Supervision Policy
Roles, Responsibilities and Patient Care Activities of Residents

Geriatric Psychiatry
Residency

University of Washington Medical Center
Harborview Medical Center
Puget Sound VA Health Care System
Children’s Hospital and Regional Medical Center

Resident:
A physician who is engaged in a graduate training program in medicine (which includes all specialties, e.g., internal medicine, surgery, psychiatry, radiology, nuclear medicine, etc.), and who participates in patient care under the direction of attending physicians (or licensed independent practitioners) as approved by each review committee. Note: The term “resident” includes all residents and fellows including individuals in their first year of training (PGY1), often referred to as “interns,” and individuals in approved subspecialty graduate medical education programs who historically have also been referred to as “fellows.”

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 the supervising physician (or other appropriate licensed practitioner) for the service they are rotating on when they are uncertain of diagnosis, how to perform a diagnostic or therapeutic procedure, or how to implement an appropriate plan of care.

Attending of Record (Attending): An identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) 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 (or “supervisor” if your RRC permits supervision by non-physicians) 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. (programs may wish to add their own defined response time – e.g., “within 15 – 30 minutes”)
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
Geriatric Psychiatry Fellows (PGY5) are part of a team of providers caring for patients. The team includes an attending and may include other licensed independent practitioners, other trainees and medical students. Fellows may provide care in both the inpatient and outpatient settings. They may serve on a team providing direct patient care, or may be part of a team providing consultative or diagnostic services. Each member of the team is dedicated to providing excellent patient care.

Fellows evaluate patients, obtain the medical history and sometimes perform physical examinations. They are expected to develop a differential diagnosis and problem list. Using this information, they arrive at a plan of care or a set of recommendations in conjunction with the attending. They document the provision of patient care as required by hospital/clinic policy. Fellows may write orders for diagnostic studies and therapeutic interventions as specified in the medical center bylaws and rules/regulations. They may interpret the results of laboratory and other diagnostic testing. They may request consultation for diagnostic studies, the evaluation by other physicians, physical/rehabilitation therapy, specialized nursing care, and social services. Fellows may initiate and coordinate hospital admission and discharge planning. Fellows discuss the patient’s status and plan of care with the attending and the team regularly. Fellows help provide for the educational needs and supervision of any junior residents and medical students.

The clinical responsibilities for each resident are based on 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. The following is a guide to the specific patient care responsibilities by year of clinical training. Residents must comply with the supervision standards of the service on which they are rotating unless otherwise specified by their program director.

Please note some residents may be engaged in one or more years of research training during their residency. Only years of clinical training are considered below.

Attending of Record
In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged primary attending physician (or licensed independent practitioner if approved by your RRC) who is ultimately responsible for that patient's 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 individual program policy. 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 situations
the individual attending would like to be notified of, the attending should include in his or her notification to residents all situations that require attending notification per program or hospital policy. The primary attending physician may at times delegate supervisory responsibility to a consulting attending physician if a procedure is recommended by that consultant. For example, if an orthopedic surgeon is asked to consult on a patient on the medicine service and decides the patient needs a joint aspiration, the medicine attending may delegate supervisory responsibility to that orthopedic surgeon to supervise the medicine resident who may perform the joint aspiration. 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 junior 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 more junior 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.

**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. 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:

Fellows in Geriatric Psychiatry generally do not perform invasive procedures. In the rare instance that they would participate in a procedure, they will be directly supervised by a qualified trainee or member of the medical staff.

**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 reversible 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 practitioner must be contacted and apprised of the situation as soon as possible.

**Supervision of Consults**

Residents may provide consultation services. The attending of record is ultimately responsible for the care of the patient and thus must be available to provide direct supervision when appropriate for optimal care and/or as indicated by program policy. The availability of the attending and should be appropriate to the level of training, experience and competence of the consult resident and is expected to be greater with increasing acuity of the patient’s illness. Information regarding the availability of attendings should be available to residents, faculty members, and patients. Residents performing consultations on patients are expected to communicate verbally with their supervising attending at regular time intervals of 24 hours. Any resident performing a consultation where there is credible concern for patient’s life or limb requiring the need for immediate invasive intervention MUST communicate directly with the supervising attending as soon as possible prior to intervention or discharge from the hospital, clinic or emergency department so long as this does not place the patient at risk. If the communication with the supervising attending is delayed due to ensuring patient safety, the resident will communicate with the supervising attending as soon as possible. Residents performing consultations will communicate the name of their supervising attending to the services requesting consultation.

**Supervision of Hand-Offs**

"Hand-offs" occur during the geriatric psychiatry residency primarily during the inpatient rotation when the geriatric psychiatry resident at the end of the day would be handing over coverage to the general psychiatry resident covering the night shift. The geriatric psychiatry resident will leave clear notes regarding status of the inpatients and will communicate orally with the covering resident regarding any patients who may be unstable and may require attention during the night shift.

**Circumstances in which Supervising Practitioner MUST be Contacted**

There are specific circumstances and events in which residents must communicate with appropriate supervising faculty members. The Supervising Practitioner MUST be contacted for patients who have acute suicidal or homicidal ideation.

**Resident Competence & Delegated Authority**

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. For an R5 Geriatric Psychiatry Fellow it is most appropriate based upon 4 years of post-graduate training and letters of recommendation to assume that they are capable of practicing independently with the exception of having all their chart notes reviewed and countersigned and are fully capable of supervising more junior residents or medical students. Geriatric Psychiatry Fellows are closely observed during their first two months of their R5 year. If any such fellows do not have the capacity to practice quasi-independently and supervise more junior trainees, a faculty member will work with them closely to bring them up to the appropriate level of independence.
Faculty Development and Resident Education around Supervision and Progressive Responsibility

The Geriatric Psychiatry Residency Program subscribes to the SUPERB SAFETY model:

Attendings should adhere to the SUPERB model when providing supervision. They should
1. **Set** Expectations: set expectations on when they should be notified about changes in patient's status.
2. **Uncertainty** is a time to contact: tell resident to call when they are uncertain of a diagnosis, procedure or plan of care.
3. **Planned Communication**: set a planned time for communication (i.e. each evening, on call nights)
4. **Easily available**: Make explicit your contact information and availability for any questions or concerns.
5. **Reassure** resident not to be afraid to call: Tell the resident to call with questions or uncertainty.
6. **Balance** supervision and autonomy.

Residents should seek supervisor input using the SAFETY acronym.
1. **Seek** attending input early
2. **Active clinical decisions**: Call the attending when you have a patient whose clinical status is changing and a new plan of care should be discussed. Be prepared to present the situation, the background, your assessment and your recommendation.
3. **Feel uncertain about clinical decisions**: Seek input from the supervising physician when you are uncertain about your clinical decisions. Be prepared to present the situation, the background, your assessment and your recommendation.
4. **End-of-life care or family/legal discussions**: Always call your attending when a patient may die or there is concern for a medical error or legal issue.
5. **Transitions of care**: Always call the attending when the patient becomes acutely ill and you are considering transfer to the intensive care unit (or have transferred the patient to the ICU if patient safety does not allow the call to happen prior to the ICU becoming involved).
6. **Help with system/hierarchy**: Call your supervisor if you are not able to advance the care of a patient because of system problems or unresponsiveness of consultants or other providers.

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