

SAUSHEC EM Residency Supervision Policy (From Residency Policy Manual)

IV. Responsibilities and Supervision

A. Responsibilities and Duties in the ED:

1. The residency leadership has developed job descriptions, responsibilities and progression guidelines for each residency year. They are broken down into quarterly goals separated under the six ACGME core competencies. This allows residents to gauge their own progression during their residency and guides the resident's faculty mentor in measuring that individual resident's progression. The program leadership uses these metrics to verify that the resident is competent to move on to the next level of the residency or to graduate. See quarterly progression matrix.
2. The ACGME and EM-RRC have developed Milestones, which are to be implemented over the next couple of years, that the program uses to show the individual competencies, abilities and ability of each resident to practice individually in the specialty of EM. These Milestones will be used in conjunction with the ACGME core competencies to measure residents' progress
3. Pre-shift responsibilities:
 - a. The EM-1 should arrive in time to completely check the department airway carts, the ultrasound equipment /probes and to begin their clinical duties before clinical rounds.
 - b. The EM-2 is responsible for arriving to the shift in sufficient time to begin clinical duties.
 - c. The EM-3 should arrive in time to coordinate administrative aspects such as divert status, bed status, and general situational awareness in the ED.
4. Shift Change/Transition in Care
 - a. Shift change is an extremely important event in the ED. The shift begins and ends with rounds. Transition of care for each individual patient will occur during this time. Rounds should begin promptly at the change of shift. It is the off-going and on-coming senior resident's responsibility to see that rounds begin on time.
 - b. It is the professional responsibility of each resident to arrive early enough to prepare for rounds on time. Residents arriving late for their shifts will be required to work additional clinical hours, which will be scheduled so as not to conflict with the ACGME duty hour rules.
 - c. The acting Chief Residents will be responsible for managing these issues. The off-going and on-coming faculty will have direct supervision of this process and will be responsible for the accuracy of the transitions.
 - (1) Rounds serve two purposes. First and foremost it serves as the device by which off-going physicians transfer care of patients to on-coming providers. In its most basic form, this requires communicating five basic items: 1) who the patient is, 2) why they are here, 3) what you think their problem is, 4) what you have done in the workup and management, 5) what is left to be done including proposed disposition, if known. Patient safety is paramount in this transfer of care.
 - (a) Because this is such a highly critical time in the care of our patients, multiple organizations including the residency have developed transition in care checklists to help decrease the errors that occur during these transitions.
 - (2) The other critical function of rounds is education. Interesting cases, physical findings, test results, treatment options, etc., are discussed in a manner in which all can benefit and in which the general practice of emergency medicine is taught to residents, interns, and students.
 - d. Duty is not complete until all patients currently in the ED, including those being evaluated by interns, students and physician assistants, have been checked out to the on-coming residents. Ideally, the off-going resident should introduce the on-coming resident to all patients for which he/she will be responsible. A written annotation indicating to whom and at what time patient care responsibilities have been transferred and exactly what is left to be done should be made in the patients' ED record. The on-coming resident should write

an acceptance note summarizing the case and pending items after he/she has reviewed the chart and history/physical.

- e. Additionally, patients whose arrival to the ED is pending (incoming ambulance traffic, MEDCOM transfers, etc.) and other administrative matters (e.g., lab malfunction, CT scanner issues, ICU full, divert status, etc.) should be relayed during rounds.
5. Charting
 - a. Complete history and physical exam, diagnosis, impression with discussion of the medical decision-making process, ED course, as well as time of arrival/discharge and any other pertinent information.
 - b. Documentation of all laboratory, ECG and radiologic findings.
 - c. All charts must clearly identify (using a stamp or legible printing) the primary ED provider for the patient, whether that is a medical student, EMPA, or resident.
 - (1) Also, clearly identify the supervisor primarily responsible for staffing the patient (e.g., the EM-3).
 - (2) Finally, identify the faculty physician of record on the chart.
 - (3) All this name identification is important to fulfill the hospital's obligation to patient safety and trainee supervision.
 - (4) Patient identification is also very important for the safety of the patient. The hospital has chosen for their two patient identifiers; the patient's name and their birthday. This needs to be verified during each new patient encounter and when an informed consent is required.
 - d. In most cases, referrals are accomplished electronically using CHCS. Emergent and 72 hour consultations require telephone approval from the consulting service. This process is constantly improving and changing. The departmental operation section will update the providers with any new changes.
 - e. Residents should never take the SF 558 (ED Treatment Record), dictations or any other medical records away from the ED.
 - f. Generally, patients are not given a copy of their ED record such as the SF 558 prior to discharge. This function is handled by the outpatient records department.
 - g. Diagnoses and procedures should be documented on the ED record. No unapproved abbreviations are to be utilized. List diagnoses by order of priority (most serious first). Symptoms may be preferred method of documenting the diagnoses, e.g., Acute Febrile Illness as opposed to streptococcal pharyngitis.
 - h. Uses of abbreviations are severely restricted by hospital policy and residents are advised to keep current on their use. (Approved abbreviation documents)
 - i. All charts will be directly reviewed prior to the final disposition of the patient. During this time feedback may be given on different charting styles.
 6. Interaction with nursing and ancillary personnel
 - a. Efficient functioning of the ED requires cooperation of the physicians, nurses, medics, clerical staff, as well as ancillary support services such as laboratory and radiology personnel.
 - b. Residents are expected to behave in a professional manner during interaction with hospital personnel.
 - c. Any perceived problems with the behavior or performance of hospital personnel should be dealt with professionally and brought to the attention of the faculty physician on duty.
 - d. The residency along with the department of emergency medicine adhere to the hospital's TEAM STEPPS policy. All resident will be trained in the TEAM STEPPS approach to patient care. Close and appropriate resident and nurse interaction is vital to the success and proper patient care.
 7. Interaction with consultants
 - a. Effectively interacting with consultants is a vital skill of the successful emergency physician.
 - b. Each resident will have the opportunity to interact with consultants on a daily basis. Disagreements will arise. Generally speaking, junior residents should involve their senior resident who, in turn, should deal with his/her peer on the involved service. The ED faculty should allow the senior resident to resolve issues. If faculty involvement is deemed

