RESIDENT SUPERVISION

PURPOSE

The purpose of this Resident Supervision policy is to set forth the University of Tennessee College of Medicine ("UT College of Medicine" or "Sponsoring Institution") policies and procedures regarding supervision of residents and fellows (individually, a "resident" or collectively "residents") participating in the ACGME-accredited graduate medical education programs sponsored by UT College of Medicine (each a "Program"). Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to each patient; assuring each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth. One of the core principles of graduate medical education is the concept of graded and progressive responsibility. As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence.

REFERENCE

Consistent with Section IV.J. of the ACGME Institutional Requirements, a Sponsoring Institution must have a policy regarding the supervision of residents. The Sponsoring Institution must ensure that each of its Programs establishes a written, Program-specific supervision policy consistent with this policy and with the ACGME Common and Specialty-/Subspeciality-specific Program Requirements. The Sponsoring Institution must also oversee the supervision of residents consistent with this policy and Program-specific policies and provide the means by which residents can report inadequate supervision and accountability in a protected manner that is free from reprisal, in compliance with Section III.B.4. of the ACGME Institutional Requirements.

POLICY

I. Levels of Supervision and Definitions

A. Levels of Supervision. Programs must use the following classifications of supervision to promote oversight of resident supervision while providing for graded authority and responsibility:

- Direct Supervision – the supervising physician is either (a) physically present with the resident during key portions of the patient interaction, or (b) *if permitted* by a Program's applicable ACGME Review Committee and the supervision policy of the specific Program, the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.

- Indirect Supervision – the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate Direct Supervision.

- Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

B. Additional Definitions. When used in this policy, the following words, and all forms of these words, have the meanings below:

- Conditional Independence – graded, progressive responsibility for patient care with defined oversight.

- Levels of Supervision – Direct Supervision, Indirect Supervision or Oversight, as set forth in this policy and the ACGME Common Program Requirements.
- Milestones – description of performance levels residents are expected to demonstrate for skills, knowledge and behaviors in the six Core Competency domains.

II. Program Letters of Agreement

In order to ensure residents receive appropriate educational experiences under the appropriate Levels of Supervision, Programs must annually review resident clinical assignments and update Program Letters of Agreement (each a "PLA"), as needed, including for a change in Program Director or Site Director. There must be a PLA between a Program and each Program participating site that governs the relationship between the program and a participating site providing a required Program assignment. PLAs must be renewed and signed every two years by the Program Director and Site Director. PLAs (between a Program and a participating site providing a required assignment) must be reviewed by the Program Director and approved by the DIO. The PLA should include the following information:

- Identify faculty name/or general faculty group who teaches/supervises residents;
- specify their responsibilities for teaching, supervision, and formal evaluation of residents;
- specify the duration and content of the educational experience; and
- state that residents must abide by the policies of the site, the Program, and the Graduate Medical Education Committee ("GMEC").

A copy of the signed PLA will be sent to and maintained in the GME office. The Program Director must monitor resident supervision, review faculty supervision assignments to ensure they are of a sufficient duration to assess the knowledge and skills of each resident and delegate to each resident the appropriate level of patient care authority and responsibility.

III. Supervision of Residents

A. Supervision Responsibilities. Each patient must have an identifiable, appropriately credentialed and privileged attending physician (or licensed independent practitioner as specified by each ACGME Review Committee) who is responsible and accountable for that patient's care. The identity of the attending physician (or licensed practitioner information) must be available to residents, faculty members, other members of the health care team, and patients. When providing direct care, residents and faculty members must inform each patient of their respective roles in that patient's care.

B. Levels of Supervision. Programs must demonstrate that the appropriate Level of Supervision is in place for each resident, based on the resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the patient care situation. Each ACGME Review Committee may specify which activities require different Levels of Supervision.

Depending on the needs of the patient and the skills of the resident, the supervising physician may be a more advanced resident. Some portions of care provided by the resident may require the physical presence of the supervising faculty member while other portions of care may be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in institution or by means of telecommunication technology. In other circumstances, appropriate supervision may be a post-hoc review of resident-delivered care with feedback. Each Program must define when physical presence of a supervising physician is required.

