Graduate Medical Education (GME) Supervision Policy

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Description:
In order to maintain high clinical and educational standards and to ensure compliance with applicable regulations in these areas, UCSD School of Medicine requires adequate resident supervision appropriate to each level of training, recognizing that graduate medical education is based on a system of graded responsibility in which the level of resident responsibility increases with years of training. UCSD ensures that training at all affiliated institutions is in accordance with these principles.

Definitions:

GME Training Program: The responsible program within a Department of the School of Medicine that recruits House Officers, oversees their training and conducts the evaluation process.

Resident or House Officer: Any M.D. or D.O. in a training program that leads to eligibility for either general certification or subspecialty certification by an approved ABMS Specialty Board, or any M.D. or D.O. in a training program where ABMS Specialty Board certification has not been created. This includes all trainees in ACGME or non-ACGME accredited programs.

Supervising Practitioner: Licensed, independent physicians, dentists, podiatrists, optometrists, credentialed and privileged in accordance with applicable UCSD requirements. A supervising practitioner must have appropriate credentials and experience, and be approved by the sponsoring entity in order to supervise residents. In some training settings, other health care professionals with documented qualifications and appropriate academic appointments may function as supervising practitioners for selected training experiences. Supervising practitioners can provide care and supervision only for those clinical activities for which they have clinical privileges.

Supervision Guidelines:
Communication and collaboration between supervising practitioners and residents is required. Identification of the respective duties and responsibilities of supervising practitioners and residents provides the foundation upon which supervision is based. Residents must be supervised in such a way that they assume progressively increasing responsibility for patient care.
care according to their level of training, ability and experience. The GME Training Program faculty must determine the level of responsibility afforded each resident.

Components of Supervision:

- Educational objectives are defined.
- The supervising practitioner assesses the skill level of the resident by direct observation.
- The supervising practitioner authorizes independent action by the resident.
- The supervising practitioner defines the course of progressive independence from performing functions together with decreasing frequency of review. This process starts with close supervision, progressing towards independence as skills are observed and mastered.

Components of Supervision:

- Documentation of supervision by the involved supervising practitioner must be customized to settings based on guidelines for best practice and regulations by the ACGME, The Joint Commission, and other regulatory agencies. One of the four components listed below must always be present in the medical record. There are also certain settings, outlined in this policy, for which a specific type of documentation is required by accreditation and regulatory agencies:
  - Progress note by the supervising practitioner
  - Addendum to the resident’s progress note by the supervising practitioner
  - Counter-signature of the progress note by the supervising practitioner
  - A medical record entry documenting the name of the supervising practitioner and that discussion occurred about the case

- Written evaluation and feedback are integrated into the progression from one training level to another. At all times, and at any level, the resident has access to advice and direction from the supervising practitioner.

POLICY:

- Each GME Training Program will comply with external regulatory agency requirements regarding the supervision of House Officers and the care of patients. *To the extent that the individual ACGME Program Requirements exceed this Supervision Policy, the RRC Requirements must also be met.*

- In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient’s care.

- Each GME Training Program will assign a supervising practitioner(s) to be responsible for compliance with this policy at each affiliate.

- The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.
Levels of Supervision

- To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:
  - Direct Supervision – the supervising physician is physically present with the resident and patient.
  - Indirect Supervision:
    - 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.
    - 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 provide Direct Supervision.
  - Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

- 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.

- Senior residents or fellows should serve in a supervisory role of 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.

- Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.

- 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.

Ambulatory Sites

- Residents will be able to identify an available supervising practitioner at all times during patient care.
- A supervising practitioner will be physically present and available to residents during the entire ambulatory clinic session or outpatient procedure.
- Return patients will be seen by, and discussed with, the supervising practitioner at such a frequency as to ensure that the course of treatment is effective and appropriate. The supervising faculty member will be identifiable for each resident’s patient care encounter; any of the four types of documentation listed above is acceptable.
A supervising practitioner will personally see all new patients referred for consultation. Documentation must at a minimum include co-signature of the consultative note.

