2020-2021
Guide to Verification of Procedural Autonomy

The term "resident" is inclusive of all trainees at SIU School of Medicine, whether training in a residency or fellowship program.

BACKGROUND:

For a resident physician to perform bedside procedures safely, ACGME and Clinical Learning Environment Review (CLER) expectations and requirements are enlisted. Therefore, the residency, and fellowship training programs are required to have a process for their Clinical Competency Committee (CCC) to assess and document an individual resident's achievement of competence to perform an identified specific procedure with indirect supervision (procedural autonomy). This process must also ensure that residents who have been granted procedural autonomy know when they must involve their attending or senior resident (patient acuity, etc.). This Guide is intended to assist the residency programs in meeting this requirement.

In addition, each clinical site (MMC, SJH, affiliated hospitals, etc.) is also expected to establish a mechanism for the clinical care team to be able to verify the level of procedural autonomy for specific procedures for an individual resident. We will keep programs apprised as this mechanism is established for our clinical sites and how to provide or enter this information.

ACGME COMMON PROGRAM REQUIREMENTS:

- V.A.1.a) Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment.
- V.A.1.c) The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones, and must:
    - V.A.1.c).(1) use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and,
    - V.A.1.c).(2) provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice.

CLER PATHWAYS TO EXCELLENCE: EXPECTATIONS FOR AN OPTIMAL CLINICAL LEARNING ENVIRONMENT TO ACHIEVE SAFE AND HIGH-QUALITY PATIENT CARE VERSION 2.0

SUPERVISION Pathway 3: Roles of clinical staff members other than physicians in resident and fellow supervision

The clinical learning environment:

a. Ensures that clinical staff members other than physicians act on concerns related to the supervision of residents and fellows.

b. Ensures that clinical staff members other than physicians are knowledgeable about the clinical site's expectations for supervision and progressive autonomy throughout the residency and fellowship experience.

c. Ensures that clinical staff members other than physicians escalate concerns when supervision policies and procedures are not followed at the clinical site.

SUPERVISION Pathway 5: Clinical site monitoring of resident and fellow supervision and workload

The clinical learning environment:

a. Maintains information systems, accessible by the clinical care team, to verify the level of supervision required for residents and fellows to perform specific patient procedures.

b. Monitors the use of systems to verify the level of supervision required for residents and fellows to perform specific patient procedures.

c. Ensures that mechanisms are in place to systematically monitor and expeditiously address potential patient care vulnerabilities due to resident and fellow supervision.

STEPS FOR PROGRAMS

1: Identify the Procedures

Identify the bedside procedures specific to your program for which a resident can be granted the autonomy to perform with indirect supervision. This will include technical procedures, such as:

- Lumbar Puncture
- Endotracheal Intubation
- Drawing an ABG
- Placing a Central Venous Line
- Suturing/excision of lesion

It can also include cognitive procedures, such as:

- Running a Code
- Evaluation and Management of Emergency Presentations

(For some programs, this list will include procedures for which a trainee will always require direct supervision, but you need to verify readiness for autonomous practice upon graduation.)

2: Outline the Process for establishing competence

a) The process the program will utilize during the assessment meeting to:

- Assess and document an individual resident's achievement of competence to perform a particular procedure without direct supervision
- Assess and document an individual resident's maintenance of competence over time
- Ensure that residents who have been given clearance to perform a procedure with indirect supervision know when they must involve their attending or senior resident.

Assessment of individual resident or fellow's competence in performance of specific procedures can be integrated into regular Clinical Competency Committee (CCC) meetings or Milestone Assessment meetings. At the time of an ACGME site visit, a program is asked to outline the above steps very specifically, so it is our standard for this endeavor. Read it very carefully to ensure that your process for verification of competence includes all three of the above things and that it is transparent and easily accessible to faculty, trainees and (especially) CCC members.

b) The minimum required assessment of a resident's procedural competence include the following:

- direct observation of performance
- feedback and deliberate practice
- faculty assessment of performance
- The assessment must be made using an instrument for which faculty development has been provided.

Clinical experiences and focused educational models may be aspects of assessment for procedural competence, but they cannot substitute for direct observation.

Attainment of a given PGY level cannot be the sole basis for competence.

If part of your program's assessment is successful completion of a certain number of procedures under supervision, you must state how "successful completion" is defined. A commonly used standard is "Resident performed all steps of procedure competently with little or no intervention from supervisor". You must also have a process in place to ensure that the faculty responsible for assessing successful completion are familiar with the assessment tool and expectations. Programs use a variety of platforms to document directly observed performance of procedures. Making sure that residents and faculty have easy access to the tools and are completing them in real time is vital.

