Policy / Procedure:

Resident Supervision and Job Descriptions

KEY TERMS: Residents, Employee Assistance, Medical Education

I. PURPOSE:

The purpose of this policy is to enhance graduate medical education and assure the highest quality of care for our patients by outlining the supervision requirements for residents, articulating residents' job descriptions and responsibilities and outlining attending physician responsibilities.

Carilion Clinic (CC) is committed to providing appropriate supervision for residents by teaching staff (faculty or members of the medical staff who have agreed to participate in the formal process of teaching residents) such that the residents progressively assume increasing responsibility for patient care according to the level of training, ability and experience. On-call schedules for teaching staff are structured to ensure that supervision is always available to residents on duty.

II. SCOPE:

This policy applies to all ACGME accredited post-graduate training programs sponsored by Carilion Clinic or AOA accredited Carilion based programs sponsored by the Via Virginia College of Osteopathic Medicine, as well as to visiting residents rotating at CC through institutional agreements and participating in approved educational programs.

III. DEFINITIONS:

Resident – refers to all interns, residents, and fellows participating in CC post graduate training programs.

Residency Program – any post-graduate medical education program approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA).

IV. PROCEDURE:

A. Responsibilities

Each residency program, in accordance with specialty guidelines and requirements, establishes the requirement for on-site resident supervision. Each program director will establish detailed

written policies for supervision in their respective residencies. All departmental supervision policies must be reviewed and approved by the GMEC.

1. Communication – The Designated Institutional Official (DIO), the Director of Osteopathic Medical Education, as appropriate, and Residency Program Directors.

2. Enforcement – The DIO, the Director of Osteopathic Medical Education, as appropriate, Residency Program Directors, Departmental Chairs, and members of the Medical Executive Committee.

3. Implementation – Office of Graduate Medical Education, Residency Program Directors and Coordinators.

B. Communication Regarding Residents and Residencies

The Graduate Medical Education Committee and the medical staff, through its Medical Executive Committee, must communicate regularly. At least annually, the DIO will discuss with the MEC the safety and quality of care being provided by residents, their related educational and supervisory needs, and the performance of residents.

C. Supervision

1. Supervision of Residents

Residency training is an educational experience designed to offer residents the opportunity to participate in the clinical evaluation and care of patients in a variety of patient care settings. The goal of residency training is to develop each resident physician into an independent practitioner by allowing increasing responsibility in the assessment of patients and the development and implementation of therapeutic strategies. However, it remains the responsibility of all participating staff physicians to closely supervise house staff in the care of patients. All aspects of patient care rendered by resident physicians must receive close supervision.

All aspects of patient care are ultimately the responsibility of the attending physician and involved consultants. The level of resident participation and responsibility is determined by the attending physician. This decision is based on the resident's level within the residency program, job description, and documented competency to perform specific procedures.

Attending physicians have the right to prohibit resident participation in the care of their patients without penalty. When allowing residents to participate in the care of their patients, the attending does not relinquish their rights or responsibilities to examine and interview, admit or discharge their patients; write orders, progress notes, and discharge summaries; obtain consultations; or to correct/change resident medical management and decision-making that is deemed to be inconsistent with the decisions of the attending.

It is the responsibility of the resident to communicate effectively with their supervising physician regarding the findings of their evaluation, physical examination, interpretation of diagnostic tests, and intended interventions on a continuous basis. The supervisory physician is defined as that staff physician who has immediate oversight responsibility of all aspects of patient care rendered by the students, interns, and residents. In most cases, the supervisory physician is also the attending physician or consultant on the case. Supervising physicians must have clinical privileges delineated by the medical staff consistent with the clinical services being provided by residents under their supervision. On some teaching services the supervisory physician does not have direct patient care responsibilities. In this circumstance the attending and/or consulting physicians must remain active in the care of the patient and the house staff must maintain regular contact (at a minimum daily) with them. Each residency program and service will inform house staff whether there is a designated supervisory physician or whether each attending or consulting physician is responsible for supervising house staff in the care of patients.

The attending physician and consulting physicians must review all entries by house staff in the medical record on a daily basis and make any necessary corrections or additions in the entries. Attending and consulting physicians must document that they have personally performed the key components of each medical encounter in order to maintain compliance with CMS guidelines for teaching physicians.

2. Resident Duties and Responsibilities

A. Admission History and Physical/Consultations

Residents at all levels of training may perform history and physical examinations and consultations without the attending physician being physically present. It is the responsibility of the resident to discuss their findings with the attending physician upon completion of their examination. The attending must perform and confirm the key portions of the history and physical exam, make additions and corrections in the documented history and physical, and co-sign the resident's documentation. The attending physician must do so within 24 hours of admission or sooner if needed to assure appropriate and timely diagnosis and treatment.

B. Order and Interpret Diagnostic Studies

Residents at all levels of training may order diagnostic laboratory and imaging studies. It is the responsibility of the resident to discuss with the attending physician which diagnostic studies to order and the interpretation of results. The attending physician will confirm his/her interpretation of the key results in the medical record, most often using the admission History and Physical or in the daily progress note for this documentation.