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. Each Program Director must evaluate each resident's abilities based on specific criteria, guided by the Milestones.

C. Supervision by Faculty. Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of the resident. Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. All faculty members supervising residents on a university rotation must have a University of Tennessee Health Science Center ("UTHSC") faculty appointment.

   Each Program must create and maintain guidelines for the circumstances and/or events in which a resident must communicate with a supervising faculty member. Each resident must know the limits of his/her scope of authority, the circumstances under which he/she is permitted to act with Conditional Independence, and those events and circumstances that require communication with the supervising faculty member. Initially, PGY-1 residents must be under Direct Supervision with progression to Indirect Supervision only as specified by the applicable ACGME Review Committee.

D. Supervision by Senior Residents. Senior residents should serve in a supervisory role of junior residents in recognition of their progress towards independence, based on the needs of each patient and the skills of the individual resident. A more senior resident may be designated by the Program Director as a supervising physician when he/she has demonstrated the medical knowledge, procedural competency skill set, and supervisory capability to teach and oversee the work of junior residents. Initially, PGY-1 residents must initially be supervised under Direct Supervision, with the supervising physician physically present during the key portions of the patient interaction.

IV. Program-Level Supervision Policies and Procedures

Each Program is required to establish a written Program-specific supervision policy consistent with GME institutional policies, ACGME Common and Specialty-/Subspeciality-specific Program Requirements, and applicable ACGME Review Committee requirements. Programs must use the ACGME Levels of Supervision and the UT GME Patient Care Supervision schema below and must demonstrate that appropriate Levels of Supervision are in place. Program-specific policies and procedures must include the following:

- Definition of who is qualified to supervise residents (in addition to faculty attendings) including more advanced residents or licensed independent practitioners as specified by the applicable ACGME Review Committee.
- Criteria in compliance with applicable ACGME Review Committee requirements that define when a resident is approved to safely and effectively perform certain procedures or clinical activities without Direct Supervision and when the physical presence of a supervising physician is required.
- The Program Director will define the mechanism by which residents can be deemed competent to perform a procedure(s) under Indirect Supervision or Oversight. Lists of approved clinical activities should be maintained for each resident so that they can be made available for review by all patient care personnel.
- Requirement that PGY-1 residents shall initially (if applicable to Program training levels) be under Direct Supervision, with the physical presence of the supervising physician during key portions of

the patient interaction. A Program's policy should incorporate a listing of achieved competencies under which PGY-1 residents may progress to Indirect Supervision, in accordance with Review Committee conditions.

- Guidelines for circumstances and events in which residents must communicate with the supervising faculty. These guidelines should be specific to patient situations, resident level, who is to be contacted (by position) and what to do if the contact does not respond.
- A description of clinical responsibilities for each resident based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services. The applicable ACGME Review Committee may specify optimal clinical workloads.
- Education for residents and faculty on supervision policies and procedures including the ACGME requirement that residents and faculty members should inform patients of their respective roles in each patient's care.

Programs must annually review faculty supervision assignments and the adequacy of supervision levels. A copy of each Program's current supervision policy should be submitted to the GME office. Compliance with these requirements will be monitored by the GMEC through periodic audits, review of annual Program evaluation meeting minutes, and the internal review process.

V. Oversight, Mechanisms to Report Supervision Violations

UT College of Medicine must oversee the supervision of residents consistent with this Policy and Program-specific policies. Residents are encouraged to report incidents of inadequate supervision at UT College of Medicine or any of its participating sites. Reports may be made to the Program Chief Resident, the GME Chief Resident (as available), the GMEC Resident Forum representatives, the Program Director, Department Chair, Assistant DIO, Associate DIO, or DIO, or by emailing or contacting the Office of GME. Resident reports of inadequate supervision may be made without fear of recrimination or reprisal.

VI. UNIVERSITY OF TENNESSEE GRADUATE MEDICAL EDUCATION PATIENT CARE SETTING RESIDENT SUPERVISION STANDARDS

The following are minimum standards for resident supervision and documentation in patient care settings. These standards are designed to promote patient safety and educational excellence while maintaining autonomy based on demonstrated educational competence. These requirements are effective for all training sites without regard to patient insurance status or time of day. All Program residents and faculty members will abide by the supervision and documentation schema as noted below. Individual Programs and hospitals may have more stringent supervision and documentation requirements.

