PROCEDURE GME08

Subject: SUPERVISION and ACCOUNTABILITY OF RESIDENTS

Effective Date: DECEMBER 2004

Applies to: HOUSTON METHODIST HOSPITAL SYSTEM - GME

Date Revised/Reviewed: NOVEMBER 2017

Originating Area: GRADUATE MEDICAL EDUCATION COMMITTEE

Target Review Date: NOVEMBER 2020

I. GENERAL STATEMENT

The end objective of Graduate Medical Education (GME) is the development of competent physicians who can function independently. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth. During residency training, Program Directors and Faculty must ensure that Residents are carefully supervised and observed in order to determine each Resident's abilities to perform technical and interpretive procedures and to manage patients. Although they are not Licensed Independent Practitioners (LIPs), Residents must be given graded levels of responsibility so that they can mature into their roles as judgmentally sound, technically skilled, and independently functioning credentialed health care providers.

This procedure establishes the minimal requirements for Supervision of Residents in the Participating Institutions affiliated with Houston Methodist Hospital Programs of GME. A Participating Institution may have additional requirements for Supervision of Residents. The requirements of individual Programs of GME may also be more restrictive than the minimums established by this Procedure.

II. GENERAL REQUIREMENTS FOR SUPERVISING RESIDENTS

A. LIPs must supervise all patient care performed by Residents as part of their training curriculum. A LIP must be a member of the Medical Staff of the particular hospital in which the LIP is supervising Residents. The LIP must be credentialed for the specialty care and diagnostic and therapeutic procedures being supervised. The supervising LIP is ultimately responsible for patient care.

B. Each patient must have an identifiable, appropriately-credentialed and privileged LIP who is responsible and accountable for the patient's care. This information must be available to residents, faculty, other members of the health care team, and patients. Residents and faculty must inform each patient of their respective roles in that patient's care when providing direct patient care.

C. The Program Director must ensure, direct, and document the supervision of Residents at all times. Residents must be provided with rapid, reliable systems for communicating with Supervising Medical Staff. The Program must demonstrate that the appropriate level of supervision in place for all Residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation.

D. Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. The schedules of Supervising Medical Staff must be structured to provide Residents with continuous supervision and consultation.

E. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones. Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. Senior Residents or fellows should serve in a supervisory role to 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.

F. The Program must use the following ACGME classifications of supervision:
    1. Direct Supervision—the Supervising Physician is physically present with the Resident and the patient
    2. Indirect Supervision
        a. 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
        b. With Direct Supervision available—the Supervising Physician is not physically present within the hospital or other site of care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision
    3. Oversight—the Supervising Physician is available to provide review of procedures/encounters with feedback provided after care is delivered

G. Each Program Director working with the Program's Faculty and other staff must develop a Program-specific Resident Supervision policy. The Program-specific policy must comply with policies on Resident Supervision from Joint Commission or the Hospital's accrediting agency, Methodist's GMEC, the Organized Medical Staff of each hospital in which Residents will be trained, and all Medicare and Medicaid requirements. Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. At a minimum, each Program Resident supervision policy must:
    1. Delineate the role, responsibilities, and patient care activities of Residents
    2. Establish guidelines for circumstances and events in which Residents must communicate with the supervising Faculty members.
    3. Ensure that PGY1 Residents are supervised either directly or indirectly with direct supervision immediately available

4. Follow RRC specific requirements concerning the achieved milestones under which PGY1 Residents may progress to Indirect Supervision with Direct Supervision Available
5. Make it clear to all involved with a patient's care what a Resident (by name or by postgraduate year of training) can and cannot do concerning patient care with less than Direct Supervision
6. Provide general job descriptions (see sample in Exhibit 1), Supervision, and documentation plans by postgraduate year of training

H. The GMEC oversees the Annual GME Survey as a mechanism by which Residents/Fellows can report inadequate supervision in a protected manner. Residents may also use the GME Ombudsman program to make such reports.

