

UB Graduate Medical Education Supervision Policy

May 2008

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 Code 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.
- **Direct Supervision**
 - A resident requires direct supervision until he/she has been certified as capable of performing an action in a semi-independent manner (credentialed).
 - Direct supervision requires the physical presence of a properly credentialed supervisor during the event or procedure.
 - First year residents (PGY1) must have a direct supervisor available on-site at all times.
- **Indirect Supervision**
 - 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.
 - If faculty members are readily available (generally, within twenty to thirty minutes) in person when needed, the on-site supervisor can be:
 - an individual who is either in the final year of post-graduate training, or higher than a PGY3, and credentialed as supervisor.

- 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.
- **Supervision During Electives, Required Rotations & Consultations**
 - Residents on rotations/electives outside their "home" department will be supervised by faculty in the assigned "host" program.
 - 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.
 - 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:
 - an attending progress note;
 - an attending's addendum to a resident's note;
 - co-signature of a resident's note by the attending; and
 - 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:
 - the name of the faculty member who functioned as the supervisor;
 - the degree of involvement of the faculty member;
 - a summary of the resident and supervisor's discussions, communications, actions, and findings;
 - the specific issues of the diagnostic and therapeutic plans;
 - the date and time of the personal evaluation of the patient; and
 - 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

- 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.

- 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.
 - 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.

Responsibilities of the Resident

- 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.
 - 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

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

- Document the supervision activity in the patient's record.
- **Procedures**
 - Supervise training ONLY in those clinical situations where the faculty member has privileges for independent clinical practice.
 - Notify the requesting faculty if he/she is not credentialed to perform the procedure for which the resident requires supervision.
 - 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.
 - Provide appropriate supervision for preoperative examination and assessment.
 - Provide appropriate supervision for postoperative examination and assessment no less frequently than daily.
- **New Admissions**
 - Review and evaluate all new resident hospital admissions (within 24 hours of admission including weekends and holidays).
 - Provide appropriate supervision for the patient's evaluation, management decisions and procedures.
 - 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**
 - 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.
 - 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.
 - 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**
 - Round with the residents to review patient's progress and treatment plans.
 - Review and sign progress notes.
 - Discuss and review all discharge plans.
 - 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.

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 can not 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 serious 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.