# SUPERVISION POLICY

**Roles, Responsibilities and Patient Care Activities of Residents**

***University of Washington Family Medicine Residency Program***

## Definitions

**Resident:**
A physician who is engaged in a graduate training program in family medicine, and who participates in patient care under the direction of attending physicians. 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 a supervising physician or other appropriate licensed practitioner when they are uncertain of diagnosis, how to perform a diagnostic or therapeutic procedure, or how to implement an appropriate plan of care.

**Attending Physician (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 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.

**PGY- 1 (Junior Residents / Interns):**
PGY-1 residents are primarily responsible for the care of patients under the guidance and supervision of the attending physician and senior 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 or senior 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.

**PGY- 3 (Senior Residents):**
Senior residents 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 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 Physician:**
In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged 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 program policy (see below). 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 these situations, the attending should include in his or her notification to residents all situations that require attending notification per program or hospital policy. 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 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.

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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.

## Specific Supervision Policies

**Inpatient Medicine and Pediatrics:**
All routine medicine and pediatric patients admitted by residents must be evaluated within the first 24 hours after admission, and at least once each day of the hospital stay of that patient, by an attending physician. Typically, most patients are seen within 6-12 hours of admission. The resident is required to notify and discuss every admission with the attending physician at or soon after the patient is admitted based on patient illness acuity.

An attending physician must urgently evaluate any unstable patient at the time of admission, with further direct supervision depending upon the stability of the patient.

**Inpatient Obstetrics:**
All obstetrics patients admitted by residents must be evaluated within the first 24 hours after admission, and at least once each day of the hospital stay of that patient, by an attending physician. Typically, most patients are seen within 6 hours of admission. The resident is required to notify and discuss every L&D patient with the attending at the time of admission, periodically through a normal labor course, at the time a complication develops, if an indication for obstetrics consultation develops, and immediately after consultation with the obstetrics service in the event there wasn't time prior to the consultation. The resident is encouraged at any time to request on-site faculty presence.

Direct supervision by an attending physician is indicated in these circumstances:

- Low-risk deliveries, once a primiparous patient is complete or a multiparous woman is 6 to 8 cm, dependent on the specific circumstances of each case.
- Complicated obstetric patients, as appropriate to the circumstances of each case. This supervision may be provided by either the family medicine attending physician, or by the consulting obstetrician in the event that Family Medicine has transferred care to obstetrics.

**Outpatient Settings:**
**Office visits.** All patients seen by residents at office visits must be directly supervised by the attending physician, except those under the "primary care exception", which is as follows:

a. Applies only to office codes 99201, 99202, and 99203, and 99211, 99212, and 99213 (the first three levels of new patient and established patient office visits) and HCPC codes G0402, G0438, and G0439 for Medicare first and subsequent annual wellness visits.
b. Allows the attending physician to discuss the history, physical, and plan of care with the resident and confirm these elements without actually seeing the patient; however, each must be discussed before the end of that half-day of clinic.
c.

**All other visits** (nursing home, home visits, emergency room, etc.). The attending physician must directly supervise all patients seen by residents for the visit to be billed. If only indirect supervision or oversight is provided by the attending, the visit is not to be billed.

## 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. Any procedure performed by a resident must be directly supervised unless the resident has been approved to perform that procedure independently. 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:

- Any operating room procedure.
- Vaginal delivery, including repair of vaginal lacerations or episiotomy, repair of cervical laceration, uterine exploration
- Colposcopy and cervical cryotherapy
- D&C or D&E, uterine
- Exercise treadmill test
- Flexible or rigid sigmoidoscopy
- Sedation for procedures
- Vasectomy
- All other invasive procedures not listed.

Direct supervision required by a qualified member of the medical staff until competency demonstrated; then indirect supervision with direct supervision available:

A resident may be released for independent performance of a procedure that is within the usual scope of practice of family physicians in that institution, when the resident has been supervised for a number of that procedure sufficient for faculty to assure the resident's competency in knowledge and skill for independent practice relating to that procedure.

| Procedure | Number of procedures completed *with competency* for independent performance (or training equivalent) |
|---|---|
| Abdominal paracentesis | 3 procedures |
| Application of casts or splints | 3 procedures |
| Arterial catheterization | 3 procedures |
| Arthrocentesis | 3 procedures |
| Central line placement: internal jugular | 3 procedures |
| Central line placement: subclavian | 3 procedures |
| Lumbar puncture | 3 procedures |
| I&D of abscess | 1 procedure |
| IUD placement | 3 procedures |

| | |
|---|---|
| Nasogastric tube placement | 1 procedure |
| Neonatal circumcision | 6 procedures |
| Obstetrical procedures: placement of cervidil, IUPC, fetal scalp electrode, limited OB ultrasound | Completion of R1 OB rotation |
| Skin biopsy | 3 procedures |
| Skin lesion excision | 3 procedures |
| Thoracentesis | 3 procedures |
| Toenail removal | 3 procedures |
| Urethral catheter | 1 procedure |

Oversight required by a qualified member of the medical staff:
Dressing changes, suture placement and removal, central venous catheter removal, cryotherapy of small skin lesions (<5 mm), anoscopy, breast exam, pelvic exam, pap smear and endocervical cultures.

