SUPERVISION POLICY

Roles, Responsibilities and Patient Care Activities of Subspecialty Residents (Fellows)

Pediatric Critical Care Medicine Fellowship Program

Seattle Children’s Hospital and Harborview Medical Center

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 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 PCCM attending physician who is ultimately responsible for the management of the individual patient and for the supervision of residents/fellows 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/fellows.

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 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.

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.

PGY-4 (“First-Year” or Junior PCCM Fellow)
PGY-4 residents are primarily responsible for the care of patients under the guidance and supervision of the PCCM attending physician in the PICU and CICU at Seattle Children’s Hospital and the PICU/BICU at Harborview Medical Center. They should generally be the primary focal point for communication when questions or concerns arise about the care of their patients. On clinical services in which residents or medical students are present, the PCCM fellow will serve in a direct supervisory capacity. On ICU services without residents, the PCCM first-year fellow will serve as the first point of contact and will report to a senior PCCM fellow or PCCM attending physician. However, in all circumstances, when questions or concerns persist, the attending physician should be contacted in a timely fashion. PGY-4 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 ICU physician when appropriate.

PGY-5 (“Second-Year or Intermediate PCCM Fellow) Intermediate PCCM fellows may be directly or indirectly supervised by an attending physician but will provide all services under supervision. They may supervise lower level residents and/or medical students; however, the attending physician is ultimately responsible for the care of the patient. They may provide direct patient care, supervisory care or consultative services, with progressive graded responsibilities as merited.

PGY-6 (“Third-Year or Senior PCCM Fellow) Senior PCCM 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. Senior fellows should serve in a supervisory role of medical students, junior and intermediate residents, and first-year PCCM fellows in recognition of their progress towards independence, as appropriate to the needs of each patient and the skills of the senior PCCM 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 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 resident is expected to be greater with less experienced residents/fellows and with increased acuity of the patient’s illness. The
attending must notify all residents and 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 residents and 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. For example, if a pediatric surgery surgeon is asked to consult on a patient on the PICU service and decides the patient needs a chest tube, the PCCM attending may delegate supervisory responsibility to that pediatric surgeon to supervise the PCCM fellow who may perform the chest tube placement. This information should be available to residents/fellows, faculty members, and patients.

The attending may specifically delegate portions of care to residents/fellows 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/fellows to senior PCCM fellows assigned to the service, but the attending must assure the competence of the senior PCCM fellow before supervisory responsibility is delegated. Over time, the senior PCCM 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. Residents/fellows and attendings should inform patients of their respective roles in each patient’s care.

The attending and supervisory PCCM fellow are expected to monitor competence of more junior residents/fellows 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/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 resident/fellow requires supervision, this may be provided by a qualified member of the medical staff or by a PCCM fellow (intermediate or senior level) who is authorized to perform the procedure independently. In all cases, the attending physician is ultimately responsible for the provision of care by residents/fellows. 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**
- Right heart (Swan-Ganz) catheterization
- Initiation of extracorporeal life support (ECLS)
- Pericardiocentesis
- Cardioversion
- Flexible fiberoptic bronchoscopy
- Any procedure(s) that requires attending physician presence per hospital policy (e.g., administration of bolus propofol dose at Seattle Children’s Hospital)
SUPERVISION POLICY

Direct supervision required by a qualified member of the medical staff until designated by program faculty as being competent to perform the procedure without direct supervision
Endotracheal intubation (oral or nasal)
Central venous catheter placement/exchange
Arterial catheter placement
Chest tube placement/thoracentesis
ECLS circuit change
Hemodialysis catheter placement/exchange
Exchange transfusion
Abdominal paracentesis
Cardiopulmonary resuscitation
Initiation of continuous renal replacement therapy (CRRT)

Indirect supervision required with direct supervision immediately available by a qualified member of the medical staff until designated by program faculty as being competent to perform the procedure without supervision
Procedural sedation
Initiation of non-invasive positive pressure ventilation (CPAP/BiPAP)

Indirect supervision required with direct supervision available by a qualified member of the medical staff (procedures typically performed by general pediatric residents)
Lumbar Puncture
IV catheter placement
Venipuncture
Arterial puncture for blood sampling
Placement of intraosseous needle

Oversight required by a qualified member of the medical staff
Initiation of mechanical ventilation in patient with secure airway (endotracheal tube or tracheostomy)

Any procedure not specifically listed is understood to require direct supervision covered under the emergency procedure supervision policy (below)

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

PCCM fellows and residents/fellows rotating in the ICUs may provide pediatric critical care consultation services under the direction of PCCM attending physicians or senior PCCM fellow. The attending of record is ultimately responsible for the care of the patient and thus must be available
SUPERVISION POLICY

to provide direct supervision when appropriate for optimal care. The availability of the attending and supervisory fellows should be appropriate to the level of training, experience and competence of the consult fellow 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/fellows performing consultations on patients are expected to communicate verbally with their supervising attending at regular time intervals and prior to the time that a final recommendation is made to the service/care team requesting ICU consultation. Any resident/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 resident/fellow will communicate with the supervising attending as soon as possible. Residents/fellows performing consultations will communicate the name of their supervising attending to the services requesting consultation.

Additional specific circumstances and events in which residents/fellows performing consultations must communicate with appropriate supervising faculty members include: All patients for which a recommendation is made for admission to an ICU at Seattle Children’s Hospital or Harborview Medical Center.

**Supervision of Hand-Offs**

Patient care hand-offs can occur “fellow-to-fellow”. It is incumbent upon each fellow to review care plans with the supervisory ICU attending physician at the time of assuming direct patient care responsibilities. This can occur either through ICU team rounds or a direct conversation with the designated supervisory ICU attending physician.

**Circumstances in which Supervising Practitioner MUST be Contacted**

There are specific circumstances and events in which residents/fellows must communicate with appropriate supervising faculty members. These include:

1. Death of any patient under the care of the PCCM attending physician or ICU team
2. Decision to change code status
3. Administration of cardiorespiratory arrest requiring resuscitation (successful or unsuccessful)
4. Adverse event or complication (expected or unexpected)
5. Initiation/activation of E-CPR
6. Diversion of a patient requiring ICU to another facility or care site because of lack of ICU facility
7. Conflict arises with other medical/surgical services involved in joint patient care
8. Concern expressed by patient/family member regarding quality of care, request for transfer, etc.....

If the resident/fellow in unable to reach the supervising ICU attending physician, the resident/fellow should contact the ICU service Medical Director or PCCM Division Chief. If these individuals cannot be reached, the resident/fellow should contact the hospital Medical Director on call.

**Resident/Fellow Competence & Delegated Authority**
SUPERVISION POLICY

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident/fellow is assigned by the PCCM fellowship program director and PCCM faculty members. The program director and faculty evaluate each fellow's abilities based on specific criteria. These are:

1. Demonstration of adequate medical knowledge/patient care decision making skills as demonstrated by direct observation of patient care by program faculty
2. In-training examination scores
3. Performance on annual oral case discussion ("Hot Seat Challenge")
4. Review of semi-annual faculty evaluations
5. Input by individual fellow advisor

All decisions for promotion/completion require approval of PCCM fellowship clinical competency committee.

Faculty Development and Resident Education around Supervision and Progressive Responsibility

Residency/fellowship 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/fellow not to be afraid to call: Tell the resident/fellow to call with questions or uncertainty.

Residents/fellows should seek supervisor (attending or senior fellow) input using the SAFETY acronym.

1. Seek attending input early
2. Active clinical decisions: Call the supervising 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: Effective August, 2013