

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 Annelisa Herter in the OGME. 217-545-3134 aherter@siu.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 through a secure platform (not Google drive, third party sites, etc.) 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.