SUPERVISION POLICY

Training Program in Cardiovascular Disease

Roles, Responsibilities and Patient Care Activities of Clinical Fellows

University of Washington Medical Center
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Definitions

Resident:
A physician who is engaged in a graduate training program in medicine (which includes all specialties), and who participates in patient care under the direction of attending physicians (or licensed independent practitioners) as approved by each review committee.

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 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.
   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. The following is a guide to the specific patient care responsibilities by year of clinical training. Residents must comply with
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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 in Cardiology are considered below.

PGY-4-6 (Cardiology Fellows) Cardiology Fellows are considered senior residents and may be directly or indirectly supervised. They may provide direct patient care, supervisory care or consultative services, 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, junior and intermediate 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 care of the patient.

Attending of Record
In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged primary attending physician 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
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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:

**Direct supervision required by a qualified member of the medical staff**
- All left heart catheterization procedures including coronary angiography, left heart catheterization, aortography, left ventricular angiography and coronary graft angiography.
- All cardiology interventional procedures in cardiac catheterization or electrophysiology laboratory
- Pericardiocentesis (except in emergency situations)
- Placement of an intra-aortic balloon pump
- Transesophageal echocardiography
- Temporary pacer insertion (except in emergency situations)
- Elective synchronized electric cardioversion (except in emergency situations)

**Direct supervision required by qualified medical staff member (time period clinical training)**
- Transthoracic echocardiography performance or interpretation (night-call) for first 6 months of training and faculty overview of 40 procedure interpretations
- Right heart catheterization until training during Internal Medicine Residency verified and competency confirmed on direct observation on 2 or more procedures.
- Exercise stress ECG, stress myocardial perfusion testing, and stress echocardiography until competency confirmed on documentation of direct observation of 3 or more procedures
- Cardiac device (pacemaker and internal cardiac defibrillator) interrogation until competency established by direct observation of 2 or more procedures

**Indirect supervision required with direct supervision available by a qualified member of the medical staff**
- Exercise stress ECG testing
- Exercise stress testing with cardiac imaging
- Exercise stress echocardiography for non-ischemia indication
- Dobutamine stress echocardiography
- Cardiac device (pacemaker and internal cardiac defibrillator) interrogation

**Oversight required by a qualified member of the medical staff**
- Interpretation of transthoracic echocardiography
- ECG interpretation
- Consults and inpatient clinical care
- Bedside right heart catheterization
- Placement of temporary transvenous pacers
- Bedside placement of arterial hemodynamic monitoring

**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 practitioner must be contacted and apprised of the situation as soon as possible.
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**Supervision of Consults**
Residents may provide consultation services under the direction of supervisory residents including fellows. 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 individual program policy. The availability of the attending and supervisory residents or fellows should be appropriate to the level of training, experience and competence of the resident and is expected to be greater with increasing acuity of the patient's illness. Information regarding the availability of attendings and supervisory residents or fellows should be available to residents, faculty members, and patients. Residents performing consultations on patients are expected to communicate verbally with their supervising attending on at least a daily basis. 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**
Each program must have a policy regarding patient care hand-offs. This policy must include expectations of supervision with each type of hand-off situation. For the inpatient UWMC clinical services, fellows must provide verbal and written sign-out in a face-to-face discussion with the Cardiology nocturnist faculty member prior to leaving the hospital. Similarly, when arriving to the inpatient services, fellows must receive verbal/written sign-out in a face-to-face discussion with the Cardiology nocturnist faculty member upon arriving to the hospital. If fellows leave clinical services during the work day (conferences, ambulatory clinics, etc.), appropriate care hand-offs should occur with clinical care team members or providers to ensure continuity of care (i.e. nocturnist, ARNP, co-fellow, resident) As documented in the ACGME's common program requirements, programs must design clinical assignments to minimize the number of handoffs and must ensure and monitor effective, structured handoff processes to facilitate both continuity of care and patient safety. Fellows must be competent in communicating with team members in the hand-off process.

**Circumstances in which Supervising Practitioner MUST be contacted**
There are specific circumstances and events in which residents must communicate with appropriate supervising faculty members. Refer to the procedure list above regarding the supervision level required for cardiac procedures and consults. Other circumstances or events include, but are not limited to:

*Abnormal laboratory results raising credible concern for patient’s life or significant morbidity*

*Concerning ECG or ambulatory telemetry monitoring device findings raising credible concern for patient’s life or significant morbidity*

**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 as designated by faculty members within the Division of Cardiology who are responsible for the procedures/consults as detailed above.
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Faculty Development and Resident Education around Supervision and Progressive Responsibility

Residency programs must provide faculty development and resident education on best practices around supervision and the balance of supervision and autonomy. One best practice to consider is 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 resident to call with questions or uncertainty.
6. **Balance supervision and autonomy**.

Residents should seek supervisor (attending or senior resident) input using the SAFETY acronym.

1. **Seek attending input early**
2. **Active clinical decisions**: Call the supervising resident or 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/hierarchYy**: 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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