For assistance and/or advice on maximizing New Innovations to capture direct observation please reach out to Julie Rhodes in the OGME. 217-545-3134 jrhodes@siumed.edu

c) Educational experiences, providing opportunity for direct observation of residents' performance of the procedure might include:

- Skills lab
- Focused educational modules related to the procedure (Verification of Proficiency (VOP) modules)
- Completion of designated clinical rotations
- Reflection and self-assessment exercises

d) The following faculty assessment tools are encouraged to obtain objective data:

- Procedural Competency Assessment Tools (PCATs)
- Checklist with directly observed workplace procedures (Mini CCX tools)
- Checklist with faculty review of videotaped skills lab procedures

3: Develop and maintain a document for tracking and distribution

In order to make this process transparent to residents, faculty, site visitors, nursing staff and other stakeholders and to make information on each resident's procedural autonomy accessible to all, you must develop and implement a method for tracking, documenting and disseminating the procedural autonomy for each of your trainees for each of the procedures you have identified in Step 1. Programs are not required to use a designated format for this purpose, but are highly encouraged to make it user friendly, easily shared, and accessible by program administration. This document should be updated regularly (at least every 3 to 6 months) and shared on a recurring basis with trainees, faculty and nursing staff. It is imperative that the data be up to date. For some clinical sites, we will be able to upload and monitor this data in the hospital privileging system.

You may combine Steps 1-3 into one document or keep them separate. *The important thing is that any faculty, CCC member, program staff member or resident should be able to easily locate the information when asked.*

See APPENDIX 1 for examples of how to organize and document your information.

APPENDIX 1

1. EXAMPLE OF PROCEDURAL AUTONOMY PROCESS

Materials for CCC Review				
Procedure	**Method**	**Direct Observation Instruments**	**Maintenance of Competence (All include absence of critical incidents)**	**Must call Attending/Senior (All include unstable patient, resident unsure of skills in clinical situation)**
Lumbar Puncture	Educational/VOP Module Performed successfully under Direct Supervision x 2	*List instruments*	Perform successfully under Direct Observation 1 year and 3 years after autonomy granted	Patient BMI > 30
Central Venous Line Placement	Educational Module/VOP Pass VOP Skills Test			
Management of cardiac or respiratory arrest (run a code)	Current ACLS Certification Successful Completion of Critical Care rotations PGY level 4 or 5			
Excision of Lesions of the Skin and Subcutaneous Tissues	Performed successfully under Direct Supervision x 2			
Endotracheal Intubation	Current ACLS Certification Educational/VOP Module Pass VOP skills test Performed successfully under Direct Supervision X 10			
Paracentesis	Performed successfully under Direct Supervision x 5			

Once Procedural Autonomy is granted:

How is the Resident informed: *At semiannual review, resident is given list of procedures with autonomous practice privilege noted*

How are faculty informed*: Every 6 months list of procedures with autonomous residents updated and distributed to faculty*

How are other providers (Nursing, etc) informed? *Hospital X: Info entered into physician credentialing portal. Hospital Y: Every 6 months list of procedures with autonomous residents updated and distributed to charge nurse, uploaded in NI, etc.*

How does resident know when they must involve their attending or senior resident? *Listed on Autonomy notification sheet; outlined in supervision policy*

2. EXAMPLE OF RESIDENT TRACKING SHEET

Requires Direct Supervision	Has Successfully Met Program Criteria for Procedural Autonomy	Granted Procedural Autonomy	Maintenance of Competence
1	2	3	4

Competency/Procedure	Resident 1	Resident 2	Resident 3	Resident 4	Resident 5
Lumbar Puncture	1	2,3	2*		
Central Venous Line Placement	1	2*	2,3		
Management of cardiac or respiratory arrest (run a code)	1	2,3	2,3,4		
Excision of Lesions of the Skin and Subcutaneous Tissues	2, 3	2,3,4			
Endotracheal Intubation	1	2,3,4			

*Completed requirement, CCC has not yet met to review

Measurable Assessment Tools

NI procedure logger:

Programs can customize the Roles of the resident/fellow in their Procedure Logger module by creating new or editing existing roles to reflect the resident's ability as observed during the faculty member's direct observation.

Some possible role language would be:

- **Direct Supervision** *The supervising physician is physically present with the resident during the key portions of the patient interaction*
- **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.*
- **Oversight** *The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.*
- **Show and Tell** *The attending is demonstrating the procedure to the trainee*
- **Active Help** *The attending is leading the resident through the case*
- **Passive Help** *The resident leads the case while the attending provides skilled assistance*
- **Supervision Only** *The attending is providing essentially no guidance to the resident who is typically performing the case with a less skilled assistant.*

PROS:

- Can document procedural experience and direct observation at the same time.
- Can coordinate role language with other instruments (the language above is used by SIMPL and ACGME apps)
- Can customize role language

CONS:

- Duplicative for programs that use ACGME WebADs case logs and/or other logging/feedback apps
- Since the resident selects their role, the faculty cannot change this, it will be imperative that programs educate their residents and faculty to ensure common understanding of the scope of each role.
- Cumbersome for faculty to document targeted skill assessment into Procedure Logger

NI On-Demand Evaluations:

Programs can create an on demand evalution for their direct observation assessments. The evaluations can be tailored to program and assessment.

PROS:

- Can tailor assessment items and likert scale to each identified procedure
- Faculty can document both level of supervision and assessment in same instrument
- On Demand, so can be generated in (relatively) real time by the faculty (evaluator) or resident (subject)

CONS:

- Up front time to develop instruments and set up on demand sessions in NI