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Supervision Policy

Definitions:

Resident: A physician who is engaged in a graduate training program in family medicine, and who participates in patient care under the direction of attending physicians. As part of their training program, residents are given graded and progressive responsibility according to the individual resident's clinical experience, judgment, knowledge, and technical skill. 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. Residents are responsible for asking for help from a supervising physician or other appropriate licensed practitioner when they are uncertain of diagnosis, how to perform a diagnostic or therapeutic procedure, or how to implement an appropriate plan of care.

Attending Physician (Attending): An identifiable, appropriately credentialed and privileged attending physician who is ultimately responsible for the management of the individual patient and for the supervision of residents involved in the care of the patient. The attending delegates portions of care to residents based on the needs of the patient and the skills of the residents.

Supervision: To ensure oversight of resident supervision and graded authority and responsibility, the following levels of supervision are recognized:

1. Direct Supervision: the supervising physician is physically present with the resident and 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 patient care, but is immediately available by means of telephonic and/or electronic modalities and is available to come to the site of care in order to provide Direct Supervision.

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

Clinical Responsibilities

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. The specific role of each resident varies with their clinical rotation, experience, duration of clinical training, the patient's illness and the clinical demands placed on the team.

Specific patient care responsibilities by year of clinical training:

PGY- 1 (Interns): PGY-1 residents are primarily responsible for the care of patients under the guidance and supervision of the attending physician and senior residents (PGY 2 and PGY 3). They should generally be the point of first contact when questions or concerns arise about the care of their patients. However, when questions or concerns persist, supervising residents and/or the attending physician should be contacted in a timely fashion. PGY-1 residents are initially directly supervised and when merited will progress to being indirectly supervised with direct supervision immediately available by an attending or senior resident when appropriate.

PGY- 2 (Intermediate residents): may be directly or indirectly supervised by an attending physician or senior resident but will provide all services under supervision. They may supervise PGY-1 residents and/or medical students; however, the attending physician is ultimately responsible for the care of the patient.

PGY- 3 (Senior Residents): Senior residents may be directly or indirectly supervised. They may provide direct patient care or supervisory care with progressive graded responsibilities as merited. They must provide all services ultimately under the supervision of an attending physician. Senior residents should serve in a supervisory role of medical students, PGY-1 residents and PGY-2 residents in recognition of their progress towards independence, as appropriate to the needs of each patient and the skills of the senior resident; however, the attending physician is ultimately responsible for the care of the patient.

Attending Physician: In the clinical learning environment, each patient must have an identifiable, appropriately credentialed and privileged attending physician who is ultimately responsible for that their care. The attending physician is responsible for assuring the quality of care provided and for addressing any problems that occur in the care of patients and thus must be available to provide direct supervision when appropriate for optimal care of the patient and/or as indicated by program policy (see below). The availability of the attending to the resident is expected to be greater with less experienced residents and with increased acuity of the patient's illness. The attending must notify all residents on his or her team of when he or she should be called regarding a patient's status. In addition to these situations, the attending should include in his or her notification to residents all situations that require attending notification per program or hospital policy. This information should be available to residents, faculty members, and patients. The attending may specifically delegate portions of care to residents based on the needs of the patient and the skills of the residents and in accordance with hospital and/or departmental policies. The attending may also delegate partial responsibility for supervision of PGY-1/intern residents to senior residents assigned to the service, but the attending must assure the competence of the senior resident before supervisory responsibility is delegated. Over time, the senior resident is expected to assume an increasingly larger role in patient care decision making. The attending remains responsible for assuring that appropriate supervision is occurring and is ultimately responsible for the patient's care. Residents and attendings should inform patients of their respective roles in each

patient's care. The attending and supervisory resident are expected to monitor competence of interns and intermediate residents through direct observation, formal ward rounds and review of the medical records of patients under their care. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.

Specific Supervision Policies Inpatient Medicine and Inpatient Pediatrics: All routine medicine and pediatric patients admitted by residents must be evaluated within the first 24 hours after admission, and at least once each day of the hospital stay of that patient, by an attending physician. Typically, most patients are seen within 12 hours of admission. The resident is required to notify and discuss every admission with the attending physician at or soon after the patient is admitted based on patient illness acuity. An attending physician must urgently evaluate any unstable patient at the time of admission, with further direct supervision depending upon the stability of the patient.