All residents' patient care activities are ultimately supervised by a credentialed and privileged attending physician (or an approved licensed independent practitioner). **Programs must define the resident procedures or clinical tasks that are permitted by year of training with and without Direct Supervision**. **Programs must maintain records of each resident's attainment of procedural/clinical task competencies.** Listings of procedural competencies by resident name and by Program can be accessed on the GME Resident Supervision web site: http://uthsc.edu/GME/supervision.php.

Supervision Setting / Clinical Activity	Required Level of Supervision / Description	*Minimum Level of Supervision Documentation
A. OPERATING / DELIVERY ROOM	• **Direct Supervision by Attending Physician** Departmental attending must be **physically present** within the building where the procedure occurs and **immediately available** to the resident and patient for the major components of the procedure. The departmental attending must be notified prior to the scheduling of the procedure and must be aware of the documented competency level of the resident.	Degree of involvement documented.

Supervision Setting / Clinical Activity	Required Level of Supervision / Description	*Minimum Level of Supervision Documentation
B. NON-ROUTINE, NON-BEDSIDE, NON-OR PROCEDURES (e.g., Cardiac Cath, Endoscopy, Interventional Radiology, etc.)	• **Direct Supervision by Attending Physician** Departmental attending must be **physically present** within the building where the procedure occurs and **immediately available** to the resident and patient, for the major components of the procedure. The departmental attending must be notified prior to the scheduling of the procedure and must be aware of the documented competency level of the resident.	Degree of involvement documented.
C. EMERGENCY DEPARTMENT	• **Direct Supervision by Attending Physician** Departmental attending must be **physically present** within the building where the procedure occurs and **immediately available** to the resident and patient, for the major components of the procedure. The departmental attending must be notified prior to the scheduling of the procedure and must be aware of the documented competency level of the resident.	Level 4
D. EMERGENCY CARE – Immediate care is initiated to preserve life or prevent impairment. The procedure is initiated with the departmental attending physician contacted.	The departmental attending must be notified prior to the scheduling of the procedure.	Degree of involvement documented.

In the following patient care settings, the Program Director may designate a more senior resident/fellow to supervise a junior resident.

E. INPATIENT CARE / New Admissions	• **Indirect Supervision** • **Oversight** The departmental attending physician must see and evaluate the patient within one calendar day of admission.	Level 2
INPATIENT CARE / Continuing Care	• **Oversight**	Level 4
INPATIENT CARE / Intensive Care	• **Indirect Supervision**	Level 4

Supervision Setting / Clinical Activity	Required Level of Supervision / Description	*Minimum Level of Supervision Documentation
INPATIENT CARE / Hospital Discharge and Transfers	• **Oversight** The attending must be involved in decision to discharge or transfer patient.	Level 3
F. OUTPATIENT CARE / New Patient Visit	• **Indirect Supervision**	Level 2
OUTPATIENT CARE / Return Patient Visit	• **Oversight**	Level 5
OUTPATIENT CARE / Clinic Discharge	• **Oversight**	Level 5
G. CONSULTATIONS Inpatient, Outpatient and Emergency Department	• **Oversight** Post-hoc review with feedback by supervising faculty/resident physician.	Level 4
H. RADIOLOGY / PATHOLOGY	• **Oversight** Post-hoc review with feedback by supervising faculty/resident physician.	All reports verified by dept. attending physician prior to release.
I. ROUTINE BEDSIDE and CLINIC PROCEDURES	• **Indirect Supervision**	Level 4

*Levels of Supervision Documentation:
1. Departmental attending Physician Note
2. Department attending Physician Addendum to the resident's note (not a co-signature)
3. Departmental attending physician co-signature implies that the departmental attending physician has reviewed the resident's note, and absent an addendum to the contrary, concurs with the content of the resident's note.

4. Resident documentation of departmental attending physician supervision (e.g., "I have seen and/or discussed the patient with my departmental attending physician, Dr. _, who agrees with my assessment and plan.")
5. Documentation to be determined by individual program director.