NIGHT FLOAT ROTATION CURRICULUM

Goals, Objectives & Competency Framework — PGY-Stratified (PGY-1 / PGY-2 / PGY-3)

Internal Medicine Residency Program

Overnight Admitting & Cross-Cover (Wards) Service

Field	Detail
Rotation / Block	Night Float (Ward Overnight Admitting & Cross-Cover)
Program	Internal Medicine Residency
Institution	San Antonio Regional Hospital, Upland, CA
Applicable Levels	PGY-1, PGY-2, PGY-3 (objectives cumulative by level)
Typical Duration	2 week blocks; see IM night-float limits below
Program Director	Nandini Gowda, MD
Rotation Director (s)	**Team B- Bilal Rayes, MD;** **will roll out to Team A & Team C next year**
Version	2.0 (2026 ACGME alignment)
Effective Date	7-1-26
Approval Routing	**PEC approval pending**
Scheduled Review	Annual (or upon guideline / Program Requirement revision)

Regulatory basis of this document

This curriculum is written to conform to the ACGME Common Program Requirements (Residency) and the ACGME Program Requirements for Graduate Medical Education in Internal Medicine currently in effect for the 2025–2026 academic year, including the ACGME-approved interim revision effective February 9, 2026.

The February 2026 interim revision suspended enforcement of several administrative requirements (e.g., primary clinical site, Program Letter of Agreement renewal interval, program aims, Self-Study, and the 10%/88-hour clinical-and-educational-work-hour exception) pending a major revision expected to be posted for public comment before the end of 2026. The core clinical-and-educational-work-hour limits and supervision standards reflected below remain fully in force.

Contents

Organization and Lines of Responsibility

Site / Service: SARH Wards — overnight admitting and cross-cover of internal medicine teaching-service patients.

Night Float is a core inpatient experience in which residents provide overnight care for teaching-service patients, including new admissions and the cross-cover of established patients. The night team is supervised by an on-site supervising senior resident and by an attending physician who is available on site or immediately available by telephone or other electronic means. The resident functions as a key member of the overnight team, provides compassionate, evidence-based care, and progressively assumes more autonomous decision-making in a graded fashion appropriate to level of training, patient complexity, and patient acuity.

The rotation emphasizes independent clinical judgment with appropriate and early escalation, recognition and initial management of acute overnight deterioration, safe transitions of care, and high-quality structured handoff communication. Consistent with the Internal Medicine Program Requirements, residents from other specialties must not supervise internal medicine residents on internal medicine inpatient rotations. Senior residents serve in a supervisory and teaching role to junior members of the night team.

Purpose and Prerequisites

Purpose: To develop the skills required for safe, effective, and increasingly autonomous overnight inpatient care — rapid triage, stabilization of the acutely ill or deteriorating patient, high-value diagnostic and therapeutic decision-making under uncertainty, and reliable transitions of care across the night-to-day interface.

- **Prerequisites:** Successful completion of institutional onboarding, EHR training, and BLS/ACLS certification.
- Completion of, or concurrent training in, the program's standardized handoff (I-PASS) and escalation pathways.
- PGY-1 residents enter with direct or closely available supervision and advance along the entrustment scale as competence is demonstrated.

General Goal and Overarching Objectives

General Goal: During Night Float, the resident is responsible for the overnight admission, cross-cover, and stabilization of inpatient teaching-service patients, and for safe transitions of care to and from the day teams.

Overarching objectives (developed progressively across all three years)

- Provide safe, timely, evidence-based overnight care with appropriate and early escalation.
- Recognize and manage acute clinical deterioration and lead or participate in rapid responses and codes.
- Perform efficient triage and prioritization of simultaneous clinical tasks and pages.
- Deliver and receive high-quality, structured handoffs that preserve continuity and patient safety.
- Communicate effectively with patients, families, nursing, and the day and night teams, including goals-of-care and code-status discussions.
- Practice fatigue-mitigation and well-being strategies that protect both patient safety and self-care.
- Assume responsibility in a graded fashion, progressing toward unsupervised practice by completion of training.

