SUPERVISION POLICY

General Statements

The graduate training programs of the University at Buffalo (UB) Jacobs School of Medicine and Biomedical Sciences (JSMBS) provide each resident with appropriate and adequate supervision for all patient care activities commensurate with the resident’s competence level. Program faculty determine the level of supervision 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 must be documented appropriately and accurately in the patient record. This policy was developed to conform to the New York State Part 405 Regulations and the requirements or standards of the Joint Commission, ACGME, or the appropriate credentialing agency. Hospital supervision expectations and requirements are included in the medical staff bylaws medical staff at each hospital/health care system. At the VAWNYHS, these expectations are delineated in the VHA Handbook of Resident Supervision.

This policy applies to all residents in all UB-sponsored programs at all training sites.

Basic Principles of Supervision

In all situations, the faculty member is ultimately responsible for the care of the patient.

- Residents provide patient care under the supervision of a faculty member at all times. Supervision may be direct or indirect.

- Gaining experience in performing procedures is an integral part of the education of the resident. However, procedures should only be performed by residents with the adequate knowledge, skill, and judgment, and with appropriate faculty supervision.

- The program must demonstrate that the appropriate level of supervision is provided for all residents who care for patients. Supervision is exercised through a variety of methods. The amount and type of supervision required depends upon the type of patient care and the resident’s level of competence.

- Surgery: Faculty supervision of residents includes (at a minimum):
  1. Personal supervision of all surgical procedures requiring general anesthesia or an operating room procedure.
  2. Preoperative exam and assessment by the attending physician (with documentation in the medical record).
  3. Postoperative exam and assessment no less frequently than daily by the attending physician (again with documentation in the medical record).
• The program director and faculty members grant the privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care for each resident.

• The program director evaluates each resident’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.

• The clinical responsibilities for each resident are based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services. Optimal clinical workload will be further specified by each Review Committee.

Levels of Supervision

Programs must use the following classification of supervision:

• **Direct Supervision**
  o A resident requires direct supervision until he/she has been certified as capable of performing an activity or procedure in a semi-independent manner (credentialed).
  o Direct Supervision – the supervising physician is physically present with the resident and patient.
  o First year residents (PGY1) must have an on-site direct supervisor available at all times.

• **Indirect Supervision**
  o Indirect supervision for a resident who has been certified to perform a procedure in a semi-independent manner (credentialed), the faculty member or supervisor does not need to be physically present during the procedure. There are two classifications of indirect supervision specified by the ACGME:
    ▪ with direct supervision immediately available – the supervising physician is in the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
    ▪ with direct supervision available – the supervising physician is not in the hospital or other site of patient care, but is immediately available by telephone and/or electronic modalities, and is available to provide Direct Supervision.
  o Indirect supervision may be provided by a resident if both the supervising resident and the faculty member are credentialed in the procedure to be performed. Indirect supervision is restricted to those procedures included in the residency training program’s credentialing plan.

• **Oversight**
  o Oversight – after care is delivered, the supervising physician is available to review procedures/encounters and provide feedback.
• **Supervision During Electives, Required Rotations & Consultations**
  
  o Residents on rotations/electives outside their “home” department will be supervised by faculty in the assigned “host” program.
  
  o 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.
  
  o The consulting resident should report and discuss all strategies with their “host” department faculty supervisor.

• The program director and UB are not responsible for supervision of the resident during moonlighting or other clinical activities that are unrelated to the training program.

**Basic Principles of Documentation**

• Resident supervision must be appropriately and accurately documented in the patient record. This includes consultations, admitting notes, procedure/operative notes, progress notes, and discharge summaries for inpatients, outpatients, and patient in the Emergency Department.

• The following are acceptable forms of documentation by a faculty supervisor:
  
  o an attending progress note;
  
  o an attending’s addendum to a resident’s note;
  
  o co-signature of a resident’s note by the attending; and
  
  o resident documentation of attending supervision/involvement.

• The faculty member’s documentation must meet the minimal Medicare standards or those specified by the Office of the Medical Inspector General, except at the VAVNYHS where documentation guidelines are outlined in the VHA Handbook.

• The resident’s documentation in the medical record should include the following:
  
  o the name of the supervising faculty member;
  
  o the degree of involvement of the faculty member;
  
  o a summary of the resident and supervisor’s findings, discussions, actions, and recommendations;
  
  o the specific issues of the diagnostic and therapeutic plans;
  
  o the date and time of the personal evaluation of the patient; and
  
  o 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

- Comply with New York state regulations.
  - New York State requires that supervising or attending physicians provide on-site supervision at all times. In hospitals that document that the patients’ attending physicians are immediately available by telephone and readily available in person, the on-site supervision may be carried out by residents who are in their final year of training, or who have completed 3 years of accredited postgraduate training.
  - In hospitals where the patients’ attending physicians are NOT immediately available, New York State requires that supervision be provided by a sufficient number of board certified/eligible physicians in the appropriate specialty or residents who have completed 4 years of training in the specialty.