Inpatient Obstetrics: All obstetrics patients admitted by residents must be evaluated within the first 24 hours after admission, and at least once each day of the hospital stay of that patient, by an attending physician. Typically, most patients are seen within 6 hours of admission. The resident is required to notify and discuss every L&D patient with the attending at the time of admission, periodically through a normal labor course, and immediately if a complication develops. Residents are to call obstetrics attending with each triage evaluation. The resident is encouraged at any time to request on-site faculty presence. Direct supervision by an attending physician is indicated in these circumstances:

- Low-risk deliveries - once a primiparous patient is complete or a multiparous woman is 6 to 8 cm, dependent on the specific circumstances of each case.
- Complicated obstetric patients, as appropriate to the circumstances of each case.

Outpatient Settings: Office visits. All patients seen by residents at office visits must be directly supervised by the attending physician, except: office codes 99201, 99202, and 99203, and 99211, 99212, and 99213 and annual wellness codes G0402, G0438, and G0439 for Medicare first and subsequent annual wellness visits. If aforementioned codes are billed, the attending physician may discuss the history, physical, and plan of care with the resident and confirm these elements without actually seeing the patient; however, each must be discussed before the end of that half-day of clinic.

All other visits (nursing home, assisted living, home visits, etc.). The attending physician must directly supervise all patients seen by residents for the visit to be billed. If only indirect supervision or oversight is provided by the attending, the visit is not to be billed.

Supervision of Invasive Procedures

In a training program, as in any clinical practice, it is incumbent upon the physician to be aware of his/her own limitations in managing a given patient and to consult a physician with more expertise when necessary. Any procedure performed by a resident must be directly supervised unless the resident has been approved to perform that procedure independently. When a resident requires supervision, this may be provided by a qualified member of the medical staff or by a resident who is authorized to perform the procedure independently. In all cases, the attending physician is ultimately responsible for the provision of care by residents. When there is any doubt about the need for supervision, the

attending should be contacted. The following procedures may be performed with the indicated level of supervision:

Direct supervision required by a qualified member of the medical staff:

• Any operating room procedure

• Vaginal delivery, including repair of vaginal lacerations or episiotomy, repair of cervical laceration, uterine exploration

• Colposcopy and cervical cryotherapy

• D&C or D&E, uterine biopsy

• Exercise treadmill test

• Flexible or rigid sigmoidoscopy

• Sedation for procedures

• All other invasive procedures not listed

Direct supervision required by a qualified member of the medical staff until competency demonstrated; then indirect supervision with direct supervision available:

A resident may be released for independent performance of a procedure that is within the usual scope of practice of family physicians in that institution, when the resident has been supervised for a number of that procedure sufficient for faculty to assure the resident's competency in knowledge and skill for independent practice relating to that procedure. Procedure Number of procedures completed with competency for independent performance (or training equivalent)

Application of casts or splints: 3 procedures

Arterial catheterization: 3 procedures

Arthrocentesis/injection: 3 procedures

Central line placement - internal jugular: 3 procedures

Central line placement – subclavian: 3 procedures

Central line placement – femoral: 3 procedures

Cryotherapy of actinic keratoses: 1 procedure

EKG: 1 procedure

Lumbar puncture: 3 procedures

I&D of abscess: 1 procedure

IUD placement: 3 procedures

Contraceptive implant: 3 procedures

Nasogastric tube placement 1 procedure

Neonatal circumcision: 6 procedures

Obstetrical procedures: 3 procedures

- amniotomy
- IUPC
- fetal scalp electrode
- limited OB ultrasound (for fetal lie and position)
- NST reading

Osteopathic Manipulative Technique (OMT): 1 procedure

Sebaceous cyst removal: 1 procedure

Skin biopsy (excisional, shave, or punch): 3 procedures

Skin lesion excision: 3 procedures

Skin tag removal: 1 procedure

Toenail removal: 3 procedures

Urethral catheter: 1 procedure

Venipuncture: 1 procedure

Oversight required by a qualified member of the medical staff: Dressing changes, suture placement and removal, central venous catheter removal, cryotherapy of small skin lesions

Emergency Procedures: It is recognized that in the provision of medical care, unanticipated and life-threatening events may occur. The resident may attempt any of the procedures normally requiring supervision in a case where death or irreversible loss of function in a patient is imminent, and an appropriate supervisory physician is not immediately available, and to wait for the availability of an appropriate supervisory physician would likely result in death or significant harm. The assistance of more qualified individuals should be requested as soon as practically possible. The appropriate supervising provider must be contacted and apprised of the situation as soon as possible.

Medical Student Supervision

Supervision of Medical Students: The rules regarding the supervision of medical students, which apply in both the inpatient and outpatient settings, are as follows. The rules are intended to assure that quality care is being provided to patients through appropriate support of learners in the teaching environment. A resident may serve as the “supervising physician” for purposes of medical student supervision, but the rules for supervision of the resident are the same as if the resident were seeing the patient without the student.