Levels of Supervision and Progressive Autonomy

Residents are supervised overnight by an on-site supervising senior resident and by an attending physician available on site or immediately available by telephone or electronic means. Consistent with the current ACGME Common

Program Requirements, the level of supervision provided to an individual resident is determined by that resident's level of training together with the complexity and acuity of the specific patient. The program uses the following three ACGME-defined levels of supervision:

Level	Definition (ACGME)
Direct Supervision	The supervising physician is physically present with the resident and patient; or, where permitted for the setting, is not physically present but is concurrently monitoring the care through appropriate telecommunication technology.
Indirect Supervision	The supervising physician is not physically present with the resident and patient and is not concurrently monitoring the care, but is immediately available to the resident for guidance and is available to provide direct supervision when needed.
Oversight	The supervising physician is available to review encounters and procedures, with feedback provided after care is delivered.

PGY-1 residents must initially be supervised directly (in person or, where the setting permits, through the telecommunication-based form of direct supervision) and progress to indirect supervision with direct supervision immediately available as they demonstrate the competencies defined by the program. Night Float relies predominantly on indirect supervision with graded autonomy: PGY-1 residents escalate early and frequently; supervising senior residents provide on-site supervision to juniors and escalate to the attending for higher-acuity decisions.

Mandatory escalation triggers — when to contact the supervising physician

Consistent with the ACGME requirement that programs define the circumstances in which residents must communicate with the supervising physician, residents must contact the supervising senior resident and/or attending without delay for any of the following. This list is a floor, not a ceiling; residents escalate whenever uncertain.

- Any clinical deterioration, or a patient meeting rapid-response or code criteria.
- New or anticipated need for ICU-level care or transfer.
- Death of a patient, or a patient approaching end of life.
- Critical laboratory or imaging results, or a new unexpected diagnosis of significance.
- New need for blood products, urgent procedures, or a bedside procedure requiring supervision per program policy.
- Any change in code status, or a goals-of-care or end-of-life discussion with a patient or family.
- Any patient-safety event, medication error, or adverse event.
- Any situation exceeding the resident's scope of authority or level of comfort, or when a patient or family requests to speak with the attending.

Assessment Framework — Entrustment

The basic unit of assessment is entrustment. Supervising attendings and seniors determine the level at which they trust the resident to perform each skill overnight. Entrustment ratings are mapped to the Internal Medicine Milestones and reported to the Clinical Competency Committee (CCC).

Level	Descriptor
1	Cannot perform the skill even with assistance (critical deficiency).
2	Can perform the skill under proactive, full supervision.

Level	Descriptor
3	Can perform the skill with reactive supervision (readily available on request).
4	Can perform the skill independently.
5	Can act as a supervisor and instructor for the skill.

The Six ACGME Core Competencies — Objectives by Level of Training

Objectives are stratified for PGY-1, PGY-2, and PGY-3 residents, reflecting increasing entrustment in the overnight environment. Senior objectives are cumulative — PGY-2 residents also meet PGY-1 objectives, and PGY-3 residents meet all prior objectives. Objectives map to the Internal Medicine Milestones (v2.0) as indicated in the mapping table that follows this section.

1. Patient Care

Residents will provide patient care that is compassionate, appropriate, and effective for the overnight admission, cross-cover, and stabilization of hospitalized patients.

PGY-1 — Initiate and escalate under supervision

- Perform a focused admission history and physical examination on overnight admissions of mild to moderate complexity under supervision.
- Evaluate and initiate management of common cross-cover calls (e.g., chest pain, dyspnea, hypotension, fever, altered mental status, pain, abnormal glucose, and electrolyte pages).
- Recognize the deteriorating patient and escalate promptly to the senior resident or attending; activate a rapid response when indicated.
- Prioritize and triage multiple simultaneous tasks and pages.

