UB Graduate Medical Education
Supervision Policy

Approved: December 2011

General Statements

The graduate training programs of the University at Buffalo School of Medicine and Biomedical Sciences (UB) will provide each resident with appropriate and adequate supervision for all patient care activities commensurate with an individual resident’s level of competence. The level of supervision is determined by the program faculty in accordance with the guidelines of the appropriate credentialing body (i.e. ACGME, CODA, etc.) and specialty boards. As the basic principles of supervision are patient safety, education, communication and documentation, resident supervision is to be documented appropriately and accurately in the patient record.

This policy was developed to conform to the New York State Part 405 Regulations and the various requirements or standards of the Joint Commission, ACGME, or the appropriate credentialing agency.

The term “resident” refers to all graduate trainees (interns, fellows, residents) in all programs sponsored by UB.

Concepts of supervision are found in the bylaws of the medical staff at each hospital or health care system and delineate the expectations of and requirements for the faculty, staff, and residents. At the VAWNYHS, these expectations are delineated in the VHA Handbook of Resident Supervision (http://www.va.gov/oaa/rsources_resident_supervision.asp)

This policy applies to all residents in all UB sponsored programs at all training sites.

Basic Principles of Supervision

- The faculty member is responsible for the care of the patient in all situations according to the relevant policies of the training site.

- Although gaining experience in performing procedures is an integral part of the education of the resident, procedures may be performed only by residents with the required knowledge, skill, and judgment, and under an appropriate level of supervision by faculty.

- The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients. Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident delivered care with feedback as to the appropriateness of that care.

- New York State requires on-site supervision 24/7 by supervising or attending physicians. In hospitals that can document that the patients attending physicians are immediately available by telephone and readily available in person when needed, the onsite supervision of routine hospital care and procedures may be carried out by postgraduate trainees who are in their final year of or who have completed at least 3 years of accredited postgraduate training.
• In hospitals where the patients’ attending physicians are NOT immediately available as described above, New York State requires that supervision be provided by physicians who are board certified or admissible in those respective specialties or who have completed a minimum of 4 postgraduate years of training in such specialty. There shall be sufficient number of these physicians present in person in the hospital 24 hours/day 7 days/week to supervise the postgraduate trainees in their specific specialties.

• Surgery: Supervision by attending physicians of the care provided to surgery patients by postgraduate trainees must include at a minimum:

  1. Personal supervision of all surgical procedures requiring general anesthesia or an operating room procedure
  2. Preoperative exam and assessment by the attending physician, and
  3. Postoperative exam and assessment no less frequently than daily by the attending physician.

• The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.

• The program director must evaluate each resident’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.

• The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services. Optimal clinical workload will be further specified by each Review Committee.

• **Levels of Supervision**
  To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:

  • **Direct Supervision**
    1. A resident requires direct supervision until he/she has been certified as capable of performing an action in a semi-independent manner (credentialed).
    2. Direct supervision requires the physical presence of a properly credentialed supervisor with the patient during the event or procedure.
    3. First year residents (PGY1) must have a direct supervisor available on-site at all times.

  • **Indirect Supervision**
    1. Indirect supervision allows semi-independent activity of a credentialed resident and does not require the physical presence of the faculty member or supervisor during the procedure. There are two classifications of indirect supervision specified by the ACGME:
       with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
       2. with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

    • Indirect supervision may be provided by residents if both the supervising resident and his/her resident supervisee are credentialed in the procedure to be performed. Indirect supervision is restricted to those procedures included in the residency training program’s credentialing plan.
• **Oversight**
  1. Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

• **Supervision During Electives, Required Rotations & Consultations**
  1. Residents on rotations/electives outside their “home” department will be supervised by faculty in the assigned “host” program.
  2. Any consultation by a resident who is on an elective or “off service” from a particular specialty must involve the faculty supervisor for the “host” specialty.
  3. The consulting resident should report and discuss all strategies with their “host” department faculty supervisor.

• Neither the University nor the Program Director is responsible for supervision of the resident during moonlighting or other clinical activities that are not related to the training program.

**Basic Principles of Documentation**

• Resident supervision must be documented appropriately and accurately in the patient record. This principle covers documentation of consultations, admitting notes, procedural activity, continuing care notes, and discharge summaries for inpatient and outpatient care encounters, procedures, emergency care, consults and surgeries.

