



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

## SAUSHEC ANESTHESIOLOGY SUPERVISION POLICY

Academic Year 2014-2015

### 1. PURPOSE

This policy outlines the requirements for supervision of SAUSHEC Anesthesiology residents. This policy is in accordance with the institutional requirements of the Accreditation Council for Graduate Medical Education (ACGME), the standards (GO 2.5 and MS 2.5, 6.9 and 6.9.1) on resident supervision established by The Joint Commission (TJC), and SAUSHEC's Institutional Policy on Resident Supervision. This guidance provides minimum requirements that must be adhered to within the SAUSHEC Anesthesiology Program. In addition, this document delineates the following:

### 2. GENERAL

- a. All DoD GME programs must adhere to the requirements of the ACGME and TJC.
  - 1) The ACGME requires residents to be supervised by teaching staff in such a way that residents assume progressively increasing responsibility according to their level of education, ability, and experience. This process is an underlying educational principle for all GME, regardless of specialty.
  - 2) TJC requires those responsible for governance to establish policy, promote performance improvement, and provide for organizational management and planning. Under TJC guidelines, the hospital's governing body or authority ultimately is responsible for the quality of care the hospital provides. To carry out this responsibility, the governing body or authority provides for the effective functioning of activities related to graduate medical education, as well as quality patient care delivery, performance improvement, risk management, medical staff credentialing, financial management; and professional graduate education, when provided.
- b. Local policy is to be established in accordance with ACGME and TJC standards taking into account available resources and command structure.

### 3. INTRODUCTION

- a. Pursuant to TJC standards, in hospitals participating in GME programs, rules and policies of the medical staff must include a defined process for supervision by a licensed independent practitioner with appropriate clinical privileges of each resident

- carrying out patient care responsibilities. There must be a mechanism for effective communication between the committees responsible for professional graduate education, the medical staff and governing body about the quality of care provided by residents and their supervisory and educational needs. GME programs are expected to be in compliance with ACGME requirements and able to demonstrate compliance with any residency review committee citations related to these standards.
- b. In DOD teaching hospitals, patient care and health professions training occur together and there must be delineation of responsibilities to ensure that patients are cared for by qualified practitioners. It is also required that, as residents acquire higher levels of knowledge and skill, they will assume increasing responsibility for patient care.
  - c. The intent of this document is to ensure the patients are cared for by qualified clinicians and that the specific level of care is documented in the patient's record. This is fundamental both for the provision of quality patient care and for the provision of education and training for future health care professionals. The fact that medical, surgical, and mental health care is increasingly delivered in outpatient settings requires that these principles be as relevant to outpatient as they are for inpatient settings.
  - d. It is assumed that quality patient care and educational excellence are mutually enhancing.
  - e. The SAUSHEC approach to resident supervision requires careful accommodation of unique local resources and patient care issues, as well as ACGME and TJC requirements.

#### **4. SCOPE**

- a. Attending physicians, as licensed independent practitioners, are responsible for the care provided to their patients. This responsibility requires personal involvement with each patient and each resident participating in the care of the patient. Each patient must have an attending physician whose name is recorded in the patient record. Other attending physicians, may, at times, assume the responsibility for the care of the patient and supervision of the residents. It is the responsibility of the attending physician to ensure that the residents involved in the care of the patient are informed of such delegation and can readily access an attending at all times.
- b. Residents must function under the supervision of attending physicians. A responsible attending physician must be available to the resident in person or by telephone or other telecommunication device and be able to be present within a reasonable period of time as defined by department/service chief. Trainees and staff must be informed and understand the department's standards for staff availability.

