

	Name of Policy: Southern Illinois University and Affiliate Hospital Policy on Patient Care Activities and Supervision Responsibilities for Graduate Medical Education Trainees and Attending Physicians	
	Last Approval Date: June 21, 2019	Effective Date: July 1, 2019

Purpose

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

This policy will establish the minimum requirements for trainee supervision in clinical sites in which SIU School of Medicine residents and fellows train. An affiliated hospital or clinical site may have additional requirements for supervision as they pertain to that specific hospital. Individual training programs may also have additional requirements for their faculty/attendings and trainees.

Section I. Definitions

Trainee: A physician who participates in an approved Graduate Medical Education (GME) program. This term includes interns, residents and fellows in any GME program approved by the SIU GMEC, regardless of ACGME accreditation status.

Attending Physician: A licensed, independent practitioner who holds admitting and/or attending physician* privileges consistent with the requirements delineated in the bylaws of the affiliated hospital and/or SIU School of Medicine.

Full Time Faculty: An attending physician who is employed by SIU School of Medicine.

Community Faculty: An attending physician who is not employed by SIU School of Medicine, but has been granted privileges to teach and supervise residents by the individual residency program.

*Occasionally, supervision is provided by a licensed, independent practitioner from a discipline other than medicine (i.e. midwives, dentistry/oral surgery, etc). Supervision standards and expectations are the same as for Attending Physicians.

Section II. Program Responsibilities

It is the responsibility of individual program directors to:

1. Approve the selection and ongoing participation of teaching faculty at all teaching sites. (whether Full Time or Community).
2. Monitor resident supervision at all teaching sites.
3. To promote oversight of resident supervision while providing for graded authority and responsibility, ensure that the program uses 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.

Initially, PGY-1 residents must be supervised either directly, or indirectly with direct supervision immediately available.

4. Establish and implement protocols describing how PGY-1 residents are determined to have met a level of competence sufficient to progress to Indirect Supervision with Direct supervision available.
5. Ensure that faculty supervision assignments are of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility.
6. Establish written policies describing trainee roles and responsibilities at each level of training for their residency programs.
7. Establish written policies on how residents are determined to have met a level of competence in specific procedures sufficient to perform that procedure in the absence of direct supervision. (See Section V.)
8. Ensure that these policies are in compliance with requirements of the ACGME, the Joint Commission, CMS and the by-laws of affiliated hospitals, and are distributed annually (in writing or electronically) to all residents and all full time and community faculty for each residency program.
9. Review and update annually a listing of procedures pertinent to that specialty with an indication of the requirements for performing an activity with and without direct supervision. (See Section V).
10. Establish a written program-specific supervision policy consistent with this institutional policy and the respective ACGME Common and specialty/subspecialty-specific Program Requirements. (See Appendix A)
11. Review annually the program supervision policy to ensure that it is in compliance with accrediting agency standards for both graduate medical education and for all training sites.
12. Ensure that all attending physicians (whether full time or community faculty) are educated annually regarding appropriate supervision standard requirements, physical presence requirements and documentation requirements.
13. Ensure that residents/fellows can report inadequate supervision in a protected manner that is free of reprisal.

14. Establish written policies describing the program requirements for promotion to the next level of training. The program director, with input from the program's Clinical Competence Committee, will determine at least annually whether each resident has progressed satisfactorily to advance to the next level of training and/or demonstrated the skills necessary to supervise junior residents.

Section III. Medical Staff Responsibilities

In all clinical sites participating in GME training, the medical staff has a defined process for supervision of each trainee in carrying out patient care responsibilities. Such supervision will be provided by an attending physician with appropriate clinical privileges with the expectation that the trainee will develop into a practitioner who has the knowledge, skills, experience and abilities to provide care to patients within the scope of their training program.

The medical staff has overall responsibility for the quality of the patient care provided by individuals with clinical responsibilities. In this way, the medical staff assures that each participant in a GME program is supervised in their patient care responsibilities by a member of the medical staff who has been granted clinical privileges through the appropriate medical staff process.

Section IV. Attending Physician Responsibilities

The supervising attending is ultimately responsible for the care of the patient who is under their plan of treatment. The level or type of supervision required by trainees in various levels of training must be consistent with progressively increasing resident responsibility during a training program as well as ACGME supervision requirements and common standards of patient care, based on the needs of the patient and the skills of the trainee.

The degree of attending involvement in patient care will be commensurate with the type of care that the patient is receiving and the level of training, education and experience of trainee(s) involved in the patient's care. The intensity of supervision required varies by specialty, level of training, the experience and competency of the trainee, and the acuity of the specific clinical situation. An attending physician may provide less direct personal care of a patient seen for routine care or when supervising a senior trainee, and should provide more direct personal care of a patient receiving complex care or when supervising a junior level trainee. An attending physician may authorize the supervision of a junior trainee by a more senior trainee who is receiving supervision based on the attending physician's assessment of the senior levels trainee's experience and competence, unless limited by regulation.

