XIII. Policy on Supervision of Residents *Revised 4/13/2022*

I. References

In accordance with Section IV.J of the ACGME Institutional Requirements, the Sponsoring Institution must maintain an institutional policy regarding the supervision of residents and must ensure that each of its ACGME-accredited programs establishes a written, program-specific supervision policy consistent with the institutional policy and the respective ACGME Common Program and Specialty/Subspecialty Requirements. In accordance with Section III.B.4 of the ACGME Institutional Requirements, the Sponsoring Institution must oversee supervision of residents consistent with an institutional and program-specific policies and mechanisms by which residents can report inadequate supervision and accountability in a protected manner that is free from reprisal.

II. Purpose

Every physician shares in the responsibility and accountability for their efforts in the provision of patient care. This Policy on Supervision of Residents is adopted to ensure that each residency program that is sponsored by the Tulane University School of Medicine defines, widely communicates and monitors a structured chain of supervision and accountability as it relates to the supervision of patient care.

III. Definitions

1. Conditional Independence: graded, progressive responsibility for patient care with defined oversight.
2. Direct Supervision: the supervising physician is either (a) Physically Present with the resident during key portions of the patient interaction, or (b) ***if permitted*** by a residency program's applicable ACGME Review Committee and the supervision policy of the specific participating site, the supervising physician and/or patient is not Physically Present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.
3. Indirect Supervision: the supervising physician is not Physically Present or providing concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate Direct Supervision.
4. Levels of Supervision: Direct Supervision, Indirect Supervision, or Oversight, as set forth in this Policy and the ACGME Common Program Requirements.
5. Milestones: the descriptions of performance levels residents are expected to demonstrate for skills, knowledge and behaviors in the six core competency domains, as set forth in the ACGME Glossary of Terms.
6. Physically Present: the teaching physician is located in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service.
7. Oversight: the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

IV. Supervision of Residents

A. Supervision Requirements and Progressive Authority

1. Residency Program Supervision Policies: Each residency program must develop a supervision policy for its program that is consistent with this Policy and the ACGME Common Program and Specialty/Subspecialty Requirements. Each residency program must: (a) define when Physical Presence of a supervising physician is required, consistent with the program's ACGME Review Committee requirements, and (b) set guidelines for circumstances and events when residents must communicate with the supervising faculty member(s). It is the responsibility of each resident to know the scope of their authority and the circumstances under which the resident is permitted to act with Conditional Independence.

2. Supervision Responsibilities - Generally: Proper supervision of residents is expected at Tulane Medical Center and at each program participating site to ensure consistently high standards of patient care. Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable ACGME Review Committee) who is responsible and accountable for the patient's care and who is listed as the physician in charge of the patient's medical treatment in the patient's medical record. Information regarding the attending physician (or licensed independent practitioner) must be made available to residents, faculty, other members of the healthcare team and patients. When providing direct patient care, it is the responsibility of the residents and faculty to inform each patient of their respective roles in that patient's care.

3. Levels of Supervision: Each Program Director is responsible for evaluating each resident's abilities based on specific criteria, guided by the Milestones. The Program Director and faculty members must establish the appropriate Level(s) of Supervision for each resident based on the resident's level of training and ability, evaluations and patient complexity and acuity. The Level of Supervision for each resident must be commensurate with the resident's performance in the ACGME core competencies. Levels of Supervision should be documented in the resident's end-of-the-year summative evaluation and promotion letter, if applicable. Residents who fail to meet expected criteria should not be promoted and residents who advance in the residency program should incur progressively greater levels of responsibility. Initially, PGY-1 residents are required to be Directly Supervised. PGY-1 residents can progress to being supervised Indirectly as may be specified by their applicable ACGME Review Committee.