- Each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient’s care. This information should be available to residents, faculty members, and patients.

- Residents and faculty members should inform patients of their respective roles in each patient’s care.

- Programs must set guidelines for circumstances in which a resident must communicate with the supervising faculty member (such as the transfer of a patient to an intensive care unit, or end-of-life decisions).

- The program must have a resident supervision plan that addresses both patient safety and resident education. It must comply with the standards set by the New York State DOH and the ACGME/CODA. The plan must be shared with residents and faculty annually.
  - The supervision plan must include:
    - a definition of the clinical responsibilities of each resident at each level of training;
    - a mechanism of providing feedback and program notification if a resident or faculty member 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 this policy and circumstances where residents can function as supervisors.
• 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 meets the requirements outlined in this policy. This credentialing plan must be shared with residents and faculty annually.
  o The credentialing plan must include:
    ▪ a list of specific treatments and procedures which can only be performed by residents who have been credentialed;
    ▪ 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 residency management system as outlined in the residents’ Privileging Policy;

• Ensure that all faculty supervisors have 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

• 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.

• PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available. [Each Review Committee will describe the achieved competencies under which PGY-1 residents’ progress to be supervised indirectly, with direct supervision available.]

• Appropriately credentialed senior residents or fellows may supervise junior residents.

• Be aware of and follow the program’s credentialing and supervision plans.

• Request supervision from the faculty member or supervisor if asked to perform a bedside procedure, when he or she is not credentialed, has insufficient experience with the procedure, or when the procedure is beyond the level of skill of the resident.

Responsibilities of the Faculty

• 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.

• Have appropriate privileges at each clinical site.
• At all times, the supervising faculty member has the ultimate responsibility for each patient’s care.

• Follow the requirements for direct supervision, indirect supervision, and documentation of supervision.

• 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.
- Directly supervise the 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.
- Directly supervise all procedures where the resident is not credentialed, or the procedure requires general anesthesia, an operating room, or special procedure site.
- Provide appropriate supervision and documentation for preoperative and postoperative examination and assessment.

**Inpatient Care**
- Review, evaluate and document supervision of all new resident hospital admissions and consultations (within 24 hours including weekends and holidays).
- Provide (and document) appropriate supervision for the patient's evaluation, management decisions and procedures each day, including the day of discharge.
- Ensure that discharge or transfer of the patient from an inpatient team or clinic to any other team or site is appropriate.
SUPERVISION POLICY: FREQUENTLY ASKED QUESTIONS

Can a resident be a supervisor?

_Anticipated action or response_

An appropriately credentialed resident who meets the legislative requirements can function as a supervisor. 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.

Who can be a supervising physician?

_Anticipated action or response_

A physician, a member of the medical staff, or a more senior resident designated by the program director can supervise a junior resident. Such designation must be based on demonstrated competency in medical expertise and supervisory capability. In rare instances, a Review Committee may allow non-physician, licensed, independent practitioners designated by the program director to supervise residents. In all cases, each program’s supervision policies should clearly state the types of supervision that are permissible. Programs should ensure that any policy revisions are compliant with specialty-specific requirements.

What is meant by “progressive authority and responsibility, conditional independence, and a supervisory role in patient care” for residents?

_Anticipated action or response_

Residents enter programs as novices and are expected to graduate as accomplished physicians capable of functioning competently and without supervision. Depending on the specialty, this transition may take several more years. The use of specialty specific milestones will help program directors and faculty members determine the levels of responsibility assigned to each individual resident. Great care must be taken in determining the level of involvement each resident will have in direct patient care so as to ensure patient safety. Another level of advancement lies in the granting of supervisory authority to a resident over a more junior resident. This will require not only documentation of medical knowledge and procedural competency skill sets, but also documented ability to effectively teach and oversee the work of others. At any level of assignment, the initial few days or weeks should be carefully monitored to ensure that the
individual resident is capable of functioning in his/her assigned role. If not, then remediation will be necessary before the assignment can continue.

What should a resident do if he/she cannot determine the identity of or contact the supervising faculty member?

*Anticipated action or response*

The resident 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 cannot locate the covering faculty member should contact primary faculty member, 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. Direct communication between the Emergency Medicine physician and the consulting faculty member 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 (DNR) order if he/she does not know the policy and procedure for the clinical site.

The resident may write 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.