

## SAUSHEC RADIOLOGY SUPERVISION POLICY

1. **Definition:** Supervision constitutes any method of staff oversight of patient care for the purpose of ensuring quality care and enhancing learning; this term does not necessarily require the physical presence of the independent gathering of data about the patient on the part of the supervising staff provider.

### **2. General Principles of Supervision**

Careful supervision and observation are required to determine the trainee's ability to gather and interpret clinical information, perform technical procedures, interpret procedures and safely manage patients. Although not privileged for independent practice, trainees must be given progressively graduated levels of patient care responsibility while concurrently being supervised to ensure quality patient care. Each patient must have a responsible attending whose name is recorded in the patient record, who is available to the residents, and who is involved with and takes responsibility for patient care being provided by the trainees he/she is supervising. This information should also be available to the patients. Residents and faculty members of the health care team should inform patients of their respective roles in each patient's care.

### **3. Diagnostic Radiology**

1. The provision for graduated resident responsibility includes over-reading of 100% of diagnostic radiology studies by staff radiologists during the period of residency training to assure maximum quality of care being provided to the patients as well as to assure timely feedback to the residents concerning any discrepancies in interpretation. Careful supervision of technique, including specification of study parameters or protocols (e.g., with CT or MR exams) or patient interactions (e.g., excretory urograms, gastrointestinal fluoroscopic studies, interventional procedures) is also part of the training.

2. Supervision of radiology residents can be either **direct** or **indirect**. Direct supervision means the staff radiologist directly assists in study interpretation or performance of a procedure with the resident. Indirect supervision means the resident initially interprets a study or performs a procedure alone and renders a preliminary report before the staff radiologist gives the final interpretation. A more senior resident can also provide supervision to a junior resident in initial interpretation of exams and performance of procedures provided the senior resident is already certified as competent in that specific area. However, 100% of exams will be over-read by a staff radiologist.

3. Resident progress is evaluated primarily in the "Radiology Resident Rotation Evaluation" form. The evaluation scale is "does not meet expectations (1)," "meets expectations (3)," or "exceeds expectations (5)." A 2 or 4 may be used in the Likert 5 point scale as well. This scale applies to all PGY training levels and the staff will assess the score based upon performance level at the residents' year in training. A minimum score of "3" is required in every element under "Patient Care" and "Medical Knowledge" in order to successfully pass that rotation. A resident that does not receive a passing grade in these core elements must repeat the rotation before progressing to the next level of training. A resident that passes a rotation is assumed to

possess the skills necessary to interpret examinations in that subspecialty area with indirect supervision (based upon the residents' year in training). No resident will have call duties until they've completed one year of radiology training.

4. A goal of SAUSHEC radiology training program is to gradually progress from direct supervision of residents to indirect supervision and ultimately to the graduating resident being capable of performing the duties of a general radiologist as a licensed independent practitioner. The level of supervision given to each resident is the responsibility of the staff radiologist in charge of that resident and is based on the resident's performance during previous rotations and on the rotation they are currently assigned.

5. All examinations initially interpreted by a resident radiologist with indirect supervision will have the findings annotated as a "preliminary report" in the PACS report field so that the clinicians can know that a staff radiologist has not yet reviewed it. After staff radiologist review, the preliminary notation is removed, and staff name and notification of review is placed in the comments section, and the report can be considered final.

6. Progress of residents to the next year of training requires the following:

1. Passing all the core elements under "Patient Care" and "Medical Knowledge" (score of at least "3"). If a resident fails a rotation, that rotation must be repeated and passed that academic year before progression to the next academic year will be allowed.
2. Review of training performance and scores on ACR in-service exams and ABR board exams during that academic year
3. Written recommendation of progression for that resident to the next year of training by the Program Director or Associate Program Director.

1<sup>st</sup> Year Residents: 1<sup>st</sup> year radiology residents are learning the basic skills of image interpretation, dictation, service management, and interactions with both patients and clinicians. The resident will have rotations in the following subspecialty areas of radiology: thoracic, GI/GU, ultrasound, CT, bone, nuclear medicine, pediatrics, and neuroradiology. The goal of these first rotations is to prepare the resident for independent call responsibilities that start in March of their first year of training. Assessing if the resident is prepared for this responsibility is accomplished in three ways:

1. Monthly evaluations: A minimum score of "3" in all elements in Patient Care and Medical Knowledge. A score of "1,2" will result in the resident repeating the rotation before taking independent call.
2. Staff and senior resident observation of the 1<sup>st</sup> year resident taking "buddy call" early in their first year.
3. Successful completion of the 1<sup>st</sup> year on-call curriculum given in January or February.