4. Supervision by Faculty: The overall responsibility for the treatment of each patient lies with the faculty (and attending physician if different) to whom the patient is assigned and who supervises the resident. Faculty supervision assignments must be of a sufficient duration to assess the knowledge and skills of each resident and to delegate the appropriate level of patient care authority and responsibility. Faculty must be involved in the care of the patient to the extent necessary to assure consistently high standards of patient care and faculty shall delegate portions of care to residents based on the needs of the patient and skills of each resident. The faculty member assigned to a patient is responsible for, and must be familiar with, the care provided to the patient, and is expected to fulfill this responsibility, at a minimum, in the following manner:

a. Direct the care of the patient and provide the appropriate Level of Supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, the experience and judgment of the resident being supervised and within the scope of the approved clinical privileges of the staff practitioner;

b. Document this supervision via admission, operative, procedure or progress notes, or an acceptable linking-note to the resident's documentation. The faculty member's involvement in the patient's care and supervision of the resident should be reflected in both the resident's note and the faculty's addendum;

c. Assure that all technically complex diagnostic and therapeutic procedures which carry a significant risk to the patient are: medically indicated; fully explained to and understood by the patient to meet informed consent criteria; and properly executed, correctly interpreted, and evaluated for appropriateness, effectiveness and required follow-up. Evidence of following these procedures should be documented; and

d. Direct appropriate modifications of care as indicated in response to significant changes in diagnosis or patient status. Evidence of this assurance should be documented.

5. Supervision by Senior Residents: For certain aspects of patient care, the supervising physician may be a more senior resident who can serve in a supervisory role to the resident in recognition of the resident's progress towards independence. Other portions of care provided by the resident may need to be supervised by a Physically Present supervising physician or by an appropriately available supervising faculty member or senior resident, either in the institution, or by means of telecommunication technology. The privilege of progressive authority and responsibility, Conditional Independence, and a supervisory role in patient care must be assigned by each resident's Program Director and faculty members.

B. Setting-Specific Supervision Requirements

1. Supervision of Residents Performing Invasive Procedures in the Operative Suite: The inherent risks associated with all types of surgery and invasive procedures require that faculty provide an appropriate Level of Supervision to the resident performing the procedure.

   a. For all invasive procedures performed by residents in the operating room or procedural suite, faculty must provide Direct Supervision.

   b. Faculty supervising residents will review the indications for the procedure and document in the patient's medical record their concurrence with the indication, risks and benefits, the resident's performance, the interpretation of the results and the complications, if any.

   c. Faculty will supervise residents performing the evaluation of patients, scheduling of cases, assignment of case priorities, the preoperative preparation and the intra-operative and postoperative care of surgical patients and patients undergoing invasive procedures. This supervision will be reflected in the faculty member's progress notes at appropriate times in the course of each patient's hospitalization.

   d. As residents advance in their education and training, the Level of Supervision provided by the faculty member may change. A greater degree of responsibility and autonomy provided to a resident during surgical/invasive procedures will depend upon the resident's general aptitude, demonstrated competence, prior experience with similar procedures, the complexity and degree of the risks involved in the anticipated

surgical/invasive procedure. Program Directors are responsible with documenting the assigned Level of Supervision for each resident in the resident's record. This will include the types of diagnostic or therapeutic procedures the resident may perform, the degree of autonomy afforded to the resident in performing those procedures and those procedures for which the resident may act as a teaching assistant.

e. As a general rule, senior residents, when acting in the role of a supervising physician to a less experienced resident, may supervise the performance of surgical/invasive procedures of lesser or more routine complexity; however, this does not release the faculty member's responsibility to oversee the patient's care. When a resident is acting in a supervisory role to another resident, the faculty member remains responsible for the quality of care of the patient, providing appropriate supervision and meeting medical record documentation requirements as required by this Policy.

2. Supervision of Residents Performing Invasive Procedures at the Bedside: If a resident has demonstrated competence in an invasive procedure performed at a patient's bedside, a faculty member does not need to be Physically Present unless Physical Presence is a requirement of the program's ACGME Review Committee. However, the faculty member remains ultimately responsible for ensuring that the procedure is safely performed, which includes reviewing with the resident the indications for the procedure. Faculty must document in the patient's medical record their concurrence with the indication, risks and benefits, the resident's performance, the interpretation of the results and the complications, if any.

   a. All bedside procedures and incidental resident tasks must be Indirectly Supervised and some procedures and tasks must be Directly Supervised. The decision as to which residents are able to perform which procedures and cognitive tasks without Direct Supervision is made by the Program Director and faculty based on the resident's performance, as assessed by the Clinical Competency Committee.

   b. Program Directors must maintain a list of invasive bedside procedures and tasks that can be performed by program residents without Direct Supervision.

      i. Program Directors and faculty, with direction from the Clinical Competency Committee's assessment, will assign to each resident which invasive bedside procedures the resident can perform without Direct faculty or senior resident supervision. This assignment is not based solely upon the resident's PGY status, but rather assigned individually based upon the resident's aptitude, demonstrated competence and prior experience with the procedure in question.

