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| <b>Tufts Medical Center<br/>Hospital-Wide Policy</b>                             | <b>Subject:<br/>GME Resident Supervision</b> | <b>File Under:</b><br>Policy # GME 109<br>(Hospital-Wide Policy 2026)                    |
| <b>Issuing Department:</b><br><br>Graduate Medical Education<br>Committee (GMEC) |  | <b>Latest Revision Date:</b><br>July, 2011<br><br><b>Latest Review Date:</b>             |
| <b>Original Procedure Date:</b><br>May, 2001                                     | <b>Page 1 of 6</b>                           | <b>Approved By:</b><br>Designated Institutional Official<br>Chair, GMEC<br>Director, GME |

**Purpose**

The purpose of GME is to provide an organized educational program with guidance and supervision of the resident, facilitating the resident's ethical, professional and personal development while ensuring safe and appropriate care for patients.

This policy will establish the minimum requirements for resident supervision in teaching hospitals in which The Tufts Medical Center residents train. Individual training programs may also have additional requirements for their faculty/attendings and trainees.

**Eligibility**

The following definitions are used throughout the document:

Resident – a professional post-graduate trainee in a specific specialty or Subspecialty

Medical Staff – a professional who has been credentialed to provide care in his/her specialty or subspecialty by a hospital

Staff Attending – the immediate supervisor of a resident who is credentialed for specific procedures in their specialty and subspecialty that he/she is supervising

## Policy

It is the responsibility of individual program directors to establish detailed written policies describing resident supervision at each level for their residency programs. These written descriptions of resident supervision must be distributed annually and/or made readily available (e.g. electronic format) to all residents and faculty/attending physicians for each residency program. At all times, patient care will be the responsibility of a supervisor with appropriate clinical privileges.

The requirements for on-site supervision will be established by the program director for each residency program in accordance with ACGME requirements and will be monitored through periodic departmental reviews, with institutional oversight through the GMEC internal review process.

Careful supervision and observation are required to determine the trainee's abilities to perform technical and interpretive procedures and to manage patients. Although they are not licensed independent practitioners, trainees must be given graded levels of responsibility while assuring quality care for patients. Supervision of trainees should be graded to provide gradually increased responsibility and maturation into the role of a judgmentally sound, technically skilled, and independently functioning credentialed provider. The type of supervision (physical presence of attending physicians, home call backup, etc.) required by residents at various levels of training must be consistent with the requirement for progressively increasing resident responsibility during a residency program and the applicable program requirements of the individual RCs, as well as common standards of patient care.

In addition, the policy for each program must be in compliance with applicable Joint Commission standards, summarized below:

- At all times, patient care will be the responsibility of a licensed independent practitioner with appropriate clinical privileges.
- Written descriptions of the roles, responsibilities, and patient care activities of the residents, by level, are available to medical faculty and to health care staff.
- The descriptions identify mechanisms by which the program faculty and program director make decisions about an individual resident's progressive involvement and independence. Those parameters may include but may not be limited to: a given number of successfully performed, observed procedures; a total number of procedures or processes performed; the general impression of competence and professionalism perceived by faculty, etc.
- Delineation of order-writing privileges, including which orders if any must be countersigned

## **Procedure**

**A.** All residents' patient care activities are ultimately supervised by credentialed providers ("staff attendings") who are licensed independent practitioners on the medical staff of Tufts Medical Center. The staff attendings must be credentialed for the specialty care and diagnostic and therapeutic procedures that they are supervising. In this setting, the supervising staff attending is ultimately responsible for the care of the patient. By exception, supervision of residents may be performed by physician extenders (e.g., physician assistants or nurse practitioners) with particular expertise in certain diagnostic or therapeutic procedures, if so designated by the program director.

Ultimate responsibility for the residents' patient care, in this case, will rest on the credentialed staff who oversees the physician extender's practice.

**B.** Each Tufts Medical Center Program Director will define the policies in his/her program to specify how trainees in that program progressively become independent in specific patient care activities while still being appropriately supervised by medical staff. A program's resident supervision policies must be in compliance with The Joint Commission policies on resident supervision. The policy will delineate the role, responsibilities and patient care activities of trainees and will delineate which trainees may write patient care orders, the circumstances under which they may do so (e.g., "all situations"), and what entries if any must be countersigned by a supervisor. Each Tufts Medical Center Program Director will complete a listing of resident clinical activities that are permitted by level of training, the required level of supervision for each activity, and any requirements for performing an activity without direct supervision. See Appendix

A as an example.