All patients seen by the trainee will have an assigned attending physician. At a minimum the attending physician is expected to:

1. Exercise responsibility and control over the care rendered to each patient by a trainee.
2. Document the degree of participation in patient care in accordance with CMS, the Joint Commission and hospital/clinic policies.
3. Effectively role model safe, effective, efficient and compassionate care and provide timely documentation to program directors for their use in trainee assessment and evaluation.
4. Be knowledgeable of the individual program policies and procedures regarding resident supervision, assessment and advancement as outlined in Section II.
5. Provide timely feedback to the resident regarding their clinical interaction with the patient.

Section V: Procedures

Residents will be supervised by attending physicians who must be credentialed in that setting or hospital for the specialty care and diagnostic and therapeutic procedures for which they are providing supervision.

Each program should establish written policies determining the level of competence in specific procedures sufficient to perform that procedure in the absence of direct supervision (i.e. resident credentialing). These policies should include:

1. The criteria by which the program will determine that the resident has successfully completed the procedure.
2. The level of training in which residents are expected to achieve competency in doing each procedure.
3. Whether the procedure requires direct supervision or indirect supervision.
4. The method by which the resident will receive feedback about the procedure that communicates general competency strengths and areas needing improvement.

The program director for each Springfield program will complete a listing of procedures pertinent to that specialty with an indication of the required level of supervision for each procedure. Each year, the program director will review and update the procedures list as needed and submit it to the Associate Dean for Graduate Medical Education so that it can be provided to affiliate training sites.

Section VI: Supervision of Trainees in the Inpatient Setting

The attending physician or provider has the primary responsibility for the medical diagnosis and treatment of the patient. Trainees may write daily orders on inpatients. 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 their senior resident or attending staff physician as appropriate. Attending staff may write orders on all patients under their care. Trainees will follow all local hospital policies regarding the writing of both verbal and written orders.

The attending physician on the *primary* service will personally see all hospitalized patients at least once daily.

The attending physician on *consultative services* will personally see patient for initial consultation within the specified time frame (usually 24 hours) and thereafter frequently enough to ensure safe and appropriate patient care, until the time of sign-off. When patients are acutely unwell, and/or the trainees are junior or off-service learners, this may necessitate daily attending visits.

The attending physician will, at a minimum:

- 1) Examine the patient within 24 hours of admission, when there is a significant change in patient condition or as required by good patient care.
- 2) Review the patient's history, the record of examinations and tests, and make appropriate reviews of the patient's progress.
- 3) Confirm or revise the diagnosis made by the trainee and determine major changes in the course of treatment to be followed.
- 4) Either perform personally the physician services required by the patient or supervise the treatment so as to assure the appropriate services are provided by trainees and that the care meets the proper quality level.
- 5) For surgical or other complex, high risk medical procedures, the attending physician must be immediately available to assist the trainee who is under the attending physician's direction.
- 6) Make decisions to authorize or deny any admissions, discharges or transfers.

- 7) Sign all DNR orders, or document appropriate involvement in the decision.
- 8) Assure that a properly completed, signed and witnessed consent form is obtained and placed in the patient's record prior to the performance of any operative or invasive procedure.
- 9) Assure that supervision of care for inpatients is documented in the patient record. It is the attending physician's responsibility to see that all documentation must be in accordance with appropriate regulations and the standards of good patient care and must provide evidence in writing of supervisor concurrence with the admission, history, physical examination, assessment, treatment plan and orders.
- 10) Document appropriate attestation and/or sign all residents' notes in EHR.

Section VII: Supervision of Trainees in Outpatient Clinics

All outpatient visits provided by trainees will be conducted under the supervision of a staff provider who has full responsibility for the care provided. The extent and duration of the attendings physical presence will be variable, depending on the nature of the clinical situation and the level of training and capabilities of the trainee. The responsibility or independence given to trainees depends on their knowledge, skills and experience as judged by the responsible attending physician. The attending physician supervisor must be designated and be available in accordance with all ACGME institutional and program requirements and CMS standards and specific departmental policies.

Section VIII: Supervision of Trainees in the Emergency Department

All trainees within the Emergency Department must be under the supervision of qualified emergency medicine attendings. When residents from other services provide care to patients in the emergency department, they must be supervised by emergency medicine attendings or by faculty from their service.

Section IX: Supervision of Trainees in the Operating Room

The attending physician must be present in the operating room for the key or critical portion of all cases and must remain in immediate proximity and available to return to the procedure immediately if needed. ("Immediate proximity" is generally defined as within the OR Suite and immediately available to return to the operating room if needed). If the attending physician leaves the OR Suite after the completion of the key portion of the procedure or another case would prohibit them from returning to the original case, the attending physician must make arrangements with another physician to be immediately available for the original case.

It is the attending surgeon's responsibility to obtain written informed consent that is in compliance with all CMS, the Joint Commission and hospital regulations, including the role of the resident/fellow in the surgery or procedure.

