SUPERVISION POLICY

Roles, Responsibilities and Patient Care Activities of Residents

University of Washington Child (Pediatric) Neurology Residency Program

This policy pertains to the care of pediatric neurology patients at Seattle Children’s Hospital only. The supervision of residents in the child neurology program who are rotating on core (adult) neurology rotations will be governed by the core neurology resident supervision policy.

Definitions

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, neurology, pediatrics, etc.), and who participates in patient care under the direction of attending physicians.

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 educations 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 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.

Supervising Physician: (or “supervisor” in certain cases when a resident is supervised by a non-physician) The health care provider who is overseeing the care provided to a patient by a resident. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow.

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.
SUPERVISION POLICY

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 the supervision standards of the service on which they are rotating unless otherwise specified by their program director.

Junior Residents (Psychiatry, Neurological Surgery and Pediatrics PGY1)
PGY-1 residents are primarily responsible for the care of patients under the guidance and supervision of the attending physician and senior and intermediate residents. 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 (see definitions above) by an attending, senior or intermediate resident when appropriate. In Pediatric Neurology, the Junior Resident is typically a resident from another program (Pediatrics, Neurological Surgery or Psychiatry) doing a neurology rotation.

1) Same patient responsibilities as the Intermediate Resident during the day, but does not take night call.
2) Signs out all patients to on-call Neurology resident prior to leaving for day.

The Intermediate Resident (Neurology PGY2 or PGY3 and Pediatric Neurology PGY3)
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.

1) Handles all non-emergency consults along with the Chief Resident during regular hours.
2) Writes admission notes on patients admitted and transferred to the General Neurology service that are assigned to him or her by Chief Resident or Attending.
3) Informs the primary care physicians about the progress of their patients.
4) Is responsible for punctual and complete pre- rounding prior to and presentations during daily attending rounds.
5) Provides a list of patients seen in consultation or for admission during nights and weekends on-call to the Chief Resident.
6) Assists Chief Resident in supervision and teaching of students on the service.
SUPERVISION POLICY

7) Presents, with help and guidance of Chief Resident and Attending, at Friday morning Pediatric Neurology conference.
8) Alternates night call with the Chief Resident and elective residents (with assignment by Chief Resident at beginning of rotation), with the same expectations for involvement of the Attending physician.

In Pediatric Neurology, the first year child neurology resident (PGY3) spends eleven months in adult neurology rotations. During these months, the residents adhere to the Supervisory Lines of Responsibility for the Care of Patients for the core Adult Neurology Residency. Please refer to that document for details.

Senior Residents (PGYs-4 and 5, The Pediatric Neurology Chief Resident) Senior residents may be directly or indirectly supervised by an attending physician. 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 the care of the patient.

1) Oversees patient care on General Neurology service, as well as consults throughout Seattle Children's Hospital and the Neonatal Intensive Care Unit at the University of Washington Medical Center. Takes primary responsibility of selected patients on the General Neurology service and consultation service (in rotation with the Junior Resident and Rotating Resident). For those particular patients, informs the primary care physicians about the progress of their patients.
2) Confirms that each new patient admitted to the neurology service has a note by one of the residents on the General Neurology team and that admitting orders are completed expeditiously.
3) Maintains a current list within the Children’s Clinical Information System (CIS) of all active patients on inpatient and consult services.
4) Provides advice, assistance, and clinical supervision to other residents as an intermediary until the patient is reviewed by the attending physician.
5) Controls deployment of residents and students on the General Neurology service, with assistance and guidance as required from the attending physician.
6) Supervises the General Neurology service on daily basis.
7) Takes first call for ER consults during regular hours.
8) Backs up Junior Neurology resident (Adult Neurology PGY2 or PGY3 and Pediatric Neurology PGY3), and rotating Pediatrics, Psychiatry and other residents.
9) Approves (after communication with the Attending) all transfers to and from other services.
10) Is responsible for presenting at UW Department of Neurology Grand Rounds and at the weekly Friday morning Pediatric Neurology case conference at Children’s, both on a scheduled basis.
11) Is responsible for on-call schedule at Children’s.
12) Supervises and teaches Junior Resident, Rotating Resident and medical students, with guidance of attending physician.

