

SAUSHEC UROLOGY RESIDENCY SUPERVISION POLICY (page 53 Urology Residency Handbook)

The SAUSHEC Urology Supervision of Residents Policy is in accordance with the following policies:

- ACGME Common Program Requirements, Section VI.D. Supervision of Residents, dated July 1, 2011.
- ACGME Program Requirements in Urology, Section VI.D. Supervision of Residents, dated July 1, 2009.
- SAUSHEC Supervision of Residents Policy.

The bold, enumerated sections below correlate with the requirements set forth in the aforementioned ACGME documents, and the following paragraph details the SAUSHEC Urology Supervision of Residents Policy.

VI.D.1. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.

VI.D.1.a) This information should be available to residents, faculty members, and patients.

VI.D.1.b) Residents and faculty members should inform patients of their respective roles in each patient's care.

Urology residents participate in three distinct clinical learning environments: outpatient care in the urology clinic, inpatient care as the admitting service or consulting service, and the operating room.

Outpatient Care in the Urology Clinic

The residents are assigned to (1) outpatient urology clinics, (2) pre- or post-operative clinics, or (3) office procedure clinics.

- (1) Outpatient Urology Clinics: The residents actively participate in the urology clinic at the sponsoring institution and the pediatric urology rotation at the University of Texas Health Science Center at San Antonio. The patients at these clinics are assigned to appointments with a privileged attending urologist and are fully aware of the attending urologist ultimately responsible for their care. Additionally, residents introduce themselves as a "resident physician" and identify the attending urologist that they are being supervised by for that specific appointment. Also, hospital badges with a picture ID are required to be worn by

all personnel and identify each individual by their respective roles (resident versus staff).

- (2) Pre- or Post-Operative Clinics: Residents are assigned to pre-operative and post-operative clinics. During the pre- and post-operative clinics, the residents evaluate and counsel patients scheduled for surgery or returning for follow up after surgery. The residents specifically see the patients that they will participate or have participated in the operative care of in these pre- and post-operative clinics. The attending urologist is identified on the pre- and post-operative documents including the surgical consent form that the patients signs.
- (3) Office Procedure Clinics: In the office procedure clinics, the resident identifies himself or herself as a “resident physician” under the supervision of the assigned staff urologist of the day. Additionally, the names and roles of the resident and the supervising attending urologist will be listed on the consent form that the patient signs prior to the procedure.

Inpatient Care as the Admitting Service or Consulting Service

For postoperative patients on the urology service, the attending surgeon of record will supervise the residents. The attending surgeon will have identified himself or herself during the pre-operative period so that the patient is aware who is ultimately responsible for their care. The on-call attending urologist will supervise the residents in the care of consultations on inpatients admitted to other services, patients admitted to the urology service through the emergency department, or postoperative urology patients if the patients’ surgeon is not available for any reason. When the residents see these patients, they will introduce themselves as “residents” working under the supervision of the on-call attending urologist.

Operating Room

All patients undergoing elective or emergent surgery will be directly supervised in the operating room by a privileged attending urologist. Preoperatively, the attending urologist and resident will identify themselves and their respective roles to the patient.

VI.D.2. The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients. 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 portions 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.

VI.D.3. Levels of Supervision

To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:

VI.D.3.a) Direct Supervision – the supervising physician is physically present with the resident and patient.

VI.D.3.b) Indirect Supervision:

VI.D.3.b).(1) 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.

VI.D.3.b).(2) 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.

VI.D.3.c) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

Urology residents are supervised in all three distinct clinical learning environments: outpatient care in the urology clinic, inpatient care as the admitting service or consulting service, and the operating room.

Outpatient Care in the Urology Clinic

The residents are supervised in each of the clinics to which they are assigned: (1) outpatient urology clinics, (2) pre- or post-op clinics, or (3) office procedure clinics.

- (1) Outpatient Urology Clinics: PGY1 and PGY2 residents in these clinics will be directly supervised. Faculty will work closely with all urology residents in the outpatient clinics and review/cosign all clinic notes. The outpatient care provided by urology residents of all levels will be individually discussed at quarterly faculty meetings. With consensus agreement, the appropriate outpatient clinic level of supervision (direct or indirect with direct immediately available) will be determined for each urology resident. This determination will be documented and made known by the Program Director to all staff and individual residents via the “Quarterly Resident Supervision Report” (see Attachment). The level of supervision will be determined based upon the faculty’s assessment each resident’s medical knowledge, patient care, and professionalism during outpatient clinics. The report will include a recommendation for the level of supervision in outpatient urology clinics for each resident. Because of the

availability of attending urologists and clinic design, the lowest level of supervision in outpatient clinics is indirect with direct supervision immediately available. All patient notes generated by the residents will be reviewed and signed by the attending urologist assigned to that specific clinic.

- (2) Pre- or Post-Operative Clinics: These appointments are indirectly supervised with direct supervision immediately available. The operative and post-operative plans are typically already discussed between the resident and the surgeon of record before these appointments. If the surgeon of record is not available during the patient appointment, the on-call urologist or staff urologist of the day is available to provide immediate direct supervision as needed. Documentation generated during these patient visits will be reviewed and signed by the surgeon of record.
- (3) Office Procedure Clinics: The following office procedures are commonly performed in the urology clinic:
- Flexible Cystoscopy in males
 - Rigid Cystoscopy in females
 - Retrograde Pyelogram
 - Transrectal Ultrasonography with Prostate Biopsy
 - Vasectomy

PGY1 interns will not perform office procedures. Pre-urology PGY2 residents that perform office procedures will always be directly supervised by the attending urologist assigned as staff of the day. New Uro1 urology residents will also be directly supervised by the attending urologist scheduled as staff of the day. After the new Uro1 resident demonstrates proficiency in 5 directly supervised cases of each type listed above, he/she will submit to the program director a list of patient names, procedures, and supervising attending urologists. After confirming proficiency by the supervising attending urologists, the program director will change the supervision requirement for that specific procedure to indirect supervision with direct supervision immediately available on the next "Quarterly Resident Supervision Report" (see attachment). If the program director cannot establish a consensus of proficiency, the resident will be asked to submit another list of 5 patients on which the procedure was performed under direct supervision. The resident will be advanced to indirect supervision with direct supervision immediately available when proficiency is established by the program director. Because of the availability of attending urologists, the lowest level of supervision in outpatient clinics is indirect with direct supervision immediately available. All patient notes generated by the residents will be reviewed and signed by the attending urologist assigned as staff of the day.

