

SUPERVISION

Effective Date:

Sept. 2015


Reviewed:

POLICY:

It is the policy of Mercy Medical Center Residency Programs to support and enforce the resident supervision requirements set by accrediting bodies.

The following are common program requirements for supervision of residents:

1. 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.
 - a. This information should be available to residents, faculty members, and patients.
 - b. Residents and faculty members should inform patients of their respective roles in each patient's care.
2. The program must demonstrate the appropriate level of supervision is in place for all residents who care for patients.
3. Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care.
4. Levels of Supervision
 - a. To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:
 - (1) Direct Supervision – the supervising physician is physically present with the resident and patient.
 - (2) 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 Director 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.
 - (3) Oversight – the supervising physician is available to provide review of procedures/ encounters with feedback provided after care is delivered.
 - b. 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.
 - (1) The program director must evaluate each resident's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.
 - (2) Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.

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(3) 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.

- c. 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. (See S.U.P.E.R.V.I.S.I.O.N general guidelines.)

Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

In particular, PGY-1 resident should be supervised either directly or indirectly with direct supervision immediately available.

- d. 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.

The following general "S.U.P.E.R.V.I.S.I.O.N." guidelines have been established for Mercy Medical Center Residency Programs. It is stressed that residents should never feel intimidated or belittled when asking for assistance.


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- S.** Safety of the patient as well as safety of the resident are of paramount importance. The medical center will not compromise the safety of a patient in any way. All patient care will be supervised by the attending faculty to varying degrees to allow for increasing autonomy and growth of the resident. It is the Graduate Medical Education Committee's goal to create a nurturing environment where residents may feel safe and secure at all times while gaining independence. A faculty member is always assigned to supervise the residents.
- U.** Ultimate responsibility resides with the attending physician who supervises all resident activities. All clinical work is done under the supervision of an attending faculty. While the degree of supervision in any given examination/procedure will vary with the particulars of the event, as well as the level of the training of the resident, the ultimate responsibility for the written report created is that of the attending faculty.
- P.** Personal responsibility and accountability. Residents and faculty are expected to hold themselves up to the highest standards. Professionalism should be maintained at all times. It is understood that at times errors will be made. It is also understood that these errors should serve as learning points as to avoid them in the future.
- E.** Expiration. It is inevitable that at some point in a resident's career they will have to deal with the death of a patient. In this event the resident will notify their senior resident and attending immediately. Resident will be given proper training in regards to end of life issues, death pronouncements, communicating death to families and necessary paperwork. Attending faculty will be available at all times to provide support to residents following the death of a patient.
- R.** "Ready or Not." PGY-1 residents will participate in a supervisory evaluation at the completion of their PGY-1 year. The components of the evaluation are program-specific and defined in the attachments below. These evaluations will be scored by supervising faculty. Successful completion of the evaluation will be necessary for the resident to be given supervisory privileges for the upcoming year.
- V.** Vital Signs. All significant change in patient vital signs or mental status will be communicated to the resident's supervisor. Should a patient become unstable at any time, this will be communicated to the attending faculty.
- I.** Invasive procedures. Residents will be supervised by a more senior resident or attending faculty until they are felt competent to perform that procedure independently. Hospital privileging criteria will also be followed.
- S.** Status. Any change in patient status needs to be communicated to the attending faculty. Any change in level of care requiring a change in unit acuity, will be immediately communicated to the attending faculty. Any change in code status will also be relayed to the attending faculty.
- I.** Introductions & Issues. Faculty and residents will introduce themselves and inform their patients of their role in each patient's care. All family or patient issues or concerns will be brought first to the attention of the supervising resident. If resolution cannot be obtained, all issues will be discussed with the attending faculty. Issues that arise between nursing, consulting services, ancillary care, etc. will be brought to the attention of the attending faculty.
- O.** On Call. A printed, emailed or online call schedule is sent out monthly to residents, faculty, patient care floors, and the paging operators. In the event of unforeseen circumstances, such as illness, the resident will be informed by the program director, senior resident or program coordinator if there are changes in the supervising faculty. All faculty will be available during the day and when on call via telephone and/or beeper.
- N.** Notification. Faculty will be notified of all elective and ICU admissions, or transfers from outside hospitals, within 2-4 hours of arrival. All discharges will be discussed with the attending faculty. All changes in care plans will be communicated to the attending faculty. If no covering faculty can be contacted, then the program director or associate program director will be contacted in order to make a final decision on the plan and/or treatment. When the residents are called for consults in the Emergency Department or the wards, the attending faculty will be notified immediately following the resident's evaluation.

