McMaster University | Postgraduate Medical Education

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Guidelines for Redeployment for Residents

Who will be redeployed?

1. Program Directors have provided a list of available residents for the remaining blocks of the academic year to PGME, with the currently scheduled rotations to the end of the academic year. Only designated individuals from each of the redeployment rotations will have access to this information in order to schedule residents.

   Please note that we are asking Program Directors to review the number of available residents for May and June, as projected clinical need indicate that the number, we have identified thus far may not sufficient for the clinical need projected for May and June.

2. Residents have been identified by the programs as junior or senior, depending on the redeployment assignment, program and prior experiences.
   a. All non-medicine residents, regardless of year of training, redeployed to GIM will be assigned as a junior on the CTU with appropriate supervision.
   b. Subspecialty residents with the Department of Medicine will be assigned senior roles, as defined by the Internal Medicine residency program.

3. Faculty redeployment schedules are been completed by the Chiefs of the relevant departments. All faculty at HHS and SJH have been asked to redeploy to areas outside their discipline, depending on service needs within their clinical area and skill sets. Faculty will also be required to provide clinical care in their current areas of practice without resident support, if their residents are redeployed.

How will redeployment work?

4. Residents from programs defined as high-need (IM, EM, ICU) may have their schedules changed and be called back from off-service rotations to cover clinical needs withing the department. Details regarding internal redeployment within departments should be obtained from the Program Director and Chiefs.

5. GIM and ICU are identified as highest needs areas for redeployment. All redeployment assignments will be based in these two areas for at least the month of April. Emergency medicine will not require residents for April but may require redeployment residents in May and June. Assessment clinics will not require residents as will primarily be staffed by faculty and other health professionals. At the present time, pediatric clinical needs will be covered by faculty, residents and fellows within the department of Pediatrics.

6. Redeployment will be for a duration of 4 weeks. Residents who have completed redeployment will move to the bottom of the list; depending on the impact of COVID19, there remains the possibility that residents may be redeployed more than once in the next three months. However, all efforts will be made to restrict redeployment to one block (4 weeks) for all residents.

7. Due to the changing demand of residents needed week by week according to the projected number of COVID-19 patients, the current block system cannot be maintained. This will lead

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to programs requiring changes to core scheduling over two blocks. Based on current modelling, the surge and increased clinical need are anticipated to start from the third week of April with numbers continuing to increase till end of May/ beginning of June. However, this may be modified as time progresses and new prediction models come into effect.

8. Two lists will be created:
   - Redeployment: all residents should anticipate redeployment for a scheduled date (earliest likely to be April 13th for GIM and April 20th for ICU).
   - Secondary list of reserve residents who will only be redeployed if there are unexpected surges of clinical activity that require increased number of health care providers; or to replace a resident who must be removed from the scheduled redeployment activity.

9. Residents and Program Directors will be notified of redeployment (both primary and reserve) as far in advance as possible (5-7 days). If there are unexpected surges and/ or leave of absences that require more residents or replacement for those already scheduled (primary list), there may be much less notice (but minimum 24 hours) for residents on the reserve list to start redeployment. Hospital Chiefs in consultation with Program Directors will be responsible for ensuring coverage, including call, for the base programs if the resident is being redeployed.

10. Residents who are not redeployed and remain on their regularly scheduled rotations may have increased clinical workloads (e.g. increased frequency of on-call) due to redeployment of other residents. All attempts will be made to adhere to the call maximums outlined in the PARO-CAHO collective agreement.

11. There is currently a great deal of uncertainty regarding the start of the surge and when extra residents outside the base specialty will be required. There may be a chance that residents scheduled to be redeployed on April 13th may not be required due to low numbers of admitted patients. We will make every attempt to notify residents and program directors by Friday of the week prior to the Monday start of the redeployment. This does mean that program directors will need to have a plan for alternate educational experiences if their residents are not redeployed for that week.

12. Residents based at Regional Campuses will remain there and will be redeployed within that area. There is also the recognition that family medicine residents based in the community are serving the needs of the community and are currently being redeployed within the region.

13. GIM and ICU will be adapting to new scheduling models for all redeployment activities. All scheduling models currently follow the PARO-CAHO collective agreements. Where possible, schedules will be the same across HHS sites and SJH. Redeployment rotations will be scheduled for a Monday start, rather than Tuesday. New schedules will apply to all residents on the rotation.

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Please note: This is the most current proposed schedule for both GIM and ICU. Both may be subject to change; you will be notified as soon as possible if any changes. There may also be differences amongst the sites, though we continue to strive to make the schedule as uniform as possible.

