SUPERVISION POLICY

Roles, Responsibilities and Patient Care Activities of Residents

University of Washington Neurology Residency Program

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. 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 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. 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.
   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
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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.

**PGY-1 (Junior Residents)**

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.

**PGY-2 (Intermediate Residents)**

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.

**PGYs-3 and 4 (Senior Residents)**

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.

**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
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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.

**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
Abdominal paracentesis, until the resident has performed 3 paracenteses
Thoracentesis, until the resident has performed 5 thoracenteses
Intrathecal administration of medications
Sedation for procedures (aka conscious sedation)
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Swan-Ganz catheter placement
All other invasive procedures not listed.

With regard to the placement of central lines, either subclavian or internal jugular, the resident may place lines with direct supervision once s/he has completed the training related to line placement as designated by the Department of Internal Medicine. The resident may then place lines with indirect supervision with direct supervision available by a qualified member of the medical staff, only once further training and experiences regarding line placement have been accomplished, as designated by the Department of Internal Medicine.

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
Abdominal paracentesis, once the resident has performed 3 paracenteses under direct supervision.
Thoracentesis, once the resident has performed 5 thoracenteses under direct supervision.

Oversight required by a qualified member of the medical staff
Phlebotomy, placement of peripheral intravenous catheters, dressing changes, suture removal, nasogastric tube placement, arterial puncture for the performance of obtaining an Arterial Blood Gas

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.

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 problem 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 (discussed with attending physician who agrees with the assessment and plan), at least by phone, by the day following the consult request.
Urgent: Patient should be seen by the resident and staffed, at least by phone, within 12 hours
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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.

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:
1) When a vascular interventional procedure is being considered.
2) When a resident has consulted on an ED patient at the UW or the VA and recommends that the patient be discharged.*
3) After a resident has assessed a patient presenting with an acute stroke, the resident will contact the Stroke Attending; in many cases, the Stroke Attending may also choose to notify the primary consulting Neurology attending or may ask the resident to do so.

*At HMC, when an N1 resident has consulted on an ED patient and recommends that the patient be discharged, the N1 should contact either a senior resident or their attending to discuss that patient.

If an attending does not respond to a resident in a timely manner, the resident should:
1) Contact the Neurology attending who is on call on the other Neurology service if the patient in question is at HMC; or
2) Contact a Neurology attending who is on call from one of the other hospitals or the Neurology attending carrying the Stroke phone.

Supervision of Hand-Offs

Each program must have a policy regarding hand-offs. Please see the Neurology “Patient Handover Guidelines.”

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) Operation requiring general anesthesia
4) Vascular interventional procedure (including intra-arterial TPA, clot extraction)
5) Request for transfer from an outside hospital or Emergency Department
6) At the VA and the UWMC, when a resident has consulted on an ED patient and recommends that the patient be discharged. *
7) When a patient is transferred from the floor to the ICU
8) After a resident has assessed a patient presenting with an acute stroke, the resident will contact the Stroke Attending; in many cases, the Stroke Attending may also choose to notify the primary Neurology attending or may ask the resident to do so.

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   2) Contact a Neurology attending who is on call from one of the other hospitals or the Neurology attending carrying the Stroke phone.

**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.

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**Policy review date**
August, 2013