## 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 Medical Students

The rules regarding the supervision of medical students, which apply in both the inpatient and outpatient settings, are as follows. The rules are intended to assure that quality care is being provided to patients through appropriate support of learners in the teaching environment. A resident may serve as the "supervising physician" for purposes of medical student supervision, but the rules for supervision of the resident are the same as if the resident were seeing the patient without the student.

**Interactions with patients:** Medical students may interview and examine patients. However, the supervising physician for the student MUST repeat the key portions of the history with the patient, and MUST do the entire physical exam in addition to the student exam. The student may discuss the plan of care with the patient, but must be either supervised directly and confirmed with the patient by the supervising physician, or repeated in its entirety by the supervising physician.

**Documentation:** Medical students notes may be written as part of the chart. The supervising physician may use part of the student's write-up of the history (in particular only the ROS and PSH), but must personally document the chief complaint and HPI, the physical exam, and the plan of care.

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## 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 the time of consultation and with any significant change in patient status thereafter. 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

ACGME requirements:

- Programs must design clinical assignments to minimize the number of transitions in patient care.
- Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.
- Programs must ensure that residents are competent in communicating with team members in the hand-over process.
- The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care.

Settings where appropriate Patient Handoff must occur:

- Patients admitted to the UW Family Medicine service from a UW Medicine clinic or other outpatient facility.
- Patients discharged from the UW Family Medicine service back to a UW Medicine clinic or other outpatient facility.
- Shift change from daytime to on call or nighttime provider on all hospitalized patients with active healthcare issues.
- Shift change from on call or nighttime provider on all hospitalized patients with active healthcare issues.
- Hospitalized patients transferring between any consult and service teams and Family Medicine.
- Outpatients with active healthcare issues that should by the on call, nighttime or weekend Family Medicine team.

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Expectations for regular handoffs:

- Family Medicine team members working on inpatient services will on a daily basis communicate any appropriate handoffs to and from the on-call providers verbally in person. The senior resident on the Family Medicine service supervises this hand off time.
- Except on rare occasion, in person verbal sign-out will occur among residents and trainees; during an exception, either verbal phone or Facetime sign-out may occur. Texting or emailing sign-out is not permitted among trainees.
- Each morning and evening, patient handoffs will occur between the nighttime resident providers and the daytime resident teams. In this manner, competency of residents in communicating with team members in the hand-over process may be assessed and monitored.
- The CORES sign-out sheet with appropriate and updated patient information will be exchanged during the transition of care between day and nighttime providers. This sheet should include patient identifying information, current active medical conditions, medications, allergies, code status, attending physician, primary care physician and a to do list for the upcoming shifts.
- Attending physicians should provide direct phone sign out to the oncoming attending on all patients with active medical conditions and in person sign out on any unstable patient or patient nearing obstetrical delivery.

See end of document for guidelines on verbal and written hand-off communications.

## Circumstances in which Supervising Practitioner MUST be Contacted

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

- All new admissions to the hospital
- New consults requested of the Family Medicine service
- All transfers of care to the Family Medicine service or from Family Medicine to another service
- Low-risk deliveries, once a primiparous patient is complete or a multiparous woman is 6 to 8 cm, dependent on the specific circumstances of each case.
- Complicated obstetric patients, as appropriate to the circumstances of each case. This supervision may be provided by either the family medicine attending physician, or by the consulting obstetrician in the event that Family Medicine has transferred care to obstetrics.
- Any unstable patient at the time of admission
- Any sudden or unexpected deterioration of a patient cared for by the Family Medicine service
- Any discharge against medical advice or death of a patient cared for by the Family Medicine service

If a supervising physician does not respond for any reason to a resident phone call in a timely manner:

1. If a supervising resident does not respond, contact the attending physician directly by personal pager, paging operator (598-3300) or personal cell or home phone.
2. If an attending physician does not respond:

a. If an urgent medical situation is occurring, contact an in-hospital attending or senior resident on another service as indicated for assistance or transfer of care (ICU, OB, NICU, ED, Anesthesia, Cardiology).
b. If not urgent, send page to "List - ResFacPager" list (in First Class) urgently to request "Urgent Attending coverage needed - please respond if available {with your call-back number}".
c. In either case, when able, send a message in follow up to the Family Medicine Service Chief (Judy Pauwels, MD) and Residency Program Director (Mark Beard, MD) letting them know of the non-response by the attending.