Interactions with patients: Medical students may interview and examine patients. However, the supervising physician for the student MUST repeat the key portions of the history with the patient, and MUST do the entire physical exam in addition to the student exam. The student may discuss the plan of

care with the patient, but must be either supervised directly and confirmed with the patient by the supervising physician, or repeated in its entirety by the supervising physician.

Documentation: Medical students notes may be written as part of the chart. The supervising physician may use part of the student's write-up of the history but must personally document the chief complaint and HPI, the physical exam, and the plan of care.

Supervision of Hand-Offs

ACGME requirements:

• Programs must design clinical assignments to minimize the number of transitions in patient care.

• Sponsoring institutions and programs must ensure and monitor effective, structured handover processes to facilitate both continuity of care and patient safety.

• Programs must ensure that residents are competent in communicating with team members in the hand-over process.

• The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care.

Settings where appropriate Patient Handoff must occur:

• Patients admitted to the Adult/Pediatric Medicine service.

• Patients discharged from the inpatient service(s) to outpatient or external facilities

• Shift change from daytime to on call or nighttime provider on all hospitalized patients with active healthcare issues

• Shift change from on call or nighttime provider on all hospitalized patients with active healthcare issues

• Hospitalized patients transferring between any consult and service teams and Family Medicine.

• Outpatients with active healthcare issues that should by the on call, nighttime or weekend Family Medicine team.

Expectations for regular handoffs:

• Family Medicine team members working on inpatient services will on a daily basis communicate any appropriate handoffs to and from the on-call providers verbally in person. Hand off will be in I-PASS format and I-PASS format will be taught during orientation and revisited in didactics periodically for fine-tuning. The senior family medicine resident supervises hand off time, and if concerns arise about a resident's ability to hand off information, the attending will directly supervise hand off time.

• Except on rare occasion, in person verbal sign-out will occur among residents and trainees; during an exception, either verbal phone sign-out may occur. Texting or emailing sign-out is not permitted among trainees.

• Each morning and evening, patient handoffs will occur between the nighttime resident providers and the daytime resident teams. In this manner, competency of residents in communicating with team members in the hand-over process may be assessed and monitored.

• The I-PASS sign-out sheet with appropriate and updated patient information will be exchanged during the transition of care between day and nighttime providers. This sheet should include patient identifying information, current active medical conditions, medications, allergies, code status, attending physician, primary care physician and a to do list for the upcoming shifts.

• Attending physicians should provide direct phone sign out to the oncoming attending on all patients with active medical conditions and in person sign out on any unstable patient or patient nearing obstetrical delivery

Circumstances in which Supervising Practitioner MUST BE CONTACTED:

There are specific circumstances and events in which residents must communicate with appropriate supervising faculty members. These circumstances are:

• All new admissions to the hospital

• New consults requested of the Family Medicine service

• All transfers of care to the medicine service or from medicine service to another service

• Low-risk deliveries, once a primiparous patient is complete or a multiparous woman is 6 to 8 cm, dependent on the specific circumstances of each case (as previously detailed).

• Complicated obstetric patients, as appropriate to the circumstances of each case

• Any unstable patient at the time of admission

• Any sudden or unexpected deterioration of a patient cared for by the Medicine service

• Any discharge against medical advice or death of a patient cared for by the medicine service

In Event Upper Level Resident Does Not Respond:

If a supervising resident does not respond, contact the attending physician directly by personal pager, personal cell phone or home phone.

In Event an attending physician does not respond:

a. If an urgent medical situation is occurring, contact an in-hospital/in-house attending or senior resident as indicated for assistance.

b. If not urgent attempt to contact other core faculty and/or program director by page, cell, paging application, etc.

In either case: contact the hospital site director (Samantha Olzeski, DO) and Residency Program Director (Tyler Elam, DO) letting them know of the non-response by the attending.

Resident Competence & Delegated Authority

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident is assigned by the program director and faculty members as an essential element of professional development. The residency program will evaluate each resident's abilities based on specific criteria through the Family Medicine Resident Clinical Competency Committee and approve each graded increase in resident responsibility during their training. The Clinical Competency Committee will evaluate each resident's clinical competence based on his or her progress along residency training milestones of development and certify each resident's ability to proceed to the next graded level of responsibility. The residents will be assessed on surrogate markers of competence/milestones in medical knowledge, patient care skills, communication skills, problem-based learning, professionalism and systems-based practice. Faculty and residents will participate in education around supervision and responsibility as part of yearly orientations.

GMEC Approved 6/12/23