Institutional Supervision and Accountability Policy

Scope:
All UW residencies and fellowships accredited by the Accreditation Council for Graduate Medical Education (ACGME) and sponsored by the UW School of Medicine.

Background:
Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth. [CPR VI.A.2.a)]. Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. [CPR VI.A.2.a])

Personnel 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, 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 (PGY-1), 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 [CPR VI.A.2.e).(1)] 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): In the clinical learning environment, an identifiable, appropriately-credentialed and privileged primary attending physician (or licensed independent practitioner as approved by RRC) who is responsible and accountable 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 acuteness of the patient’s illness. The attending must notify all residents on the team of when he or she should be called regarding a patient’s status. In addition to these situations, the individual attending should include in his or her notification all situations that require attending notification per program or hospital policy.

The attending must delegate portions of care to residents based on the needs of the patient and the skills of each resident [CPR VI.A.2.d).(2)] 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 responsible for
the 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.

Policy: Effective programs, in partnership with their Sponsoring Institutions, must define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care [CPR VI.A.2.a]]. Programs must meet the following requirements:

Each patient must have an identifiable and appropriately credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient’s care. [CPR VI.A.2.a.(1)].

Residents and faculty members must inform each patient of their respective roles in that patient’s care when providing direct patient care [CPR VI.A.2.a.(1).(b)]. This information must also be available to residents, faculty members and other members of the healthcare team [CPR VI.A.2.a.(1).(a)].

Levels of Supervision:
Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member, fellow, or senior resident physician, either on site or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback. [CPR VI.A.2.b]]

The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident’s level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. [CPR VI.A.2.b.(1)]

To promote oversight of resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision: [CPR VI.A.2.c]]

1. Direct supervision – the supervising physician (or “supervisor” if specialty RRC permits supervision by non-physicians) is physically present with the resident and patient. [CPR VI.A.2.c.(1)]

2. Indirect supervision: [CPR VI.A.2.c.(2)]
   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. [CPR VI.A.2.c.(2).(a)]
   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. [CPR VI.A.2.c.(2).(b)]

3. Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. [CPR VI.A.2.c. (3)]
Clinical Responsibilities:
The specific clinical responsibilities of each resident varies with PGY-level, clinical rotation, experience, duration of clinical training, the patient's illness, and the clinical demands placed on the team and the availability of support services. The following is a general outline of patient care responsibilities by year of clinical training. Residents must comply with the supervision standards of their clinical assignments 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.

**Junior Residents (PGY-1)**
PGY-1 residents are primarily responsible for the care of patients under the guidance and supervision of the attending physician and senior 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. Initially, PGY-1 residents must be supervised either directly, or indirectly with direct supervision immediately available (see definitions above) by an attending or senior resident when appropriate. [CPR VI.A.2.e).(1).(a)]

**Intermediate Residents, as defined by RRC**
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.

**Senior Residents, as defined by RRC**
Senior residents may be directly or indirectly supervised. They may provide direct patient care, supervisory care or consultative services, with progressive graded responsibilities as merited. Senior residents should serve in a supervisory role to medical students, junior and intermediate residents in recognition of their progress towards independence, based on the needs of each patient and the skills of the individual resident [CPR VI.A.2.d).(3)]; however, the attending physician is ultimately responsible for the care of 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 procedural 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. Each training program must specify an indicated level of supervision for common specific invasive procedures.

The primary attending physician may at times delegate supervisory responsibility to a consulting attending physician if a procedure is recommended by that consultant. This information should be available to residents, faculty members, and patients.

**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 supervising physician is not immediately available, and to wait for the availability of an appropriate supervising 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 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 specified by each training program. 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 will be determined by each training program.

**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 optimize transitions in patient care, including their safety, frequency, and structure [CPR VI.E.3.a)]. Programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety [CPR VI.E.3.b]]. Programs must ensure that residents are competent in communicating with team members in the hand-over process. [CPR VI.E.3.c]]. Programs must maintain and communicate schedules of attending physicians and residents currently responsible for care [CPR VI.E.3.d]]. Each program must ensure continuity of patient care, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency. [CPR VI.E.3.e]]

**Circumstances in which Supervising Practitioner MUST be Contacted:**
Each training program must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). [CPR VI.A.2.e]]

**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 [CPR VI.A.2.d]]. The program director must evaluate each resident’s abilities based on specific criteria, guided by the Milestones. [CPR VI.A.2.d].(1)]
**Faculty Duration of Assignments:**
Faculty supervision assignments must 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. [CPR VI.A.2.f]

**Program Policies:**
The UW School of Medicine requires all ACGME-accredited residency and fellowship training programs to develop and maintain a policy on resident supervision. Program policies must meet the educational objectives and patient care responsibilities of the training program, and must comply with the requirements regarding supervision of residents according to specialty-specific Program Requirements, the Common Program Requirements, and the Institutional Supervision and Accountability Policy. In addition, the policy must also address:

1. Method used by the program to inform patients, residents/fellows, faculty members, and other members of the health care team of each patient’s assigned attending physician.
2. Any Review Committee specific conditions and the achieved competencies under which PGY-1 residents’ progress to be supervised indirectly with direct supervision available.
3. A comprehensive list of each clinical activities/procedures with the appropriate level of supervision for each PGY-level, which includes any consideration specified by specialty-specific Program Requirements.
4. A comprehensive list of all specific circumstances and events in which residents must communicate with appropriate supervising faculty members.
5. The required frequency of verbal communication by a resident performing consultations on patients with their supervising attending.
6. The duration of faculty supervision assignments to demonstrate that faculty have sufficient time to assess the knowledge and skills of each resident.

Records of program’s supervision policies are maintained by the GME Office in MedHub and are available on the GME internet site.

**Reporting Adverse Events:**
The resident must report any complication, near miss, or patient problem/safety issue to the supervising faculty. In addition, residents and physicians are strongly encouraged to utilize the Patient Safety Net (PSN) or other relevant institutional event reporting system. UW Medicine quality, patient safety, and clinical risk management professionals collaborate to review incident reports on a daily basis. Incidents involving serious outcomes of care that may qualify as adverse events and require further review via Root Cause Analysis (RCA) are identified and reported to senior leadership. The Risk Management and Quality Improvement departments review incident reports for possible reportable or reviewable events and take immediate steps to investigate and mitigate situations involving patient harm, including consideration for patient and healthcare professional well-being. In recognition of our patient's rights to autonomy in making healthcare decisions and to improve our culture of safety by demonstrating accountability for patient harm, UW Medicine is increasing its transparency with patients and their families when harm occurs.