SUPERVISION POLICY – UPCOMING CHANGES 7/1/2020

Effective July 1, 2020, the Accreditation Council for Graduate Medical Education (ACGME) will implement revisions to the Common Program Requirements including changes to Supervision Policy. The GME Policy and Procedure Manual will be updated and uploaded to the GME website when appropriate approvals have been obtained.

The main focus to the supervision requirements is addition of telecommunication technology.

Residents must be adequately supervised by the appropriate availability of the supervising faculty member, fellow, or senior resident physician, either on site or by means of telecommunication technology. Some activities require physical presence of the supervising faculty member.

The program must define when physical presence of a supervising physician is required.

Direct Supervision
The definition of direct supervision has been revised in the requirements to include [Specialties will chose to require either or both of the below bullet points]:

- The supervising physician is physically present with the resident during the key portions of the patient interaction.
- 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. [i.e. telemedicine]

For PGY-1 residents, residents must initially by supervised directly during the key portions of the patient interaction. Each specialty can describe the conditions under which PGY-1 resident’s progress to be supervised indirectly.

Indirect Supervision
The definition of indirect supervision has been revised. Indirect supervision with direct supervision immediately [physically] available and indirect supervision with direct supervision available [phone] terminology is no longer used in the program requirements.

Indirect supervision is now defined as the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to resident for guidance and is available to provide appropriate direct supervision.
D. SUPERVISION AND ACCOUNTABILITY

Each program director must ensure, direct, and document adequate supervision of residents/fellows at all times. There must be program-specific policies and guidelines for resident/fellow supervision and progressive levels of responsibility for each year that are distributed to all residents/fellows and teaching faculty.

The clinical responsibilities for each resident/fellow must be based on PGY-level, patient safety, resident/fellow education, severity and complexity of patient illness/condition and available support services.

Purpose:
This policy will establish the minimum requirements for resident/fellow supervision in teaching hospitals in the University of Alabama Health System and its teaching affiliates. Each of our teaching hospitals, as well as training programs, might have additional requirements that each trainee (resident or fellow) will follow.

Attending Responsibilities:
Residents are supervised by the assigned service attending. During evaluation of patients, supervision can be direct supervision, indirect supervision with direct supervision immediately available, indirect supervision with direct supervision available or oversight. During performance of bedside procedures supervision is direct supervision, indirect supervision with direct supervision immediately available, indirect supervision with direct supervision available or oversight. The attending physician reviews the evaluation and plan with the resident. The attending physician oversees all clinical decisions, is available for the performance of the procedure to ensure patient safety and an optimal educational experience.

Resident/Fellow Responsibilities (for being supervised):
Residents are responsible for evaluation of the patients at the University Hospital, discussion of the patient with the responsible attending physician, contributing to development of the plan, and participating in the bedside procedures. As residents increase in experience they will have increased autonomy and need less assistance in performing bedside procedures, and contribute more significantly to development of the plans. In all situations, the attending physician is responsible for all patient care decisions and will be immediately available to the resident.

Scope:
The following policy applies to all programs and residents/fellows.

Definitions:
1. Resident: a professional post-graduate trainee in a core program (i.e. Pediatrics, General Surgery) or an independent program (i.e. Neurosurgery).
2. Fellow: a professional post-graduate trainee that has completed required training in a core program or independent program and now pursues additional training in a subspecialty (i.e. cardiology, adolescent medicine, forensic pathology).
3. Faculty Attending: the immediate supervisor of a resident/fellow or a fellow who is duly credentialed in his/her hospital for specific procedures in their specialty and subspecialty that he/she is supervising

Policy:
1. The program director must ensure that the teaching staff at all participating institutions and clinical sites provide appropriate supervision of residents/fellows that is consistent with proper patient care and the educational needs of the residents/fellows.
a) Each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable RRC) who is ultimately responsible for that patient’s care at all clinical sites utilized for the education of residents/fellows.

i) This information should be available to residents/fellows, faculty members, other members of the health care team, and patients

ii) Residents/fellows and faculty members should inform patients of their respective roles in each patient’s care

b) Faculty attending and call schedules must be structured to provide residents/fellows with continuous supervision and consultation.

c) Residents/Fellows and other health care personnel must be provided with rapid, reliable systems for communicating with supervising faculty.