PGY-2 — Manage independently and stabilize (in addition to PGY-1)

- Independently manage overnight admissions and cross-cover of moderate to severe complexity with indirect supervision.
- Lead the initial stabilization of the acutely deteriorating patient and participate in rapid responses; determine the appropriate level of care and need for ICU transfer.
- Adjust management based on evolving overnight data and communicate changes clearly to the day team.

PGY-3 — Lead the night team, supervise, and teach (in addition to PGY-1 and PGY-2)

- Supervise and support junior residents in overnight admissions, cross-cover, and triage.
- Lead resuscitation and codes and manage the post-arrest patient; direct the night team.
- Independently manage complex and undifferentiated overnight patients at the level expected for unsupervised practice.

Instructional / Training Methods: *Experiential overnight patient care, supervised admissions and cross-cover, rapid-response and code participation, simulation.*

Evaluation Methods: *Direct observation by supervising senior/attending, faculty entrustment ratings, review of overnight admissions and events.*

2. Medical Knowledge

Residents will demonstrate knowledge of the evaluation and acute management of common overnight clinical problems and apply it to patient care using current evidence and guidelines.

PGY-1 — Initiate and escalate under supervision

- Demonstrate foundational knowledge of the presentation and initial management of the common overnight cross-cover problems listed in the appendix below.
- Understand the indications for and interpretation of overnight diagnostics (ECG, portable chest radiograph, point-of-care ultrasound where credentialed, basic labs, ABG/VBG, lactate).

PGY-2 — Manage independently and stabilize (in addition to PGY-1)

- Apply knowledge to complex, atypical, and multi-system overnight presentations.

- Justify, on the basis of current best evidence and guidelines, acute diagnostic and therapeutic decisions made overnight.

PGY-3 — Lead the night team, supervise, and teach (in addition to PGY-1 and PGY-2)

- Demonstrate comprehensive knowledge across the breadth of acute inpatient medicine.
- Integrate ambiguous overnight data to reach a diagnosis and teach the underlying reasoning to juniors.

Instructional / Training Methods: *Case-based learning from overnight cases, night-team teaching, didactics, guideline review.*

Evaluation Methods: *Case-based questioning, review of overnight decision-making, faculty evaluation, in-training examination trends.*

3. Practice-Based Learning and Improvement

Residents will investigate and evaluate their overnight practices, appraise and assimilate scientific evidence, and continuously improve patient care.

PGY-1 — Initiate and escalate under supervision

- Seek, receive, and act on feedback — including feedback from the day team on overnight decisions — and reflect on performance.
- Use point-of-care evidence resources to address knowledge gaps during overnight care.

PGY-2 — Manage independently and stabilize (in addition to PGY-1)

- Appraise and apply evidence to acute overnight clinical questions and integrate self-reflection.
- Identify recurring overnight challenges and adjust personal practice.

PGY-3 — Lead the night team, supervise, and teach (in addition to PGY-1 and PGY-2)

- Lead review of overnight events and near-misses and facilitate the learning of junior team members.
- Participate in handoff or patient-safety quality-improvement initiatives.

Instructional / Training Methods: *Feedback across the night-to-day interface, case review, point-of-care evidence use, QI participation.*

Evaluation Methods: *Self-assessment and reflection, review of near-misses, teaching evaluations.*

4. Interpersonal and Communication Skills

Residents will demonstrate communication skills that ensure effective overnight information exchange and safe transitions of care.

PGY-1 — Initiate and escalate under supervision

- Give and receive structured handoffs (I-PASS) at sign-out and document overnight events clearly and concisely in the EHR.
- Communicate effectively with nursing staff, patients, and families overnight, using closed-loop communication for critical results and escalations.

PGY-2 — Manage independently and stabilize (in addition to PGY-1)

- Lead sign-out to and from the day team and communicate critical updates promptly to the attending.
- Conduct difficult overnight conversations with families with support (e.g., acute deterioration, code-status clarification).

