fellows transferred into program with documentation of previous experienced and summative competency-based performance evaluations [if applicable] [*CPR III.C.1*]
Documents to have available:

1. Case and procedure logs- check Program Requirements
2. Documentation presentations to faculty and residents/fellows on fatigue and impaired physician [dates/flyer, etc]
3. Conference schedules
4. Documentation of conference attendance
5. Faculty and residents/fellows on-call schedules
6. Due process/grievance policy
7. Program specific policy on eligibility/selection
8. Program specific policy on promotion
9. Policy on non-teaching patients [check Program Requirements]
10. Lines of responsibility policy
11. Documentation of active competency-based performance improvement
12. Master Affiliation Agreements
13. Current program letter of agreement-
14. Documentation of internal review- [spreadsheet with date of panel review, participants’ titles, type of data collected, and date reviewed by GMEC]
15. Institutional Policies
   a. GME disaster policy
   b. Conflict of Interest Policy
      i. Policy on Vendor relationships
   c. Policy of accommodation for residents with disabilities
16. Support documents for PIF- if you referred to document, procedure, best practice, etc- make sure you have support documentation
17. ACGME Survey- make sure you have plan to address questions that are out of compliance and that residents/residents/fellows can support that plan when questioned.
Content of Resident Files:

ACGME e-Bulletin [August 2008] listed minimum content that should be in current residents' ‘educational files' maintained by programs:

1. Written evaluations from faculty and others
2. Periodic evaluations (at minimum every 6 months) by Program Director, his/her designee and/or a resident evaluation committee
3. Records of resident physician’s rotations and other training experience, including surgical and procedural training as applicable
4. Records of disciplinary actions, as pertinent to the given resident
5. For residents engaged in moonlighting, a prospective, written statement of permission from the program director (as specified in the institutional requirements)
6. Signed resident/fellow contract/agreement
7. Resident diploma/ECFMG Certificate
8. Materials required by ACGME institutional and special program requirements; and
9. Other content as determined by the Program Director and/or the sponsoring institution

NOTE: for residents successfully completing the program, the permanent file should contain a summative evaluation that ‘verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision'.