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. 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 intermediate and senior residents, and of junior residents to senior residents assigned to the service, but the attending must assure the competence of the intermediate or 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.

The chain of command for clinical care of patients on the Pediatric Neurology service includes the neurology attending physician, the chief resident and the junior resident physicians.

**The Attending physician:** An attending physician is designated for the supervision of each resident undertaking any clinical activity. The responsible individuals are listed on the attending schedules, EEG lab schedules and clinic schedules. Pediatric Neurology Organizational Note: Pediatric Neurology inpatients at Seattle Children’s Hospital are divided between two teams: 1) General Neurology team, and 2) Epilepsy team. The attending physicians are different for these two services. The General Neurology attending is responsible for all patients admitted to the general neurology service and also sees all consultations with the team. The Epilepsy attending coordinates and supervises the care of patients admitted for EEG telemetry and initiation of the ketogenic diet. Epilepsy patients are cared for by the epilepsy attending and a pediatric nurse practitioner. Child Neurology residents may do rotations on this service. Patients that are admitted to the Epilepsy service are followed by medical hospitalists at night and on weekends, and attending supervision is
SUPERVISION POLICY

by the epileptologist on service. The following guidelines are applicable for attendings on both services.

1) Has ultimate responsibility for patient care and must assure that all diagnostic decisions and therapeutic services performed by the resident are medically indicated, properly supervised and properly executed. The attending physician has final authority for patient care decisions.

2) Reviews the following with residents at the start of each rotation:
   a) Frequency, time, and duration of attending rounds, and the expectation for pre-rounding to be done by residents prior to the morning attending rounds.
   b) Circumstances under which the attending physician expects to be contacted include but are not limited to new admissions, transfers or consults, need for diagnostic or surgical procedures, deaths or complications of care, significant negative change in a patient’s condition.

3) Is prepared to visit the hospital at any hour to assist the resident in managing patient care.

4) Notifies the resident of cross-coverage for any expected absences.

5) Understands that the primary role with respect to the resident is teaching and modeling appropriate clinical behavior and professionalism.

6) Should attempt to establish an honest and positive relationship with the resident that is conducive to constructive learning experiences. In this context, the attending will provide constructive feedback.

7) Relates to consultants and community resources by telephone or in person when the resident requests assistance.

8) Reviews telephone advice given by the resident and helps ensure follow-up and communication to primary care physician and the pediatric neurologist who follows the patient of events and actions taken.

9) Regularly speaks with patient family members.

10) Notifies the resident of decisions, promises, plans, and actions related to patient management following or prior to discussion with patients, families, consultants, or other resources.

Pediatric Neurology Continuity Clinic

1) Each resident will participate in a half-day pediatric neurology continuity clinic on a weekly basis throughout their three-year residency program. Clinic sessions will be canceled if the resident is scheduled for in-house night call at another hospital during the night before the clinic. Clinic sessions will also be canceled when the resident is on vacation or other official leave.

2) As clinic schedules are made-up many months in advance, the continuity clinic staff must be made aware of resident call schedules and vacation/leave schedules, so that affected clinics can be canceled and resident appointment templates can be managed efficiently.

3) Resident appointment templates will contain both new patient and return patient slots. It is expected that for patients requiring continuing neurologic care, that they will be followed by the same resident over time. In addition, patients seen by a resident during an in-patient rotation can be followed by the resident in their continuity clinic at the discretion of the attending physician who managed the case along with the resident.

4) The resident will evaluate patients that are appointed to the resident’s clinic template. After taking a history and examining the patient, the resident will discuss the case with the attending physician and formulate a differential diagnosis and plan for evaluation and treatment. The patient will then be examined by the attending physician and additional
SUPERVISION POLICY

medical history will be taken, as needed. The resident will then counsel the patient and family about the diagnosis and any proposed evaluation and treatment.