PGY-3 — Lead the night team, supervise, and teach (in addition to PGY-1 and PGY-2)

- Model effective handoff and closed-loop communication and coach juniors in sign-out.
- Lead family and goals-of-care discussions in acute overnight situations and coordinate the night team.

Instructional / Training Methods: *Structured handoff practice, direct observation of sign-out, supervised family communication.*

Evaluation Methods: *Handoff assessment tool, direct observation, multisource feedback (nursing, peers).*

5. Professionalism

Residents will demonstrate professional responsibility, ethical behavior, and attention to well-being in the overnight environment.

PGY-1 — Initiate and escalate under supervision

- Demonstrate reliability, punctuality for handoff, accountability, and protection of patient confidentiality.
- Adhere to fatigue-mitigation and well-being practices that protect patient safety and self-care, and accurately report clinical-and-educational work hours.

PGY-2 — Manage independently and stabilize (in addition to PGY-1)

- Model professional behavior for interns and manage competing overnight demands ethically.
- Ensure a safe, complete handoff even under fatigue and high workload.

PGY-3 — Lead the night team, supervise, and teach (in addition to PGY-1 and PGY-2)

- Serve as a professional role model, support the well-being of the night team, and address lapses constructively.
- Lead ethically in acute overnight situations and advocate for patients.

Instructional / Training Methods: *Role modeling, well-being and fatigue-mitigation curriculum, direct patient care.*

Evaluation Methods: *Multisource feedback, faculty ratings, self-reflection, professionalism reporting.*

6. Systems-Based Practice

Residents will demonstrate awareness of and responsiveness to the health-care system and provide safe, high-value overnight care.

PGY-1 — Initiate and escalate under supervision

- Recognize that overnight decisions involve cost and risk and affect quality of care, and use system resources (rapid response, nursing, pharmacy, laboratory) appropriately.
- Understand ACGME clinical-and-educational-work-hour and handoff requirements and the local escalation chain.

PGY-2 — Manage independently and stabilize (in addition to PGY-1)

- Ensure safe transitions of care and recognize system factors that contribute to overnight adverse events and handoff errors.
- Practice cost-conscious, high-value overnight testing and treatment.

PGY-3 — Lead the night team, supervise, and teach (in addition to PGY-1 and PGY-2)

- Lead care coordination and safe transitions across the night-to-day interface.
- Champion handoff standardization and patient-safety initiatives at the system level.

Instructional / Training Methods: *Supervised care, handoff systems, work-hour and patient-safety discussion, multidisciplinary collaboration.*

Evaluation Methods: *Direct observation, review of transitions of care, faculty ratings, QI participation.*

Mapping to the Internal Medicine Milestones (v2.0)

The rotation objectives feed the semiannual Milestones assessment. The Clinical Competency Committee reviews entrustment ratings, direct observations, handoff assessments, and multisource feedback at least twice yearly and assigns Milestone levels, which the program reports to the ACGME. The table indicates the primary Milestone sub-competencies most directly assessed on Night Float.

Competency	Primary IM Milestone sub-competencies emphasized on Night Float
Patient Care	PC1 (history/exam/clinical reasoning), PC2 (management), PC3 (acute/emergent care & stabilization)
Medical Knowledge	MK1 (applied foundational science / clinical knowledge), MK2 (diagnostic testing & therapeutics)
Practice-Based Learning & Improvement	PBLI1 (feedback & self-improvement), PBLI2 (evidence-based practice)
Interpersonal & Communication Skills	ICS1 (patient/family communication), ICS2 (interprofessional & team communication / handoffs)
Professionalism	PROF1–PROF3 (accountability, well-being, ethical principles)
Systems-Based Practice	SBP1 (patient safety & QI), SBP2 (system navigation / transitions), SBP3 (high-value care)

Note: Sub-competency labels follow the ACGME Internal Medicine Milestones (v2.0). Programs should confirm exact numbering against the current published Milestones set.

