Section 2	General Policies & Procedures	Effective:	December 2000
		Revised:	April 2002, November 2006, May 2010, July 2011, February 2015,
Policy 2.5.	Resident Supervision Policy		November 2019, December 2019 April 2020 Dec 2020
		Responsibility:	Designated Institutional Official

Resident Supervision Policy

Purpose

The purpose of GME is to provide an organized educational program with guidance and supervision of the resident, facilitating the residents' ethical, professional and personal development while ensuring safe and appropriate care for patients.

This policy will establish the minimum requirements for resident supervision in clinical environments in which The University of Texas Health Science Center at San Antonio (UTHSA) residents train. A UTHSA-affiliated teaching hospital/health system may have additional requirements for resident or fellow supervision. Individual training programs may also have additional requirements for their faculty/attendings and residents.

Definitions

Section I. Definitions

The following definitions are used throughout the document:

Resident – a professional post-graduate resident or fellow in a specific specialty or subspecialty

Licensed Independent Practitioner (LIP) – a licensed physician, dentist, podiatrist, or optometrist who is qualified usually by board certification or eligibility to practice his/her specialty or subspecialty independently

Medical Staff – an LIP who has been credentialed to provide care in his/her specialty or subspecialty by a hospital

Staff Attending – the immediate supervisor of a resident or fellow who is credentialed in his/her hospital for specific procedures in their specialty and subspecialty that he/she is supervising

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. Other portions of care provided by the residents 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 or fellow-delivered care with feedback as to the appropriateness of that care. **Levels of Supervision:** To promote appropriate resident supervision and graded authority and responsibility, programs must use the following classification of supervision: **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.
Policy	**Section II. General** Supervision of residents should be organized to provide gradually increased responsibility and maturation into the role of a judgmentally sound, technically skilled, and independently functioning "privileged" provider. Program Directors will define specific criteria for evaluation of resident abilities allowing for a progressive authority and responsibility, conditional independence, and taking on of supervisory roles. The program director will also define the specific criteria used to determine when a resident or fellow can progress to the next level of training and when residents are assessed as being competent to graduate. In addition, the policy for each program must be in compliance with below: • At all times, patient care will be the responsibility of a licensed independent practitioner with appropriate clinical privileges in that health care system. • Descriptions of the roles, responsibilities, and patient care activities of the residents, by level, are available to medical faculty and to health care staff located in New Innovations. When necessary, nurses, residents and/or other healthcare personnel will telephone the attending staff physicians (who is available 24/7) or Program Director to confirm whether a resident is approved to

perform a procedure without direct faculty supervision. Reference Section IX for details on procedural verification by hospital or clinic personnel.

- The descriptions identify mechanisms by which the program faculty and program director make decisions about an individual residents' progression of conditional independence. Those parameters may include but may not be limited to: a given number of successfully performed, observed procedures; a total number of procedures or processes performed; the general impression of competence and professionalism perceived by faculty, etc.
- Delineation of order-writing privileges, including which orders if any must be countersigned.

Residents must be provided the equivalent personal protective equipment (PPE) as utilized by their faculty supervisor. If the same level of PPE is not available, then the resident should not participate in the care until the same level of PPE is provided or an emergency is declared by the faculty supervisor. Such declared emergencies must be reported to the program director as soon as practicable. For the purposes of this policy, vaccines are considered a personal protective intervention and therefore a form of PPE that, if available contemporaneously to the resident's faculty in the same clinical setting, must be made available to the resident as well. Choosing not to be vaccinated will not allow for opting out of or being excluded from same clinical setting.

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- Supervision of residents may occur through telephonic, video, or other electronic modalities. The defined levels of supervision: direct, indirect with direct immediately available, indirect with direct available, and oversight apply to telephonic, video, or other electronic means of supervision as they do to supervision by the physical presence of the supervisor.

Section III. Procedures

- All resident patient care activities are ultimately supervised by credentialed providers ("staff attendings") who are licensed independent practitioners on the medical staff of the UTHSA teaching hospitals and/or clinics in which they are attending. The staff attendings must be credentialed in that hospital or clinic for the specialty care and diagnostic and therapeutic procedures that they are supervising. In this setting, the supervising staff attending is ultimately responsible for the care of the patient.

  By exception, supervision of residents may be performed by physician extenders (e.g., physician assistants or nurse practitioners) with particular expertise in certain diagnostic or therapeutic procedures, if so designated by the program director.

Ultimate responsibility for the residents' patient care, in this case, will rest on the credentialed staff who oversees the physician extender's practice.