GIM:
2 separate resident schedules/rosters to be done in 4-week blocks

- *Schedule A – Daytime Ward Schedule*
  - *9-hour days*
  - *0800 to 1700*
  - *7 consecutive days on duty followed by 7 consecutive days off*
  - *Each resident to do a total of 14 days in the month in two 7-day blocks*

- *Schedule B – 16-hour (5pm-9am) ED/ward coverage*
  - *1:4 call (7 calls per 28-day block)*
  - *Residents will not be on clinical duties on days that they are not scheduled for a shift*
  - *In times of surging capacity (>240 patients) 16-hour shifts will be converted to 24-hr shifts*

ICU (HHS):

All faculty and residents will move to 12-hour shifts.

- *For residents:*
  5 (12-hour) night or day shifts followed by 5 days off, followed by 5 night or day shifts
  Example:
  Resident X- 5 nights, 5 days off, 5 days
  Resident Y- 5 days, 5 days off, 5 nights

14. All residents will be provided with orientation packages prior to redeployment and orientation on site on Day 1 of redeployment. All residents will be assessed during the redeployment activity; with the minimum expectation of a redeployment In-training Assessment Report. At least one EPA will be identified for Residents in Royal College CBD programs by the Program Director that can be attempted/ completed while on the redeployment rotation. All redeployment rotations will be documented on MedSIS and if possible, depending on the specific program and required competencies would be counted towards program completion.

15. Hospitals are currently cohorting the COVID19 positive patients in different geographic areas within the hospital. For as long as it is possible, junior residents on GIM will not be assigned clinical duties on the COVID19 areas. These patients will primarily be cared for by faculty and senior residents to minimise the number of exposed residents and preserve PPE.

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16. PGME will be sending a weekly anonymous survey to all residents on redeployment rotations to assess your sense of safety and support while on the rotation. Responses will be collated by PGME and discussed with the contact people (listed below) to ensure that we correct any issues in a timely manner. Please be reassured that all collected data will be anonymous.

Factors to be used for Selecting Residents for Redeployment:

Please remember that we will use these guidelines but always with the proviso that it will depend on clinical need and resources. Updates of these guidelines will be provided in a timely manner to all residents and program directors.

17. All residents within the training program (IM; ICU; EM) will be redeployed within that area; exceptions will be those residents who are scheduled for a rotation in another high-needs area
    (e.g. IM Resident scheduled for ICU)

18. Whenever possible, residents will be redeployed to the site where they have previously completed CTU or ICU- however this may not always be possible. Other options may include keeping residents at the site they are located for the previous rotation.

19. Number of residents required by GIM and CTU is being calculated on a weekly basis so there will be staggered redeployment schedules. Numbers of required residents are based on projected numbers of inpatients, available staffing and gaps in coverage. All residents who are scheduled for core rotations on CTU and ICU over the next three blocks will not be moved.

20. Residents in the final year of training (PGY2s in Family Medicine, PGY5s in RC programs): Recognizing that extensions of training due to redeployment creates further hardship for our final-year residents, core rotations that are essential for completion of training and are still able to deliver the necessary educational experience will be preserved, if possible. For residents who are in earlier years, we expect that core rotations may still be able to be delivered through the remainder of training, with the recognition that this will be easier to achieve for residents in 5-year programs versus 2-years. The Postgraduate Deans across Canada are in discussions with the Royal College and CFPC regarding rules around waivers of training.

21. Limiting movement across sites: This has been a directive of the hospitals. Where possible, residents will be redeployed to the site where they are based for current clinical activities. For example:
    Residents who are currently completing CTU for Block 10 may be asked to complete their redeployment on the same CTU staring in Block 11 (with the first week (April 6th to 12th) being off as per the GIM schedule); similarly, for ICU. These residents and program directors will be notified by Monday April 6th at the latest.

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22. Residents on non-clinical rotations (research etc.) or on clinical rotations that are markedly reduced in activity (e.g. ambulatory care, laboratory) will be redeployed first while maintaining the principle of limiting redeployment to 4 weeks per resident, if possible.

23. All schedules are currently in compliance with PARO-CAHO collective agreement. If there are changes that are potentially in violation, PGME and PARO will be consulted prior to implementation

Communication:

24. There will be one designated individual who will send you the schedule and orientation packages. This will be sent to you early this week as soon as the schedules are finalised. This person will also be available for any questions that may arise or any concerns that arise during the redeployment block. Prior to distribution to residents, PGME and Program Directors/ Program Administrators will be notified
    - **PGME:** Will ensure that this is reflected in redeployment spread sheets and available for questions
    - **Program Directors/ Program Administrators:** will review any issues within the existing service (e.g. change in call schedules) and PAs will change the training lines on MedSIS to Redeployment rotation.

GIM-SJH: Dr. Jason Cheung
GIM-HGH: Dr. Marianne Talman
GIM-Juravinski: Dr. Leslie Martin
ICU-HHS: Dr. John Centofanti **ICU-SJH: Dr. Mark Soth**