SUPERVISION, PROGRESSIVE AUTHORITY AND RESPONSIBILITY OF RESIDENTS/FELLOWS POLICY

Purpose: To set institutional standards for supervision of residents that ensures their education and our compliance with ACGME institutional standards at the University of Connecticut School of Medicine and its affiliated hospitals.

[Note: These standards are not meant to comply with standards required for billing purposes. Please see the Medicare Guidelines for Teaching Physicians, Interns, and Residents]

Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident/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.

Ensuring adequate supervision of residents/fellows is the responsibility of the program director, faculty physicians, departments, and the institution.

The following are standards for University of Connecticut School of Medicine resident/fellow positions, irrespective of the affiliated site where the resident/fellow is training/working. These are minimum rules. No program can fall below these standards, but they will be expanded if:

- Medical Staff rules at a given institution exceed these.
- Additional standards are required by The Joint Commission, CMS or any other regulatory body.
- An individual program has more stringent RC requirements for supervision.
- The clinical setting where the resident/fellow physician is training/working has additional rules.

Standards: Each patient must have an identifiable, appropriately credentialed and privileged attending physician or licensed independent practitioner who is responsible and accountable for the patient's care. This information must be available to residents/fellows, faculty members, and other members of the health care team.

All patient care performed by residents/fellows during training will be under the supervision of a physician faculty member, a licensed provider, fellow, or a more senior resident, either on site, or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising faculty member. The specifics of this supervision must be documented in the medical record by the supervising faculty member, licensed provider or supervising resident/fellow.

Residents/fellows, faculty members and licensed providers should inform their patients of their respective roles in each patient's care when providing direct patient care.

Levels of Supervision: Appropriate supervision of residents/fellows must be available at all times. The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's/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.

- **Direct Supervision:** The supervising physician* is physically present with the resident during the key portions of the patient interaction or 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.
- **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.
- **Oversight:** The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

*(*Supervising Physician: The supervising physician can be a faculty member or a more senior resident/fellow than the resident needing supervision.)*

Each resident/fellow must know the level of supervision required for them in all circumstances. PGY-1 residents must have, at all times, either direct or indirect supervision. Senior residents/fellows may serve as a direct or indirect supervising physician for a more junior resident or fellow, based on the needs of the patient and the skills of the individual resident or fellow as designated by the program director.

The supervising physician/licensed provider must be immediately available in person or by telephone 24 hours a day. Programs must ensure this occurs. Residents/fellows must know who the supervising physician/licensed provider is and how to reach this individual. Schedules and contact information for supervising physicians (faculty or more senior residents/fellows) and licensed providers must be readily available to all parties involved with patient care.

Certain situations require communication between the resident/fellow and supervising attending. At a minimum, the resident/fellow must notify the supervising attending physician /licensed provider of any significant changes in the patient's condition, including but not limited to:

- Patient admission to the hospital
- Transfer of a patient to a higher level of care including the intensive care unit
- Need for intubation or ventilator support
- Cardiac arrest or significant changes in hemodynamic status
- Development of significant neurological changes
- Development of major wound complications
- Medication errors requiring clinical intervention
- Any clinical problem that requires an invasive procedure or surgery
- Any condition which requires the response of a consulting team
- Change in code status
- Death

Supervision by Service:

Inpatient supervision: Every patient admitted to the hospital has an attending physician who is a member of the hospital attending or affiliated medical staff. The attending physician will remain responsible for the medical care of the patient in every aspect throughout the hospital stay of the patient unless the

responsibility is formally transferred to another service and this transfer is appropriately noted in the patient's medical record. When the attending physician is acting in the capacity of a supervisor, they must obtain a comprehensive presentation for each admission from the resident/fellow. This includes a history and physical exam. On the non-emergency admissions, charts shall contain a provisional diagnosis and plan by the attending physician written no more than 7 days prior to the admission, or within twenty-four (24) hours after admission. On all emergency patients, histories and physicals shall be recorded within 12 hours after admission. In either case, the history and physicals must be written prior to any surgery. If the history and physical is written by a resident/fellow, the attending physician shall review and authenticate the resident's/fellow's history and physical examination within twenty-four (24) hours. The authentication shall consist of the provider's outline of the salient points of the history, physical, and management plan. The attending physician must also require the resident/fellow to present the progress of each inpatient daily, including discharge planning. While residents may write progress notes in patient's charts, the attending physician will also write appropriate progress notes documenting the portions of care they specifically provide or supervise. Simply counter-signing a resident's/fellow's note is insufficient. All required supervision must be documented in the medical record by the resident/fellow and the supervising faculty member. The interval between practitioner's progress notes shall not exceed three days for non-critical nor daily for critical patients. Residents/fellows must communicate with the attending physician to ensure that the orders they write are consistent with the attending physician's medical treatment plan for the patient. No countersignature by the attending physician is required for orders written by a resident/fellow.

Outpatient supervision: The supervising physician/licensed provider must require residents/fellows to present each outpatient's history, physical exam and proposed diagnostic or treatment plan. All required supervision must be documented in the medical record by the resident/fellow and the supervising provider. *(Exception to this is relevant for services which practice under Medicare's Primary Care Exception Rule).* For services which have been approved to practice under Medicare guidelines, residents/fellows can be supervised with Direct Supervision, Indirect Supervision, or Oversight depending on the resident/fellow level and the supervision policy of the resident's/fellow's program.

Supervision of consultations: The supervising consulting attending/licensed provider must communicate with the resident/fellow and obtain a presentation of the history, physical exam, and proposed decisions for each consultation. This must be done within an appropriate time but no longer than twenty-four (24) hours after notification of the consultation request. All required supervision must be documented in the medical record by the resident and/fellow the supervising attending/licensed provider.

Supervision of procedures: The supervising attending must be certain that procedures performed by the resident/fellow are warranted, that adequate informed consent has been obtained, and that the resident/fellow has appropriate supervision during the procedure to include sedation.

- For procedures performed in the operating room, residents/fellows will always be supervised by an attending physician for the key portions of the procedure.
- For procedures performed outside of the operating room, residents/fellows will be supervised by an appropriately credentialed supervising physician or LIP. Again, the supervising physician can be a faculty member or a more senior resident/fellow than the resident/fellow needing supervision

All required supervision must be documented in the medical record by the resident/fellow and the supervising physician or LIP.

Supervision of emergencies: During emergencies, the resident/fellow should first and foremost provide care for the patient and notify the supervising physician/licensed provider as soon as possible to present the history, physical exam, and necessary diagnostic or treatment. All supervision must be documented in the medical record by the resident/fellow and/or the supervising provider.

Progressive authority and responsibility for residents: Increasing responsibility for patient care is an integral part of the medical education process. Specific roles and tasks for patient care must be assigned by program directors and faculty members.

- Roles and responsibilities for residents/fellows are determined by the program director.
- Decisions regarding the level of supervision necessary for patient care provided by an individual resident/fellow must be based on evaluation of that resident/fellow using specific criteria guided by the Milestones.
- A faculty member acting in the capacity of a supervising attending physician must delegate portions of patient care to residents/fellows based on the needs of the patient and the skills and experience of the resident.
- Each resident/fellow must know the limits of his/her scope of authority and responsibility and the circumstances under which varying levels of supervision apply.

Revised 6/17, 3/21, 12/21
Reviewed 4/19, 2/23