Roles, Responsibilities and Patient Care Activities of IR residents

INTERVENTIONAL RADIOLOGY

UW/HMC/VA/CHMC

Definitions

**Resident:** A physician who is engaged in a graduate training program in medicine, and who participates in patient care under the direction of attending physicians. *Note: The term “resident” includes all residents and 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 IR fellow or attending that they are working with 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.

**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 and is immediately available to provide Direct Supervision within 10 minutes.
   b) *with direct supervision available* – the supervising physician is not physically present within the hospital, 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 each hospital 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)**
Do NOT typically rotate with IR. However, if present PGY-1 residents function under direct supervision by an attending or senior resident at all times.

**PGY-2-5 (Intermediate Residents)** Intermediate residents may be directly or indirectly supervised by an attending physician or senior resident but will provide all services under supervision.

**PGY-6 (IR FELLOWS)** IR 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. They 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.

All procedures requiring image guidance are performed under direct or indirect supervision with direct supervision immediately available. Only patient management and bedside procedures such as tunneled CVC removal should be performed with direct supervision available.

**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 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.

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 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 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 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**
- Image guided drainage procedures (including but not limited to pleural, abdominal, biliary, urinary)
- All intra-arterial procedures
- All percutaneous ablation procedures
- All embolization procedures
- Transjugular portosystemic shunt
- IVC filter placement/removal
- Hemodialysis access interventions
- Venous access procedures

**Direct supervision required by a qualified member of the medical staff until competency has been demonstrated**
- N/A

**Indirect supervision required with direct supervision immediately available by a qualified member of the medical staff**
- N/A

**Indirect supervision required with direct supervision available by a qualified member of the medical staff**
- Tunneled CVC removal

**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 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 **WITHIN 12 HOURS**. 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

Fellows must directly communicate with the fellow on-call every night at the completion of the day’s work to hand-off patient care. Each fellow is responsible for patient care at each respective hospital until at least 17:30 and until official handoff has occurred.

The on-call fellow is responsible for contacting the fellows at each respective hospital before morning report (07:30) to hand-off any patient care issues from overnight.

Circumstances in which Supervising Practitioner MUST be Contacted

Any significant change in a patient’s clinical status that is on our primary service or that had an intervention by our service must be communicated to an attending immediately.

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 will evaluate each resident’s abilities based on quarterly 360 evaluations that will be reviewed with each fellow individually.

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**

**05/15/2013**