Supervision of Residents and Fellows

Wisconsin Northern & Central GME Consortium (WiNC)

Initial GMEC Approval:	10-15-2019
Last GMEC Review Date:	

Scope

This policy pertains to all WiNC-sponsored residency/fellowship programs.

Purpose

To provide appropriate and educationally helpful supervision for residents and fellows during patient care activities, ensuring safe and effective care for patients and compliance with requirements from the Accreditation Council for Graduate Medical Education (ACGME).

Policy Guidelines

Approach to Supervision

1. All patient care provided by residents and/or fellows, in all settings within the context of the training program, will be supervised by appropriately credentialed and privileged faculty who are ultimately responsible for the patients' care. On occasion residents and fellows may be supervised by a non-physician; however, oversight by a faculty physician member is required.
2. During resident and fellow patient care sessions in the clinic there must be qualified faculty physician who is engaged in active teaching and supervision of residents/fellows. The faculty physicians must be free of other competing obligations and responsibilities. The number of supervising faculty will be appropriate for the number and educational competency level of the residents/fellows to be supervised, and the number of patients being seen.
    a. Faculty Supervision Requirements for Residents: there must be at least one supervising faculty for every four residents working in the clinic at any one time. If only one resident is seeing patients, a single supervising faculty member may engage in other activities to a maximum of 50%, however the teaching and supervision of the residents must take priority. Likewise, time spent with other learners (i.e.: medical students, PA students, etc.) must not diminish the supervision of residents.
    b. Faculty Supervision Requirements for Fellows: Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced fellow. Other portions of care provided by the fellow can be adequately supervised by the immediate availability of the supervising faculty member or fellow physician, either on site or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of fellow-delivered care with feedback.
3. Residents and fellows will receive timely and reliable notification of who their supervising faculty is/are for all patient care activities. Additionally, reliable information for contacting supervising faculty will be provided for residents and fellows on call.
4. Each WiNC residency and fellowship program must ensure that an appropriate level of supervision is in place. Specifically, PGY-1 trainees should be supervised either directly or indirectly with direct supervision immediately available. The supervising physician can be a program-approved attending physician, senior resident or fellow. The designated levels of supervision are
    a. Direct supervision
        i. The supervising physician is physically present with the resident and patient.
    b. Indirect supervision with
        i. 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
        ii. 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

c. Oversight
    i. Supervising physician is available to provide review of procedures/encounters with feedback provided after care has been delivered.

5. It is expected that residents' and fellows' abilities to provide safe and appropriate patient care will develop and expand throughout their training. This includes an expectation that senior residents and fellows should advance to be able to provide a supervisory role for junior learners.
6. Progressive authority and responsibility for providing patient care will be assigned to residents and/or fellows by the Program Director and faculty members, and communicated to the resident/fellow. Patients will be informed of the role of the resident(s) and/or fellow(s) and the supervising physician(s) who provide their care.

Institutional and Program Supervision Responsibilities

1. The WiNC Graduate Medical Education Committee is responsible for:
    a. Monitoring programs to ensure that supervision of residents/fellows is consistent with:
        i. The provision of safe and effective care for patients
        ii. Educational needs and skill level of trainees
        iii. Progressive responsibility that is appropriate for each trainee's level of education, competence, and experience
        iv. Current accreditation requirements This will be accomplished by:
            1. Review of results from the annual WiNC confidential survey of all residents/fellows in training
            2. Review of results from surveys conducted by the ACGME
            3. Information gathered during the Self Study
            4. Periodic review of program policies and systems at GMEC meetings
            5. Program reports as requested

2. The local Program Director is responsible for:
    a. Implementing and monitoring systems to provide residents/fellows with timely reliable systems for communicating with supervising faculty.
    b. Assigning progressive authority and responsibility to residents/fellows in the provision of patient care This entails:
        i. Setting guidelines for:
            1. Appropriate levels of patient care activities and skills relevant for each resident/fellow training year, and communicating this to residents/fellows and faculty
            2. Circumstances and events where residents/fellows must communicate with supervising faculty members, and communicating this to residents/fellows and faculty
        ii. Developing systems to evaluate and monitor individual resident and fellow patient care competency and skills based on specific criteria, guided by the Milestones. In addition, this information must be communicated with individual residents/fellows and faculty as appropriate.
    c. Ensuring that faculty who provide supervision for residents and fellows during patient care activities are:
        i. Qualified, and appropriately credentialed and privileged
        ii. Informed about their responsibilities in supervising, and educated on skills needed to supervise effectively
        iii. Scheduled in a way
            1. To provide for an appropriate level of supervision for each resident and/or fellow during patient care activities
            2. To be of sufficient duration to assess the knowledge and skills of residents and/or fellows to appropriately delegate their level of patient care authority and responsibility
    d. Setting up processes to ensure that patients are informed of the role and responsibilities of the resident and/or fellow and the supervising faculty who provide their care
    e. Providing oversight to ensure appropriate resident and/or fellow supervision at each participating learning site
3. Supervising faculty are responsible for:

a. Being readily available to residents and/or fellows during their assigned supervisory session(s)
b. Ensuring that resident and/or fellow teaching and supervision is their first priority during assigned supervision sessions
c. Ensuring safe and appropriate care for patients seen by residents and/or fellows
d. Delegating portions of patient care to residents and/or fellows based on
    i. the provision of safe care for patients
    ii. the patient's needs, and severity and complexity of their illness/condition
    iii. available support services
    iv. the resident's and/or fellow's training year and individual competency skill level
e. Providing appropriate and helpful supervision for each resident's and/or fellow's care of patients, whether in the clinic, hospital, patients' homes, nursing care facility, or during call
f. Reviewing and evaluating patient care provided by residents and/or fellows
g. Reviewing and co-signing all resident notes in all patient care settings

