



**San Antonio Uniformed Services  
Health Education Consortium  
San Antonio, Texas**

**Resident Supervision Policy  
July 2012**

1. Residency training is an educational experience designed to offer residents the opportunity to participate in the clinical evaluation and care of patients in a variety of patient care settings to include the general medicine wards, the medical intensive care unit (MICU), and the Cardiac Care Unit (CCU). While it is the goal of this training program to allow for progressive authority and graded responsibility for each resident according to their individual abilities as they progress through training, all aspects of patient care rendered by resident physicians must receive close supervision.
2. All facets of patient care are ultimately the responsibility of the supervising physician. Supervising physicians have the right to prohibit resident and medical student participation in the care of their patients without penalty, and when allowing care of their patients by residents do not relinquish their rights or responsibilities to: examine and interview; admit or discharge their patients; write orders, progress notes; and discharge summaries; obtain consultations; or to correct resident medical record entries deemed to be erroneous or misleading.
3. When a resident is involved in the care of a patient it is their responsibility to communicate effectively with their supervising physician regarding the findings of their evaluation, physical examination, interpretation of diagnostic tests, and intended interventions.
4. The supervising physician is defined as that physician who has immediate oversight responsibility of all aspect of patient care rendered by the residents and may be a staff or fellow.
5. 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 types 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.
6. Levels of Supervision

- a. Direct Supervision – the supervising physician is physically present with the resident and patient.
  - b. Indirect Supervision:
    - i. 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.
    - ii. With 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.
  - c. Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.
7. 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.
  8. In particular, PGY1 residents should be supervised either directly or indirectly with direct supervision immediately available by a PGY2 or PGY3 resident, subspecialty fellow, or staff physician.
  9. Procedures
    - a. Residents may perform procedures unsupervised if they are certified to perform the procedure independently. All other procedures must be directly supervised by the physical presence of a physician who is certified to perform the procedure independently.
    - b. Individuals may be certified to perform procedures unsupervised by the program director only after they have successfully completed the minimum number of required supervised procedures and when a supervising physician has documented that they are competent to perform the procedure. An electronic and hard copy record of the resident’s procedure certification will be maintained on file in the Internal Medicine Residency office.
    - c. Because individual residents attain certification of specific procedures at different points in their residency education, any concerns or questions regarding certification of a resident’s competency in any procedure should be directed to the internal medicine program director (or supervising physician during non-duty hours).
    - d. All procedures except for venopuncture, peripheral intravenous line placement, nasogastric tube placement, or those procedures performed during an emergency, such as a code, require prior notification of the supervising physician.

- e. Medical students are not allowed to perform any procedures unsupervised.
- f. Support staff confirmation of resident procedural competency:
  - i. A trainee will be considered qualified to perform an invasive procedure without direct supervision if, in the judgment of the supervising staff (and according to his/her specific training program guidelines), the trainee is competent to safely and effectively perform the procedure. Residents at certain year levels in a training program may be designated as competent to perform certain procedures under indirect supervision with or without direct supervision immediately available based upon specific criteria defined by the program. Trainees may perform procedures that they are deemed competent to perform for standard indications under oversight, provided that the staff is notified in a timely fashion. The patient's attending of record will be ultimately responsible for all procedures performed on patients. See section VIII for performance of procedures in emergencies.
  - ii. When requested by hospital nurses or other personnel with need to know, attending staff physicians must verify whether residents can perform procedures without direct supervision. Attending staff can comply with this Medical Staff requirement because:
    - 1. Residents will demonstrate professionalism by informing their attending physician and other hospital personnel when they are not approved to perform a procedure without direct supervision or not approved to supervise another resident perform a procedure.
    - 2. The program director will inform attending physicians in the specialty how to access the resident-specific information to identify procedures each resident is approved to perform without direct supervision and/or supervise other residents' procedures.
  - iii. When necessary, hospital nurses and other personnel will telephone/page the attending staff physician (who is available 24/7) to confirm whether a resident is approved to perform a procedure without direct supervision.

#### 10. Internal Medicine Continuity Clinic and Ambulatory Rotations

- a. Residents may perform history and physical examinations without the supervising physician being physically present.
- b. PGY1 Residents – Upon completion of their evaluation the first year residents will give a complete presentation of the history, their physical examination findings, interpretation of diagnostic tests, and intended interventions to the supervisory staff. The supervising physician will confirm any key portions of

history and physical exam. The resident will annotate the name of the supervising staff in the patient care document and make it available to the supervisory staff for review and co-signature.