      ii. The Clinical Competency Committee will create an a priori criteria by which the Committee will determine which residents are competent to perform invasive bedside procedures and other tasks without Direct Supervision. This criteria will include minimum numbers of successful procedures/tasks, a review of such procedures in a procedure log, and additional criteria (i.e., simulation center training) as determined by the Clinical Competency Committee.

      iii. The Program Director is responsible for communicating this criteria to the GME office for review. Any changes in the criteria will require a re-review by the GMEC.

iv. At the end of each semester, the Program Director will provide an updated list of the individual residents who have been determined to perform the various procedures/resident tasks without Direct Supervision to the participating sites for that residency program and to the GME Office.

C. Transitions of Care

1. Residency programs are required to design clinical assignments to optimize patient care transitions, including their safety, frequency and structure. In order to facilitate both continuity of care and patient safety, residency programs must ensure and monitor effective, organized hand-over processes and residents must be competent in communicating with team members in the hand-over process.
2. Program Directors must educate core faculty members and residents regarding effective transitions of care. This instruction should include:
    a. The principles and purpose of close-loop communication;
    b. Appropriate identification of illness severity;
    c. Appropriate patient summaries, as defined by the patient's complexity and tenuousness;
    d. Appropriate action lists, as defined by the patient's complexity and tenuousness;
    e. The importance of in-person sign-in and sign-out of patients who will require on-going care via a colleague (i.e., a night-float resident);
    f. Where to locate/identify the component of the written (or electronic) sign-out form that ensures patient safety;
    g. The importance of timely completion of documents essential to facilitating successful transitions of care from one arena to the next; and
    h. Situational awareness and contingency planning.
3. Attending physician and resident schedules for those who are responsible for care must be maintained and communicated by residency programs and clinical sites. Program Directors, in collaboration with the DIO, must ensure that participating sites engage residents in standardized transitions of care consistent with the setting and type of patient care.

    a. PGY-1 residents must be Directly Supervised in their transitions of care (i.e., sign-out) by senior residents or faculty until which time the Program Director has determined that the PGY-1 resident can safely conduct transitions of care.

    b. Program Directors, working with site directors, must ensure that PGY-1 residents are Directly supervised in their transitions of care (i.e., sign out) until which point the Program Director is satisfied that the PGY-1 resident has demonstrated sufficient mastery of transition communications to warrant transition of care duties without Direct Supervision.

D. Reporting Fall-Outs in Supervision

1. The School of Medicine, in collaboration with the GME office, recognizes that the clinical environment can be complex and dynamic on a day-to-day basis. Nonetheless, there should

not be an occasion in which residents are inadequately supervised or in a position where they believe their clinical responsibilities are above their own abilities.

2. Residents and faculty are responsible, regardless of whether they were directly involved in the incident or not, to report events of inadequate supervision. Residents and faculty may report these events without fear of negative consequences or reprisal.
3. Residents and faculty should report events involving inadequate supervision via one or more of the following mechanisms:
    a. Direct reporting to attending physicians, Program Directors, Chief residents, departmental Chairs, the GMEC, the GME office or DIO; and/or
    b. The University's Professionalism Reporting Platform https://medicine.tulane.edu/education/professionalismenvironment-learning-program.

V. References/Associated Policies

- Tulane University School of Medicine, Graduate Medical Education *X. Policy on Core Curriculum and the Core Competencies*
- Tulane University School of Medicine, Graduate Medical Education *XIV. Policy on Evaluation and Promotion*
- Tulane University School of Medicine, Graduate Medical Education *XXII. Policy on Program Evaluation, Improvement, and Annual Program Reporting*
- Tulane University School of Medicine, Graduate Medical Education *XV. Policy on Remediation, Suspension, Dismissal and Grievance*
- Tulane University School of Medicine, Graduate Medical Education *I. Policy on Resident Eligibility and Selection*
- Tulane University School of Medicine, Graduate Medical Education *II. Policy on Equal-Opportunity, Affirmative Action, and Disabilities*
- Tulane University School of Medicine, Graduate Medical Education *VI. Policy on Moonlighting*
- Tulane University School of Medicine, Graduate Medical Education *VIII. Policy on Clinical and Educational Work Hours*