• The following are acceptable forms of documentation by a faculty supervisor:
  1. an attending progress note;
  2. an attending’s addendum to a resident’s note;
  3. co-signature of a resident’s note by the attending; and
  4. resident documentation of attending supervision/involvement.

• The faculty’s documentation must meet the minimal Medicare standards or those specified by the Office of the Medical Inspector General, except at the VAWNYHS where documentation guidelines are outlined in the VHA Handbook.

• The medical record should reflect the following in the resident’s notes or dictation:
  1. the name of the faculty member who functioned as the supervisor;
  2. the degree of involvement of the faculty member;
  3. a summary of the resident and supervisor’s discussions, communications, actions, and findings;
  4. the specific issues of the diagnostic and therapeutic plans;
  5. the date and time of the personal evaluation of the patient; and
  6. any additional requirements determined by the medical staff policies and/or the administrative procedures at the clinical site.

• The frequency of documentation should be appropriate to the patient’s condition.

**Responsibilities of the Residency Program**

• In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient’s care.
• This information should be available to residents, faculty members, and patients.

• Residents and faculty members should inform patients of their respective roles in each patient’s care.

• Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.

• Develop and maintain a resident supervision plan that provides for safe and effective patient care, educational needs of residents, and progressive responsibility that is appropriate to residents’ level of education, competence, and experience. It must comply with the minimum standards set by the New York State Department of Health (Code 42-405) and the guidelines established by the program's RRC or appropriate credentialing body. In the case of discrepancies, the more rigorous standards must be met. The plan must be shared with residents and faculty annually.

  1. The supervision plan must include, but is not limited to, the following:

     ▪ a definition of the clinical responsibilities of each resident at each level of training;
     ▪ a mechanism of providing feedback and program notification if either the member of the faculty or a resident identifies a problem with supervision;
     ▪ contact information and instructions should programmatic assistance be required;
     ▪ action to be taken in emergency situations where a resident is not credentialed;
     ▪ action to be taken if the supervising member of the faculty is unavailable or does not respond to attempts at communication;
     ▪ provisions to meet the requirements outlined in “Basic Principles” for direct supervision, indirect supervision, and supervision during electives, required rotations & consultations; and
     ▪ circumstances where residents can function as supervisors on-site.

• Develop and maintain a system for documenting supervision in the resident rotation schedules and the attending on-call schedules.

• Develop and maintain a credentialing plan that is consistent with this supervision plan, and meets the requirements of NYS DOH, ACGME, and other appropriate credentialing bodies. This credentialing plan must be shared with residents and faculty annually.

  o The credentialing plan must include, but is not limited to the following:

     ▪ a list of specific treatments and procedures which can only be performed by residents who have been credentialed to perform the specific treatment and/or procedure after submission and approval of documentation of prior experience, or observation and assessment of their skill by a credentialed resident or faculty member;
     ▪ a methodology for documenting and approving prior experience;
     ▪ a methodology for observing and assessing resident skills;
     ▪ a procedure for documenting resident privileges in UB GME’s web-based management system as outlined in the residents’ Privileging Policy; and
     ▪ a mechanism that allows residents to assume progressively increasing responsibility according to the level of education, ability and experience as determined by the program faculty.
- Ensure that all residents will function under the supervision of faculty who hold appropriate UB faculty appointments in the Schools of Medicine and Biomedical Sciences or Dental Medicine and have been credentialed at the specific training site.

- The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.

- The program must:
  - provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;
  - use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);
  - document progressive resident performance improvement appropriate to educational level; and,
  - provide each resident with documented semiannual evaluation of performance with feedback.

- The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.

**Responsibilities of the Resident**

- Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence. In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available. [Each Review Committee will describe the achieved competencies under which PGY-1 residents progress to be supervised indirectly, with direct supervision available.]

- Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.

- Be aware of and follow the program’s credentialing and supervision plans.

- Actively participate in the training program’s credentialing plan.

- Request supervision from the faculty member or supervisor if asked to perform a bedside procedure, when he or she has insufficient experience with the procedure and/or universal protocol, or when the procedure is beyond the level of skill of the resident.