- The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident is therefore assigned by the program director, with faculty members' feedback.

  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.

  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.

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

- Each UTHSA Program Director will complete a listing of resident clinical activities that are permitted by level of training, the required level of supervision for each activity, and any requirements for performing an activity without direct supervision. See Appendix A as an example.

  Some Program Directors may choose to list clinical activities without reference to year of training and only the requirements for performing an activity without direct supervision.

- Program Directors of ACGME-accredited programs will submit their listing of clinical activities by postgraduate year or by expected level of training to the Office for Graduate Medical Education for review and approval by the appropriate Action Committee.

- Program Directors of non-ACGME programs will have their fellows in Type 2 and Type 3 fellowships held to the same standard as residents in ACGME-accredited programs and the process outlined above in 1. will apply to those fellows. Fellows in Type 1 non-ACGME programs who are appointed as members of the UT Health San Antonio faculty and credentialed by one of our partner hospitals as an LIP on their medical staff will have their procedures defined as part of their credentialing process.

- Each UTHSA Program Director should annually review resident clinical activities by level and make changes as needed.

- Program Directors of ACGME-accredited programs will submit any new job descriptions and their updated listing of clinical activities by postgraduate year to the Office for Graduate Medical Education for review and approval by the appropriate Action Committee.

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

- 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 RRC has described the achieved competencies under which PGY-1 residents' progress to be supervised indirectly, with direct supervision.

- The Program Director will ensure that all supervision policies are distributed to and followed by residents and the medical staff supervising the residents. Compliance with the UTHSA residents' supervision policy will be monitored by the Program Directors.

Section IV. Supervision of Residents in the Inpatient Setting

- All lines of responsibility and authority for inpatient care delivered by inpatient ward or ICU teams are directed to a credentialed staff provider. Residents should write daily orders on inpatients for whom they are participating in the care. These orders will be implemented without the co-signature of a staff physician. It is the responsibility of the resident to discuss their orders with the attending staff physician. Attending staff may write orders on all patients under their care. Residents will follow all local teaching hospital policies for how to write orders and notify nurses and will follow the "verbal orders" policies of each patient care area.

- General position descriptions of residents by year of training which may be adopted by programs are available in Appendix B. The descriptions may not apply to all programs, such as subspecialties which do not have PGY1 or PGY2 levels. Program Directors have the discretion to use or modify these descriptions as appropriate to their specialty or subspecialty.

- Staff supervision of care for hospitalized patients must be documented in the inpatient record. Documentation requirements for inpatient care are outlined next. These are the minimal

requirements and may be more stringent depending on the UTHSA teaching hospital.

- Documentation, in writing, by *staff* must be in accordance with hospital policies. This documentation includes especially: concurrence with the admission, history, physical examination, assessment, treatment plan; orders concurrence with major interventional decisions; concurrence when any major change occurs in the patient's status, such as transfer into or out of an intensive care unit or changes in "Do Not Resuscitate" status. Documentation, in writing, by residents must also be in accordance with hospital policies.

Section V. Supervision of Residents on Inpatient Consult Teams

All inpatient consultations performed by residents will be documented in writing, with the name of the responsible staff consultant recorded. The responsible staff consultant must be notified verbally by the resident doing the consult within an appropriate period of time as defined by the particular consulting service. The consulting staff is responsible for all the recommendations made by the consultant team.

Section VI. Supervision of Residents in Outpatient Clinics

All outpatient visits provided by residents will be conducted under the supervision of a staff provider. The Program Director may, for each resident, define the conditions under which supervision may be other than direct (e.g., a defined period of clinical experience, with faculty feedback). The supervising staff will interview and examine the patient at the staff's discretion, at the resident or fellow's request, or at the patient's request. The supervising staff has full responsibility for care provided, whether or not he/she chooses to verify personally the interview or examination.

Section VII. Supervision of Residents in the Emergency Department

The responsibility for supervision of residents providing care in the Emergency Department (ED) to patients who are not admitted to the hospital will be identical to that outlined in the schema for outpatient supervision above. The responsibility for supervision of residents who are called in consultation on patients in the ED will be identical to that outlined in the schema for consultation supervision above. Consulting staff should be notified appropriately of ED consultations.

Section VIII. Supervision of Residents in Interpretive Settings

It is the responsibility of each training program/department in these areas to establish supervisory regulations in compliance with The Joint Commission & RC requirements.