I. Each Program Director must provide a listing of Residents' clinical activities that are permitted by year of training, the required level of Supervision for each activity, and any requirements for Residents' performing an activity without Direct Supervision (see samples in Exhibits 2 and 3). Alternatively, the Program Director may list clinical activities without reference to the year of training and provide only the requirements for performing an activity without Direct Supervision.
   1. Program Directors of ACGME-accredited Programs will submit their listing of clinical activities to the Graduate Medical Education Committee for review and approval yearly.
   2. Program Directors of non-ACGME accredited programs will submit their listing of clinical activities to the Director of Graduate Medical Education for review and approval yearly.

J. Documentation of all patient encounters or reports of patient diagnostic examinations must identify the Supervising Medical Staff and indicate the level of involvement. Four types of documentation are allowed:
   1. The supervising Medical staff's note or other entry into the patient's medical records
   2. The supervising Medical Staff's addendum to the Resident's note
   3. Countersignature of the supervising Medical Staff to signify that the Medical Staff has reviewed the Resident's note, and, absent to an addendum to the contrary, concurs with the content of the Resident's note or entry; reports related to reviews of patient material (such as pathology, radiology) must be verified and countersigned by the Supervising Medical Staff
   4. Resident documentation of the Medical Staff's supervision in which the Resident identifies the supervising Medical Staff: "I have seen and discussed the patient with my supervising staff, Dr. X, and Dr. X agrees with my assessment and plan"

K. <u>Supervision of Residents in Different Patient Care Settings</u>.

   1. <u>Inpatient settings</u>.
      a. For admissions, the Supervising Medical Staff must see and evaluate the patient within 24 hours. The Supervising Medical Staff must document findings and recommendations regarding the treatment plan by the end of the calendar day following admission.
      b. For continuing care, each Program's Supervision policy must delineate which Residents by name or by postgraduate year of training may write patient care orders, the circumstances under which they may do so, and

what entries, if any, must be countersigned by the Supervising Medical Staff.

c. For inpatient ward or ICU teams, the Supervising Medical Staff has the primary responsibility for the patient's medical diagnosis and treatment. Residents may write daily orders on inpatients in whose care they are participating. These orders will be implemented without the co-signature of the Supervising Medical Staff. It is the responsibility of the Resident to discuss his or her orders with the Supervising Medical Staff. The Supervising Medical Staff may write orders on all patients under their care. Residents must follow the Participating Institution's policies for how to write orders and to notify nurses of verbal orders, if permitted, in each patient care area.

d. For discharge or transfer, the Supervising Medical Staff must be personally involved. The Supervising Medical Staff must countersign the discharge summary or discharge or transfer note.

2. Inpatient consultation teams. All inpatient consultations performed by Residents will be documented in writing with the name of the responsible Medical Staff consultant recorded. The Resident must notify the responsible consultant within an appropriate period of time as defined by the particular consulting service. The Medical Staff consultant is responsible for all recommendations made by the Resident consultant team. If requested by the patient's primary health care provider, the consulting Medical Staff must see the patient in a timely manner that is agreeable to both the referring and the consulting Medical Staff.

3. Operating room. Except in emergencies, the Supervising Medical Staff must evaluate each patient preoperatively. The Supervising Medical Staff must write a pre-procedural note describing findings, diagnosis, plan for treatment, and/or choice of procedure to be performed. This note may be written up to 30 days preoperatively. Informed consent must be obtained according to the policy of the Participating Institution in which the procedure will be performed. Post-operative documentation must comply with JCAHO requirements, the Organized Medical Staff's policies, and all Medicare and Medicaid requirements.

   a. The Supervising Medical Staff must be present in the operating room for the critical parts (including patient and operative site identification) of all Major Cases. In some cases, positioning of an unstable patient may be considered a critical part of an operation.

   b. If, in the opinion of the Supervising Medical Staff, an operative procedure is minor and of low potential for significant morbidity and the Resident is deemed competent to perform the procedure without Direct Supervision (as defined in the Program's curriculum and Supervision policy), the Resident may proceed as directed after proper patient and operative site identification. However, the Supervising Medical Staff remains responsible for all aspects of the patient's care despite his or her absence.

