

UTHSCSA Graduate Medical Education Policies

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	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 resident's 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 (UTHSCSA) residents train. A UTHSCSA-affiliated teaching hospital/health system may have additional requirements for resident supervision. Individual training programs may also have additional requirements for their faculty/attendings and trainees.

**Definitions Section I. Definitions**

The following definitions are used throughout the document:

Resident – a professional post-graduate trainee 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 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 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.**

**Levels of Supervision:**

To ensure oversight of 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**

It is the responsibility of individual program directors to establish detailed written policies describing resident supervision at each level for their residency programs. These written descriptions of resident supervision must be distributed annually and/or made readily available (e.g. electronic format) to all residents and faculty/attending physicians for each residency program. At all times, patient care will be the responsibility of a licensed independent practitioner with appropriate clinical privileges. The requirements for on-site supervision will be established by the program director for each residency program in accordance with ACGME requirements and will be monitored through periodic departmental reviews, with institutional oversight through the GMEC internal review process. Careful supervision and observation are required to determine the trainee's abilities to perform technical and interpretive procedures and to manage patients. Although they are not licensed independent practitioners, trainees must be given graded levels of responsibility while assuring quality care for patients. Supervision of trainees should be graded to provide gradually increased responsibility and maturation into the role of a judgmentally sound, technically skilled, and independently functioning credentialed provider. The type of supervision (physical presence of attending physicians, home call backup, etc.) required by residents at various levels of training must be consistent with the requirement for progressively increasing resident

responsibility during a residency program and the applicable program requirements of the individual RCs, as well as common standards of patient care.

In addition, the policy for each program must be in compliance with applicable Joint Commission standards, summarized below:

- At all times, patient care will be the responsibility of a licensed independent practitioner with appropriate clinical privileges in that health care system.
- Written descriptions of the roles, responsibilities, and patient care activities of the residents, by level, are available to medical faculty and to health care staff.
- The descriptions identify mechanisms by which the program faculty and program director make decisions about an individual resident's progressive involvement and 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

### **Section III. Procedures**

- A. All residents' patient care activities are ultimately supervised by credentialed providers ("staff attendings") who are licensed independent practitioners on the medical staff of the UTHSCSA teaching hospital in which they are attending. The staff attendings must be credentialed in that hospital 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.

- B. Each UTHSCSA Program Director will define the policies in his/her program to specify how trainees in that program progressively become independent in specific patient care activities while still being appropriately supervised by medical staff.

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 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.

- C. Each UTHSCSA 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.*

- 1. 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 of the Designated Institutional Official and to the Graduate Medical Education Committee (GMEC) for review.*
- 2. Program Directors of non-ACGME programs will submit their job descriptions and listing of clinical activities by postgraduate year to the appropriate body or committee for approval and then submit the approved policy to the Designated Institutional Official.*

- D. Each UTHSCSA Program Director should annual review the residents' clinical activities by level and make changes as needed.

- 1. 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 of the Designated Institutional Official and to the Graduate Medical Education Committee (GMEC) for review.*

*Program Directors of non-ACGME programs will submit any new job descriptions and updated listing of clinical activities by*

*postgraduate year to the appropriate body or committee for approval and then submit the approved policy to the Designated Institutional Official*

- E. 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.
  - 1. 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.
  - 2. 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.
- F. The Program Director will ensure that all supervision policies are distributed to and followed by trainees and the medical staff supervising the trainees. Compliance with the UTHSCSA resident supervision policy will be monitored by the Program Directors.

#### **Section IV. Supervision of Trainees in the Inpatient Setting**

- A. All lines of responsibility and authority for inpatient care delivered by inpatient ward or ICU teams are directed to a credentialed staff provider. Trainees 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. Trainees 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.
- B. General position descriptions of trainees 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.
- C. 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 UTHSCSA teaching hospital.

- D. 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 trainees must also be in accordance with hospital policies.

#### **Section V. Supervision of Trainees on Inpatient Consult Teams**

All inpatient consultations performed by trainees will be documented in writing, with the name of the responsible staff consultant recorded. The responsible staff consultant must be notified verbally by the trainee 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 Trainees in Outpatient Clinics**

All outpatient visits provided by trainees 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 trainee'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 Trainees in the Emergency Department**

The responsibility for supervision of trainees 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 trainees 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 Trainees 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 Trainees Performing Procedures**

A trainee will be considered qualified to perform a procedure if, in the judgment of the supervising staff and his/her specific training program guidelines, the trainee 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, trainees 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 resident's 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 resident should be registered at all times in pertinent patient care areas, and available for review by all patient care personnel. (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 Resident to Perform the Activity Without Direct Supervision:**

Examples: Resident 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) resident**

The PGY1 resident 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 team with the attending. The resident and attending must communicate with each other as often as is necessary to ensure the best possible patient care.

The PGY1 resident 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 resident. Such transfer notes shall summarize the hospital course and list current medication, pertinent laboratory data, active clinical problems, and physical examination findings. The supervising resident 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 team must notify the attending physician of the change in resident teams and review the management plan with him/her.

### **2. Postgraduate year 2 (PGY2) resident**

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 resident 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

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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.