Section IX. Supervision of Residents Performing Procedures

A resident will be considered qualified to perform a procedure if, in the judgment of the supervising staff and his/her specific training program guidelines, the resident is competent to perform the procedure safely and effectively. Residents at certain year levels in a given training program may therefore be approved to perform certain procedures without direct supervision, based upon specific written criteria set forth and defined by the Program Director. As such, residents may perform routine procedures that they are approved to perform (such as arterial line placement) for standard indications without prior approval or direct supervision of staff. However, the residents' staff of record will be ultimately responsible for all procedures on inpatients. In addition, residents may perform emergency procedures without prior staff approval or direct supervision when life or limb would be threatened by delay. All outpatient and inpatient procedures will have the staff of record documented in the procedure note, and that staff will be ultimately responsible for the procedure.

As previously mentioned, Program Directors will define the mechanism by which residents can be deemed competent to perform a procedure(s) without supervision. Additionally, a listing of approvals by individual will be located in NI and accessible by nurses, residents, and other hospital or clinic personnel. If unable to satisfactorily confirm procedure verification in NI, nurses, residents and other hospital personnel may call the attending or the Program Director. (If procedure approvals are made by PG years, the table per Appendix A may suffice for this.)

Residents who require direct supervision to perform procedures may be supervised by either staff or, instead, by more senior residents, when those latter are also "approved" by the program to perform the procedure independently.

Appendix A – Specific Clinical Activities and Level of Supervision

The template will be filled out by the Program Director to address the specific clinical activities and the level of supervision required. For each Clinical Activity, the following areas need to be addressed on the accompanying template:

Resident Level at Which an Activity Can be Performed: PGY year, if applicable

Method of Instruction:
Examples: Direct Clinical Instruction, Courses (e.g. ACLS)

Level of Instructor and Direct Supervisor: by PGY year or Attending

Requirements for Certification to Perform Activity Without Direct Supervision:
Examples: Program Certification, PGY year

Method of Confirming Certification of Residents or Fellows to Perform the Activity Without Direct Supervision:
Examples: Residents or fellows Procedure Tracker (in New Innovations); Site-of-Training hard copy display.

Template for Procedures List –

Template

Appendix B – General Descriptions of Level of Training

1. Postgraduate year 1 (PGY1) residents

The PGY1 residents will participate in daily rounds and write daily progress notes which include an interim history and physical exam, laboratory and radiographic data, and an assessment and plan. If a significant new clinical development arises, there will be timely communication by a member of the resident's team with the attending. The residents and attending must communicate with each other as often as is necessary to ensure the best possible patient care.

The PGY1 residents may be responsible for completion of discharge summaries. Transfer notes and acceptance notes between critical care units and floor units, when required, can be written by the PGY1 residents. Such transfer notes shall summarize the hospital course and list current medication, pertinent laboratory data, active clinical problems, and physical examination findings. The supervising residents and the attending must be involved to ensure that such transfer is appropriate.

All PGY1 residents, when leaving an inpatient team, must write an "off-service" note summarizing pertinent clinical data about the patient. The new resident's team must notify the attending physician of the change in residents or teams and review the management plan with him/her.

2. Postgraduate year 2 (PGY2) residents

PGY2 residents, when assigned to the service, will take responsibility for organizing and supervising the teaching service in concurrence with the attending physician and will provide the PGY1 residents and medical students under his/her supervision with a productive educational experience. In this role, they work directly with the PGY1 residents in evaluating all new admissions and reviewing all H&Ps, progress notes, and orders written by the PGY1 residents daily. They will also supervise, in consultation with the attending physician and if approved by the PD to perform independently, all procedures performed by the PGY1. PGY2 residents may perform any of the PGY1 tasks outlined above at the discretion of the attending or patient care area policies. PGY2 residents must maintain close contact with the attending physician for each patient and notify the attending as quickly as possible of any significant changes in the patient's condition or therapy. All decisions related to invasive procedures, contrast radiology, imaging modalities, and significant therapies must be approved by the attending.

3. Postgraduate year 3 and above (PGY3) residents

PGY3 residents will follow all responsibilities of the PGY2 outlined above when acting in a similar supervisory capacity. PGY3 residents may perform any of the PGY1 or PGY2 tasks outlined above at the discretion of the attending or patient care area policies. They will also be available to provide assistance with difficult cases and provide instruction in patient management problems when called upon to do so by other residents.

	They will assume direct patient care responsibilities when needed to assist more junior residents during times of significant patient volume or severity of illness. Supervision of procedures will be as outlined for PG 2 residents.
Reference	ACGME Institutional Requirements Effective 7/1/15, VI.D.