- c. PGY2 Residents – Second year residents will give a brief presentation to the supervising physician. The supervising physician will interview and/or examine the patient at their discretion, the resident’s request, or at the patient’s request. The resident will annotate the name of the supervising staff in the patient care record and make it available to the supervising staff for their review and co-signature.
- d. PGY3 Residents – Third year residents will give a brief presentation on all new patients to the supervising physician and on any follow-up patients requiring a significant change in the patient care plan. Follow-up patients who do not have significant changes in their care plan do not need to be presented but their patient care record must be made available to the supervisory staff for review and co-signature. The supervising physician will interview and/or examine the patient at their discretion, the resident’s request, or at the patient’s request. The resident will annotate the name of the staff physician in the patient record and make it available to the supervising staff for their review and co-signature.
- e. All documentation by residents and supervising physicians must be legible to those who use the medical record, including signatures.
- f. Residents may write or enter orders on patients for whom they are participating in their care. These orders will be implemented without the co-signature of the supervising attending.
- g. Medical Students – may perform history and physical examinations without the supervising physician being physically present but the supervising physician must repeat the interview and physical examination on every patient. Medical students may not write an official clinic note intended to be entered into the medical record. Medical students are not allowed to write or enter orders on patients without the co-signature of the supervising attending.

## 11. Medicine Subspecialty Clinics

- a. Resident supervision in regards to patient care and the medical record will be the same for all residents rotating in the medicine subspecialty clinics. The supervision of residents in regards to patient care and the medical record will not vary by PGY level in the medicine subspecialty clinics. Residents may perform history and physical examinations, and consultations without the supervising physician being physically present. It is the responsibility of the resident to discuss their findings with the supervising physician upon completion of their examination. The supervising physician will confirm any key portions of the history and physical exam. The supervising physician must make additions and corrections in the documented history and physical, and co-sign the residents’ documentation.

- b. All documentation by residents and supervising physicians must be legible to those who use the medical record, including the full printed name of any signature that is illegible.
- c. After discussion with the attending staff, residents may write or enter orders on patients in whose care they are participating. These orders will be implemented without the co-signature of an attending or consulting physician.
- d. Residents rotating in the medical subspecialty clinics will not be allowed to give independent verbal consultations at any time. Recommendations either need to be written and co-signed or delivered verbally by the supervising fellow or staff.
- e. Medical students may perform history and physical examinations without the supervising physician being physically present but the supervising physician must repeat the interview and physical examination on every patient. Medical students may not write an official clinic note intended to be entered into the medical record. Medical students are not allowed to write or enter orders on patients without the co-signature of the supervising attending.

12. Medicine General Medicine Wards, Night Float, Medical Intensive Care Unit (MICU) and Cardiac Care Unit (CCU)

a. Admissions

- i. Second and third year residents (PGY2 and PGY3) can admit patients to the general medicine wards and the intensive care units.
- ii. The supervising faculty must be notified about all patients admitted to their team. This must be done within 12 hours of an admission or sooner if there are any questions regarding initial evaluation or treatment of a patient.
- iii. Any admission to the ICUs must be discussed with the ICU fellow or staff at the time of initial evaluation. Residents on the ICU service must evaluate any ICU admission within 30 minutes of arrival. The supervising fellow or staff must be notified within 2 hours of an ICU admission.
- iv. The supervising faculty must be notified immediately of any significant change in a patient's status, change in the goals of care (i.e. comfort care only), transfer to a higher level of care, or death.
- v. The following criteria necessitate notification to the medical ward and night float supervising physician within 2 hours after the initial assessment:
  - 1. Nursing interventions required at least every 2 hours for more than 8 hours

2. Vital sign monitoring required at least hourly for up to 4 hours
  3. Hemodynamic instability or lability
  4. Cardiac dysrhythmias requiring drug suppression or cardioversion; any potentially fatal dysrhythmia
  5. Unstable coronary syndrome, new ST-T changes, or elevated troponins
  6. Oxygen saturation < 90% requiring FiO<sub>2</sub> > 50%, continuous CPAP or BiPAP, or hypercapnea with pH < 7.35
  7. Hemodynamically unstable GI bleeding or GI bleeding requiring transfusion after initial stabilization
  8. Encounters with ethical concerns or significant medico-legal implications
- vi. It is recognized that the above list is not exhaustive. There are other instances and medical conditions for which common judicious practice dictates notification to the supervising physician. It is the resident's responsibility to communicate effectively with their supervising physician regarding the findings of their evaluation, physical examination, interpretation of diagnostic tests, and intended interventions when these situations arise.
  - vii. The supervising faculty must be notified before performing any procedure requiring informed consent.
  - viii. Residents providing consultation on patients admitted to other services must contact their supervising consult faculty within two hours after their initial evaluation and prior to making any final recommendations. The name of the supervising staff must be annotated in the record.

b. History and Physical Examinations

- i. Residents may perform history and physical examinations and consultations without the supervising physician being physically present. It is the responsibility of the resident to discuss their findings with the supervising physician. The supervising physician must evaluate the patient, review the history and physical documented by the resident, and write or enter a separate note of concurrence with the admission treatment plan, history, and physical exam within 24 hours of admission. For admissions to critical care units, there must be documentation of notification of the admission and concurrence of the supervising physician with trainee health care plans within four hours of admission.