2. Outpatient clinics. Residents will provide outpatient services to patients under a Supervising Medical Staff. The Supervising Medical Staff will interview and examine the patient at his or her discretion, the Resident's request, or the patient's request. The Supervising Medical Staff has full responsibility for care provided, even if he/she does not personally verify the Resident's interview or examination or the patient's laboratory data. The

name of the Supervising Medical Staff will be clearly recorded in the patient's records.

a. For new visits, the Supervising Medical Staff must be physically present in the clinic and see or discuss every new patient with the Resident.
b. For return visits, the Supervising Medical Staff must be physically present in the clinic and see or discuss each returning patient at a frequency sufficient to ensure effective and appropriate treatment. At a minimum, the outpatient note must identify the Supervising Medical Staff.

3. Emergency Department. Residents will provide emergency services to patients under a Supervising Medical Staff whose responsibility for supervision is identical to that outlined for supervision of Residents in outpatient clinics (III.I.4.). The supervision of Residents who are called to consult on patients in the Emergency Department is identical to that outlined for Supervision of Residents on inpatient consultation teams (III.I.2.). Residents should notify their Medical Staff consultants promptly about Emergency Department consultations.

4. Interpretive settings. Residents who primarily interpret laboratory tests, imaging studies, or pathology specimens must be supervised by designated Medical Staff and this Supervision must be documented. Each Program with interpretive settings must establish supervisory regulations that comply with JCAHO and specific RRC requirements.

5. Routine bedside and clinic (non-operating room) procedures. Routine bedside and clinic procedures include lumbar punctures, central lines, and centeses. Each Program must describe those procedures that Residents, identified by name or by postgraduate year of training, may perform without Direct Supervision. The Resident who performs the procedure must write the procedure note that identifies the Supervising Medical Staff.

6. Non-routine, non-bedside, non-operating room procedures. Non-routine, non-bedside, non-operating room Procedures include cardiac catheterization, endoscopy, and invasive radiology. The Supervising Medical Staff must authorize the procedure and must be physically present in the procedural area. The procedure note must identify the Supervising Medical Staff and his or her degree of involvement.
   a. Conscious sedation will only be performed where adequate patient monitoring is available and resuscitation can be readily performed. Conscious sedation will only be performed under the Direct Supervision of an appropriately credentialed Supervising Medical Staff.
   b. The Resident may perform an invasive procedure without Direct Supervision only if, in the opinion of the Supervising Medical Staff, the Resident is competent to perform the procedure safely and effectively. Each Program must describe those procedures that Residents, identified by name or by postgraduate year of training, may perform without Direct Supervision. However, the Supervising Medical Staff remains responsible for the patient's care.
   c. When life or limb would be threatened by a delay, Residents may perform emergency procedures without prior approval of Supervising Medical Staff. In this case, the most senior Resident available will perform or supervise the procedure.

d. Medical and other professional students will not perform a procedure without Direct Supervision of a Supervising Medical Staff or a Resident qualified to perform the procedure without Direct Supervision.

7. Emergency situations. Any Resident will be permitted to do anything possible to save the life of a patient or to prevent serious harm to a patient. However, Residents must make all reasonable efforts to obtain assistance from more senior Residents or any Medical Staff available and will contact the Supervising Medical Staff as soon as possible. The Resident will document in the patient's record all aspects of the emergency patient care, including who was contacted.

