

## **VIRGINIA COMMONWEALTH UNIVERSITY HEALTH SYSTEM POLICY ON THE SUPERVISION OF HOUSESTAFF**

The Medical College of Virginia of Virginia Commonwealth University Health System subscribes to the philosophy that the most effective learning environment for post-graduate medical trainees is one that allows sufficient freedom for housestaff to share responsibility for decision-making in patient care, and yet provides adequate and appropriate faculty supervision and involvement in order to provide feedback to trainees about their actions, and to address the quality and safety of the care rendered to patients.

In order to preserve this type of learning environment for its teaching programs, the Institution advocates the following principles as elements of its policy on housestaff education and supervision:

1. Housestaff, working under the authority and supervision of attending faculty, are regarded as the primary coordinators of care for all patients admitted to the teaching inpatient services, emergency rooms, and clinics, and, as such, are responsible for the writing of orders, for the maintenance of records, and for the execution of diagnostic, therapeutic, and discharge plans.
2. Depending on their level of training, it is appropriate and essential that junior housestaff be supervised by more senior housestaff in accordance with Accreditation Council for Graduate Medical Education (ACGME) requirements (see below) and training program and site-specific guidelines.
3. All spheres of housestaff activity will be supervised by attending faculty members who share responsibility with house officers for patient care rendered, and who have ultimate authority for final decision-making. The structure of housestaff-attending interactions and the form that faculty supervision of housestaff takes will vary according to site and type of patient care setting and will be developed by the training programs.

The ACGME Common Program Requirements effective July 1, 2011 state the following regarding supervision of residents:

### VI.D. Supervision of Residents

VI.D.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.

VI.D.2. The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients. 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.

### VI.D.3. Levels of Supervision

To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:

- a) Direct Supervision - the supervising physician is physically present with the resident and patient.
- b) 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 Direct Supervision.
- c) 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.
- d) Oversight - The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

VI.D.4. 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.

- a) 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.
- b) 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.
- c) 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.

VI.D.5. 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.

- a) 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.
  - (1) In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.

VI.D.6. 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.

### VI.E. Clinical Responsibilities

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

All VCUHS residency and fellowship training programs must have specific supervision policies that abide by these ACGME requirements. The program specific policies may be more stringent than the ACGME requirements but not less so. The program specific policies must address

supervision requirements at all affiliated training sites. Program specific policies on supervision must be reviewed, and updated as needed, at least annually.

The program specific supervision policies must address the following:

1. Levels of supervision (as defined in ACGME section VI.D.3 above) for site specific locations (when applicable to the training program) including but not limited to in-patient teaching services (general wards and intensive care units), clinics, consult services, emergency departments, operating rooms and during invasive procedures.
2. Guidelines for the circumstances and events which necessitate notification of the responsible faculty member or escalation beyond a housestaff member's immediate supervisor. As a minimum, it is suggested that housestaff be required to notify the patient's attending physician, in a timely fashion independent of the time of day, of any substantial controversy regarding patient care, any serious change in the patient's course including, at a minimum: unexpected death, need for surgery, transfer to an intensive care unit or to another service for treatment of an acute problem, end-of-life decisions, or for any other significant change in condition.
3. The means by which the program director and faculty will assign and document the privilege of progressive clinical and procedural responsibilities, conditional independence and supervisory responsibilities delegated to the resident. This must be reviewed and updated in New Innovations every 6 months. Assessment responsibilities for programs are fully defined in the VCUHS GME policy "THE ASSESSMENT, PROMOTION, DISCIPLINE AND DISMISSAL OF RESIDENTS IN GRADUATE MEDICAL EDUCATION PROGRAMS". (A structured two day patient safety simulation program is a component of the interns' orientation. Successful completion of this program may be used as one component determining the initial level of required supervision. Should the program elect to utilize this tool in assessing the initial level of required supervision, the program policy should indicate how failure to complete the program successfully will alter the supervision of the intern and how the program will assess subsequent competency.)

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