MERCYHEALTH

Regional Academic Affairs

TITLE: Resident/Fellows Supervision Policy	POLICY NUMBER:	S-30
DEPARTMENT: Graduate Medical Education	Effective Date:	01/04
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PURPOSE:

This policy governs the responsibilities of residents/fellows (herein after "resident") and supervising physicians at Mercy Health (MH). It provides the procedural requirements pertaining to supervision of residents focusing on resident supervision from an educational perspective. It ensures compliance with Accreditation Council for Graduate Medical Education (ACGME), Council for Podiatric Medical Education (CPME) and other applicable accrediting bodies and outlines responsibilities for Physicians at Teaching Hospitals as outlined by the Office of the Inspector General (OIG).

DEFINITION:

Supervision is an intervention provided by a supervising practitioner also referred to in this document as the "teaching physician" and/or faculty to a resident. This relationship is evaluative, extends over time, and has simultaneous purposes of enhancing the professional functioning of the resident while monitoring the quality of professional services delivered. Supervision is exercised through observation, consultation, directing the learning of the resident, and role modeling.

BACKGROUND:

In a health care system where patient care and the training of health care professionals occur together, there must be a clear delineation of responsibilities to ensure that qualified practitioners provide patient care. As resident trainees acquire the knowledge and judgment that accrue with experience, they are allowed the privilege of increased authority for patient care.

1. Mercy Health - St. Vincent Medical Center, as the sponsoring institution, (MSVMC) follows the institutional requirements of the ACGME, the CPME and other accrediting and certifying bodies. Accrediting bodies require that the Residency/Fellowship Program Directors and faculty take responsibility for providing residents with direct experience in progressive responsibility for patient management. The process of progressive responsibility is the underlying educational principle for all graduate medical and professional education, regardless of specialty or discipline. Supervising clinician educators involved in this process must understand the implications of this principle and its impact on the patient and the resident.

2. Hospitals of Mercy Health must comply with the institutional requirements and accreditation standards of the Joint Commission (JC) and other health care accreditation bodies. Qualified health care professionals with appropriate credentials and privileges provide patient care and provide the supervision of residents.

3. The intent of this policy is to ensure that patients are cared for by clinicians who are qualified to deliver that care and that this care is documented appropriately and accurately in the patient record. This is fundamental both for the provision of excellent patient care and for the provision of excellent education and training for future health care professionals.

4. The quality of patient care, patient safety, and the success of the educational experience are inexorably linked and mutually enhancing. Incumbent on the clinician educator is the appropriate supervision of the residents as they acquire the skills to practice independently.

SCOPE:

The provisions of this policy are applicable to patient care services including, but not limited to, inpatient care, outpatient care, emergency care, and the performance and interpretation of diagnostic and therapeutic procedures.

1. Supervising physicians/practitioners are responsible for the care provided to each patient, and they must be familiar with each patient for whom they are responsible. Fulfillment of that responsibility requires PERSONAL involvement with each patient and each resident who is participating in the care of that patient. Each patient must have a supervising licensed independent practitioner whose name is identifiable in the patient record. Other supervising physician/practitioners may at times be delegated responsibility for the care of the patient and the supervision of the residents involved. It is the responsibility of the supervising physician/practitioner to be sure that the residents involved in the care of the patient are informed of such delegation and can readily access a supervising physician/practitioner at all times.
2. Within the scope of the training program, all residents must function under the supervision of supervising practitioner/physician faculty. Services generally provide 24-hour, 7-day a week (24/7) resident coverage and call schedules will be provided. Call schedules are to delineate both resident and attending physician coverage.
3. Each training program is constructed to encourage and permit residents to assume increasing levels of responsibility commensurate with their individual progress in experience, skill, knowledge, competence, and judgment.
4. Each participating site must adhere to current accreditation requirements as set forth by the ACGME /CPME/JC, HFAP or other applicable accrediting body.
5. In order to ensure patient safety and quality care while providing for an optimal educational experience of the resident in the ambulatory setting, it is expected that an appropriately credentialed supervising licensed independent practitioner/physician is physically present during clinic hours.