Clinical and Educational Work Hours (Formerly "Duty Hours")

Night Float must be scheduled within all ACGME clinical-and-educational-work-hour limits currently in effect. The following limits apply to all residents:

Requirement	Standard
Maximum weekly hours	80 hours/week, averaged over 4 weeks, inclusive of all in-house clinical and educational work, clinical work done from home, and all moonlighting.
Days off	At least one day in seven free of clinical work and required education, averaged over 4 weeks; in-house call must not be scheduled on the free day.
Maximum continuous work	Up to 24 hours of continuous scheduled clinical assignment, plus up to 4 additional hours for effective transitions of care/education; no new patients may be accepted after 24 hours.
Rest between periods	Residents should have 8 hours off between scheduled clinical work and education periods, and must have at least 14 hours free after 24 hours of in-house call.
In-house call frequency	No more frequent than every third night, averaged over 4 weeks.

Overnight admission and census caps (Internal Medicine)

- A PGY-1 resident must not be assigned more than 5 new patients per admitting day (an additional 2 may be assigned if they are in-house transfers), must not be assigned more than 8 new patients in a 48-hour period, and must not be responsible for the ongoing care of more than 10 patients.
- When supervising more than one PGY-1 resident, a PGY-2/PGY-3 must not be responsible for the supervision or admission of more than 10 new and 4 transfer patients per admitting day, or more than 16 new patients in 48 hours.

These Internal Medicine census limits (Program Requirements 4.11.e.7–4.11.e.12) apply to overnight admitting and cross-cover and must be reflected in night-team assignments.

Regulatory currency note: *The standards in the table above — including the 24-hour maximum continuous assignment plus up to 4 hours for transitions of care, and the current treatment of at-home call — are those in force for the 2025–2026 year.*

Transitions of Care and Handoffs

Safe handoffs are central to Night Float and are a recognized, high-risk source of preventable error. Residents are expected to:

- Use a standardized handoff format (I-PASS: Illness severity, Patient summary, Action list, Situation awareness/contingency planning, Synthesis by receiver) for both verbal and written sign-out.
- Receive an evening handoff from the day teams, clarifying anticipated overnight issues and explicit contingency ("if–then") plans.
- Maintain and update the written/EHR handoff document in real time with overnight events, actions taken, and pending items.
- Deliver a concise, accurate morning handoff to the day teams, highlighting new admissions, clinical changes, and outstanding tasks.
- Use closed-loop communication and read-back for critical results, medication orders, and escalations.

Fatigue Mitigation and Well-Being

Residents are expected to adopt strategies that preserve both patient safety and personal well-being:

- Employ strategic napping and alertness-management strategies during overnight shifts where feasible and consistent with patient care.
- Recognize signs of fatigue and impairment in themselves and colleagues and escalate when patient safety may be affected; the program must provide a mechanism to relieve a resident who is too fatigued to provide safe care.
- Arrange safe transportation home after night shifts (the institution should provide adequate facilities/means for safe transportation when a resident is too fatigued to drive).
- Adhere to clinical-and-educational-work-hour limits and report concerns to the Program Director without fear of reprisal.
- Use available well-being resources and protect sleep, nutrition, and recovery between shifts.

Teaching Methods

Experiential Overnight Care

- Residents learn primarily through supervised, graduated responsibility for overnight admissions and cross-cover.
- Supervising seniors and attendings provide real-time teaching and feedback on overnight decision-making and escalation.
- Case-based learning and post-event debriefs reinforce management of acute overnight events.

Structured Learning

- Structured handoff practice and feedback using a standardized tool.
- Simulation for rapid responses, codes, and acute deterioration where available.
- Independent, case-driven reading anchored to current guidelines.

Assessment and Evaluation

- Direct observation and feedback by the supervising senior resident and attending, including of handoffs and overnight management, using entrustment ratings.
- Verbal mid-rotation individual feedback for every resident.
- End-of-rotation written summative evaluation incorporating input from supervising physicians and, where available, nursing and peers (multisource feedback).
- Handoff assessment using a standardized instrument.
- All assessments feed the Clinical Competency Committee, which assigns Internal Medicine Milestone levels semiannually.
- Residents complete confidential evaluations of the rotation, faculty, and supervising seniors; results inform the annual program evaluation by the PEC.