5) The resident will be responsible for completing any written documentation of the patient evaluation as required by the particular clinic. The formal clinic note will be dictated by the resident and will indicate the name of the attending physician who staffed the case. The resident will be responsible for reviewing and editing the transcribed note within one week of the clinic visit, after which point the note will be signed electronically by the attending physician of record for the case.

6) The residents will be responsible for taking telephone calls from parents or other physicians regarding their continuity clinic patients. If the resident is rotating at another hospital, the Pediatric Neurology nursing staff will field such calls and then contact the resident to discuss the case. All telephone calls must be documented in the Seattle Children’s Hospital electronic medical record.

7) Any continuity clinic patient who requires an elective minor procedure (e.g., skin biopsy, lumbar puncture) will have that procedure performed by the resident at a time scheduled outside of regular Continuity Clinic hours. The procedure should be scheduled so that both an attending physician can supervise the procedure and pediatric neurology nursing support is available.

8) Patients with epilepsy whose care over time becomes more complex and whose future management will require the expertise of a pediatric epileptologist (e.g., epilepsy surgery evaluation, ketogenic diet, VNS placement) can have their longitudinal care transferred to a pediatric epilepsy attending, or the continuity clinic resident and epilepsy attending can co-manage the patient.

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 certain cases, as set forth below, a non-physician provider, including an ARNP or PA who is authorized to perform the procedure, may supervise. 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 for the following procedures:
Lumbar Puncture, until the resident has performed 5 lumbar punctures

Indirect supervision required with direct supervision available by a qualified member of the medical staff
Lumbar puncture, once the resident has performed 5 lumbar punctures under direct supervision

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. 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. This will be based on the acuity of the patient’s illness and the urgency with which this should be addressed. In general consultations should be seen and discussed with the attending physician as follows:

**Routine:** Patient should be seen by the resident and staffed (seen with attending physician who agrees with the assessment and plan) by the next day. The resident can contact with attending with questions any time prior to staffing the patient.

**Urgent:** Patient should be seen by the resident and staffed by the attending. If the patient is seen during normal work hours, it will be staffed that day. If seen in the evening or overnight, it will be staffed in person in the morning, but by phone over night.

**Emergent:** Patient should be seen within one hour and staffed, at least by phone, immediately thereafter.

In many cases the level of urgency will be determined by the primary team requesting consult. If there are uncertainties, the resident may talk with the health care provider requesting the consult and/or the resident’s attending physician. Also, if the resident needs assistant with an emergent or critical case, the attending is available to return to the hospital after hours to assist the resident.

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

Seattle Children’s Hospital has a strict policy for patient handoff that is available on its internal website. It is accessible through “Resources and Information for Providers.”

### Circumstances in which Supervising Physician MUST be Contacted

Residents must contact their primary attending physician to discuss the following circumstances or events:

1) Patient’s death (unless this was expected)
2) Initiation of a DNR order
3) Request for transfer from an outside hospital or Emergency Department
4) When a patient is transferred from the floor to the ICU
**SUPERVISION POLICY**

**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. At the end of each rotation, the faculty member who has supervised the resident completes an evaluation. Faculty members are directed to “use as your standard the level of knowledge, skills and attitudes expected from the clearly satisfactory resident at [the resident’s] stage of training”. The program director reviews all of these evaluations and meets with each resident to discuss their progress twice yearly. Determinations regarding progressive responsibility and ability to serve in a supervisory capacity are based on evaluations from patient care months. Residents must achieve, on average, scores in the “expected level of performance” range or above in the categories of Patient Care and Medical Knowledge in order to progress to the next stage of progressive responsibility and supervisory capacity. Residents who are not performing at that level must undergo remediation, and will be allowed to advance once they can demonstrate abilities in the “expected level of performance” as determined by the Program Director and their faculty mentor.

**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.
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/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.

Current date
August, 2013