2<sup>nd</sup> Year Resident: The resident is expected to function with more autonomy. It is during this year that the resident gets the first rotation in vascular-interventional radiology and in mammography. On the Interventional Radiology rotations, the residents will be given increasing responsibility within a case as their own technical skills progress, but at all times, the faculty member is immediately available to assure the proper performance of the procedure. This 100% direct supervision also applies to interventional procedures whether they are performed in the

angiography suites or in ultrasound, CT or fluoroscopy rooms in other areas of the Radiology Department.

3<sup>rd</sup> and 4<sup>th</sup> Year Residents: The resident accepts more responsibility for supervision and teaching. At all times, the responsible radiology faculty member is kept informed of decisions and recommendations by the resident radiologist to assure proper case management, patient safety and utilization of proper knowledge and decision process by the resident.

4. Each resident will be responsible for maintaining a “Procedure Competency Certification Form.” This form will outline radiology procedures that the radiology resident is able and allowed to perform without direct supervision. A specific procedure can be “signed off” by a staff radiologist when the staff radiologist is satisfied that the resident understands the indications for the procedure, is aware of potential complications and appropriate management of those complications, and is technically capable of performing the procedure. An updated copy of this form will be kept in the resident’s training folder/web-based learning portfolio. It is the resident’s responsibility to see that the form is completed in a timely manner and kept up-to-date. A resident cannot perform one of these radiology procedures without direct supervision unless a staff radiologist has “signed off” on that procedure on the “procedure competency form.” For all invasive procedures a staff radiologist will be present for the critical portion of the examination. Radiology follows SAUSHEC’s Supervision policy (Section VIII) regarding support staff verification of resident procedural competence.

**7. Transitions in Patient Care:** Our primary transitions in patient care occur at the end of the normal duty day (defined as 1630), and at the end of the SAMMC night float call shift with the Emergency Radiology rotation resident and staff between 0730-0800. These transitions are between the resident/staff call team and the duty-day resident/staff team and occur in person. A third transition occurs at 2000 each weeknight between the short-call resident (1630-2000) at SAMMC and the night float resident. This is overseen by the staff as the on-call staff radiologist must ensure the short call resident's studies have been reviewed, dictated, and approved before the short call resident leaves the hospital. A staff-to-staff shift change occurs at SAMMC at 2315-2330 on weeknights. The on-call evening staff duty hours are 1600-2330. The overnight staff duty hours are from 2315-0800. Appropriate staff overlap ensures seamless patient care and resident supervision. On call staff duty hours on weekends and holidays at SAMMC are from 0700-1930 and 1900-0730. The number of transitions in care is reduced on weekends and holidays.

We have radiology staff in-house 24/7 at SAMMC, where radiology residents perform on-call duties. The radiology staff and radiology residents at SAMMC also provide after-hours coverage for any radiology studies performed at the WHASC UCC. An on-call transition dry erase board is maintained at SAMMC to facilitate seamless hand-off of pending imaging exams in addition to 100% verbal, in-person handoff of emergency and in-patient studies.

During clinical duty hours at SAMMC, the resident and faculty on the Emergency Radiology rotation manage all Studies from the Emergency Department (phone and pager access) between the hours of 0700 - 1630 and ensure appropriate transition to the on-call resident and staff.

As of 1 July 2011, there are now two residents on overnight call at BAMC (as there is no overnight coverage for the WHMC UCC). The senior resident provides supervision to the junior resident and is responsible for workload distribution and completion.

The chief residents and senior residents, in addition to the program leadership and radiology faculty, provide mentoring regarding transitions in patient care. In addition, at least annually, the program director and chief resident provide a small group discussion of hand-over procedures as part of our emergency radiology curriculum. The dry erase board in the radiology resident on-call reading room serves as our visual hand-off checklist.