necessary then the ED faculty should interact with the involved service faculty and in most instances refrain from interacting directly with the residents of another service.

B. Supervision

1. This policy is in compliance with the following rules and regulations:

- a. SAMMC Bylaws
- b. ACGME EM Common Residency Requirements
- c. SAUSHEC Resident Supervision Policy
- d. Program policy for procedural competency

The residency has created an electronic system that allows providers, nurses and administrative personnel to verify the procedure competence of each individual resident. We use the New Innovations residency tracking system to accomplish this task. See support document for the details. In accordance with SAUSHED Due Process Policy, the ED EM Staff in the hospital 24/7 may provide the required verification.

e. This policy applies to all physician residents and interns, PA residents and medical students performing patient care in the SAMMC Department of Emergency Medicine under the supervision and control of the faculty (attending) emergency physician or faculty EMPA. This policy also represents the minimum standard of supervision for trainees at away locations

f. It is SAUSHEC policy that any resident involved in a medico legal or Risk Management (RM) case will notify the program director.

- (1) In most cases, this can be through routine notification.
- (2) The purpose is to ensure that the medico legal or RM case is conducted in the context of the residency program and that the resident's due process rights are protected.

2. Presenting patients

All Providers from the medical student to the faculty member will use the hospital's 2 patient identifiers at the onset of each encounter. All members will identify what role they play in the treatment team.

a. Medical Students:

- (1) Will present all their patients to the senior resident or faculty early on in their evaluation of the patient. If the patient is, or potentially is, seriously ill the student should immediately present the patient to the senior or faculty.
- (2) Medical students will discuss orders and review all lab and x-ray results with the faculty or senior. Generally speaking, if the student presents the patient to the senior (or faculty) he/she should direct all further management questions, results, etc. to the same senior (or faculty). This allows for continuity of care and supervision. Students should clarify to whom they should present patients with the senior and faculty before the beginning of the shift.
- (3) Medical students will primarily be under direct supervision from a Senior resident

b. EM-1, R-1 (off-service) Residents:

- (1) Will present all their patients to the senior resident or faculty early on in their evaluation of the patient. Early on, the provider will be under direct supervision from either the senior resident or faculty member. If the patient is, or potentially is, seriously ill the EM-1/R-1 should immediately present the patient to the senior or faculty.
- (2) Early in the year, EM-1/R-1 residents should discuss orders and review all lab and x-ray results with the faculty or senior. Orders by physicians, regardless of PGY level, do not require co-signature in the Emergency Department.
 - (a) Generally speaking, if the EM-1/R-1 resident presents the patient to the senior (or faculty) he/she should direct all further management questions, results, etc. to the same senior (or faculty). This allows for continuity of care and supervision.
 - (b) EM-1/R-1 residents should clarify to whom they should present patients with the senior and faculty before the beginning of the shift.
 - (c) While in the ED, the EM-1/R1 will be under direct supervision by the senior resident or faculty member on shift. This supervision will be advanced to indirect

with immediate availability as the EM1/R1 achieves the different EM- RRC & program milestones

c. EM-2 and EM-3 Residents:

- (1) Will formally present their uncomplicated patients to the faculty physician when the final treatment plan and disposition are being formulated. The EM-2 and EM-3 should continually update the faculty during changes in the medical management of the patient. As a rule, EM-2 residents should present their patients to the staff physician.
- (2) Complicated patients or potentially unstable patients should always be brought to the attention of the senior resident or faculty early in the ED course.
- (3) While in the department all EM-2 and EM-3 will be under indirect with immediately available supervision of the attending on shift. During the course of the year, the supervision of these residents will be transitioned to indirect supervision. Because of the volatile nature of an emergency medicine practice, an attending physician is always in the ED 24/7. The transition occurs as the resident meets his/her progression matrix milestones. See matrix milestone for details and EM-RRC Milestones. These documents are also located in NI departmental document section.