Rotation Structure

- Residents work overnight shifts as scheduled, arriving in time to receive evening handoff from the day teams and remaining through morning handoff.
- Residents cover new admissions and cross-cover of teaching-service patients under the supervision of an on-site supervising senior resident and an available attending.
- Residents escalate to the supervising senior or attending for higher-acuity decisions and rapid responses.
- Case-based learning is emphasized; residents review the management of patients seen overnight.
- All scheduling complies with ACGME clinical-and-educational-work-hour requirements and the Internal Medicine night-float limits, and is subject to Program Director approval.
- Residents must notify the supervising physician promptly if they are unable to be available for an assigned shift.

Appendix A — Common Overnight Cross-Cover Presentations & Current-Standard Anchors

The problems below are the focus of the Medical Knowledge objectives and are commonly encountered overnight. Responsibility is graded by complexity and level: PGY-1 residents initiate evaluation and escalate; PGY-2 residents manage independently and stabilize; PGY-3 residents lead and teach. The referenced standards indicate the current evidence base residents are expected to apply; they are teaching anchors, not order sets.

Overnight presentation	Current-standard anchor
Chest pain / suspected ACS	2021 AHA/ACC Chest Pain guideline; high-sensitivity troponin pathways; risk-stratified disposition.
Acute dyspnea / hypoxia; acute heart failure	2022 AHA/ACC/HFSA HF guideline; diuresis and afterload strategy; oxygenation targets.
Hypotension, shock, and sepsis	Sepsis-3 definitions; Surviving Sepsis Campaign 2021 — early appropriate antimicrobials (within 1 hour for septic shock), balanced crystalloids, lactate-guided resuscitation, norepinephrine first-line for MAP ≥65.
Hypertensive urgency vs. emergency	Controlled BP reduction in true emergencies (end-organ injury); avoid precipitous drops; oral therapy for asymptomatic elevation.
Tachy- and bradyarrhythmias; atrial fibrillation with RVR	2023 ACC/AHA/ACCP/HRS atrial fibrillation guideline; rate vs. rhythm control; thromboembolic risk; unstable → cardioversion.
Fever / new suspected infection	Source-directed workup and stewardship-conscious empiric therapy; neutropenic-fever pathways where applicable.
Altered mental status, delirium, agitation	Nonpharmacologic delirium prevention first-line; treat underlying cause; avoid benzodiazepines except in withdrawal.
Falls and acute injury	Post-fall assessment including head-injury and anticoagulation review.
Acute pain / analgesia	Multimodal, opioid-sparing analgesia; naloxone availability for opioid safety.
Nausea and vomiting	Cause-directed antiemetic selection; QT-interval awareness.
Hyper- and hypoglycemia; DKA/HHS	Hypoglycemia protocol; DKA/HHS per the 2024 ADA hyperglycemic-crises consensus report — fluids, insulin, and potassium, with quantitative β-hydroxybutyrate for diagnosis and severity; withhold insulin until potassium is repleted if K < 3.3 mmol/L; subcutaneous insulin acceptable for mild/uncomplicated moderate DKA.
Acute electrolyte abnormalities	Emergency hyperkalemia management — membrane stabilization with IV calcium, intracellular shift (insulin/dextrose, beta-agonist), then elimination; rate-controlled sodium correction in hyponatremia to avoid osmotic demyelination.
Oliguria, anuria, acute kidney injury	Volume and obstruction assessment; nephrotoxin review; indications for urgent renal replacement.
Acute gastrointestinal bleeding	Restrictive transfusion threshold (Hb ~7 g/dL in most stable patients); resuscitation, risk stratification, and timing of endoscopy per current ACG guidance.
Alcohol / substance withdrawal	CIWA-Ar–guided (or PAWSS-informed) benzodiazepine therapy; phenobarbital protocols where adopted; thiamine before glucose.
Acute respiratory failure requiring escalation	HFNC/NIV selection and monitoring; clear intubation and ICU-transfer triggers.
Behavioral emergencies / restraints	Least-restrictive approach; CMS restraint standards; time-limited orders and monitoring.
Anaphylaxis	Prompt intramuscular epinephrine (anterolateral thigh) as first-line therapy — no absolute contraindication; adjunctive fluids, airway support, and observation for biphasic reaction.