Key Terms

1. "**Teaching physician**" means a physician (other than a resident) who involves residents in the care of his/her patients.
2. "**Resident**" means an individual who participates in an approved graduate medical education (GME) program. The term includes interns and fellows in approved GME programs. A medical student is **never** considered a resident.
3. "**Teaching setting**" means any hospital-based provider setting that receives Medicare or Medicaid payment for the services of residents under the direct GME payment methodology.
4. "**Student**" means an individual who is enrolled in an accredited medical school. **A student is never considered to be an intern or a resident.**
5. "**Documentation**" means notes recorded in the patient's medical records by a resident or teaching physician.
6. "**Physically present**" means that the teaching physician is in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient, and/or performs a face-to-face service.
7. "**Critical or key portions**" means that part(s) of a service that is/are a critical or key part of the service.

ROLES AND RESPONSIBILITIES:

Resident training occurs in the context of different services and in a variety of appropriately structured clinical settings, including inpatient, outpatient, and community settings. Residents and Faculty must inform patients of their exact role in providing their direct care.

1. **Residency/Fellowship Program Director.** The Residency/Fellowship Program Director is responsible for the quality of the overall education and training program, and for ensuring that the program is in compliance with the institutional/common program requirements and the specialty specific program requirements.

2. **Designated Institutional Official (DIO).** The DIO has the authority and responsibility for the oversight and administration of the sponsoring institution's ACGME /CPME or other accredited graduate medical education programs and is responsible for ensuring compliance with all applicable accreditation requirements.

3. **Supervising Practitioner.** The supervising practitioner also referred interchangeably with "teaching physician" is responsible for, and must be personally involved in, the care provided to individual patients in inpatient and outpatient settings. When a resident is involved in the care of the patient, the responsible supervising practitioner must continue to maintain a personal involvement in the care of the patient. A supervising practitioner must provide an appropriate level of supervision. Determination of this level of supervision is a function of the experience and demonstrated competence of the resident and of the complexity of the patient's health care needs.

   The term "Supervising Practitioner" is synonymous with teaching physician attending or faculty. ACGMECPME defines faculty as "any individuals who have received a formal assignment to teach resident physicians", and thus all supervising practitioners must have formal faculty assignments by the respective Program Directors.

   a. **General.** The supervising practitioner directs the care of the patient and provides the appropriate type of supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment of the resident being supervised. All services must be rendered under the supervision of the responsible practitioner or must be personally furnished by the supervising practitioner.

   b. **Documentation.** Documentation of supervision must be entered into the medical record by the supervising practitioner and reflected within the resident progress note. The medical record needs to reflect the involvement of the supervising practitioner.

4. **Resident.** The residents (including interns and fellows), as individuals, must be aware of their limitations and not attempt to provide clinical services or do procedures for which they are not trained. They must know the graduated level of responsibility described for their level of training and not practice outside of that scope of their competency. Residents are providing care to patients under the guidance and supervision of the teaching faculty at all times. Each resident is responsible for communicating significant patient care issues; for example, a new admission, change in the status of a patient to a higher or lower level of care and/or an acute change in the clinical status of the patient to the supervising practitioner. Such communication must be documented in the record. Failure to function within graduated levels of responsibility or to communicate significant patient care issues to the responsible supervising practitioner are serious matters and may result in steps including but not limited to the removal of a resident from the program.

