Hospital-wide Policy	**Title:** Supervision of Residents
Issuing Department: Educational Department	**Reviewed/Revision Date: February 2017**
IMPORTANT NOTICE: The official version of this policy is contained in the Policy and Procedure Manager (PPM) and may have been revised since the document was printed.	

Purpose

The Department of Graduate Medical Education at Tufts Medical Center provides its training programs with developing appropriate structures to supervise its trainees (i.e. "residents") by facilitating the ethical, professional and personal development of trainees in an environment that ensures safe and appropriate care for patients. The policy establishes the responsibility of individual program directors to develop and distribute written policies and procedures that describe the nature, scope and structure of supervision provided to residents at each Post Graduate (PG) year.
In addition, the policy for each program must be in compliance with applicable Joint Commission standards, summarized below:

- At all times, patient care is the responsibility of a licensed independent practitioner with appropriate clinical privileges.
- 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.

Definitions

The following definitions are used throughout the document:

Resident – a professional post-graduate trainee in a specific ACGME accredited training program. In the context of this policy, the term "residents" applies to all interns, residents, and fellows in accredited training programs under the administrative domain of the GME office. (NOTE: Fellows who are in non-accredited training programs, who may be appointed to the attending staff and who are not under the administrative domain of the GME Office, are not covered by the terms of this policy).

Medical Staff – an independently licensed professional credentialed through the Medical Staff Office with an appointment and clinical privileges approved by the Board of Trustees to provide independent care in his/her specialty or subspecialty.

Attending staff – A Trainee's supervising attending staff faculty member, who has been granted clinical privileges for a specific scope of practice, in the specialty or subspecialty area in which they are providing supervision.

Policy

Careful supervision and observation are required to determine a resident's ability to perform technical and interpretive procedures and to manage patients appropriately. Although they are not licensed independent practitioners, trainees must be given graded levels of responsibility while assuring safe and effective care for patients.

The supervision policy for each program should be scaled and graded to provide gradually increased responsibility and maturation into the role of a judgmentally sound, technically skilled, and independently functioning 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 and the applicable program requirements of the individual RCs, as well as commonly accepted standards of patient care.

The Program Director shall provide explicit written descriptions of lines of responsibility for the care of patients, which shall be made clear to all members of the teaching teams. Residents shall be given a clear means of identifying supervising physicians who share responsibility for patient care on each rotation, including rotations at off-site facilities.

In outlining the lines of responsibility, the Program Director will use the following classifications of supervision:

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

2. Indirect Supervision, with Direct Supervision immediately available: the supervising physician is readily available to provide Direct Supervision.

3. Indirect Supervision with Direct Supervision available: the supervising physician is not physically present within the hospital or other site of patient care but is readily available to provide Direct Supervision.

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

HOP, (House Officer Procedure Verification), a procedural database that lists each program's trainees and their competence with performing bedside procedures with indirect and direct supervision is available on the Tufts MC Intranet under the Medical tab at the following link: http://neintraprodweb/hop/Logoff.aspx . Each program will be responsible for maintaining the online database which will be accessible to all nurses and faculty at the medical center.

Procedure

The 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 is the responsibility of a faculty attending supervisor with clinical privileges appropriate to the clinical specialty area in which they are providing supervision.

Attending staff providers must be credentialed to provide the specialty care and diagnostic and therapeutic procedures they are supervising. In this setting, the supervising 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. In these situations, ultimate responsibility for the care provided by the resident is the responsibility of the attending responsible for the physician extender.

A. Each Tufts Medical Center 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. The policy will delineate the role, responsibilities and patient care activities of trainees and define which trainees may write patient care orders, the circumstances under which they may do so (e.g., "all situations"), and what entries, if any, must be countersigned by a supervisor.

B. Each Tufts Medical Center Program Director will describe the resident clinical activities 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). Programs are encouraged to use New Innovations to maintain such listings, and define the criteria for determining resident competency in each.

C. Program Directors should review the residents' clinical activities by level annually and make changes as necessary to reflect current clinical practice.

D. The Program Director must ensure that supervision policies are distributed to all trainees and the medical staff supervising them.

E. Program Directors will determine if residents can progress to the next higher level of training on an annual basis (see policy on "Advancement). The requirements for progression to the next higher level of training will be determined by standards set by each Program Director. This assessment will be documented in the annual evaluation of the trainees.

F. Escalation Clause: Every policy must contain specific information as to how a resident can obtain faculty input as needed and what they can do to escalate their concerns if they do not believe they have received appropriate or helpful guidance in any specific clinical situation. There must be a clear chain of command established in each program policy and the programs must provide an atmosphere of support and nurturing in allowing residents to seek guidance or help when they deem it necessary.

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 they are providing care to. 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. Trainees will follow all hospital policies for how to write orders and follow the "verbal orders" policies of each patient care area.

B. Appendix B provides general job descriptions of trainees by year of training which may be adopted by programs. 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, in writing, by the attending staff must be in accordance with hospital policies. This documentation includes 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.

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 the recommendations made by the consultant team.

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.

Supervision of Trainees in Outpatient Clinics

All outpatient visits provided by trainees will be conducted under the supervision of a medical staff member who is readily available to them. The attending staff physician will interview and examine the patient at their discretion, at the trainee's request, or at the patient's request. The attending staff provider has full responsibility for the care provided, whether or not he/she chooses to personally verify the interview or examination.

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.

Supervision of Trainees Performing Procedures

Program Directors will define the mechanism by which residents can be deemed competent to perform a procedure(s) without supervision. Residents who require the direct presence of a supervisor to perform procedures may be supervised by either staff or more senior residents, when the latter are approved by the program to perform the procedure independently.

Residents 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 be approved to perform certain procedures without direct supervision, based upon specific written criteria set forth and defined by the Program Director.

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 patient's staff of record will be ultimately responsible for all procedures on inpatients.

Residents may perform emergency procedures without prior staff approval or direct supervision when life or limb would be threatened by delay.

All outpatient procedures will have the staff of record documented in the procedure note, and that attending staff provider is ultimately responsible for the outpatient procedure.

Appendix A: Draft Template for Procedures

Instructions and Examples for Completion of 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:

- **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: Program Certification, PGY Year

Appendix B: General Job Descriptions:

Postgraduate Year 1 (PGY1) Resident:

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, and 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 "offservice" 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.

For PGY1 supervision, the attending physician 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.

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.

Postgraduate Year 3 and above (PGY3) Resident:

PGY3 residents 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

are available to provide assistance with difficult cases and provide instruction in patient management problems when called upon to do so by other residents. They 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 is as outlined for PG 2 residents.