2. To ensure oversight of resident/fellow supervision and graded authority and responsibility, the program must define the levels of supervision that is in accordance with the RRC and use the following classification of supervision:

a) **Direct Supervision (Level 1)** – the supervising physician is physically present with the resident/fellow while providing patient care

b) **Indirect Supervision with direct supervision immediately available (Level 2)** – the supervising physician is physically within the hospital or juxtaposed site of patient care (North Pavilion, West Pavilion, Spain Wallace, Women and Infants Center, VAMC) and is immediately available to provide Direct Supervision

c) **Indirect Supervision with direct supervision available (Level 3)** – the supervising physician is not physically present within the hospital or other site of patient care but is immediately available by means of telephone and/or electronic modalities, and is available to provide Direct Supervision

d) **Oversight (Level 4)** – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered

3. Residents/Fellows must be supervised by teaching staff in such a way that the residents/fellows assume progressively increasing responsibility according to their level of education, ability and experience. The program must demonstrate that the appropriate level of supervision is in place for all residents/fellows who care for patients.

a) The program director is responsible for defining the levels of responsibilities for each year of training through written descriptions of the types of clinical activities residents/fellows may perform and/or teach.

b) The level of responsibility granted to a resident/fellow is determined by the program director and/or supervising teaching faculty and must be based on documented evaluation of the resident/fellow’s clinical experience, judgment, knowledge, technical skill and the needs of the patient.

c) Senior residents or fellows should serve in a supervisory role of junior residents/fellows in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident/fellow or fellow.

d) The program director must set guidelines for circumstances and events in which residents/fellows must communicate with appropriate supervising faculty members (escalation of care policy).
e) Residents/Fellows must be aware of their limitations and may not attempt to provide clinical services or perform procedures for which they are not trained.

f) PGY-1 residents should be supervised at all times either directly (Level 1) or indirectly with direct supervision immediately available. Each Review Committee will describe the achieved competencies under which PGY-1 residents/fellows progress to be supervised indirectly with direct supervision available.

4. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident/fellow and delegate to him/her the appropriate level of patient care authority and responsibility. The program director is responsible for ensuring that all teaching faculty and residents/fellows are educated to recognize the signs of fatigue and for implementing policies and procedures to prevent and counteract the potential negative effects.

   a) Faculty members and residents/fellows must be educated to recognize the signs of fatigue and sleep deprivation; alertness management and fatigue mitigation processes; and to adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning such as naps or back-up call schedules.

   b) A process must be developed to ensure continuity of patient care in the event that a resident/fellow may be unable to perform his/her patient care duties.

5. Each training program will submit their supervision guidelines detailing level of supervision by service and level of training to the GME Office.

Example: (Internal Medicine Core Program) Inpatient Rotations

<table>
<thead>
<tr>
<th>Service</th>
<th>PGY-1</th>
<th>PGY-2 / PGY-3/ PGY-4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology Service University Hospital</td>
<td>Level 1 or 2*: PGY-2 / PGY-3</td>
<td>Level 3: fellow and attending</td>
</tr>
<tr>
<td></td>
<td>(in house)</td>
<td>Level 4: attending</td>
</tr>
<tr>
<td></td>
<td>Level 3: fellow and attending</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Level 4: attending</td>
<td></td>
</tr>
<tr>
<td>General Medicine Service VA Hospital</td>
<td>Level 2: PGY-2 / PGY-3 (in house)</td>
<td>Level 4: attending</td>
</tr>
<tr>
<td></td>
<td>Level 4: attending</td>
<td></td>
</tr>
<tr>
<td>VA ICU</td>
<td>N / A</td>
<td>Level 3: fellow and attending</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Level 4: attending</td>
</tr>
</tbody>
</table>