- ii. Medical students may not write or enter the official history and physical for their patients. Medical students may write a separate “training history and physical examination,” which does not become a permanent part of the medical record. The resident and supervising physician should review the training history and physical examination and provide feedback to the medical student.

c. Daily Progress Notes

- i. Residents may write or enter daily progress notes. It is the responsibility of the resident to discuss their findings and treatment plans documented in their progress note with the supervising physician on a daily basis. Supervising ward and ICU physicians must write or enter a daily staff note, though this may be an addendum to the signed progress note.
- ii. Medical students may not write or enter progress notes. Medical students may write a separate “training progress note,” which does not become a permanent part of the medical record. The resident and supervising physician should review the training progress notes and provide feedback to the medical student.

d. Orders

- i. Residents may write or enter orders on patients in whose care they are participating. These orders will be implemented without the co-signature of an attending or consulting physician. Residents are encouraged to evaluate all patients for whom they are initiating orders. However if it is clinically appropriate, residents are allowed to place “verbal” orders over the phone. All phone orders must be signed, dated, and timed within 24 hours.
- ii. Do Not Resuscitate (DNR) – BAMC MEMO 40-168
  - 1. Only privileged physicians who are members of the medical staff may write DNR orders.
  - 2. Licensed physicians in GME may transcribe a verbal DNR order from a privileged physician under the following conditions:
    - a. The resident has thoroughly evaluated the patient.
    - b. The resident notifies the attending physician of the need for a DNR order and receives the approval of the attending physician prior to transcribing the DNR order.

- c. The DNR order written by a physician in GME will be cosigned (or rewritten) by the Attending Physician within 24 hours. The Attending Physician will also discuss the DNR status with the patient or surrogate and document the discussion in a progress note within 24 hours.
- d. The DNR order must be entered and saved in the orders section of Essentris by the ordering physician. Telephonic initiation of DNR orders will not be accepted by a Registered Nurse. The physician who writes the DNR order should ensure that all others involved in the care of the patient, especially the nursing staff, clearly understand the order, its rationale, and its implications.
- e. As an exception, in urgent situations, when an immediate DNR is required, an unlicensed physician in GME can transcribe a verbal DNR order from the attending physician.

iii. Restraints

- 1. Only licensed PGY2 and PGY3 residents may write orders for restraints as outlined in BAMC MEMO 40-152.
- 2. Any restraint order must be renewed every 24 hours and should be co-signed by the supervising physician.

iv. Medical students are not allowed to write or give verbal orders at any time.

e. Discharge Summaries and Transfer Summaries

- i. Residents may write or enter the discharge summary or transfer summary on patients in whose care they are participating. It is the responsibility of the resident to discuss discharge plans with the attending or consulting physician prior to discharging the patient. The resident will inform the supervising physician of all discharge plans before the patient is discharged or transferred to another provider, service, or facility. The resident will annotate the name of the supervising staff in the discharge summary and make it available to the supervising staff for their review and co-signature. Patients may be discharged prior to the supervising physician co-signature provided that proper notification has been given to the supervising physician as noted above.
- ii. Medical students may not write or enter discharge summaries or transfer summaries.

f. Transitions of Care

- i. This policy specifically addresses the SAUSHEC Internal Medicine policy and protocol for patient handovers and transitions of care.
- ii. SAUSHEC Internal Medicine is committed to limiting the number of patient handovers and clinical assignments will be designed with transitions of care in mind. When transitions of care are necessary given the clinical assignment, SAUSHEC Internal Medicine promotes in person and one-on-one communication between transitioning health care teams.
- iii. SAUSHEC Internal Medicine current transition of care protocol is as follows:
  1. Transitions of care occur in the morning and at the end of the duty day.
  2. Patient handoffs for new admissions occur every morning and the accepting faculty must be physically present for a face to face discussion of the patient. These patient handovers should include a written history and physical examination. In addition, for each patient, a succinct review must occur in enough detail that the accepting physician has a full understanding of the relevant diagnoses and treatment plan.
  3. At the end of the duty day, a team member from each ward service must be available to provide a direct face to face handoff, which also includes a written summary highlighting key issues for each patient.
  4. Residents must utilize the approved template for patient handoffs and successfully fill out all sections of the template.
  5. Finally, the attending of record MUST be documented and available by pager for any additional concerns that arise or may not be addressed adequately enough on the handover template.
  6. In the event that the attending of record cannot be readily contacted, the on-call night float staff should be contacted for questions or concerns.
- iv. It is the responsibility of the supervising faculty to ensure that transitions of patient care and patient handovers occur in the manner documented above.