

PROCEDURE GME08

Subject: SUPERVISION and ACCOUNTABILITY
OF RESIDENTS

Effective Date: DECEMBER 2004

Applies to: HOUSTON METHODIST HOSPITAL
SYSTEM - GME

Date Revised/Reviewed:
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GRADUATE MEDICAL EDUCATION COMMITTEE

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I. GENERAL STATEMENT

The end objective of Graduate Medical Education (GME) is the development of competent physicians who can function independently. 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. During residency training, Program Directors and Faculty must ensure that Residents are carefully supervised and observed to determine each Resident's abilities to perform technical and interpretive procedures and to manage patients. Residents must be given graded levels of responsibility so that they can mature into their roles as judgmentally sound, technically skilled, and independently functioning credentialed health care providers.

This procedure establishes the minimal requirements for Supervision of Residents in the Participating Institutions affiliated with Houston Methodist Hospital Programs of GME. A Participating Institution may have additional requirements for Supervision of Residents. The requirements of individual Programs of GME may also be more restrictive than the minimums established by this Procedure.

II. GENERAL REQUIREMENTS FOR SUPERVISING RESIDENTS

- A. All patient care performed by Residents as part of their training curriculum must be supervised. The Attending Physician is ultimately responsible for patient care.
- B. It is the right of each patient to be cared for by residents who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care. Each patient must have an identifiable, 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, this includes the Consultative Attending. This information must be available to residents, faculty, other members of the health care team, and patients. Residents and faculty must inform each patient of their respective roles in that patient's care when providing direct patient care.
- C. The Program Director must have responsibility, authority, and accountability for supervision of residents and must ensure, direct, and document the supervision of Residents at all times. Residents must be provided with rapid, reliable systems for communicating with Supervising Medical Staff. 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.

- D. Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. The schedules of Supervising Attending must be structured to provide Residents with the appropriate level of supervision.
- E. 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 must evaluate each resident's abilities based on specific criteria, guided by the Milestones. Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each Resident. Senior Residents or fellows should serve in a supervisory role to junior Residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.

F. To promote oversight of Resident supervision while providing for graded authority and responsibility, Programs must use the following ACGME classifications of supervision:

1. Direct Supervision—

- a. the supervising physician is physically present with the resident during the key portions of the patient interaction; OR the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.

2. Indirect Supervision

the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.

3. Oversight—the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

G. 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.

H. Each Program Director working with the Program's Faculty and other staff must develop a Program-specific Resident Supervision policy. The Program-specific policy must comply with policies on Resident Supervision from Joint Commission or the Hospital's accrediting agency, Methodist's GMEC, the Organized Medical Staff of each hospital in which Residents will be trained, and all Medicare and Medicaid requirements. Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence (graded, progressive responsibility for patient care with defined oversight). Residents are encouraged to communicate with supervising Faculty Attendings any time that the resident feels the need to discuss any matter relating to patient-care. At a minimum, each Program specific Resident supervision policy must:

- 1. Delineate the role, responsibilities, and patient care activities of Residents.
- 2. Establish a process and guidelines for circumstances and events in which Residents must communicate with the supervising Faculty members. These guidelines must be available in writing for all residents. At a minimum, these circumstances must include (individual programs may add include additional circumstances) the following:
 - a. Encounter with an unstable patient in the emergency room;
 - b. Consultation for urgent condition;
 - c. Transfer of patient to a higher level of care;
 - d. Code Blue Team activation;
 - e. Medical errors in which the Resident was involved;
 - 1. Residents must disclose such medical errors in the presence of the attending
 - f. Change in DNR status;
 - g. Patient or family dissatisfaction that compromises care;
 - h. Patient requesting discharge AMA, or;
 - i. Patient death
- 3. Ensure that PGY1 Residents have the appropriate level of supervision, subject to further Review Committee conditions.