Outpatient Rotations

<table>
<thead>
<tr>
<th>Service</th>
<th>PGY-1</th>
<th>PGY-2 / PGY-3 / PGY-4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birmingham VAMC Red Clinic</td>
<td>Level 1: first 6 months</td>
<td>Level 2: attending</td>
</tr>
<tr>
<td></td>
<td>Level 2: after first 6 months of training</td>
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E. ATTENDING NOTIFICATION POLICY

Purpose:
To provide minimal standards to guide residents and fellows with a set of clinical conditions that requires immediate attending notification.

Scope:
The following policy applies to all programs and residents/fellows.

Policy:
Each training program will provide their policy to the GME Office on their staff attending notification (escalation) that contains minimal circumstances in which the attending must be notified. The policy must contain the following minimal elements.

1. Escalation of Care:
   Any urgent patient situation should be discussed immediately with the supervising attending. This includes:
   - In case of patient death
   - Any time there is unexpected deterioration in patient’s medical condition
   - Patient is in need of invasive operative procedures
   - Instances where patient’s code status is in question and faculty intervention is needed
   - A patient is transferred to or from a more acute care setting (floor to ICU and vice versa)
   - A patient’s condition changes requiring MET/CHAT team activation
   - Any other clinical concern whereby the intern or the resident feels uncertain of the appropriate clinical plan

2. Timeliness of Attending Notification:
   It is expected that the resident will notify the attending as soon as possible after an incident has occurred. Notification of the attending should not delay the provision of appropriate and urgent care to the patient. If despite the best efforts, the resident cannot reach the assigned attending, then they should notify the program director, medical director of the service or the chair of the department for guidance.

F. BEDSIDE PROCEDURES

Purpose:
The purpose of this policy is to provide guidance for residents and fellows on when to notify the attending or higher supervisor trainee when performing bedside invasive procedures.

Scope:
This policy applies to all bedside procedures performed by GME trainees on patients seen at University Hospital. Surgical procedures performed by GME trainees on patients in the operating rooms are not covered by this policy as there are already policies covering these situations.
Bed Side Procedures and Level of Training:

PGY 1 Resident:
Direct supervision by upper level resident, fellow, or faculty for all invasive procedures until proficiency demonstrated in established quantity, this number can vary by training program.

PGY 2 and Higher Resident:
Direct supervision by peer upper level resident, fellow, or faculty for all invasive procedures until proficiency demonstrated in established quantity, this number can vary by training program.

Policy:

Performance of Procedure:
1. It is the policy of University Hospital that all GME PGY1 trainees performing a bedside procedure discuss the clinical appropriateness of the procedure with the senior resident, fellow or attending. PGY2 and higher GME trainees should discuss the clinical appropriateness of a bedside procedure with the fellow or attending as needed.

2. The attending physician is responsible for determining the appropriate level of supervision required for performing a bedside procedure, the appropriate indication for the procedures, discussion of risk-benefit with residents and patients (as necessary), assessing the risk of the procedure, determining the qualification of the resident performing the procedure and providing adequate support to the trainee performing the procedure.

3. It is expected that a resident shall inform the faculty member or upper level resident when he/she does not feel capable of performing a bedside procedure.

4. The resident performing a procedure should make sure that there is adequate backup (such as senior resident, fellow, attending, interventional services, surgical services) before performing the procedure.

5. The resident should attempt the procedure no more than three times before stopping and re-evaluating the clinical situation and asking for a senior resident, fellow, attending, interventional service, or surgical service to take over the performance of the procedure.

6. The resident should call the senior resident, fellow or the attending if he/she has attempted the procedure three times unsuccessfully before attempting the procedure again.

7. The procedure should be aborted and alternate plans discussed with the attending when the risk of the procedure including discomfort to the patient outweighs the benefit of repeated attempts beyond three.

8. In case of emergency, greater than three attempts can be made but should be justified with clear documentation of the need to do so in the procedure note.