GRADUATED LEVELS OF RESPONSIBILITY AND CHAIN OF COMMAND

1. As part of their training program, residents earn progressive responsibility for the care of the patient. The determination of a resident's ability to provide care to patients without a supervising practitioner present, or to act in a teaching capacity, is based on documented evaluation of the resident's clinical experience, judgment, knowledge, and technical skill. Ultimately, it is the decision of the supervising practitioner as to which activities the resident will be allowed to perform within the context of the assigned levels of responsibility. In general, however, residents are allowed to order laboratory studies, radiology studies, pharmaceuticals, and therapeutic procedures as part of their assigned levels of responsibility. The overriding consideration in determining assigned levels of responsibility must be the safe and effective care of the patient. Residents must also refer to the program specific guidelines as they pertain to their ability to practice at different levels of training. Residents must not attempt to perform any procedures on patients within the institution that they have not been deemed competent to perform by their respective program directors.

2. Authority for supervision may be delegated, at the discretion of the attending faculty, to more senior residents. In general, the senior resident assigned to the service will be in charge of the service and is expected to assume a leadership role. Except in emergencies, the "chain-of-command" of junior resident/intern → senior resident → supervising practitioner should be followed regarding patient care decisions. In these instances, the junior resident must keep the senior resident informed of significant events regarding the service. Individual resident assignments are to be made by the senior resident at the start of each rotation.
   Under some circumstances, junior residents/interns may work directly with attending faculty.

3. Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty members.

GENERAL LEVELS OF RESIDENT SUPERVISION:

The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.

Supervision may be exercised through a variety of methods. Some activities require the actual presence of the supervising faculty. 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 properly supervised by the immediate availability of the supervising faculty member or senior resident, either in the institution, or by means of phone/electronic communication. In some instances, supervision may include a post-hoc review of the care provided with appropriate feedback to the resident.

1. Levels of Supervision:

   The programs must have a program specific policy that outlines the various levels of supervision for the various educational venues used by the program (e.g., inpatient, ICU, ED, ambulatory/outpatient). The policy must use the following classification of supervision:

A. Direct Supervision:
   1. the supervising physician is physically present with the resident during the key portions of the patient interaction; or 1.a PGY-1 residents must initially

be supervised (programs should refer to specialty Review Committee requirements for further requirements)

2. 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.

B. Indirect Supervision:

a. 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

C. Oversight:

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

PGY-1 residents must be initially directly supervised directly. Specific RRCs may detail conditions which a PGY-1 progress to indirect supervision.

Program's must have program level supervision policy based on their RRC specific program requirements. In addition to supervision levels/details, this policy must define when physical presence of supervising physician is required. This policy must also detail guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s).

SURGICAL SUPERVISION REQUIREMENTS:

Critical or key portions mean that part(s) of a service that is/are a critical or key part of a service. Critical or key portions are defined based on the type of service:

1. For surgery, the teaching physician is not required to be present during the opening and closing of the surgical area but must be present during all key portions. The determination of what a resident may or may not be able to perform during a surgical procedure beyond the above requirement is based on resident experience and competence, complexity of the case and the surgeon's best judgment with regards to patient safety and quality of care.

PATIENT SETTINGS:

Inpatient Care

1. **Inpatient Admission:** For patients admitted to an inpatient service of the medical center, the supervising practitioner must physically meet, examine, and evaluate the patient within 24 hours of admission including weekends and holidays (Unless otherwise prescribed by the medical staff bylaws, which may be more restrictive but not less restrictive than these guidelines.) Documentation of the supervising practitioner's findings and recommendations regarding the treatment plan must be in the form of an independent progress note or an addendum to the resident note, which must be entered by the end of the calendar day following admission. All admissions must be discussed with the attending physician on-call/in a supervisory role at the time of the admission.

2. **Night Float Admissions:** For patients admitted to an inpatient service of the medical center, a "night float" resident occasionally provides care before the patient is transferred to an inpatient ward team. In these cases, the supervising practitioner must physically meet and examine the patient within 24 hours of admission by the night float to the inpatient service, irrespective of the time the ward team assumes responsibility for the patient. In addition, the supervising practitioner for night float admissions must be clearly designated.

3. **Continuing Care of Inpatients:** Supervising practitioners are expected to be personally involved in the ongoing care of the patients assigned to them in a manner consistent with the clinical needs of the patient and the graduated level of responsibility of the resident.

