VCUHealth™

Policy Name:	Supervision of Trainees		
Approval Authority:	Graduate Medical Education Committee	Effective Date:	November 9, 2021
Responsible Office:	Office of Graduate Medical Education	Contact:	gmeadmin@vcuhealth.org

1. **Policy Statement**

Supervision in the setting of graduate medical education ensures that the care provided to patients is safe and effective, while allowing trainees the ability to attain the knowledge, skills and attitudes required for autonomous practice. This policy establishes guidance on the supervision of housestaff to individual training programs, both ACGME accredited and non-accredited. The policy is based on the core requirements set forth by the Accreditation Council for Graduate Medical Association (ACGME). Training programs should maintain a supervision policy that follows these tenets as well as those from the individual program Review Committees (RC). The program director must ensure that the teaching staff at all participating institutions and clinical sites provide appropriate supervision of trainees.

2. **Reason for Policy**

To provide guidance to individual training programs on trainee supervision based on the core requirements set forth by the Accreditation Council for Graduate Medical Association (ACGME).

3. **Who Should Read This Policy**

Residency and Fellowship Program Directors, Program Coordinators, Trainees and all faculty members who provide supervision to trainees.

4. **Resources**

https://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements/

5. **Definitions**

Direct Supervision: supervision in which the supervising physician is physically present or concurrently monitoring the patient care through visual and/or audio telecommunication technology.

Indirect Supervision: supervision in which the supervising physician is not physically present or providing concurrent supervision via visual and/or audio telecommunication technology but is immediately available to provide appropriate direct supervision.

Oversight: the supervising physician is available to provide review of procedure/encounters with feedback after care is delivered.

Supervising physician: attending physician, more advanced or senior resident/fellow, or other licensed independent practitioner if allowed by program's accrediting body.

6. **The Policy**
   1. **Supervision and accountability**
      a. Each patient must have an identifiable and appropriately credentialed and privileged attending or licensed independent practitioner (if specified by the training program RC) who is responsible and accountable for the patient's care.

       i. This information must be available to residents, faculty members, other members of the health care team and patients.

      ii. Residents and fellows should inform the patients of their respective role in their care.

  b. Faculty and attending call schedules must be structured to provide trainees with continuous supervision and consultation.

  c. Trainees and other members of the health care team must be provided with a rapid and reliable system for communicating with supervising physician.

2. **Levels of supervision**

  a. Supervision can be exercised through a variety of methods and the level of supervision should ensure the provision of safe and effective care. The degree of supervision and allowed autonomy should evolve progressively as a trainee gains more experience and competence. Individual training programs must demonstrate that the appropriate level of supervision is in place for all trainees based on level of training, ability, and patient complexity/acuity. *Each program must define when the physical presence of a supervising physician is required*. To ensure appropriate oversight of trainee supervision and graded responsibility programs must define the level of supervision for trainee level and situation.

      i. *Direct supervision (level 1):* the supervising physician is physically present or concurrently monitoring through visual and/or audio telecommunication technology with the trainee while providing key portions of patient care including but not limited to procedures. Each program must define when the physical presence of a supervising physician is required.

        1. PGY-1 residents must initially be supervised directly (the length of time and situation that this must occur is based on individual training program RC guidelines).

      ii. *Indirect supervision with direct supervision available (level 2)*: the supervising physician is not physically present with the trainee while providing care but is available to be physically present or via appropriate telecommunication technology immediately.

     iii. *Oversight (level 3):* the supervising physician is available to provide review of procedures/encounters and provide feedback.

3. **Documenting and assigning progression of conditional independence in practice**

  a. The program director is responsible for defining the levels of responsibilities for each year of training through written descriptions of the types of clinical activities trainees may perform or teach.

      i. There should be guidelines set for specific circumstances and events in which trainees are required to communicate with supervising faculty (escalation of care).

      ii. Trainees must know the limits of their scope of authority and the circumstances under which they are permitted to act with conditional independence.

  b. The level of responsibility granted to a trainee is determined by the program director and/or supervising faculty and must be based on the trainee abilities based on specific criteria guided by program specific Milestones.

      i. Up to date procedure logs documenting competency to perform specific procedures should be maintained in New Innovations by the trainee and available to members of the health care team.

  c. 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 trainee.

    i. Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the trainee the appropriate level of care.

  d. 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/fellow.

4. Training program responsibilities

  a. All residency and training programs must have specific supervision policies that follow the ACGME requirements. This policy should be available to all faculty and trainees of the program in New Innovations. The program specific requirements may be more stringent than those listed in this p`olicy but not less stringent. The program director is responsible for ensuring adequate supervision of trainees as well as compliance with program specific policies regarding supervision and oversight. Program specific policies must be reviewed annually and address the following:

    i. Definition of the levels of supervision.

    ii. Process of documenting and assigning progression of conditional independence in practice.

      1. Under which conditions direct supervision is required and when indirect supervision or oversight allowed.

        a. Programs that permit housestaff to independently perform procedures must provide the criteria for performance of invasive procedures without direct supervision.

    iii. Escalation of care

      1. Programs must set guidelines for circumstances and events in which trainees must communicate with the supervising faculty member.

        a. At a minimum, housestaff working in the clinical environment must notify the patient's attending physician (or covering attending), in a timely fashion and independent of the time of day, any of the following situations: controversy or concern regarding patient care, medical errors, significant deterioration in the patient's clinical course, need for surgery, transfer to an intensive care unit or to another service for treatment of an acute problem, need for intubation or ventilatory support, end-of-life decisions, and death.

GMEC reviewed and approved 11/9/2021

All policies are subject to amendment.