Section X: Supervision of Trainees in Labor and Delivery

Supervision of labor and delivery must be immediately available. When risk factors are present there must be on-site supervision. If this supervision is provided by anyone other than an attending physician, there must be documentation of the skill of the non-attending physician supervisor to function competently in this capacity. Backup plans or emergency consultative arrangements must be made in case the supervising provider encounters a clinical situation or emergency outside of the scope of their practice.

Section XI. Supervision of Trainees via Telehealth

Resident supervision via Telehealth must meet all of the parameters outlined in this document. Instances of Telehealth supervision in which the resident and supervising physician are at physically

distant sites must be approved by the **Director of SIU TeleHealth Services** and the Associate Dean for GME.

Section XII: Oversight of Supervision

Any trainee, attending, or staff member will have the opportunity to report instances of inadequate supervision in a protected manner that shall be free from reprisal. Concerns about inadequate supervision may be received via a number of mechanisms, including:

- Verbally, to program director, DIO or SIU HC CMO
- Via the Patient Safety reporting mechanism at the site at which the event occurred
- Via the Office of Graduate Medical Education website
- Via the CMO/CPE at site at which event occurred, following a critical incident, RCA or verbal or written report

Inadequate supervision will not be tolerated. Any instance of inadequate supervision that involves direct patient care will be addressed promptly, utilizing the existing policies, protocols and systems in place for standards of physician conduct at the clinical sites. Information will be shared between the clinical site and SIU SOM personnel (Department Chair, Human Resources staff, Program Director, DIO, etc.) as necessary and as allowed by law and by affiliation agreements to ensure that inadequate supervisory behaviors are addressed and resolved.

Any instance of inadequate supervision that does not involve direct patient care (i.e. unclear supervisory expectations, sub-par learning environment, etc.) will be addressed by the program director.

Supervision by SIU SOM faculty

If an instance of inadequate supervision by a SIU SOM faculty member occurs at a hospital site, it will be addressed utilizing the existing policies, protocols and systems in place for standards of physician conduct by the hospital. The SIU HC Chief Medical Officer will liaise with the hospital CMO/CPE to coordinate the most appropriate manner to address the behavior and to ensure that the appropriate SIU SOM personnel are informed of the resolution. Whenever possible, feedback given to SIU GME personnel will be confidential or in aggregate.

If an instance of inadequate supervision occurs at an SIU HC clinic, it will be addressed via SIU HC standards of conduct under the direction of the SIU HC CMO.

Supervision by SIU senior residents

Any instance of inadequate supervision by a senior resident will be addressed by the Program Director, who will work in conjunction with the hospital CMO/CPE to coordinate the most appropriate manner to address the behavior and to ensure that the appropriate SIU SOM personnel are informed of any resolution.

Supervision by community faculty

If an instance of inadequate supervision by a community faculty member occurs at a hospital site, it will be addressed utilizing the existing policies, protocols and systems in place for standards of physician conduct by the hospital. The hospital CMO/CPE will work in conjunction with the Program Director or DIO to coordinate the most appropriate manner to address the behavior and to ensure that the appropriate SIU SOM personnel are informed of any resolution.



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Trainees and Attending Physicians**

APPENDIX A

The Sponsoring Institution must ensure that each of its ACGME-accredited programs establishes a written program-specific supervision policy. Each programs' supervision policy must:

- 1) Be consistent with the institutional policy and the respective ACGME Common and specialty/subspecialty-specific Program Requirements. (IR IV.1.2s)
- 2) Outline the process and standards-based criteria by which 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. (CPR VI.A2d-d3)
- 3) 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. (CPR VI.A.2.e). These circumstances and events must include, at a minimum:
 - Patient admission to hospital (may restrict to unplanned if applicable)
 - Patient death (may restrict to unexpected if applicable)
 - Patient signs out AMA or other unplanned discharge
 - Transfer of patient to higher level of care (i.e. floor to IMC, IMC to ICU, etc.)
 - Medication/treatment error requiring intervention
 - Patient experiences an adverse outcome regardless of cause
 - End of Life decisions or DNR orders
 - Patient requires intubation or ventilatory support (may restrict to unplanned if appropriate)
 - Patient codes or Rapid Response Team is called and results in transfer to higher level of care or change in treatment plan
 - Significant change in clinical status (should expand per specialty)
 - Any clinical problem requiring an invasive procedure or surgery (may restrict to not previously discussed with attending if applicable)
 - When requesting a consultation not previously discussed
 - Family, legal or systems issues
 - Any resident or fellow uncertainty about the patient's care plans or goals
 - Residents must communicate with the RPD (or DIO) the following:
 - Feels uncomfortable or unsure of their ability to perform a procedure or patient care activity with the level of supervision provided
 - Situations in which they feel their safety is threatened
 - Situations in which they personally feel impaired or witness others working while impaired
 - Perceives that patient safety is at risk
- 4) Outline the circumstances and timeframe in which the attending must be contacted (i.e. immediately, the next morning, etc.) when residents are supervised indirectly (i.e. week-ends, ED, or consults).