*Some Program Directors may choose to list clinical activities without reference to year of training and only the requirements for performing an activity without direct supervision.*

*1. Program Directors of ACGME accredited programs will submit their listing of clinical activities by postgraduate year to the GME Office) and to the Graduate Medical Education Committee (GMEC) for review.*

*2. Program Directors of non-ACGME programs will submit their job descriptions and listing of clinical activities by postgraduate year to the appropriate body or committee for approval and then submit the approved policy to the Office for Graduate Medical Education.*

**C.** Each Tufts Medical Center Program Director should annually review the residents' clinical activities by level and make changes as needed.

*1. Program Directors of ACGME-accredited programs will submit the new job descriptions and their updated listing of clinical activities by postgraduate year to the Office of Graduate Medical Education (GME) and to the Graduate Medical Education Committee (GMEC) for review.*

2. Program Directors of non-ACGME programs will submit their new job descriptions and updated listing of clinical activities by postgraduate year to the appropriate body or committee for approval and then submit the approved policy to the office for Graduate Medical Education.

D. The Program Director will ensure that all supervision policies are distributed to and followed by trainees and the medical staff supervising the trainees. Compliance with the Tufts Medical Center resident supervision policy will be monitored by the Program Directors.

E. Annually, or more frequently as indicated, the Program Director will determine if residents can progress to the next higher level of training. The requirements for progression to the next higher level of training will be determined by standards set by each Program Director. This assessment will be documented in the annual evaluation of the trainees.

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### **Supervision of Trainees in the Inpatient Setting**

A. All lines of responsibility and authority for inpatient care delivered by inpatient ward or ICU teams are directed to a credentialed staff provider. Trainees should write daily orders on inpatients for whom they are participating in the care. These orders will be implemented without the co-signature of a staff physician. It is the responsibility of the resident to discuss their orders with the attending staff physician. Attending staff may write orders on all patients under their care. Trainees will follow all hospital policies for how to write orders and notify nurses and will follow the “verbal orders” policies of each patient care area.

B. General job descriptions of trainees by year of training which may be adopted by programs are available in Appendix B. The descriptions may not apply to all programs, such as subspecialties which do not have PGY1 or PGY2 levels. Program Directors have the discretion to use or modify these descriptions as appropriate to their specialty or subspecialty.

C. Staff supervision of care for hospitalized patients must be documented in the inpatient record. Documentation requirements for inpatient care are outlined next. These are the minimal requirements and may be more stringent depending on the hospital policy.

D. Documentation, in writing, by *staff* must be in accordance with hospital policies. This documentation includes especially: concurrence the admission, history, physical examination, assessment, treatment plan; orders concurrence with major interventional decisions; concurrence when any major change occurs in the patient’s status, such as transfer into or out of an intensive care unit or changes in “Do Not Resuscitate” status. Documentation, in writing, by trainees must also be in accordance with hospital policies.

### **Supervision of Trainees on Inpatient Consult Teams**

All inpatient consultations performed by trainees will be documented in writing, with the name of the responsible staff consultant recorded. The responsible staff consultant must be notified verbally by the

trainee doing the consult within an appropriate period of time as defined by the particular consulting service. The consulting staff is responsible for all the recommendations made by the consultant team.

### **Supervision of Trainees in Outpatient Clinics**

All outpatient visits provided by trainees will be conducted under the supervision of a medical staff member who is physically present in the clinic. This medical staff member will interview and examine the patient at the discretion of the medical staff member, at the trainee's request, or at the patient's request. The medical staff member has full responsibility for care provided, whether or not he/she chooses to verify personally the interview or examination.

### **Supervision of Trainees in the Emergency Department**

The responsibility for supervision of trainees providing care in the Emergency Department (ED) to patients who are not admitted to the hospital will be identical to that outlined in the schema for outpatient supervision above. The responsibility for supervision of trainees who are called in consultation on patients in the ED will be identical to that outlined in the schema for consultation supervision above. Consulting staff should be notified appropriately of ED consultations.

### **Supervision of Trainees in Interpretive Settings**

It is the responsibility of each training program/department in these areas to establish supervisory regulations in compliance with The Joint Commission & RC requirements.

