Roles, Responsibilities and Patient Care Activities of Residents

*Pediatric Anesthesia*

*Seattle Children’s Hospital*

**Definitions**

**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.

**Clinical Responsibilities**

**Responsibilities for Patient Care**

The Pediatric Anesthesia Fellows are part of a multi disciplinary team of providers who spend the majority of their time caring for inpatients and outpatients in the perioperative environment. The Anesthesiology team is lead by an attending Anesthesiologist appointed and credentialed by the University of Washington and Seattle Children’s Hospital who has overall responsibility for patient care at all times during this period. The Anesthesiology faculty are required by federal law to be identified and introduced to all patients prior to any induction of anesthesia, they are required to be present for key components of the patients care and immediately available at all times, this information and data is audited constantly at a local, regional and national level.

The fellows evaluate all patients whose care they are involved in. They are expected to obtain a medical history, perform a physical examination and assess laboratory and radiographic data. They are expected to provide a problem list and differential diagnoses, and then in conjunction with the attending anesthesiologist and other team members develop a management plan to be instituted. They may document the provision of patient care as required by the institutional policy and may write orders for diagnostic studies and therapeutic interventions, again as specified in the institutional regulations. In conjunction with a supervising attending, they may request consultation for diagnostic studies, the evaluation by other physicians, physical/rehabilitation therapy, the provision of specialized nursing, the provision of respiratory care and social services consultation. They will participate in procedures performed in the operating room, or procedure suite under attending anesthesiologist supervision.
As noted above during the fellowship, the fellows will most commonly be caring for patients in the operating room environment. The also spend 4 weeks caring for patients in the Cardiac Intensive Care Unit (CICU), and 4 weeks as a member of the pain service. Whilst working on the CICU and Pain teams the fellows will at all times be providing service under the supervision of the respective attending critical care and pain physicians.

**Progressive Responsibilities for Patient Management**

Fellows are pediatric anesthesiologists in training. At the start of their fellowship their experience is limited within the subspecialty. As they learn the skills necessary for their chosen specialty through didactic sessions, reading and providing patient care under the supervision of the pediatric anesthesia faculty they are given progressively greater responsibility according to their level of education, ability and experience. The fellows are given constant feedback on their performance throughout the year on a daily basis by the attending they work with, with monthly evaluations that they review with their chosen mentor and biannually with the program director to ensure their clinical and professional development are appropriate to their position.

As a prerequisite, fellows will have completed a residency in Anesthesiology, and are in the process of seeking certification by the American Board of Anesthesiology (ABA). The vast majority of the fellows will have sat the written ABA exam by the time they start their fellowships and we actively encourage them to sit the oral examinations during their fellowship year.

**Supervision of invasive procedures**

**Faculty Responsibilities for Supervision**

In a training program, as in any clinical practice, it is incumbent upon the practitioner to be aware of his/her own limitations in managing a given patient, and to consult a physician with more expertise when necessary. In all instances, the attending physician is ultimately responsible for the provision of care by trainees.

During the course of the training year the following institutional policies exist regarding specific supervisory practice:

**Supervision** is defined in this policy as the attending physician responsible for the case has been notified of a procedure and has deemed the fellow qualified to perform the procedure without direct supervision.

**Direct supervision** is defined as the presence of a qualified attending physician at the bedside.

All anesthesia fellows must be directly supervised during induction and emergence of anesthesia and during the key points of the operative procedure.

**Direct supervision** is necessary during:

- Endotracheal intubation and extubation
- Laryngeal mask insertion and removal
- Neuroaxial blockade – single shot and catheter placement
- Peripheral Nerve blockade – single shot and catheter placement
- Central venous line placement
- Arterial catheter placement
- Fiberoptic intubation and Bronchoscopy
- Transesophageal echo probe insertion

**Supervision** is necessary during:

- Neuroaxial and Peripheral nerve catheter removal
- Nasogastric tube placement
Patient positioning

**Supervision** is not necessary during:

- Phlebotomy
- Insertion of peripheral intravenous catheters
- Dressing changes
- Suture insertion and removal

**Emergency Procedures**

It is recognized that in the provision of medical care, unanticipated and life-threatening events may occur. The trainee may attempt any of the procedures normally requiring indirect or direct supervision in a case where the death or irreversible loss of function in-patient is imminent, and an appropriate supervisory physician is not immediately available. The assistance of more qualified individuals should be requested as soon as practically possible.

**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 consult 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 at regular time intervals (SPECIFY THESE INTERVALS HERE). 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.

Additional specific circumstances and events in which residents performing consultations must communicate with appropriate supervising faculty members include: *(Add your own program-specific guidelines for the specific circumstances when the resident MUST call the supervising physician. Include information about what the resident is to do if that individual does not respond in a timely manner.)*

**Supervision of Hand-Offs**

Each program must have a policy regarding hand-offs. This policy must include expectations of supervision with each type of hand-off situation. 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. Programs must ensure that residents are competent in communicating with team members in the handoff 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. (Add your own program-specific guidelines for the specific circumstances when the resident MUST call the supervising physician, based on program requirement VI.D.5. Include information about what the resident is to do if that individual does not respond in a timely manner.)

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. (Briefly describe the OBJECTIVE assessment methods used to assess patient care and medical knowledge competencies, and the criteria used to make determinations regarding progressive responsibility and ability to serve in a supervisory capacity. If this evaluation is based on specific national standards-based criteria, state the standards and criteria.)

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 the resident to call with questions or uncertainty.

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/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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