SUPERVISION POLICY

Retaliation upon, or derogatory statements made to, a trainee for request of help/supervision is never acceptable, will not be tolerated. (ACGME Common Requirements VI.E.3)

WVU GME - Policy on Supervision and Accountability – Based on Accreditation Council for Graduate Medical Education (ACGME) Common Program Requirements (CPR)

A. Programs must provide a professional, respectful, and supportive environment that is free from mistreatment, abuse, and coercion of residents, fellows, faculty, and staff. All GME-related supervision will be provided in a non-retaliatory, supportive, and respectful manner. Programs, in partnership with their Sponsoring Institution, must have a process for education of residents/fellows and faculty regarding episodes of inappropriate and unprofessional behavior, especially when exhibited toward a trainee who is requesting supervision and guidance in the patient care setting.

B. The safe and appropriate care of each patient underlies all guidelines for supervision in medical education. Although the attending physician is ultimately responsible for the care of the patient, every physician involved in a patient's care shares in the responsibility and accountability for their individual actions. Each resident/fellow and faculty member must inform each patient of their respective role in that patient's care. *[ACGME CPR, VI.A.2.a).(2)]* Effective programs, in partnership with their Sponsoring Institution, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care. The degree of supervision for a resident/fellow is expected to evolve progressively as the resident/fellow gains more experience. The level of supervision for each resident/fellow must be commensurate with that resident's/fellow's level of independence in practice, and will be influenced by the complexity, acuity, and urgency of the patient's condition. *[ACGME CPR, VI.A.2.b).(1)]*

C. Depending upon each trainee's level of independence in practice, 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, recognizing a trainee's progress toward independence. However, certain activities require the physical presence of the supervising faculty member, and each program must clearly define these activities. *[ACGME CPR, VI.A.2.d)]*

D. Levels of Supervision

1. To promote responsible and safe resident/fellow supervision, each program must define the appropriate levels of supervision for their specialty's common types of patient interactions. *[ACGME CPR, VI.A.2.f)]* The privilege of progressive authority, responsibility, conditional independence, and eventually a supervisory role in patient care must be assigned by the program director and by faculty members whose supervision assignments have been of sufficient duration to assess the knowledge and skills of each trainee. *[ACGME CPR, VI.A.2.e)]*

While providing for graded authority and responsibility, the program must use the following classifications of supervision *[ACGME CPR VI.A.2.c)]:*

i. Direct Supervision - The supervising physician is physically present with the resident/fellow during the key portions of the patient interaction, *OR, if the supervising physician and/or patient is not physically present with the resident/fellow, the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology,* (although some RRCs may choose not to permit this). All PGY1 residents must initially be supervised directly. *[ACGME CPR, VI.A.2.c).(1)]* Additional information on Direct Supervision may be found here. (CTRL-click)

ii. Indirect Supervision - The supervising physician is not providing physical or concurrent visual or audio supervision, but is immediately available to the resident/fellow for guidance and is available to provide appropriate direct supervision should that be required. *[ACGME CPR, VI.A.2.c).(2)]*

iii. Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. *[ACGME CPR, VI.A.2.c).(3)]*

E. Procedures - For procedural/case supervision, each department will develop specific guidelines describing the mechanism for resident supervision in accordance with ACGME and Joint Commission requirements. These must include the following key principles:

1. Clinical responsibilities must be conducted in carefully supervised and graduated manner, tempered by progressive levels of independence to enhance clinical judgment and skills.

2. This supervision must supply timely and appropriate feedback about performance, including constructive criticism about deficiencies, recognition of success, and specific suggestions for improvement.

3. Resident supervision must support each program's written educational curriculum.

4. Resident supervision should foster humanistic values by demonstrating a concern for each resident's well-being and professional development.

6. Residents are supervised by faculty physicians in accordance with these established guidelines.

7. Faculty call schedules are structured to assure that support and supervision are readily available to residents on duty.

8. The quality of resident supervision and adherence to the above guidelines are monitored through annual review of the residents' evaluations of their faculty and rotations, and via the GME Supervision Survey.

9. For any significant concerns regarding resident supervision, the appropriate Residency Program Director will submit a plan for its remediation to the GMEC for approval. Monthly progress reports will continue to be submitted until the situation or issue is resolved.

F. For a list of resident/fellow and attending physician patient care activities and supervision responsibilities, please CTRL-click on the following link:
Appendix L: Resident and Attending Physician Patient Care Activities and Supervision Responsibilities for Non-Operating Room Procedures

The following "SUPERVISION" guidelines have been established. It is again stressed that a resident should never feel intimidated or belittled when asking for assistance. Approved by GMEC Taskforce July 5, 2017 Approved by GMEC July 14, 2017

S Safety of the patient as well as safety of the resident are of paramount importance. The department of surgery 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 department's goal to create a nurturing environment where residents may feel safe and secure at all times while gaining independence . A faculty 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 training of the resident, the ultimate responsibility for the written report created is that of the attending surgeon.

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/or attending immediately. Resident will be given proper training in regards to end of life issues, death pronouncements, communicating death to families and necessary paper work. 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 evaluation will consist of video modules, patient scenarios

and a written assessment regarding various procedures and patient situations. 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 surgeon. P V 152 S I N

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. 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. Issues that arise between nursing, consulting services, ancillary care, etc. will be brought to the attention of the attending surgeon.

O On call. A printed, emailed or online call schedule is sent out monthly to residents, faculty and the hospital paging office. In the event of unforeseen circumstances, such as illness, the resident will be informed by the program director, senior resident or program coordinator who the supervising surgeon will be. 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 admissions or transfers within 2- 4 hours of arrival. All discharges will be discussed with the attending surgeon. All changes in care plans will be communicated to the attending faculty. If she/he is unavailable, then the program director or the chairman of the department should 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