



TRUMAN MEDICAL CENTERS

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Subject: RESIDENT SUPERVISION

Originator: Chief Medical Officer

Approval Date: November 14, 2012

Approved By: _____
Mark T. Steele, M.D., Chief Medical Officer

Policy: Those enrolled in graduate medical education training programs who are providing patient care at Truman Medical Centers will be subject to supervision in their care of patients commensurate with their training needs and their level of training and competency. All patient care and resident supervision is the ultimate responsibility of the Licensed Independent Practitioners who are members of the Medical Staff and attending the patient. The aims of resident supervision are to promote professional development and ensure patient safety. The desired features of supervision are normative (highlighting standards of care), formative (providing feedback for improvement), and supportive (providing reflection and assistance).

Purpose: To provide direction to residents and faculty who are participating in training programs at Truman Medical Centers regarding the level of supervision required to assure appropriate patient care while providing the resident with progressive levels of responsibility in the patient care process.

Scope: Corporate-wide

Definitions:

Resident: An individual at any level of training in a graduate medical education program approved by the Accreditation Council for Graduate Medical Education (ACGME) or the University of Missouri at Kansas City Medical Education Council or sponsored by TMC. Participants in subspecialty training programs, commonly referred to as fellows, are specifically included.

Licensed Independent Practitioner (LIP): Any practitioner permitted by law and by the organization to provide care and services, without direction or supervision, within the scope of the practitioner's license and consistent with individually assigned clinical responsibilities.

Faculty: Those LIPs who are credentialed by TMC to provide care in his or her specialty and whom have been granted faculty appointments by the University of Missouri at Kansas City.

Attending: The LIP/Faculty who is directly responsible for a patient's care and responsible to insure appropriate levels of resident supervision.

Consultant: A consultant is a LIP who is requested to provide care to a patient in his or her specialized area of training. A resident may serve as a consultant subject to the supervision required by this Policy.

Supervision: The amount of supervision required for each resident shall vary according to the critical nature of each patient and be commensurate with the level of training, education, experience, and demonstrated skill of a resident that is involved with the patient's care. Supervision may be provided by a senior resident when provided for in this Policy. Supervision may be exercised through a variety of methods:

Direct Supervision: The supervising physician is physically present with the resident and patient.

Indirect Supervision: (1) 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. (2) 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 supervision physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

Responsibilities:

Attending Faculty:

- I. In all settings, patient care is the ultimate responsibility of the attending faculty and any consultants and care rendered by a resident shall be rendered under faculty supervision. Faculty directly responsible for the supervision of patient care services provided by resident physicians should be available to participate in that care as if residents were not involved and faculty must be available to participate in a patient's care when requested by a resident physician.
- II. Attending faculty remain ultimately responsible to: examine and interview; admit or discharge their patients; write orders, progress notes, and discharge summaries; and obtain or provide consultations where appropriate.

- III. The attending faculty and consulting physicians should review entries made by the residents in the medical record, assure entries accurately reflect the patient and care situation, and make any necessary corrections and/or addenda in the entries in accordance with medical record policies.
- IV. Faculty functioning in their supervisory capacity may entrust portions of patient care to residents, based on the need of the patient and the competency of the resident, provided that the care provided by the resident is still supervised..

Residents:

- I. When a resident is involved in the care of a patient, it is the resident's responsibility to communicate and escalate effectively with their attending faculty regarding the findings of their evaluation, physical examination, interpretation of diagnostic tests, and intended interventions on a continuous basis.
- II. Residents shall notify the appropriate attending or consulting faculty upon patient admission, if there is any significant change in a patient's condition or prior to initiating significant changes in a patient's treatment including patient discharge. Should a resident be unable to reach their supervising physician or covering attending physician, they will go to their Program Director, Department Chair, or the Chief Medical Officer/Associate Medical Officer and/or follow the Chain of Command Policy. Failure to do so may result in report to the Program Director and appropriate Department Chair for formal review.
- III. Residents may perform history and physical examinations and consultations under the supervision of the attending faculty. It is the responsibility of the resident to discuss their findings with the attending physician upon completion of their examination. Admitting history and physical examinations shall be attested by the attending faculty.
- IV. Residents may act as consultants under the supervision of a faculty member and they must see any patient if on-call for consults when requested by a faculty member.
 - A. All outpatient consultations seen by residents or fellows should be discussed with and/or seen by the attending faculty at the time of the patient's clinic visit.
 - B. All routine hospitalized patient consultations should be seen by the attending faculty within 24 hours of the request, or sooner based on clinical need. Urgent or emergent requests for hospitalized patient consultations seen by a resident must be discussed with the attending faculty within the required time frames (1 hour emergent; 4 hours urgent) and personally seen by the attending faculty within 24 hours of

the request in instances where on-site consultations are routinely provided. Faculty-to-faculty contact is required for all hospitalized patient consultation requests.