Overnight presentation	Current-standard anchor
Suspected acute stroke	Time-critical recognition and activation of the acute stroke pathway.
Suspected venous thromboembolism	Risk-stratified diagnostic and anticoagulation approach.
Code-status clarification, rapid response, code blue	Timely goals-of-care clarification; ACLS-concordant resuscitation; post-arrest care.
New admissions and overnight triage	Prioritization by acuity; safe, complete admission handoff to the day team.

Appendix B — References

- ACGME Common Program Requirements (Residency), 2025 reformatted edition with ACGME-approved interim revision effective February 9, 2026.
- ACGME Program Requirements for Graduate Medical Education in Internal Medicine (current edition), including Supervision, Clinical Experience and Education, and On-Call/Night-Float provisions.
- ACGME List of Suspended Common Program Requirements, effective February 9, 2026.
- ACGME Internal Medicine Milestones, Version 2.0.
- ACGME Glossary of Terms (supervision definitions; direct supervision via telecommunication technology).
- Starmer AJ, et al. I-PASS handoff program (changes in medical error rates).
- 2021 AHA/ACC/ASE/CHEST/SAEM/SCCT/SCMR Chest Pain Evaluation and Diagnosis guideline.
- 2022 AHA/ACC/HFSA Heart Failure guideline.
- Evans L, et al. Surviving Sepsis Campaign 2021; Sepsis-3 consensus definitions (Singer M, et al., 2016).
- 2023 ACC/AHA/ACCP/HRS Atrial Fibrillation guideline.
- Current ACG guidance on upper/lower GI bleeding; restrictive transfusion evidence.
- Umpierrez GE, et al. Hyperglycemic Crises in Adults With Diabetes: A Consensus Report. Diabetes Care 2024;47(8):1257–1275 (ADA/EASD/JBDS/DTS).

Appendix C — Compliance Verification and Citation Table

This appendix documents the source verification performed for this curriculum. Each element was checked against the ACGME Common Program Requirements (Residency) and the ACGME Program Requirements for Graduate Medical Education in Internal Medicine in effect for the 2025–2026 academic year (interim revision February 9, 2026), and corroborated where noted against independent institutional GME work-hour policies that quote the current ACGME standard. Requirement titles are cited rather than decimal numbers where reformatted numbering may vary; reconcile any specialty-specific figure against the specialty Program Requirements in effect at scheduling.