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Program-Specific requirements for supervision of residents, including program delineations of tasks by PGY-1 residents to be supervised and evaluation processes used for determining procedural competency and end of supervisory period:

- | | |
|--------------|-------------------|
| Attachment A | Family Medicine |
| Attachment B | General Surgery |
| Attachment C | Internal Medicine |

See also Corporate Policy #11.36, Medical Staff Oversight of Residents.

Signature 


Title

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Attachment A

**Family Medicine Residency Program
Program-Specific Supervision Requirements**

In addition to the common program requirements for resident supervision, the following is provided as delineation of additional program-specific requirements.

Deliveries

There must be on-site supervision in the delivery suite/labor deck by a family physician, an obstetrician or a senior resident. When a resident provides the direct supervision, there must be on-site physician faculty supervision immediately available at the hospital.

- Acceptable supervision for a PGY-I resident caring for a low risk pregnant woman in labor includes: (a) a physician with privileges for providing OB labor & delivery services in the hospital associated with the program, (b) a resident who fulfills written program criteria for the supervision of low risk labor.
- Two residents may take credit for the same delivery if one resident is supervising the other resident. However, only one resident may take credit for the continuity delivery.

Home Visits

Faculty are not required to accompany residents on home visits, but they must be involved with the residents regarding their home visits. This includes reviewing the chart, discussing the case and any required follow-up, evaluating the resident, etc.

Mid-Level Providers

Physician assistants, nurse practitioners, clinical psychologists, licensed clinical social workers, and certified nurse midwives may, on occasion, supervise residents in unique educational setting within the scope of their licensure. Oversight by a faculty physician member during these situations is required.

Supervision of First-Year Residents

Programs must assess the independence of each first-year resident based upon the six core competencies in order to progress to indirect supervision with supervision immediately available.

Various required experiences may necessitate different sets of skills. For example, if a resident is deemed to have progressed to indirect supervision with supervision immediately available while on the family medicine service, this may not be the case in a subsequent required experience if it is the resident's first experience for another rotation such as inpatient pediatrics or surgery.


Examples of Indirect Supervision

With direct supervision immediately available:

- The resident is seeing patients in the family medical center and the supervising physician faculty member in the precepting room is immediately available to see the patient together with the resident as needed.
- The faculty member is in another area of the hospital, but is immediately available to see the patient together with the resident in the labor and delivery department as needed.

With direct supervision available:

- A resident is on call for the family medicine service and needs advice from the physician faculty member in order to manage a patient's care. This can be done either by telephone or electronically. After communication with the resident, if the attending determines additional assistance is needed, the attending physician is available and able to go to the hospital and see the patient together with the resident.

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Family Medicine Residency Program (continued)

Examples of Indirect Supervision (continued)

Oversight:

- A resident is seeing a patient in either the nursing home or at home and the supervising faculty member can then review the patient chart, discuss the case and any required follow-up with the resident, and evaluate the resident.

Optimal Clinical Workload

The program director must ensure resident patient loads are appropriate. The optimal case load will allow each resident to see as many cases as possible, without being overwhelmed by patient care responsibilities, or without compromising a resident's educational experience.

Interprofessional Teams

Nurses, physician assistants, advanced practice providers, pharmacists, social workers, child-life specialists, physical and occupational therapists, respiratory therapists, psychologists, and nutritionists are examples of professional personnel who may be part of the interprofessional teams with which residents must work as members.