- Perform only those procedures for which the resident is credentialed.
  2. If a resident is asked to perform a procedure for which he/she is not credentialed, the resident should inform the faculty member or supervising resident that he/she is not credentialed and request direct supervision.

- Contact the faculty member or supervisor to secure appropriate approval needed for documentation in the medical record.

- Follow the applicable policies and approval processes prior to engaging in any clinical activity.

**Responsibilities of the Faculty**

- Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.

- Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.
• Request and maintain the appropriate level of privileges at each clinical site.
• Document supervision according to the standards set by either the Office of the Medical Inspector General or Medicare.
• When residents participate in the care of patients, the ultimate responsibility for the patient rests with the supervising member of the faculty.
• When the resident is receiving direct supervision, the supervising faculty member must be physically present during the procedure or event.
  3. At a minimum, direct supervision is required for all procedures:
  ▪ performed in the operating room;
  ▪ performed in other special procedure sites;
  ▪ which require heavy sedation; or
  ▪ where the resident is not credentialed.
• When a resident is receiving indirect supervision, the supervising faculty member must be immediately available to the resident in person, by telephone or pager, and able to be present within a reasonable period of time (no longer than 30 minutes after contact), if needed.
  4. Generally, an attending can provide indirect supervision if:
  ▪ the resident is credentialed to perform the procedure; and
  ▪ a senior resident, who is credentialed both to perform the procedure and supervise another resident is supervising clinical activity directly.
• Recognize the signs of fatigue and sleep deprivation, and support residents in preventing and counteracting the negative effects that can impact patient care and learning.
• Comply with the expectations and requirements of the hospitals for supervision and documentation of their activity.
• Be aware of directly related UB GME policies, such as Privileging of Residents, Duty Hours, Evaluation, and Counseling and Support Services

  **Clinic**
  1. Be present for supervision during clinic hours.
  2. Provide direct supervision of resident activity unless the primary care exception applies.

  **Procedures**
  1. Supervise training ONLY in those clinical situations where the faculty member has privileges for independent clinical practice.
  2. Notify the requesting faculty if he/she is not credentialed to perform the procedure for which the resident requires supervision.
  3. Provide direct supervision of all procedures where the resident is not credentialed, procedures requiring general anesthesia, or those requiring an operating room/special procedure site.
  4. Provide appropriate supervision for preoperative examination and assessment.
  5. Provide appropriate supervision for postoperative examination and assessment no less frequently than daily.

  **New Admissions**
1. Review and evaluate all new resident hospital admissions (within 24 hours of admission including weekends and holidays).
2. Provide appropriate supervision for the patient's evaluation, management decisions and procedures.
3. Ensure that discharge or transfer of the patient from an inpatient team or clinic to any other team or site is appropriate, based on the specific circumstances of the patient's diagnoses and therapeutic regimen.

- **Official Consultations**
  1. Meet with each patient who received a consultation by a resident and perform this personal evaluation in a timely manner based on the patient's condition.
  2. Discuss and/or review with the resident the plan of evaluation or care according to the guidelines established in specific hospital’s medical staff rules and regulations.
  3. Document supervision by writing a progress note or an addendum with his/her concurrence with the consultation note by the close of the next working day for inclusion in the patient record.

- **Management/Discharge**
  1. Round with the residents to review patient's progress and treatment plans.
  2. Review and sign progress notes.
  3. Discuss and review all discharge plans.
  4. Review and sign discharge summaries written by residents.
FREQUENTLY ASKED QUESTIONS

Can a resident be a supervisor?

Anticipated action or response
A resident who meets the legislative requirements can function as a supervisor, if he/she is credentialed to do so. Residents who are in the last year of training or higher than a PGY3 can be credentialed as supervisors.

Can a fellow supervise the activity of a chief resident?

Anticipated action or response
A fellow cannot primarily supervise the training of a chief resident. A fellow can oversee and/or supervise a resident during the instruction or training experience for credentialing purposes for a specific procedure.

Who can be a supervising physician?
Anticipated action or response
A physician, a member of the medical staff, or a more senior resident designated by the program director can supervise a junior resident. Such designation must be based on demonstrated competency in medical expertise and supervisory capability. In rare instances, a Review Committee may allow non-physician, licensed, independent practitioners designated by the program director to supervise residents. In all cases, each program’s supervision policies should clearly state the types of supervision that are permissible. Programs should ensure that any policy revisions are compliant with specialty-specific requirements.