## Models for Supervision

Attendings should adhere to the SUPERB model when providing supervision. They should:

1. **S**et Expectations: set expectations on when they should be notified about changes in patient's status.
2. **U**ncertainty is a time to contact: tell resident to call when they are uncertain of a diagnosis, procedure or plan of care.
3. **P**lanned Communication: set a planned time for communication (i.e. each evening, on call nights)
4. **E**asily available: Make explicit your contact information and availability for any questions or concerns.
5. **R**eassure resident not to be afraid to call: Tell the resident to call with questions or uncertainty.
6. **B**alance supervision and autonomy.

Residents should seek supervisor (attending or senior resident) input using the SAFETY acronym.

3. **S**eek attending input early
4. **A**ctive 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.
5. **F**eel 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.
6. **E**nd-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.
7. **T**ransitions 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).
8. Help with system/hierarch**Y**: 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.

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## 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 as an essential element of professional development. The residency program will evaluate each resident's abilities based on specific criteria through the Family Medicine Resident Clinical Competency Committee and approve each graded increase in resident responsibility during their training. The Clinical Competency Committee will evaluate each resident's clinical competence based on his or her progress along residency training milestones of development and certify each resident's ability to proceed to the next graded level of responsibility. The residents will be assessed on surrogate markers of competence in medical knowledge, patient care skills, communication skills, problem-based learning, professionalism and systems-based practice until specific milestone measures are available in Family Medicine education in the upcoming 1-2 years.

## Faculty Development and Resident Education around Supervision and Progressive Responsibility

All faculty and residents will participate in education around supervision and responsibility as part of yearly orientations, as well as "pre-briefs" for residents prior to starting the Family Medicine Service rotation.

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UNIVERSITY OF WASHINGTON FAMILY MEDICINE PROGRAM

POLICY FOR RESIDENT "HAND-OFFS" OF PATIENT CARE

**Checklist for Verbal Communication During Sign-Out: The Who, What, Where, When, and How**

- **WHO** should participate in the sign-out process?
  - Outgoing clinician primarily responsible for patient's care
  - Oncoming clinician who will be primarily responsible for patient's care (avoid passing this task to someone else, even if busy)
  - Consider supervision by experienced clinicians if early in training
- **WHAT** content needs to be verbally communicated? Use situation briefing model, or **SBAR,** technique:
  - **S**ituation—Identify each patient (name, age, sex, chief complaint) and briefly state any major problems (active and those that may become active during cross-coverage).
  - **B**ackground—pertinent information relevant to current care (eg, recent vitals and/or baseline exam, labs, test results, etc); advanced directives code status.
  - **A**ssessment—working diagnosis, response to treatment, anticipated problems during cross-coverage including anything not adequately described using written form (eg, complex family discussions).
  - **R**ecommendation—to-do lists and if/then recommendations.
- **WHERE** should sign-out occur?
  - Designated room or place for sign-out (eg, avoid patient areas because of HIPPA requirements)
  - Minimize disruptions
  - Ensure systems support for sign-out (eg, computers, printer, paper, etc.)
- **WHEN** is the optimal time for sign-out?
  - Designated time when both parties can be present and pay attention (eg, beware of clinic, other obligations)
  - Have enough time for interactive questions at the end (eg, avoid rush at the end of the shift)
- **HOW** should verbal communication be performed?
  - Face to face, allowing for questions
  - Verbalize data in the same order for each patient at each sign-out
  - "Read back" all to-do items
  - Adjust length and depth of review according to baseline knowledge of parties involved and type of transition in care

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**Checklist for Elements of a Safe and Effective Written Sign-out—ANTICipate**

- ***A*dministrative data**
  - Patient name, age, sex
  - Medical record number
  - Room number
  - Admission date
  - Primary inpatient medical team
  - Primary care physician
  - Family contact information
- ***N*ew information (clinical update)**
  - Chief complaint, brief HPI, and diagnosis (or differential diagnosis)
  - Updated list of medications with doses, updated allergies
  - Updated, brief assessment by system/problem, with dates
  - Current "baseline" status (eg, mental status, cardiopulmonary, vital signs, especially if abnormal but stable)
  - Recent procedures and significant events
- ***T*asks (what needs to be done)**
  - Specific, using if-then statements
  - Prepare cross-coverage (eg, patient consent for blood transfusion)
  - Alert to incoming information (eg, study results, consultant recommendations), and what action, if any, needs to be taken during the cross-coverage
- ***I*llness**
  - Is the patient sick?
- ***C*ontingency planning/*C*ode status**
  - What may go wrong and what to do about it
  - What has or has not worked before (eg, responds to 40 mg IV furosemide)
  - Difficult family or psychosocial situations

Code status, especially recent changes or family discuss

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