d. Co signature:

- (1) All charts of patients seen by medical students must have a complete H&P written by the supervising resident (SR) or faculty after the SR/faculty has completed their own evaluation. The medical student may work as a scribe for the SR/faculty. The following like statement must be written and signed by the SR/faculty, "I (name) take ownership of the following scribe additions to the chart, (sections completed by student). " All student charts must be signed by faculty prior to the patient's disposition.
- (2) All charts of patients seen by EM-1/R-1s must be reviewed and must have a note written and signed by the senior resident on duty or faculty prior to the patient's disposition.
- (4) All charts of patients seen by EMPA residents and PA rotators (Basic Skills Course) will be cosigned either by the supervising faculty EMPA or faculty physician.
- (5) Residents are not privileged providers and can only provide patient care under the supervision of a privileged provider.
- (6) Residents who choose to practice any form of medicine outside of the program/institution (e.g., curbside treatment of your next-door neighbor while at home: strictly prohibited), whether for pay or not, are considered to be moonlighting. SAUSHEC GME and DOD Policy prohibit resident moonlighting.
- (7) The faculty physician will review all charts of patients seen by residents and students (all types) and the faculty of record will be noted on the chart.
- (8) The faculty on duty must cosign all charts of patients being transferred or admitted prior to disposition. It is the resident's responsibility to present the chart to the faculty in a timely manner for their review and signature.

e. Chart Reviews: The faculty on duty will review all resident charts. The faculty will point out deficiencies either verbally or by written notes. They may require remedial action or may be required to recall the patient for further evaluation.

f. Every attempt will be made by the faculty to provide this feedback while you are physically present in the ED.

g. It is the residents responsibility to notify the senior resident and faculty immediately:

- (1) Upon the arrival, by walk-in or ambulance, of any critically ill patients.
- (2) Upon notification of any patient arriving by ambulance.
- (3) Upon the arrival of any patient from another clinic or location within the hospital.
- (4) Upon the need for sedation or administering vasoactive medications.
- (5) Of their interpretation of x-rays and EKG's.
- (6) Upon the need for and prior to consultations. (As the resident progresses through the milestones this restriction goes away)
- (7) Prior to calling the consultant for admission.
- (9) Prior to any invasive procedures.
- (10) Prior to transfer to another facility.

- (11) Concerning any patient that refuses medical care or wishes to leave against medical advice.
- (12) Concerning any patient that has an adverse reaction or complication of any medication administered or procedure performed in the ED.
- (13) About all patients that are dissatisfied or disappointed with their ED treatment.

Table IV-1 Summary of Supervision and Responsibility of Trainees And Supervisors In the Emergency Department.

[Note that the documentation requirements shown in these tables reflect minimums from a GME and patient safety perspective. Requirements for billing may be different from depicted here.]

Level	Key Aspects of Supervision
Medical Student	<ul style="list-style-type: none"> • Early presentation of all patients to senior resident (SR) or faculty • SR/faculty will examine all patients • All orders formally approved by SR/faculty • SR/faculty will write separate note and sign chart • Faculty will cosign all charts • Patient encounters under direct supervision from senior/faculty
EM-1 R-1	<ul style="list-style-type: none"> • Early presentation of all patients to SR or faculty • SR/faculty discretion to discuss case and see patient • SR/faculty will write separate note and sign chart • Faculty will cosign all charts • Initial encounters under direct supervision from senior/faculty
EM-2	<ul style="list-style-type: none"> • Presentation of all patients to SR or faculty prior to disposition • SR/faculty discretion to discuss case and see patient • SR/faculty discretion to write separate note, but will sign chart • Faculty will cosign all charts • Under indirect supervision with immediate faculty availability
EM-3	<ul style="list-style-type: none"> • Presentation of all patients to faculty prior to disposition • Faculty discretion to discuss case and see patient • Faculty discretion to write separate note • Faculty will cosign all charts • Under Indirect faculty supervision

Level	Key Aspects of Supervisory Responsibility
Senior Resident (EM-3s, and EM-2s on selected shifts)	<ul style="list-style-type: none"> • Direct their POD resident team • Be aware of all patients in the department including EM-2's and PA's primary patients • Supervise and teach juniors • Keep faculty informed of all patient dispositions • Write notes on all patients seen • Faculty will cosign all charts
Faculty	<ul style="list-style-type: none"> • Direct and indirect supervision for all trainees and patients in ED • Supervise and teach all trainees • Faculty will cosign all charts • Present in the ED at all times