**Emergency Department Sites**

- Residents will be able to identify an available supervising practitioner at all times during patient care.
- Each new patient to the Emergency Department will be seen by or discussed with the supervising practitioner for the emergency department. The supervising practitioner will be identified in each resident’s patient care encounter; any of the four types of documentation listed above is acceptable.
- The supervising practitioner, in consultation with the resident, ensures that documentation of the discharge of a patient from the emergency department is appropriate. Any of the four types of documentation listed above is acceptable.
- Patients scheduled for direct hospital admission are not required to be seen by the supervising practitioner for the emergency department.

**Extended Care Sites**

- Each new patient admitted to an extended care facility will be seen by the supervising practitioner within 72 hours of admission; the attending must either write an independent progress note or an addendum to the resident note.
- Extended care facility patients will be seen by, or discussed with, the supervising practitioner at such a frequency to ensure that the course of treatment is effective and appropriate. Any of the four types of documentation listed above is acceptable.

**Operating Room for Inpatient or Outpatient Procedures**

- For all elective and scheduled surgical procedures, the supervising practitioner will evaluate the patient and will write a pre-procedural note describing the findings, diagnosis, and plan for treatment or choice of specific procedure to be performed. This pre-procedural evaluation and note may be completed up to 30 days in advance of the surgical procedure.
- Staff involvement in procedures will be documented according to the following scale:
  - Level A: Supervising practitioner doing the operation: The supervising practitioner performs the case, but may be assisted by the resident.
  - Level B: Supervising practitioner in OR, scrubbed: The supervising practitioner is physically present in the operative or procedural room and directly involved in the procedure. The resident performs major portions of the procedure.
- Level C: Supervising practitioner in OR, not scrubbed: The supervising practitioner is physically present in the operative or procedural suite and immediately available for resident supervision or consultation as needed.

- Level D: Supervising practitioner in OR suite, immediately available: The supervising practitioner is physically present in the operative or procedural suite and immediately available for resident supervision or consultation as needed. The resident performs the procedure.

- Level E: Emergency care: Immediate care is necessary to preserve life or prevent serious impairment. The supervising practitioner has been contacted.

- Level F: Non-OR procedure: Routine bedside and clinic procedure done in the OR. The supervising practitioner is identified.

For procedures performed at the VA, the level of staff involvement will be reported to VA Central Office via the Surgical Quarterly Report.

**Non-Operating Room Procedures**

- Routine bedside and clinic procedures include skin biopsies, central and peripheral lines, lumbar punctures, centeses, incision and drainage. Any of the four types of documentation listed above is acceptable.

- Non-routine, non-bedside diagnostic or therapeutic procedures include endoscopy, cardiac catheterization, invasive radiology, chemotherapy and radiation therapy. Supervising practitioners are responsible for authorizing performance of such procedures and must be physically present in the procedural area, but not necessarily in the same room, as the resident. Supervision for these procedures takes into account the complexity and inherent risk of the procedure, the risk of the procedure, the experience of the resident and assigned graduated levels of responsibility. Any of the four types of documentation listed in above is acceptable.

**Inpatient Sites**

- Residents will be able to identify an available supervising practitioner at all times during patient care. Supervising practitioners must be immediately available to residents.

- The supervising practitioners must physically meet, examine and evaluate new patients on the inpatient service within 24 hours, including weekends and holidays, of admission to the hospital. Documentation of the supervising practitioner’s findings and recommendations regarding the treatment plan must be in the form of an independent progress note or an addendum to the resident note, and must be entered by the end of the calendar day following admission. If the specific requirements of the pre-operative notes are included, the admission note (or addendum) may also serve as the pre-operative note.

- Supervising practitioners are expected to be personally involved in the ongoing care of patients assigned to them in a manner consistent with the
clinical needs of the patient and the graduated responsibility of the resident. Any of the four types of documentation of supervision listed above is acceptable.

- Evidence that the supervising practitioner approves the discharge or transfer of the patient from an inpatient service will be documented by the signature of the supervising practitioner on the discharge summary.

- Supervising practitioners for specialty consultations on hospitalized patients must evaluate the patients and demonstrate concurrence by counter-signature of the consultative note written by the resident.

References:
NA

Attachments:
NA

Approval Dates:
July 1, 2001; July 2011 policy reviewed and updated as needed

Contact Information:
Office of Graduate Medical Education; http://meded.ucsd.edu/gme/