- C. All Emergency Department consultations should be seen by the resident, discussed with the attending faculty and communicated to the ED resident or attending faculty within 90 minutes of initiation of the consultation.

- V. Emergency Department admissions must be seen by the resident, discussed with the supervising physician and have orders for admission written within 90 minutes of initiation of the request for admission.

- VI. Residents may evaluate hospitalized patients and write daily progress notes under the supervision of the attending faculty. It is the responsibility of both the resident and the attending faculty to discuss their findings and treatment plans documented in the progress note on a daily basis, or more often as described above, when a patient's condition changes, or prior to initiating significant changes in a patient's treatment.

- VII. Residents may write daily orders for patients. These orders will be implemented without the co-signature of an attending or consulting faculty. When pursuant to number I of the Procedure section of this policy, a resident is determined to have the competency to do so, the resident may control the ordering, preparation, and administration of medications without direct supervision. It is the responsibility of the resident to discuss their treatment plans with the attending or consulting faculty.

- VIII. All outpatients seen by residents will be conducted under the supervision of a faculty member who will have responsibility for the care of the patient and who will see the patient personally if requested by the patient or the resident.

- IX. Unless the resident has achieved independent proficiency as provided for in this Policy, procedures performed by a resident in a setting other than the Operating Room Suite, Labor and Delivery Suite, GI Lab or Cath Lab will be under direct supervision

- X. Residents will be under direct supervision as follows, except in emergency situations:
 - A. In Labor and Delivery, during the actual delivery.
 - B. In the Operating Room Suite, including the C-section Suite, for the time out and during the critical or key portions of the case.
 - C. In the GI Lab, for the time out and during the critical or key portions of the case.
 - D. In the Cath Lab, for the time out and from the time of initiation of sedation through completion of the critical or key portions of the case, including

sedation recovery period as outlined in the Moderate Sedation Analgesia (Conscious Sedation) with Addendum for Deep Sedation Policy.

Non-Physician LIPs:

- I. Non-physician LIPs acting within their scope of practice and privileges may provide resident supervision for practice and/or procedures as allowed by the ACGME and program-specific Residency Review Committee guidelines

Procedures:

- I. Each residency program director will develop a list of procedures that their residents may perform without direct supervision. Once competency has been documented in any of these specific procedures by the program for the individual resident, the resident may perform these procedures without direct supervision but with the permission of the attending faculty. Senior residents with documented competency in the procedure may supervise other residents in the performance of such procedures. Such list will be developed with input from members of the appropriate department or service, and will be submitted to the Office of Graduate Medical Education. Each residency program director will review such list on an annual basis and assure review of competency for the individual resident prior to submission of the information to the TMC Graduate Medical Education Office.
- II. Program-specific written descriptions of resident roles, responsibilities, and patient care activities shall be distributed by program directors to their program faculty supervising residents. These descriptions shall include identification of the mechanisms by which the resident's supervisors and program director make decisions about each resident's progressive involvement and independence in specific patient care activities.
- III. The UMKC Graduate Medical Education Council chair will report to the Medical Executive Committee annually concerning resident performance, patient safety and quality of care issues and related educational and supervisory needs of the residents. These reports will be forwarded by the Chief Medical Officer to the Joint Conference Committee of the TMC Board.

Authority: The Chief Medical Officer (or designee) is responsible for the implementation of this policy.

Original Approval Date: 7/1/2002

Revised Date: February 8, 2006

Revised Date: March 12, 2008

Revised Date: September 12, 2012

Revised Date: November 14, 2012

Reviewed Date: February 17, 2010 Initials: BSC
Reviewed Date: _____ Initials: _____
Reviewed Date: _____ Initials: _____