L. Each Program must submit its Supervision policy to the GMEC for approval. Each Program must distribute its policy to its Residents and Faculty. So that appropriate personnel can ensure patient safety by verifying a Resident's competence to perform a clinical activity and the level of Supervision required, the GME Department will arrange for each Program-specific Supervision policy to be posted on either:
   1. The intranet (secure) systems of the individual hospitals to which the Program's Residents rotate
   2. Methodist's GME secure site

III. COMMITTEES REVIEWING/APPROVING PROCEDURE

1. Graduate Medical Education Committee [Approved on 9 December 2004] [revised 12 February 2009] [11 August 2011] [9 November 2017]

AUTHORITATIVE REFERENCES

1. Accreditation Council for Graduate Medical Education Common Program Requirements VI.A.2. (effective 1 July 2017)
2. Veterans Health Administration Handbook 1400.1 (Resident Supervision), December 19, 2012; http://www.va.gov/oaa/resources_resident_Supervision.asp

Exhibit 1. Job Descriptions of Residents (SAMPLE)

The PGY1 Resident can:

- Take a complete history and physical on new admissions (unless otherwise specified by a particular service) and document them in the patient's chart using approved hospital forms or electronic methods. After discussion with the Supervising Medical Staff, the PGY1 can write an assessment and initial management plan and institute approved therapeutic interventions.
- Under the Supervision of a more senior Resident or the Supervising Medical Staff, conduct work rounds and write progress notes that include an interim history and physical, laboratory and radiographic data, and an assessment and plan. If a significant new clinical development arises, a member of the Resident Team will communicate in a timely fashion with the Supervising Medical Staff. The Residents and Supervising Medical Staff must communicate with each other as often as is necessary to ensure the best possible patient care.

The PGY2 Resident can:

- Take responsibility for organizing and supervising the teaching service in concurrence with the Supervising Medical Staff and provide a productive educational experience to the junior Residents and medical students under their Supervision. Work directly with PGY1s in evaluating all new admissions and reviewing all history and physicals, progress notes, and orders written by PGY1s.
- PGY2 Residents must maintain close contact with the Supervising Medical Staff of each patient and notify him or her as quickly as possible of any significant changes in the patient's condition or therapy. The Supervising Medical Staff of record must approve, in advance (except for emergency situations), all significant invasive procedures, costly imaging modalities or those with significant patient risk, and all significant therapy decision changes.

The PGY3 Resident can:

- Follow all responsibilities of the PGY2 outlined above when acting in a similar supervisory capacity. PGY3s can perform any of the PGY1 or PGY2 tasks outlined above at the discretion of the Supervising Medical Staff or patient care policies.
- Provide assistance with difficult cases and provide instruction in patient management problems when called upon to do so by other Residents. Assume direct patient care responsibilities when needed to assist more junior Residents during times of significant patient volume or severity of illness.

Exhibit 2. Level of Supervision by Activity and Training Level (SAMPLE)

Level of Supervision by Activity and Training Level for a 3-Year Subspecialty Residency

Clinical Encounter	Level of Supervision	
	0-6 months	7-36 months
Outpatient consultation	1*	3*
Inpatient consultation	2*	3*

*1 = Presentation to staff at time of clinical evaluation.
*2 = Presentation within duty day, < 8 hours (except for critical illness: immediately)
*3 = Chart/record/consult presented to staff, same duty day for outpatients; < 24 h for stable inpatients. Progression at 6 months contingent upon Program's determination of Resident competence.

Exhibit 3. Procedures Performed by Residents without Direct Supervision by Postgraduate Year of Training (SAMPLE)