"Ready or Not" Criteria for End of PGY-1 Supervision

1. Successful completion of all rotations of PGY-1 year
2. Completion of ACLS, PALS, and NRP
3. Cannot be on any probationary status
4. Recommendation by the resident's advisor for promotion
5. Demonstrated patient management skills during both inpatient and outpatient rotations as observed by the attending faculty
6. Consensus decision by the family medicine faculty during final quarter of first year at Faculty Meeting
7. Review of evaluations by faculty and senior residents on MyEvaluations.com

Criteria for Assessing PGY-2/PGY-3 Readiness to Supervising/Independent Practice

8. Successful completion of all rotations
9. Completion of ACLS, PALS, NRP, ALSO, ATLS and FCCS
10. Cannot be on any probationary status
11. Recommendation by the resident's advisor for promotion
12. Consensus decision by the family medicine faculty at quarterly reviews of resident
13. Review of evaluations by faculty and senior residents on MyEvaluations.com
14. Demonstrated patient management skills and supervisory skills during both inpatient and outpatient settings as observed by the attending faculty.

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Attachment B

**General Surgery Residency Program
Program-Specific Supervision Requirements**

In addition to the common program requirements for resident supervision, the following is provided as delineation of additional program-specific requirements.

All surgery residents are supervised by the attending faculty as well as the more senior residents participating in the care of their assigned patients. The upper level residents will typically be the one to coordinate contact with the attending on patient care issues.

- The critical portions of all procedures performed in the Operating Room are to be carried out under the direct supervision of an attending faculty.
- When supervision is required or requested by the resident, the supervising physician must be physically present at the start of non-emergent tasks. For emergency situations, direct supervision should be available within 15 minutes.
- Residents may not discharge patients without the consent of the attending faculty.

Residents will be instructed on patient care team dynamics and development, on time management, on communication and patient handoffs, and on signs and symptoms of fatigue as well as work hour limits. They will function on multi-disciplinary care teams at Mercy-DM (attending surgeons, residents at various PG levels, medical students, and other health care providers) and will be expected to perform work based on level of education, experience, and competence. Examples are OR Teams, Trauma Response Teams, as well as other patient care rounding teams.

Level	Description/Defined Tasks	Supervisors				
		Attending	PGY-5	PGY-4	PGY-3	PGY-2
PGY-1	<p>Required to complete Fundamentals of Surgery simulation curriculum prior to September 30.</p> <p>All residents may be supervised indirectly for the following tasks:</p> <p><u>Patient Management Competencies</u></p> <ol style="list-style-type: none"> 1. E&M of a patient admitted to hospital, including initial H&P exam, formulation of a plan of therapy, and necessary orders for therapy and tests. 2. Pre-op E&M, including H&P exam, formulation of a plan of therapy, and specification of necessary tests. 3. E&M of post-op patients, including the conduct of monitoring, and orders for medications, testing, and other treatments. 4. Transfer of patients between hospital units or hospitals. 5. Discharge of patients from the hospital. 6. Interpretation of laboratory results. <p><u>Procedural Competencies</u></p> <ol style="list-style-type: none"> 1. Performance of basic venous access procedures, including establishing intravenous access. 2. Placement and removal of nasogastric tubes and Foley catheters. 3. Arterial puncture for blood gases. <p>First year residents must have direct supervision throughout their first year and then until competency is demonstrated for the following tasks:</p> <p><u>Patient Management Competencies</u></p> <ol style="list-style-type: none"> 1. Initial E&M of patients in the urgent or emergent situation, including urgent consultations, trauma, and ED consultations (ATLS required). 2. E&M of post-op complications, including hypotension, hypertension, oliguria, anuria, cardiac arrhythmias, hypoxemia, change in respiratory rate, change in neurologic status, and compartment syndromes. 3. E&M of critically-ill patients, either immediately post-op or in the ICU, including the conduct of monitoring, and orders for medications, testing, and other treatments. 4. Management of patients in cardiac or respiratory arrest (ACLS 	X	X	X	X	After Approval by Surgery Education Committee