What is meant by “progressive authority and responsibility, conditional independence, and a supervisory role in patient care” for residents?

Anticipated action or response
Residents enter programs as novices and are expected to graduate as accomplished physicians capable of functioning competently and without supervision. Depending on the specialty or subspecialty, this transition may take several more years. The development and adoption of specialty-specific “milestones” (objective curricular criteria to be mastered during a given year of residency) that will govern residents’ advancement from one year of education to the next will provide one tool for guiding the authority and responsibility granted to residents. These milestones will help program directors and faculty members determine the levels of responsibility assigned to each individual resident. Until those are in place, documented criteria for such assignments need to be included in the make-up of the program. Great care must be taken in determining the level of involvement each resident will have in direct patient care so as to ensure patient safety. Another level of advancement lies in the granting of supervisory authority to a resident over a more junior resident. This will require not only documentation of medical knowledge and procedural competency skill sets, but also documented ability to effectively teach and oversee the work of others. At any level of assignment, the initial few days or weeks should be carefully monitored to ensure that the individual resident is capable of functioning in his/her assigned role. If not, then remediation will be necessary before the assignment can continue.

What should a resident do if he/she cannot determine the identity of or contact the supervising faculty member?

Anticipated action or response
A resident, who cannot contact or identify a supervising faculty member, should contact the chief resident, the program director, the site’s clinical director or chief medical officer to request assistance.
When the supervising faculty member signs out, what should a resident do if he/she cannot locate the new faculty member?

**Anticipated action or response**

A resident who cannot locate the supervising faculty member, or someone who is covering for that person, should contact the chief resident, residency program director, the site’s clinical director, or the hospital’s chief medical officer and request assistance.

When a resident is asked to evaluate a patient in the emergency department on behalf of a consulting physician, who is the resident’s supervisor?

**Anticipated action or response**

In the Emergency Department, the resident’s supervisor is the attending physician who is being called in consultation. The Emergency Medicine physician is directly responsible for all patients. A consulting resident should speak with both the supervising faculty member and the Emergency Medicine physician. Ultimately, the decisions for care will be the responsibility of the Emergency Medicine Physician with the assistance and advice of the faculty member, who is supervising the resident’s activity. Direct communication between the Emergency Medicine physician and the consulting faculty member who is supervising the resident’s activity may be needed to provide a coordinated response.

During an emergency event, acute episode or code, if a resident should perform a procedure and is not credentialed to do so, what should he/she do?

**Anticipated action or response**

The most senior supervising resident, who is present, should perform and/or supervise the procedure.

The appropriate faculty member should be contacted and apprised of the situation as soon as possible. The resident will document the nature of that discussion in the patient's record. The documentation should include all aspects of the patient’s care, including who was contacted and the date/time of the contact.

**Justification**

An "emergency" is defined as a situation where immediate care is necessary to preserve the life of, or to prevent serious impairment of the health of a patient. In such situations, any resident, assisted by other clinical personnel as available, shall be permitted to do everything possible to save the life of a patient or to save a patient from serous harm.

A resident is asked to write an order for “do not resuscitate”, but does not know the policy of the hospital or medical center, what should the resident do?

**Anticipated action or response**

A resident should not write a Do Not Resuscitate order if he/she does not know the policy and procedure for the clinical site.

The resident may write Do Not Resuscitate (DNR) orders, when he/she can assure that the orders are appropriate and the supportive documentation for DNR orders is in the patient’s medical record. The policy, procedure and process will depend on the clinical site. Regardless, all DNR orders must be discussed with competent patients or an incompetent patient’s Health Care Proxy, and signed or countersigned by the faculty member. The resident must document the process in the medical record.
What should happen if the clinical situation results in a conflict in resource allocation? For instance, can an attending physician provide deep sedation (i.e. administer propofol) and supervise a resident training experience simultaneously?

**Anticipated action or response**

Patient care requirements take precedence. If the resident needs direct supervision, the faculty member cannot provide patient care and supervise a resident training experience simultaneously. The faculty member may either find another health care professional to provide patient care or supervise the training experience. If the resident is credentialed to perform a procedure, the faculty member can provide patient care services and indirect supervision simultaneously. Any failure to comply may result in disciplinary action.