Clinical Activity/Procedure	Resident Level	Method of Instruction	Instructor Level	Level of Super-Vision	Requirements For Certification To Perform Without Direct Supervision	Method of Confirming Certification of Resident to Perform Procedure Without Direct Supervision
Admission	PGY1+	Direct Clinical Instruction	PGY2 +	NA	At the beginning of PGY1 after initial instruction	PGY Level
H&P	PGY1+	Direct Clinical Instruction	PGY2 +	NA	At the beginning of PGY1 after initial instruction	PGY Level
Breast Exam	PGY1+	Direct Clinical Instruction	PGY2 +	NA	After 5 directly supervised examinations (ABIM)	Program Confirmation of Certification[1]
Rectal Exam	PGY1+	Direct Clinical Instruction	PGY2 +	NA	After 5 directly supervised examinations (ABIM)	Program Confirmation of Certification*
Pelvic Exam, Pap Smear, Wet Mount	PGY1+	Direct Clinical Instruction	PGY2 +	NA	After 5 directly supervised examinations (ABIM)	Program Confirmation of Certification*
Progress Notes	PGY1+	Direct Clinical Instruction	PGY2 +	NA	At the beginning of PGY1 after initial instruction	PGY Level
Narrative and Discharge Summaries	PGY1+	Direct Clinical Instruction	PGY2 +	NA	At the beginning of PGY1 after initial instruction	PGY Level
Transfer Notes	PGY1 +	Direct Clinical Instruction	PGY2 +	NA	At the Beginning of PGY1 After Initial Instruction	PGY Level
Operative Notes	PGY1 +	Direct Clinical Instruction	PGY2 +	NA	At the Beginning of PGY1 After Initial Instruction	PGY Level
Orders other than restraints	PGY1 +	Direct Clinical Instruction	PGY2 +	NA	At the Beginning of PGY1 After Initial Instruction	PGY Level
Restraint orders	PGY1 +	Direct Clinical Instruction	PGY2 +	NA	At the Beginning of PGY2 After Initial Instruction	PGY Level
Informed Consent	PGY1 +	Direct Clinical Instruction	PGY2 +	NA	At the Beginning of PGY1 After Initial Instruction	PGY Level
Interpretation of Laboratory Results	PGY1 +	Direct Clinical Instruction	PGY2 +	NA	At the Beginning of PGY1 After Initial Instruction	PGY Level
Bedside X-ray Interpretation	PGY1 +	Direct Clinical Instruction	PGY2 +	NA	At the Beginning of PGY1 After Initial Instruction	PGY Level
Phlebotomy	PGY1 +	Direct Clinical Instruction	PGY2 +	NA	At the Beginning of PGY1 After Initial Instruction	PGY Level
Placement of Peripheral IV	PGY1 +	Direct Clinical Instruction	PGY2 +	NA	At the Beginning of PGY1 After Initial Instruction	PGY Level
Placement of NG tubes	PGY1 +	Direct Clinical Instruction	PGY2 +	NA	After 3 Directly Supervised Procedures (ABIM)	Program Confirmation of Certification*
Placement of Central Lines	PGY1 +	Direct Clinical Instruction	PGY2 +	NA	After 5 Directly Supervised Procedures (ABIM)	Program Confirmation of Certification*
Placement of Arterial Lines	PGY1 +	Direct Clinical Instruction	PGY2 +	NA	Program Certification	PGY Level
Lumbar Puncture	PGY1 +	Direct Clinical Instruction	PGY2 +	NA	After 5 Directly Supervised Procedures (ABIM)	Program Confirmation of Certification*
Thoracentesis	PGY1 +	Direct Clinical Instruction	PGY2 +	NA	After 5 Directly Supervised Procedures (ABIM)	Program Confirmation of Certification*
Bone Marrow Aspiration	PGY1 +	Direct Clinical Instruction	PGY2 +	NA	Program Certification	PGY Level
Bone Marrow Biopsy	PGY1 +	Direct Clinical Instruction	PGY2 +	NA	Program Certification	PGY Level
Arterial Puncture	PGY1 +	Direct Clinical Instruction	PGY2 +	NA	After 5 Directly Supervised Procedures (ABIM)	Program Confirmation of Certification*
Advanced Cardiac Life Saving	PGY1 +	Instruction ACLS Training	AHA-certified Instructor	NA	After Successful Completion of ACLS (ABIM)	Program Confirmation of Certification*

[1] All PGY2 + are certified for these procedures unless otherwise specified by the Program Director