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Level	Description/Defined Tasks	Supervisors				
		Attending	PGY-5	PGY-4	PGY-3	PGY-2
	<p>required).</p> <p><u>Procedural Competencies</u></p> <ol style="list-style-type: none"> 1. Carry-out of advanced vascular access procedures, including central venous catheterization, temporary dialysis access, and arterial cannulation. 2. Repair of surgical incisions of the skin and soft tissues. 3. Repair of skin and soft tissue lacerations. 4. Excision of lesions of the skin and subcutaneous tissues. 5. Tube thoracostomy. 6. Paracentesis. 7. Endotracheal intubation. 8. Bedside debridement. <p>First year residents will log all procedures specified in the Direct Supervisory category electronically in My.Evaluations for applicable supervisory sign off and monitoring by program director.</p>					
PGY-2	<p>Second year residents remain under direct supervision for above patient care management and procedures until they have been considered and approved for advancement by the Surgery Education Committee (SEC – meets quarterly). They may then function under indirect supervision for patient care activities from upper level residents and/or attendings and are considered “intermediate level.”</p> <p>Even after “intermediate level” status is obtained, second year residents are required to obtain PGY-3 or above oversight for surgical consultations in the ED if that patient is to be discharged.</p>	X	X	X	X	Approved PGY-2 (if still under supervision)
PGY-3	<p>Third year residents are considered at “intermediate level” and function with indirect supervision for patient care activities from upper level residents and/or attendings.</p>	X	X	X		
PGY-4	<p>Fourth year residents are considered to be in their “final years of education” and function with indirect supervision for patient care activities from the chiefs and/or attendings.</p>	X	X			
PGY-5 Chiefs	<p>Chief residents are considered to be in their “final years of education” and function with indirect supervision for patient care activities from the attendings.</p> <p>Chief residents are responsible for “running services” and coordinating communication with attendings.</p>	X				

Resident Reappointment and Promotion Criteria

Reappointment and promotion, at all levels, is predicated on completion of all assigned rotations, and faculty evaluations, as expressed in the semi-annual Clinical Competency Committee milestone-based evaluations, that show ongoing progress towards achieving competency such that at the completion of the residency the graduate can be certified as able to practice General Surgery independently.

The evaluation process will specifically assess proficiency in:

1. Clinical skills, including technical and patient management
2. Fund of knowledge
3. Professionalism, including communication capabilities, sense of responsibility, and development of an internal set of standards for behavior
4. Attendance, punctuality, and availability
5. Teaching others including patients, resident peers and medical students

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6. Adherence to rules and procedures of the residency and Medical Center
7. Timely and complete record-keeping, including chart documentation, work schedules, and updating of procedure/case lists
8. Membership and participation in hospital committee activities

In the language of the Resident Evaluation Milestones, the Mercy General Surgery Residency does not mandate that its graduates be rated at the Level 4 (highest) level in all categories at the time of graduation from the program. However, those Chief Residents whose penultimate Clinical Competency Committee (CCC) evaluation does not average at or near the Level 2.5 will be asked to sit for a special session of the CCC to discuss whether this fact, along with taking into account other facets of the resident's performance/portfolio, indicates that the resident should not be considered for graduation or certification. If the determination is that the resident is not likely to be fit for independent practice, a schedule and mitigation scheme will be determined at that meeting in hopes of allowing the resident to remediate their deficiencies such that they can graduate on time from the program.

Specific requirements for promotion/graduation:


1. ABSITE Scores
 - a. Graduating residents will be expected to achieve one of the following criteria at least 2 out of the 5 years, with at least one of those years being in their PGY-4 or PGY-5 years.
 - Total test percentile >20%
 - Raw score on the total test > or = 66%
 - Raw score on CK + PC + CM > or = 70%
 - b. PGY-5's not accomplishing this will only get completion letters after a special meeting of the Clinical Competency Committee to decide whether other performance assessment warrants waiving of this requirement.
2. Research requirements
 - a. QI project (see below)
 - b. At a minimum, case study to be completed and submitted for presentation and/or publication by the end of PGY-3 year
 - c. At a minimum, original research project (e.g., randomized prospective trial), book chapter, or research involving analysis of a large scale database in a novel manner will be completed prior to graduation from the program and submitted for presentation and/or publication
3. Any academic remediation mandated by the Clinical Competency Committee shall have been successfully accomplished
4. Quality Improvement (QI) activities
 - a. Active participation in, and attendance at, the bi-monthly QI curriculum sessions
 - b. Completion of a QI project that will be presented at the Resident Forum in May of the residents' PGY-2 year
5. Passing the FLS test is a prerequisite for graduation for all residents who entered the Mercy General Surgery Residency on or after July 1, 2014. The FLS examination will be scheduled and paid for by the residency on one occasion. If the resident fails the examination, all further attempts at the FLS exam will be at the resident's expense.
6. Completion of the FES curriculum and a passing grade on the FES test
7. Obtaining a score of 500 or > on the COMLEX or a 200 or > on the USMLE exam.