Curriculum element	ACGME US requirement (source)	Verification and status
Three levels of supervision (Direct incl. telecommunication; Indirect; Oversight)	CPR — Levels of Supervision (6.7); Direct Supervision includes concurrent monitoring via telecommunication technology	Primary text verified verbatim. PASS
PGY-1 initially supervised directly	CPR 6.7.a	Primary text verified verbatim. PASS
Supervision graded by training level, patient complexity and acuity	CPR 6.6	Primary text verified verbatim. PASS
Senior residents serve in a supervisory role to juniors	CPR 6.9.c	Primary text verified verbatim. PASS
Program-defined circumstances requiring communication with the supervising physician (mandatory escalation triggers)	CPR 6.10, 6.10.a	Primary text verified verbatim. PASS
Residents from other specialties must not supervise IM residents on IM inpatient rotations	IM PR 4.11.e.4	Primary text verified verbatim. PASS
Non-physician faculty must not supervise IM residents on inpatient rotations	IM PR 4.11.e.3	Primary text verified verbatim. PASS
Maximum 80 hours/week, averaged over 4 weeks, inclusive of in-house work, work from home, and moonlighting	CPR — Maximum Hours of Clinical and Educational Work per Week (6.20)	Primary verbatim; corroborated by Mount Sinai, Mass General Brigham, CU Anschutz. PASS
8 hours off between periods (should); 14 hours free after 24 hours of in-house call	CPR — Mandatory Time Free of Clinical Work and Education (6.21)	8-hour provision primary verbatim; 14-hour provision corroborated by Mount Sinai. PASS
One day in seven free of clinical work, averaged over 4 weeks	CPR — Mandatory Time Free (one day in seven)	Corroborated by Mount Sinai, CU Anschutz. PASS
Maximum 24 hours continuous + up to 4 hours for transitions; no new patients after 24 hours	CPR — Maximum Continuous Work	Corroborated verbatim by Mount Sinai and Mass General Brigham. PASS
In-house call no more frequent than every third night, averaged over 4 weeks	CPR — Maximum In-House On-Call Frequency	Corroborated verbatim by Mount Sinai. PASS
Night float within 80-hour and one-day-in-seven limits; consecutive-weeks / months-per-year may be further specified by the Review Committee (no fixed domestic numeric cap)	CPR — In-House Night Float (RC-option, bracketed)	Primary bracket confirmed; corroborated by Mount Sinai, Mass General Brigham, UT. Domestic 2/4/1-month cap does NOT apply (that figure is ACGME-International). PASS

Curriculum element	ACGME US requirement (source)	Verification and status
Moonlighting counts toward 80 hours; PGY-1 residents may not moonlight	CPR — Moonlighting	Corroborated verbatim by Mount Sinai, CU Anschutz. PASS
16-hour PGY-1 cap eliminated (2017); optional for programs to retain	ACGME (2017 revision)	Corroborated verbatim by Mount Sinai. PASS
Terminology “clinical and educational work hours” replaces “duty hours”	CPR — Clinical Experience and Education (Background)	Primary verbatim; corroborated by Mass General Brigham. PASS
Fatigue mitigation education; adequate sleep facilities and safe transportation for fatigued residents	CPR 6.15, 6.16	Primary text verified verbatim. PASS
Structured transitions of care; competence in handoff communication	CPR 6.19	Primary text verified verbatim. PASS
PGY-1 admission/census caps (5 new/+2 transfer per day; 8/48h; 10 ongoing) and supervising-resident caps	IM PR 4.11.e.7–4.11.e.12	Primary text verified verbatim. PASS
Semiannual CCC review of Milestones; individualized learning plans; multisource evaluation	IM PR 5.1–5.3	Primary text verified verbatim. PASS
February 9, 2026 interim revision suspensions are administrative only (do not affect work-hour or supervision standards)	CPR / IM PR revision header	Primary text verified verbatim. PASS
Proposed hard 24-hour cap and expanded at-home-call counting are NOT yet in effect	CPR major revision (proposed; public comment expected late 2026)	Confirmed proposed-only; all four institutions still document 24+4. PASS

Verification method: primary ACGME requirement text reviewed directly; independent corroboration drawn from published institutional GME work-hour policies (Icahn School of Medicine at Mount Sinai; Mass General Brigham; University of Colorado Anschutz; University of Texas). Sources reflect standards in effect for the 2025–2026 academic year. Institutional citations are provided as external corroboration and do not constitute ACGME requirements.

Approval and Version Control

Step	Name / Role	Date
Prepared by	Associate Program Director(APD) / Rotation Director	_____7-2026_____
Reviewed by	Program Evaluation Committee (PEC) & Program Director (PD)	pending
Acknowledged by	Designated Institutional Official (DIO)	pending

Document version 2.0 — aligned to ACGME standards in effect for the 2025–2026 academic year (interim revision February 9, 2026). Review annually and upon any Program Requirement or clinical-guideline revision.