C. Request Consultations and Make Multi-Disciplinary Team Referrals

Residents at all levels of training may request consultations and make referrals to members of the multi-disciplinary team (ie. Dietary, Case Management, Social Work, Health Educators). It is the responsibility of the resident to discuss which consultations or referrals to make with the attending physician. The attending physician should document their agreement.

D. Initiate Treatment in Emergent Situations

Residents at all levels of training may initiate emergent life-saving treatments such as CPR. Immediate efforts to obtain supervision by more senior residents and attending physicians should be made. The first responding resident and any supervising resident and/or attending physician should enter into the medical record documentation of the clinical information, assessments, and treatments rendered.

E. Daily Progress Notes

Residents at all levels of training may evaluate patients and write daily progress notes without the attending physician being physically present. It is the responsibility of the resident to discuss their documented findings and treatment with the attending physician on a daily basis or when a patient's condition changes. Frequent communication with attending physicians is needed to assure high quality patient care. Attending and consulting physicians may make additions and corrections in the daily progress notes. All entries must be dated, signed, and legible. Residents should document their discussions with attending physicians by writing, "Patient seen and discussed with the attending."

F. Attending or Supervising Physician Documentation

Each attending must document a daily progress note on each patient stating that they assessed and agree with the care provided by the treatment team. Attending physicians submitting a bill for E/M services must comply with the documentation standards for teaching physicians as outlined by CMS in IL-372, and subsequently clarified in Medicare Carriers Manual Part 3 – Claims Process, Transmittal 1780, dated November 22, 2002. A copy of these standards is available in the office of medical education.

When transferring care to another physician for coverage over a weekend or vacation, the attending of record must identify the physician to whom the patient's care will be transferred by documenting in the patient's record: "Dr. X will assume the care of the patient on 00/00/0000." This requirement can also be met by changing the attending on the inpatient banner in EPIC when an attending change occurs.

G. Orders

Residents at all levels of training may write orders on patients for whom they are participating in the care. These orders will be implemented without the co-signature of an attending or consulting physician. It is the responsibility of the resident to discuss their orders with the attending or consulting physician.

H. Routine Minor Clinical Procedures

Residents may provide routine minor clinical procedures independently or under the supervision of a more senior resident based on past experience and faculty-assessment of skills. These routine minor procedures include and are limited to the following:

a) Venipuncture
b) Adermal skin tests
c) Suturing of minor lacerations
d) Splinting
e) Application of dressings and bandages
f) Placement of peripheral intravenous lines
g) Removal of superficial foreign bodies
h) Nasogastric tube placement
i) Bladder catheterization
j) Transfusion of blood and blood products
k) Other minor procedures for which informed consent is not required

I. Invasive procedures

Invasive procedures, for the purpose of this policy, are defined as any clinical intervention for which informed consent is required or would reasonably be obtained with the exception of transfusion of blood and blood products. Residents at all levels of training must have direct supervision by an attending physician during all invasive procedures except as specified and documented by each residency program. If, at any time, a resident is called upon to perform one of the specified procedures that he/she is not certified by their residency program to perform independently, the patient's attending physician must be notified before informed consent is obtained.

Each residency program will develop a list of procedures that their residents may be certified to perform independent of the physical presence of the attending physician. Certification by the residency program requires documentation of observed competency by the resident in the given procedure with a subsequent recommendation by the residency program director that certification in the procedure has been granted. The list of procedures for which residents in a given department can be certified will be developed by the Program Director with input from members of the program faculty. The list will be submitted to the Office of Graduate Medical Education. Each residency program will review such lists on an annual basis. Each residency program must have a defined process for the teaching and certification of competency in the performance of procedures. The residency program must continue to

monitor resident performance of invasive procedures both prior to and after certification of competency. The residency program must provide easily accessible verification of such certification to the nursing and medical staffs. This list must be updated on a regular basis and must be available to the medical staff office and Nursing Administration via the Carilion Intranet.

Residents are responsible for providing information attesting to their certification of competency to perform a procedure upon request. Nurses may verify a resident's certification by checking the procedure certification database on the Carilion Intranet. If a resident insists on performing a procedure for which there is not evidence of their certification, the nurse should immediately notify the patient's attending physician. If the attending physician is unavailable, the nurse should notify the following individuals in the listed order until a satisfactory response is obtained:

1. The supervising attending
2. The resident's program director
3. The DIO
4. The Vice President of Medical Affairs
5. The Chief Medical Officer

J. Resident Evaluation

Residents at all levels of training must receive feedback and formative evaluation on a continuous basis. Structured formal evaluation must be provided to residents at the end of every rotation. Summative evaluation of residents must take place at least twice yearly and prior to formal promotion to the next level of training. The residency program must provide all attending physicians who provide formal resident oversight and supervision for a specific rotation a mechanism to evaluate the resident. Residency program directors are encouraged to solicit input from all attending physicians who work with their residents. Members of the medical staff are also encouraged to share their experiences, observations, and evaluations of a resident at any given time with program directors – particularly if they have a concern regarding the competency of a given resident.

V. OTHER ISSUES / CONCERNS:

Approvals

Name	Title	Dept./Committee	Date
Daniel Harrington, MD	DIO	GMEC	October 16, 2007
Daniel Harrington, MD	DIO	GMEC	January 1, 2011