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8. All senior residents will participate in all locally offered mock oral examinations (at Mercy (generally in April) and at Unity Point (the first Friday each May)) and all PGY-4's and 5's will take the Mayo Clinic mock orals scheduled routinely for the second Friday in May of each academic year. There will be no excused absences, save for illness documented by the resident's treating physician. No vacations will be scheduled for the first two weeks of May by any senior resident.

Probation and Dismissal

The probation period is typically three to nine months. Vacation during probation is not allowed. The Medical Education dismissal procedure (including the associated due process) can be found on the share drive/Medical Education-General/Policies.

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Attachment C

**Internal Medicine Residency Program
Program-Specific Supervision Requirements**

In addition to the common program requirements for resident supervision, the following is provided as delineation of additional program-specific requirements.

Mid-Level Providers

Physician assistants and nurse practitioners may, on occasion, supervise residents in unique educational setting within the scope of their licensure. Oversight by a faculty physician member during these situations is required.

Supervision of First-Year Residents

Programs must assess the independence of each first-year resident based upon the six core competencies in order to progress to indirect supervision with supervision immediately available.

Various required experiences may necessitate different sets of skills. For example, if a resident is deemed to have progressed to indirect supervision with supervision immediately available while on the internal medicine service, this may not be the case in a subsequent required experience if it is the resident's first experience for another rotation such as ICU.

Examples of Indirect Supervision

With direct supervision immediately available:

- The resident is seeing patients in the internal medicine continuity clinic and the supervising physician faculty member is immediately available to see the patient together with the resident as needed.
- The faculty member is in another area of the hospital, but is immediately available to see the patient together with the resident.

With direct supervision available:

- A resident needs advice from the physician faculty member in order to manage a patient's care. This can be done either by telephone or in person. After communication with the resident, if the attending determines additional assistance is needed, the attending physician will see the patient with the resident. During the night float rotation, coverage is provided by the nocturnists.

Optimal Clinical Workload

The program director must ensure resident patient loads are appropriate. The optimal case load will allow each resident to see as many cases as possible, without being overwhelmed by patient care responsibilities, or without compromising a resident's educational experience.


Interprofessional Teams

Nurses, physician assistants, advanced practice providers, pharmacists, social workers, physical and occupational therapists, respiratory therapists, psychologists, and nutritionists are examples of professional personnel who may be part of the interprofessional teams with which residents must work as members.

Internal Medicine Residency Program (continued)

"Ready or Not" Criteria for End of PGY-1 Supervision

1. Successful completion of all rotations of PGY-1 year.
2. Completion of BLS and ACLS.
3. Cannot be on any probationary status.
4. Recommendation by the Clinical Competency Committee.
5. Demonstrated patient management skills during both inpatient and outpatient rotations as observed by the attending faculty.

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6. Consensus decision by the Clinical Competency Committee at the end of the first year.
7. Review of faculty and other multi-source evaluations.

Criteria for Assessing PGY-2/PGY-3 Readiness to Supervising/Independent Practice

1. Successful completion of all rotations.
2. Completion of BLS and ACLS.
3. Cannot be on any probationary status.
4. Consensus decision by the Clinical Competency Committee at 6 month reviews of resident to determine if academic progress is being made.
5. Review of faculty and other multi-source evaluations.
6. Demonstrated patient management skills and supervisory skills during both inpatient and outpatient settings as observed by the attending faculty.
7. In early May of each year, the Clinical Competency Committee, will review the progress of each internal medicine resident to determine if each resident has made sufficient progress to advance to the next level of training.