

## RESIDENT SUPERVISION

### I. RATIONALE

Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual 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.

### II. PROGRAM LETTERS OF AGREEMENT

In order to ensure residents receive appropriate educational experience under the appropriate level of supervision, programs should annually review resident clinical assignments and update the Program Letter of Agreement (PLA) for each participating site providing a required program assignment. The program director must monitor resident supervision at all participating sites and should review faculty supervision assignments to determine if they are of 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. An updated PLA must be signed annually by the program director and site director and must 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 GMEC.

A copy of the signed PLA will be sent to and maintained in the GME office.

### III. SUPERVISION OF RESIDENTS

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.

- This information must be available to residents, faculty members, other members of the health care team, and patients.
- Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care.

Programs must demonstrate that the appropriate level of supervision, as defined by ACGME, in place for all residents is based on each 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 situation.

- 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.

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, guided by the Milestones. Based on the needs of the patient and the skills of the residents, faculty members functioning as supervising physicians must delegate portions of care to residents.

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. 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.

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.

Initially, PGY-1 residents must be supervised either directly or indirectly with direct supervision immediately available as described in the following four levels of supervision. [Each Review Committee may describe the conditions and the achieved competencies under which PGY-1 residents progress to be supervised indirectly, with direct supervision available.]

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.

IV. LEVELS OF SUPERVISION: Programs must use the following classification of supervision to promote oversight of resident supervision while providing for graded authority and responsibility:

- DIRECT SUPERVISION – the supervising physician is physically present with the resident and patient.
- INDIRECT SUPERVISION 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*.
- INDIRECT SUPERVISION 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*.

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

## V. PROGRAM-LEVEL SUPERVISION POLICIES AND PROCEDURES

Each ACGME-accredited training program is required to establish a written program-specific supervision policy consistent with GME institutional policies and individual Residency Review Committee (RRC) requirements. Programs must use the ACGME classification of supervision and the UT GME Patient Care Supervision schema and must demonstrate that appropriate levels of supervision are in place. Program-specific policies and procedures should include the following:

- Definition of who is qualified to supervise residents (in addition to faculty attendings) including more advanced residents/fellows or licensed independent practitioners as specified by each RRC.
- Criteria in compliance with individual RRC requirements that define when a resident is approved to safely and effectively perform certain procedures or clinical activities without direct supervision. 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 (if applicable to program training levels) should be supervised either directly or indirectly with direct supervision immediately available and, if defined by a program's RRC, a listing of achieved competencies under which PGY-1 residents progress to be supervised indirectly, with direct supervision available.
- 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. (RRC may specify optimal clinical workloads.)
- Educating 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 should annually review faculty supervision assignments and the adequacy of supervision levels. A copy of each program's current supervision policy should be submitted to GME along with a sample procedure/clinical activity competency list. 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.



## 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. They are designed to promote patient safety, provide educational excellence, but maintain autonomy based on demonstrated educational competence. These requirements are effective in all training sites without regard to patient insurance status or time of day. Residents and faculty members in training programs under the auspices of ACGME 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 competence.** 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>.

<u>Supervision Setting / Clinical Activity</u>	<u>Required Supervision Level / Description</u>	<u>*Minimum Level of Supervision Documentation</u>
<b>A. OPERATING / DELIVERY ROOM</b>	<ul style="list-style-type: none"> <li><b>Direct Supervision by Attending Physician</b> Departmental attending must be <b>physically present</b> within the building where the procedure occurs and <b>immediately available</b> 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.</li> </ul>	Degree of involvement documented.
<b>B. NON-ROUTINE, NON-BEDSIDE, NON-OR PROCEDURES (e.g., Cardiac Cath, Endoscopy, Interventional Radiology, etc.)</b>	<ul style="list-style-type: none"> <li><b>Direct Supervision by Attending Physician</b> Departmental attending must be <b>physically present</b> within the building where the procedure occurs and <b>immediately available</b> 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.</li> </ul>	Degree of involvement documented.

<u>Supervision Setting / Clinical Activity</u>	<u>Required Supervision Level / Description</u>	<u>*Minimum Level of Supervision Documentation</u>
<b>C. EMERGENCY DEPARTMENT</b>	<ul style="list-style-type: none"> <li><b>Direct Supervision by Attending Physician</b> Departmental attending must be <b>physically present</b> within the building where the procedure occurs and <b>immediately available</b> 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.</li> </ul>	<a href="#">Level 4</a>
<b>D. EMERGENCY CARE</b> – 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.**

<b>E. INPATIENT CARE /</b> New Admissions	<ul style="list-style-type: none"> <li><b>Indirect Supervision with Direct Supervision Available.</b></li> <li><b>Oversight</b> The departmental attending physician must see and evaluate the patient within one calendar day of admission.</li> </ul>	<a href="#">Level 2</a>
<b>INPATIENT CARE /</b> Continuing Care	<ul style="list-style-type: none"> <li><b>Oversight</b></li> </ul>	<a href="#">Level 4</a>
<b>INPATIENT CARE /</b> Intensive Care	<ul style="list-style-type: none"> <li><b>Indirect with Direct Supervision <i>immediately available</i></b></li> </ul>	<a href="#">Level 4</a>
<b>INPATIENT CARE /</b> Hospital Discharge and Transfers	<ul style="list-style-type: none"> <li><b>Oversight</b> The attending must be involved in decision to discharge or transfer patient.</li> </ul>	<a href="#">Level 3</a>
<b>F. OUTPATIENT CARE /</b> New Patient Visit	<ul style="list-style-type: none"> <li><b>Indirect with Direct Supervision <i>immediately available</i></b></li> </ul>	<a href="#">Level 2</a>
<b>OUTPATIENT CARE /</b> Return Patient Visit	<ul style="list-style-type: none"> <li><b>Oversight</b></li> </ul>	<a href="#">Level 5</a>
<b>OUTPATIENT CARE /</b> Clinic Discharge	<ul style="list-style-type: none"> <li><b>Oversight</b></li> </ul>	<a href="#">Level 5</a>

<u>Supervision Setting / Clinical Activity</u>	<u>Required Supervision Level / Description</u>	<u>*Minimum Level of Supervision Documentation</u>
<b>G. CONSULTATIONS</b> Inpatient, Outpatient and Emergency Department	<ul style="list-style-type: none"> <li><b>Oversight</b> Post-hoc review with feedback by supervising faculty/resident physician</li> </ul>	<a href="#">Level 4</a>
<b>H. RADIOLOGY / PATHOLOGY</b>	<ul style="list-style-type: none"> <li><b>Oversight</b> Post-hoc review with feedback by supervising faculty/resident physician</li> </ul>	All reports verified by dept. attending physician prior to release.
<b>I. ROUTINE BEDSIDE and CLINIC PROCEDURES</b>	<ul style="list-style-type: none"> <li><b>Indirect Supervision with Direct Supervision Available.</b></li> </ul>	<a href="#">Level 4</a>

<b><i>*Levels of Supervision Documentation:</i></b>
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.