4. **Discharge from Inpatient Status:** The supervising practitioner, in consultation with the resident, ensures that the discharge of the patient from an inpatient service of the medical center is appropriate and based on the specific circumstances of the patient's diagnoses and therapeutic regimen; this may include physical activity, medications, diet, functional status, and follow-up plans. Evidence of this assurance must be documented by the supervising practitioner's countersignature of the discharge summary or discharge note.

5. **Transfer from One Inpatient Service to Another, or Transfer to a Different Level of Care (Inter-service or Inter-ward Transfer):** The supervising practitioner, in consultation with the resident, ensures that the transfer of the patient from one inpatient service to another or transfer to a different level of care is appropriate and based on the specific circumstances of the patient's diagnoses and condition. The supervising practitioner from the transferring service must be involved in the decision to transfer the patient. The supervising practitioner from the receiving service must treat the patient as a new admission and must write an independent note or an addendum to the resident's transfer acceptance note

6. **Inpatient Consultations:** A supervising practitioner is responsible for clinical consultations from each specialty service. When residents are involved in consultation services, the supervising practitioner is responsible for supervision of these residents. For the consultation to be billable there must be three components that must be satisfied:

    a. A request for consultation with a reason (Diagnosis/Symptoms)
    b. An evaluation of the patient and a consultation performed
    c. A consultation note addressing the findings and recommendations from the consultant

7. **Intensive Care Units (ICU), including Medical, Cardiac, and Surgical ICUs:** For patients admitted to, or transferred into, an ICU of the medical center, the supervising practitioner must physically meet, examine, and evaluate the patient as soon as possible, but no later than 24 hours after admission or transfer, including weekends and holidays. An admission note or addendum to the resident's admission note is required within 1 day of admission. Because of the unstable nature of patients in ICUs, frequent evidence of involvement of the supervising practitioner is expected. A physician (Licensed Independent Practitioner) must see a patient within one hour of the admission to the ICU. All admissions to the ICU by a resident must be discussed with a supervising physician at the time of the admission.

8. **Change in Clinic Status:** Residents must consult with the supervising attending physician whenever there is a significant change in the clinical status of the patient at any time during the week and over the weekends. Programs must develop policies that indicate the specific patient events that require a consult with the attending physician.

Outpatient Clinic
Please refer to the Ambulatory Care Supervision Policy S-38.

Emergency Department

1. **Physical Presence:** The supervising practitioner for the emergency department must be physically present in the emergency department or immediately available at all times.

2. **Emergency Department Visits:** Each new patient to the emergency department must be seen by the emergency department faculty.

3. **Discharge from the Emergency Department:** The supervising practitioner, in consultation with the resident, ensures that the discharge of the patient from the emergency department is appropriate. The emergency department attending will sign the discharge release form prior to the patient's discharge from the department.

4. **Emergency Department Consultations:** A supervising practitioner is responsible for clinical consultations from each specialty service. When residents are involved in consultation services, the consulting service supervising practitioner is responsible for supervision of the residents when that attending physician is present in the emergency department. When the consulting service attending physician is not physically present in the emergency department, the resident will be supervised by the emergency faculty attending who is present in the emergency department. Residents from a consulting service are expected to contact their supervising practitioners while the patient is still in the emergency department in order to discuss the case and to develop and recommend a plan of management. The emergency room practitioner is responsible for the final disposition of the patient and for supervising the coordination with all consulting services.

5. **Emergency Room Admissions:** A potential admission to the hospital from the Emergency Room must be discussed with a teaching physician prior to consulting a service or an attending physician.

EMERGENCY SITUATIONS:

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 medical center personnel, is permitted to do everything possible to save the life of a patient or to save a patient from serious harm. The appropriate supervising practitioner must be contacted and apprised of the situation as soon as possible. The resident must document the nature of that discussion in the patient's record.

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