4. Follow RRC specific requirements concerning the achieved milestones under which PGY1 Residents may progress to Indirect Supervision with Direct Supervision Available.
 5. Make it clear to all involved with a patient's care what a Resident (by name or by postgraduate year of training) can and cannot do concerning patient care with less than Direct Supervision.
 6. Provide general job descriptions (see sample in Exhibit 1), Supervision, and documentation plans by postgraduate year of training.
- I. The GMEC oversees the Annual GME Survey as a mechanism by which Residents/Fellows can report inadequate supervision in a protected manner. Residents may also make reports directly to the DIO or use the GME Ombudsman program. .
 - J. Each Program Director must prepare and provide a listing of Residents' clinical activities that are permitted by year of training, the required level of Supervision for each activity, and any requirements for Residents' performing an activity without Direct Supervision (see samples in Exhibits 2 and 3). Alternatively, the Program Director may list clinical activities without reference to the year of training and provide only the requirements for performing an activity without Direct Supervision. Program Directors of ACGME-accredited as well as non-ACGME accredited Programs must submit their listing of clinical activities through New Innovations for access by Houston Methodist clinical staff.
 - K. Documentation of all patient encounters or reports of patient diagnostic examinations must identify the Supervising Attending and indicate the level of involvement. Residents must identify the Supervising and Consultative Attendings in the notes. Three types of documentation are allowed:
 1. The supervising Attending's note or other entry into the patient's medical records must reference or acknowledge the resident's note
 2. The supervising Attending's addendum to the Resident's note
 3. Countersignature by the supervising Attending to signify that the Attending has reviewed the Resident's note, and, absent to an addendum to the contrary, concurs with the content of the Resident's note or entry; reports related to reviews of patient material (such as pathology, radiology) must be verified and countersigned by the Supervising Attending
 - L. Supervision of Residents in Different Patient Care Settings.
 1. Inpatient settings.
 - a. For admissions, the Supervising Attending must see and evaluate the patient within 24 hours following admission. The Supervising Attending must document findings and recommendations regarding the treatment plan by the end of the next calendar day following admission.
 - b. For continuing care, each Program's Supervision policy must delineate which Residents by name or by postgraduate year of training may write patient care orders, the circumstances under which they may do so, and what entries, if any, must be countersigned by the Supervising Attending. The Supervising Attending must be personally involved in ongoing care.
 - c. For inpatient ward or ICU teams, the Supervising Attending has the primary responsibility for the patient's medical diagnosis and treatment and Attending Physician involvement is expected on a daily or more frequent basis. Residents may write daily orders on inpatients in whose care they are participating. These orders will be implemented without the co-signature of the Supervising Attending. It is the responsibility of the Resident to discuss his or her orders with the Supervising Attending. The Supervising Attending may write orders on all patients under their care. Residents must follow the Participating Institution's policies for how to write orders and to notify nurses of verbal orders, if permitted, in each patient care area.
 - d. For discharge or transfer, the Supervising Attending must be personally involved. The Supervising Attending must countersign the discharge summary or discharge or transfer note.

2. Inpatient consultation teams. All inpatient consultations performed by Residents will be documented in writing with the name of the responsible Attending consultant recorded. The Resident must notify the responsible Attending consultant within 24 hours of consultation. The Attending consultant is responsible for all recommendations made by the Resident consultant team. The consultative attending will see the patient within 24 hours of consultation.
3. Operating room. Except in emergencies, the Supervising Attending must evaluate each patient preoperatively. The Supervising Attending must write a pre-procedural note describing findings, diagnosis, plan for treatment, and/or choice of procedure to be performed. This note may be written up to 30 days preoperatively. Informed consent must be obtained according to the policy of the Participating Institution in which the procedure will be performed. Post-operative documentation must comply with JCAHO requirements, the Organized Medical Staff's policies, and all Medicare and Medicaid requirements.
 - a. The Supervising Attending must be present in the operating room for the critical parts (including patient and operative site identification) of all Major Cases. In some cases, positioning of an unstable patient may be considered a critical part of an operation.
 - b. If, in the opinion of the Supervising Attending, an operative procedure is minor and of low potential for significant morbidity and the Resident is deemed competent to perform the procedure without Direct Supervision (as defined in the Program's curriculum and Supervision policy), the Resident may proceed as directed after proper patient and operative site identification. However, the Supervising Attending remains responsible for all aspects of the patient's care despite his or her absence.
4. Outpatient clinics. Residents will provide outpatient services to patients under a Supervising Attending. The Supervising Attending will interview and examine the patient at his or her discretion, the Resident's request, or the patient's request. The Supervising Attending has full responsibility for care provided, even if he/she does not personally verify the Resident's interview or examination or the patient's laboratory data. The name of the Supervising Attending will be clearly recorded in the patient's records.
 - a. For new visits, the Supervising Attending must be physically present in the clinic and see or discuss every new patient with the Resident.
 - b. For return visits, the Supervising Attending must be physically present in the clinic and see or discuss each returning patient at a frequency sufficient to ensure effective and appropriate treatment. At a minimum, the outpatient note must identify the Supervising Attending.
5. Emergency Department. The ED attending must be physically present in the ED and is the attending of record for all ED patients. The ED attending must be involved in the disposition of all ED patients until patient is admitted. Residents will provide emergency services to patients under a Supervising Attending whose responsibility for supervision is identical to that outlined for supervision of Residents in outpatient clinics (III.I.4.). The supervision of Residents who are called to consult on patients in the Emergency Department is identical to that outlined for Supervision of Residents on inpatient consultation teams (III.I.2.). Residents should notify their Attending consultants promptly about Emergency Department consultations.
6. Interpretive settings. Residents who primarily interpret laboratory tests, imaging studies, or pathology specimens must be supervised by designated Attending and this Supervision must be documented. Each Program with interpretive settings must establish supervisory regulations that comply with the hospital's accrediting organization and specific RRC requirements.
7. Routine bedside and clinic (non-operating room) procedures. Each Program must describe those procedures that Residents, identified by name or by postgraduate year of