4. Residents and Fellows are responsible for:
    a. Knowing the limits of their authority in providing patient care, the circumstances under which they are permitted to act with conditional independence, and when communication with supervising faculty members is required
    b. Providing safe and effective care for their patients. In doing so, residents and/or fellows are responsible for seeking consultation from supervising faculty as appropriate for their level of training, competency level and experience, and as may be clinically indicated.
    c. Developing competency in patient care skills so as to provide supervision to junior residents as assigned by the program director
    d. Offering suggestions to their Program Director for ensuring reliable and educationally helpful supervision by faculty

References

ACGME website – http://www.acgme.org
Local program policies/guidelines/procedures relating to resident and fellow supervision

For GMEC ACGME Reference

ACGME Institutional Requirements (2022)

Supervision

IV.J.1. The Sponsoring Institution must maintain an institutional policy regarding supervision of residents/fellows. (Core)

IV.J.2. The Sponsoring Institution 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 and specialty-/subspecialty-specific Program Requirements. (Core)

III.B.4. Supervision and Accountability:

III.B.4.a) The Sponsoring Institution must oversee:

III.B.4.a).(1.) supervision of residents/fellows consistent with institutional and program-specific policies; and, (Core)

III.B.4.a).(2) mechanisms by which residents/fellows can report inadequate supervision and accountability in a protected manner that is free from reprisal. (Core)

ACGME Common Program Requirements (Residency) (2022)

VI.A.2. Supervision and Accountability

VI.A.2.a) Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.

Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

VI.A.2.a).(1) Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care. (Core)

VI.A.2.a).(1).(a) This information must be available to residents, faculty members, other members of the health care team, and patients. (Core)

VI.A.2.a).(1).(b) Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. (Core)

VI.A.2.b) Supervision may be exercised through a variety of methods. 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, fellow, or senior resident physician, either on site or by means of telecommunication technology. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.

VI.A.2.b).(1) The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)

[Review Committee may specify which activities require different levels of supervision.]

VI.A.2.c) Levels of Supervision

To promote oversight of resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision(Core)

VI.A.2.c).(1) Direct Supervision

VI.A.2.c).(1).(a) the supervising physician is physically present with the resident during key portions of the patient interaction; or (Core)

[Review Committee may further specify]

VI.A.2.c).(1).(a).(i) PGY-1 Residents must initially be supervised directly, only as described in VI.A.2.c).(1).(a). (Core)

[Review Committee may describe the conditions under which PGY-1 residents progress to be supervised indirectly]

VI.A.2.c).(1).(b) 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. (Core)

[The Review Committee may further specify]

[The Review Committee may choose not to permit VI.A.2.c.(1).(b)]

VI.A.2.c).(2) Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision. (Core)

VI.A.2.c).(3) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. (Core)

VI.A.2.d) 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. (Core)

VI.A.2.d).(1) The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones. (Core)

VI.A.2.d).(2) Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. (Core)

VI.A.2.d).(3) Senior residents or fellows should serve in a supervisory role to 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. (Detail)

VI.A.2.e) Programs must set guidelines for circumstances and events in which residents must

communicate with the supervising faculty member(s). (Core)

VI.A.2.e).(1) Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. (Outcome)

VI.A.2.f) Faculty supervision assignments must be 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. (Core)

ACGME Common Program Requirements (Fellowship) (2022)

VI.A.2. Supervision and Accountability

VI.A.2.a) Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.

Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each fellow's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

VI.A.2.a).(1) Each patient must have an identifiable and appropriately credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care. (Core)

VI.A.2.a).(1).(a) This information must be available to fellows, faculty members, other members of the health care team, and patients. (Core)

VI.A.2.a).(1).(b) Fellows and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. (Core)

VI.A.2.b) Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced fellow. Other portions of care provided by the fellow can be adequately supervised by the immediate availability of the supervising faculty member or fellow, either on site or by means of telecommunication technology. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of fellow-delivered care with feedback.

VI.A.2.b).(1) The program must demonstrate that the appropriate level of supervision in place for all fellows is based on each fellow's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)

[The Review Committee may specify which activities require different levels of supervision.]

VI.A.2.c) Levels of Supervision

To promote oversight of fellow supervision while providing for graded authority and responsibility, the program must use the following classification of supervision: (Core)

VI.A.2.c).(1) Direct Supervision

VI.A.2.c).(1).(a) the supervising physician is physically present with the fellow during key portions of the patient interaction; or. (Core)

[The Review Committee may further specify]

VI.A.2.c).(1).(b) the supervising physician and/or patient is not physically present with the fellow and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology. (Core)

[The Review Committee may further specify]

[The RC may choose not to permit VI.A.2.c).(1).(b)]

VI.A.2.c).(2) Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the fellow for guidance and is available to provide appropriate direct supervision. (Core)

VI.A.2.c).(3) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. (Core)

VI.A.2.d) The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members. (Core)

VI.A.2.d).(1) The program director must evaluate each fellow's abilities based on specific criteria, guided by the Milestones. (Core)

VI.A.2.d).(2) Faculty members functioning as supervising physicians must delegate portions of care to fellows based on the needs of the patient and the skills of each fellow. (Core)

VI.A.2.d).(3) Fellows should serve in a supervisory role to junior fellows and residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail)

VI.A.2.e Programs must set guidelines for circumstances and events in which fellows must communicate with the supervising faculty member(s). (Core)

VI.A.2.e).(1) Each fellow must know the limits of their scope of authority, and the circumstances under which the fellow is permitted to act with conditional independence. (Outcome)

VI.A.2.f) Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each fellow and to delegate to the fellow the appropriate level of patient care authority and responsibility (Core)