### **Supervision of Trainees Performing Procedures**

A trainee will be considered qualified to perform a procedure if, in the judgment of the supervising staff and his/her specific training program guidelines, the trainee is competent to perform the procedure safely and effectively. Residents at certain year levels in a given training program may therefore be approved to perform certain procedures without direct supervision, based upon specific written criteria set forth and defined by the Program Director. As such, trainees may perform routine procedures that they are approved to perform (such as arterial line placement) for standard indications without prior approval or direct supervision of staff. However, the resident's staff of record will be ultimately responsible for all procedures on inpatients. In addition, residents may perform emergency procedures without prior staff approval or direct supervision when life or limb would be threatened by delay. All outpatient procedures will have the staff of record documented in the procedure note, and that staff will be ultimately responsible for the outpatient procedure.

As previously mentioned, Program Directors will define the mechanism by which residents can be deemed competent to perform a procedure(s) without supervision. Additionally, a listing of approvals by individual resident should be registered at all times in pertinent patient care areas, and available for review by all patient care personnel. (If procedure approvals are made by PG years; the table per Appendix A may suffice for this.)

Residents who require the direct presence of a supervisor to perform procedures may be supervised by either staff or, instead, by more senior residents, when those latter are also 'approved' by the program to perform the procedure independently.

**Responsibility of:**

Graduate Medical Education Committee (GMEC)

**Author:**

Director, Graduate Medical Education

**Date:**

June, 2011

**Approval:**

Graduate Medical Education Committee

Director, GME

Medical Board

**Date:**

June, 2011

June, 2011

July, 2011

## **Appendix A: Draft Template for Procedures**

### **Instructions and Examples for Completion of Appendix A**

#### **➤ Specific Clinical Activities and Level of Supervision**

The template will be filled out by the Program Director to address the specific clinical activities and the level of supervision required. For each Clinical Activity, the following areas need to be addressed on the accompanying template:

- **Resident Level at Which an Activity Can be Performed:** PGY year, if applicable
- **Method of Instruction:** Examples: Direct Clinical Instruction, Courses (e.g. ACLS)
- **Level of Instructor and Direct Supervisor:** by PGY year or Attending
- **Requirements for Certification to Perform Activity without Direct Supervision:** Examples: Program Certification, PGY year
- **Method of Confirming Certification of Resident to Perform the Activity without Direct Supervision:** Examples: Program Certification, PGY Year

#### **➤ Template for Procedures List**

##### **Postgraduate Year 1 (PGY1) Resident**

Attending physician will participate in daily rounds and write daily progress notes which include an interim history and physical exam, laboratory and radiographic data, and an assessment and plan. If a significant new clinical development arises, there will be timely communication by a member of the resident team with the attending.

The resident and attending must communicate with each other as often as is necessary to ensure the best possible patient care.

The PGY1 resident may be responsible for completion of discharge summaries. Transfer notes and acceptance notes between critical care units and floor units, when required, can be written by the PGY1 resident. Such transfer notes shall summarize the hospital course and list current medication, pertinent laboratory data, and active clinical problems and physical examination findings. The supervising resident and the attending must be involved to ensure that such transfer is appropriate.

All PGY1 residents, when leaving an inpatient team, must write an “offservice” note summarizing pertinent clinical data about the patient. The new resident team must notify the attending physician of the change in resident teams and review the management plan with him/her.

##### **Postgraduate Year 2 (PGY2) Resident**

PGY2 residents, when assigned to the service, will take responsibility for organizing and supervising the teaching service in concurrence with the attending physician and will provide the PGY1 residents and medical students under his/her supervision with a productive educational experience. In this role, they work directly with the PGY1 residents in evaluating all new admissions and reviewing all H&Ps, progress notes, and orders written by the PGY1 resident daily. They will also supervise, in consultation with the attending physician and if

approved by the PD to perform independently, all procedures performed by the PGY1. PGY2 residents may perform any of the PGY1 tasks outlined above at the discretion of the attending or patient care area policies. PGY2 residents must maintain close contact with the attending physician for each patient and notify the attending as quickly as possible of any significant changes in the patient's condition or therapy. All decisions related to invasive procedures, contrast radiology, imaging modalities, and significant therapies must be approved by the attending.

**Postgraduate Year 3 and above (PGY3) Residents**

PGY3 residents will follow all responsibilities of the PGY2 outlined above when acting in a similar supervisory capacity. PGY3 residents may perform any of the PGY1 or PGY2 tasks outlined above at the discretion of the attending or patient care area policies. They will also be available to provide assistance with difficult cases and provide instruction in patient management problems when called upon to do so by other residents. They will assume direct patient care responsibilities when needed to assist more junior residents during times of significant patient volume or severity of illness. Supervision of procedures will be as outlined for PG 2 residents.