training, may perform without Direct Supervision. The Resident who performs the procedure must write the procedure note that identifies the Supervising Attending.

8. Non-routine, non-bedside, non-operating room procedures. Non-routine, non-bedside, non-operating room Procedures include cardiac catheterization, endoscopy, and invasive radiology. The Supervising Attending must authorize the procedure and must be physically present in the procedural area. The procedure note must identify the Supervising Attending and his or her degree of involvement.
 - a. Conscious sedation will only be performed where adequate patient monitoring is available, and resuscitation can be readily performed. Conscious sedation will only be performed under the Direct Supervision of an appropriately credentialed Supervising Attending.
 - b. The Resident may perform an invasive procedure without Direct Supervision only if, in the opinion of the Supervising Attending, the Resident is competent to perform the procedure safely and effectively. Each Program must describe those procedures that Residents, identified by name or by postgraduate year of training, may perform without Direct Supervision. However, the Supervising Attending remains responsible for the patient's care.
 - c. When life or limb would be threatened by a delay, Residents may perform emergency procedures without prior approval of Supervising Attending. In this case, the most senior Resident available will perform or supervise the procedure.
 - d. Medical and other professional students will not perform a procedure without Direct Supervision of a Supervising Attending or a Resident qualified to perform the procedure without Direct Supervision.
9. Emergency situations. Any Resident will be permitted to do anything possible to save the life of a patient or to prevent serious harm to a patient. However, Residents must make all reasonable efforts to obtain assistance from more senior Residents or any Attending available and will contact the Supervising Attending as soon as possible. The Resident will document in the patient's record all aspects of the emergency patient care, including who was contacted.
10. Telehealth: Each program must review its Review Committee Requirements to determine whether direct supervision with telemedicine is allowed.
11. Each Program must develop its own supervision policy to ensure it reflects the requirements of each Review Committee. Each Program must submit its Supervision policy to the GMEC for approval. Each Program must distribute its policy to its Residents and Faculty. So that appropriate personnel can ensure patient safety by verifying a Resident's competence to perform a clinical activity and the level of Supervision required, the GME Department will arrange for each Program-specific Supervision policy to be posted on either:
 - a. The intranet (secure) systems of the individual hospitals to which the Program's Residents rotate;
 - b. Methodist's GME secure site (New Innovations).

III. COMMITTEES REVIEWING/APPROVING PROCEDURE

1. Graduate Medical Education Committee [Approved on 9 December 2004] [revised 12 February 2009] [11 August 2011] [9 November 2017] [11 July 2019] [12 November 2020]

AUTHORITATIVE REFERENCES

1. Accreditation Council for Graduate Medical Education Common Program Requirements II.A.4. and VI.A.2. (effective 1 July 2019)
2. Veterans Health Administration Handbook 1400.1 (Resident Supervision), December 19, 2012; http://www.va.gov/oa/resources_resident_Supervision.asp