Inpatient Care as the Admitting Service or Consulting Service

All inpatients seen by urology residents for evaluation and treatment will be directly supervised, indirectly supervised with direct supervision immediately available, or indirectly supervised with direct supervision available after hours by an approved attending urologist. The on-call attending urologist will evaluate new patient admissions to the urology service and document his/her assessment in the medical record within 24

hours of admission. The on-call attending urologist or surgeon of record will evaluate and document his/her assessment in the medical record of inpatients daily for inpatients admitted to the intensive care unit or at least every 3 days for inpatients admitted to regular nursing wards.

Operating Room

All patients undergoing elective or emergent surgery will be directly supervised in the operating room by an approved attending urologist.

VI.D.4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.

VI.D.4.a) The program director must evaluate each resident's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.

VI.D.4.b) Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.

VI.D.4.c) Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.

Specific urology index cases are identified in the ACGME Resident Operative Experience Log. For each index case, a required number of cases is listed. Residents are required to update their operative log by the end of each month. The program director will review operative logs quarterly. When the resident accrues the required number of competently performed cases for a specific index case, the resident will be extended Teaching Assistant privileges for that case. This privilege will be documented in the "Quarterly Resident Supervision Report." The attending surgeon of record is required to be present for all operative cases, but he or she may delegate to a resident with Teaching Assistant privileges the "supervisory" role of the case for another more junior resident.

VI.D.5. Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.

VI.D.5.a) 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.

VI.D.5.a).(1) In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.

On-call junior residents will notify the on-call Chief Resident, and the Chief Resident will notify the on-call attending urologist under the following circumstances:

- Evaluation of an outpatient in the urology clinic who requires admission or emergent surgery.
- Evaluation of a patient as a result of consultations from other services or the emergency department who require immediate urologic treatment.
- Evaluation of an inpatient on the urology service who requires transfer to a higher level of care within the medical center.
- Death of an inpatient on the urology service.

VI.D.6. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.

At the sponsoring institution, an attending urologist will supervise residents in the urology clinic for one half day each week and for two days each week in the operating room on average. In addition, attending urologists will rotate weekly on call. Over the course of the 2.5 years of training each resident spends at the sponsoring institution, this schedule will provide sufficient duration to assess the knowledge and skills of each resident in order to delegate to him/her the appropriate level of patient care. All faculty members attend the academic conferences scheduled on Wednesday afternoon of every week and morning report daily on weekdays. These forums provide another opportunity for faculty members to assess knowledge of each resident.

At participating sites, the residents on rotations of 2 or 3 months in duration will be supervised primarily by 1 or 2 attending surgeons. Multiple attending urologists will supervise residents on the Urology San Antonio rotation, but the rotation is 12 months in duration. At all participating sites, the duration of the rotation correlates with the number of attending urologists and allows for sufficient time to assess the knowledge and skills of the resident with appropriate delegation of patient care authority and responsibility.

TRANSITIONS OF CARE

The SAUSHEC Urology Transitions of Care Policy is in accordance with the following policies:

- ACGME Common Program Requirements, Section VI.B. Transitions of Care, dated July 1, 2011.
- ACGME Program Requirements in Urology, Section VI.B. Transitions of Care, dated July 1, 2009.
- SAUSHEC Transitions of Care Policy.

The bold, enumerated sections below correlate with the requirements set forth in the aforementioned ACGME documents, and the following paragraph details the SAUSHEC Urology Transitions of Care Policy.

VI.B.1. Programs must design clinical assignments to minimize the number of transitions in patient care.

VI.B.2. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.

VI.B.3. Programs must ensure that residents are competent in communicating with team members in the hand-over process.

VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care.

Urology inpatients are managed primarily by the resident team. Ultimately, the chief resident and urology surgeon of record or on-call attending urologist are responsible for the care of the patient. All inpatients are discussed each weekday morning at 0700 at morning report. Transitions in on-call coverage occur at morning report. Safe and effective hand-overs are accomplished at morning report. All residents and staff are present including off-going and on-coming on-call staff and residents. A junior resident prepares a list of inpatients and consults. A chief resident discusses the patient status with physical exam findings, pertinent lab and radiology results, and a treatment plan is decided. The chief residents and Uro1 residents rotate for the entire year at SAMMC providing continuity of care. Staff urologists cover call for a full week at a time minimizing transitions of care. One of the 2 chief residents is always on call, and the chief residents typically cover entire weeks at a time. Occasionally, chief residents will alternate on shorter intervals due to personal needs, but chief residents will cover entire weekends to minimize transitions of care between morning reports. The call schedule for urology staff and residents is posted for the sponsoring institution on the institutional intranet page through Amnion. Under this Transitions of Care system, the resident team and staff of record are consistent with one treatment plan with minimal, if any, transitions in patient care.

Support Staff Verification of Procedural Skills

Please see the SAUSHEC Due Process Policy (Section VIII) for more details. Support staff may call the staff Urologist on call 24/7 for verification of resident procedural competence.