SUPERVISION POLICY

Roles, Responsibilities, and Patient Care Activities of Fellows

University of Washington Geriatric Medicine Fellowship

Definitions

Fellow:
A physician in sub-specialty training who has finished their training in either Internal Medicine or Family Medicine and is board-certified or board-eligible in that specialty when they begin geriatric medicine training. As part of their training program, fellows are given graded and progressive responsibility according to the individual fellow's clinical experience, judgment, knowledge, and technical skill. Each fellow must know the limits of his/her scope of authority and the circumstances under which he/she is permitted to act with conditional independence. Fellows are responsible for asking for help from the supervising physician (or other appropriate licensed practitioner) for the service on which they are rotating 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) who is ultimately responsible for the management of the individual patient and for the supervision of fellows involved in the care of the patient. The attending delegates portions of care to fellows based on the needs of the patient and the skills of the fellows.

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

1. Direct Supervision – the supervising physician or non-physician supervisor is physically present with the fellow 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 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

The clinical responsibilities for each fellow are based on PGY-level, patient safety, fellow education, severity and complexity of patient illness/condition and available support services. The specific role of each fellow 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. Fellows must comply with the
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supervision standards of the service on which they are rotating unless otherwise specified by their program director.

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

Fellows 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. Fellows 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 fellow; however, the attending physician is ultimately responsible for the 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 (or licensed independent practitioner) 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 fellow is expected to be greater with less experienced fellows and with increased acuity of the patient’s illness. The attending must notify all fellows 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 fellows 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.

The attending may specifically delegate portions of care to fellows based on the needs of the patient and the skills of the fellows and in accordance with hospital and/or departmental policies. The attending may also delegate partial responsibility for supervision of residents to fellows assigned to the service, but the attending must assure the competence of the fellow before supervisory responsibility is delegated. Over time, the fellow 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. Fellows and attendings should inform patients of their respective roles in each patient’s care.

The attending and fellow are expected to monitor competence of 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 fellow 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 fellow requires supervision, this may be provided by a qualified member
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of the medical staff or by a fellow who is authorized to perform the procedure independently. In all cases, the attending physician is ultimately responsible for the provision of care by fellows. When there is any doubt about the need for supervision, the attending should be contacted.

The geriatric medicine fellowship does not require the performance of invasive procedures, however commonly performed procedures are listed below.

The following procedures may be performed with the indicated level of supervision:

Oversight required by a qualified member of the medical staff
Arthrocentesis, phlebotomy, urethral catheterization

If the fellow desires to perform additional procedures in the course of patient care, this should first be discussed with the attending responsible and the level of supervision required will be based on the fellows previous experience/credentials, skill, and the level of difficulty or risk involved in the individual procedure.

Emergency Procedures

It is recognized that in the provision of medical care, unanticipated and life-threatening events may occur. The fellow 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.

Supervision of Consults

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 should be appropriate to the level of training, experience and competence of the fellow and is expected to be greater with increasing acuity of the patient's illness. Information regarding the availability of attendings and fellows should be available to residents, faculty members, and patients. Fellows performing consultations on patients are expected to communicate verbally with their supervising attending at regular time interval (no later than 24 hours after the consult is performed). Any fellow 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 fellow will communicate with the supervising attending as soon as possible. Fellows performing consultations will communicate the name of their supervising attending to the services requesting consultation.

Additional specific circumstances and events in which fellows performing consultations must communicate with appropriate supervising faculty members include: death of a patient, need for a patient to transfer to an ICU setting, or medical errors involving a patient (including those that do not cause direct patient harm), or situations that might have legal implications. In these circumstances, the attending should be notified as soon as possible after the event. If the attending
physician does not respond in a timely fashion, the resident is encouraged to contact the (1) the program director or (2) any other available faculty member within the geriatric medicine program.

Supervision of Hand-Offs

Hand-offs are a time of utmost importance for continuity of care and patient safety. Patient hand-offs occur under indirect attending supervision based on the experience and skill of the individual fellow.

Inpatient setting: When the fellows leaves at the end of the work day, leaves to go to another clinical or didactic experiences, or is leaving prior to a day off or vacation, the fellow must ensure that all relevant patient information including the need for follow up of tests, procedures, and consults is communicated to the attending physician or resident/fellow to whom this responsibility has been delegated in person, by telephone, and/or in writing. In the inpatient setting, fellows may delegate the hand-off of patient information to resident physicians, as long as they ensure that the hand-off is being clearly communicated to the receiving resident or fellow, and the attending physician and fellow agree that the resident is competent to perform the handoff without direct supervision. The attending is ultimately responsible for patient care, so should be notified of any unstable patients, critical tests, or any pending invasive procedures even if the fellow and attending have delegated this responsibility to a resident.

Long term care, outpatient, and home care settings: Fellows, under the indirect supervision of attendings, are responsible for ensuring that patient information is communicated in writing or via phone with the attending, licensed independent practitioner and/or fellow taking over responsibility of the patients. This includes ensuring that any test, consult, or procedure ordered by the fellow has appropriate follow up. The attending physician (or licensed independent practitioner) is ultimately responsible for the safety of handoffs, so any pending tests, procedures, or consults should be communicated to the attending of record (or licensed independent practitioner) prior to a fellow going on vacation, transitioning to another clinical rotation, and at the completion of fellowship. If the fellow is unsure to whom the patient should be handed-off, a supervising attending or program director should be notified to assist with determining the appropriate person to whom a clinic, long term care, or home care patient should be handed off.

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 include death of a patient, need for a patient to transfer to an ICU setting, medical errors involving a patient (including those that do not cause direct patient harm), or events that might lead to legal action. In these circumstances, the attending should be notified as soon as possible after the event. If the attending physician does not respond in a timely fashion, the resident is encouraged to contact the (1) the program director or (2) any other available faculty member within the geriatric medicine program.

Fellow Competence & Delegated Authority

The fellowship program uses a multifaceted assessment process to determine a fellow's progressive involvement and independence in providing patient care. Fellows are observed directly by the attending staff throughout clinical training. Formal assessments are generally obtained from supervising physicians, residents, and students on a monthly basis. Fellows are evaluated on their medical knowledge, technical skills, professional attitudes, behavior, and overall ability to manage the care of a patient. Direct feedback regarding the fellow's performance is provided by the program director twice a year.
Trainees are evaluated continuously by the attending staff and their performance is evaluated on a quarterly basis by the program director and assistant/associate program director(s). If, at any time, their performance is judged to be below expectations, the fellowship program director (or designee) will meet with the trainee to develop a remediation plan. If the trainee fails to follow that plan, or the intervention is not successful, the trainee may be dismissed from the program. If a trainee’s clinical activities are restricted (e.g., they require a supervisor’s presence during a procedure, when one would not normally be required for that level of training) that information will be made available to the appropriate attending and hospital staff.

**Faculty Development and Resident Education around Supervision and Progressive Responsibility**

Attendings should adhere to the SUPERB model when providing supervision. They should

1. **S**et Expectations: set expectations on when they should be notified about changes in patient’s status.
2. **U**ncertainty is a time to contact: tell resident to call when they are uncertain of a diagnosis, procedure or plan of care.
3. **P**lanned Communication: set a planned time for communication (i.e. each evening, on call nights)
4. **E**asily available: Make explicit your contact information and availability for any questions or concerns.
5. **R**eassure resident not to be afraid to call: Tell the resident to call with questions or uncertainty.
6. **B**alance supervision and autonomy.

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

1. **S**eek attending input early
2. **A**ctive 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. **F**eel 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. **E**nd-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. **T**ransitions 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. **H**elp 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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