- c. Training programs must permit residents to assume increasing levels of responsibility, commensurate with their individual progress, level of training, and experience, skills, knowledge, and judgment.
- d. Medical Treatment Facilities (MTF) must adhere to current accreditation requirements of the ACGME and TJC for matters pertaining to resident training programs, including the level of supervision provided. It is also expected that the requirements of the various certifying bodies, such as the member boards of the American Board of Medical Specialties (AMBS), will be incorporated into training programs and fulfilled through program level policy that ensures each graduate will become eligible to sit for a certifying examination.
- e. The provisions of this document are applicable to all patient care services, including inpatient and outpatient services, and the performance and interpretation of diagnostic and therapeutic procedures.
- f. In order to ensure quality patient care and provide opportunity for maximizing the educational experience of the resident in the ambulatory setting, it is required that an appropriately privileged attending physician be available for supervision during clinic visits. Attending physicians are ultimately responsible for ensuring the equality of care provided to their patients.
- g. Facilities must ensure that their training programs provide appropriate supervision for all residents, as well as a duty hour schedule and a work environment that is consistent with proper patient care, the educational needs of residents, and the applicable program requirements.

## 5. DEFINITION OF TERMS

These terms are generally defined due to differences in administrative and command structures within institutions conducting GME. The terms also provide flexibility to accommodate variations in specific position designations that cannot be uniformly applied.

- a. **Attending Physician (Anesthesiologist).** An attending physician is a licensed independent practitioner (LIP's) who has been granted clinical staff privileges through the medical staff process at an MTF in accordance with applicable standards. The Program Director and the service/department chief must approve an attending physician to qualify him/her to supervise residents. Attending physicians may provide care and supervision only for those clinical activities for which they are privileged. Other LIP's not designated to supervise, may practice but not supervise residents.
- b. **Board Certified.** This describes a physician who is a diplomat of a specialty board approved by the ABMS or Board of Specialty (BOS).

- c. **Board Eligible.** This describes a physician who has completed an approved residency program in which the training, education, and experience would be expected to result in formal acceptance by the appropriate ABMS or BOS specialty board.
- d. **Designated Institutional Official (DIO).** The DIO is an institutional official with the authority and responsibility of oversight and administration of GME programs. In SAUSHEC, this role is fulfilled by the Dean.
- e. **Graduate Medical Education (GME).** GME is the process by which clinical and didactic experiences are provided to residents in order to enable them to acquire the skills, knowledge, and attitudes/behaviors that are important in the care of patients. The purpose of GME is to provide an organized and integrated educational program providing guidance and supervision of the resident, facilitating the resident's professional and personal development, and ensuring safe and appropriate care for patients. The GME programs focus on the development of clinical skills, attitudes/behaviors, professional competencies, and an acquisition of detailed factual knowledge in clinical specialties.
- f. **Graduate Medical Education Committee (GMEC).** The GMEC is the institutional committee composed of the DME, Program Directors and at least one resident representative whose charter is to monitor and oversee all aspects of GME in the institution. All GMEC members, including the resident, are voting members when hearings related to adverse actions are conducted.
- g. **Institutional Clinical Authority (ICA).** This official is designated in institutional documents as having responsibility for the quality of care provided by attending and residents at the teaching facility. This official should be at the highest appropriate level subordinate to the institutional governing body. For example, this may be the Deputy Commander for Clinical Services (DCCS) (or equivalent) or another designated official appropriate to the organizational structure.
- h. **Institutional Document.** This is the organizational document that defines the structure and the chain of authority and accountability for the institution sponsoring GME.
- i. **Institutional Governing Body (IGB).** The institutional governing body is the authority ultimately responsible for the quality of health care delivery provided and the effective functioning of activities related to graduate medical education when provided.
- j. **Approved Teaching Facility (ATF).** An ATF is an institution that conducts GME.
- k. **Program Director.** The official designated in institutional documents as having direct responsibility for all training activities within a residency program, for the quality of educational experiences provided, and for assuring appropriate resident

supervision in accordance with accrediting and certifying body requirements. Appropriately credentialed individuals will be appointed as program directors for each residency training program. Program Directors will be selected according to local institutional policy and procedure.

- l. **Resident.** An individual engaged in GME and participates in patient care under the direction of attending physicians. The term “resident” includes individuals in approved subspecialty graduate medical education programs who historically have been referred to as “fellows.”
- m. **Supervision.** The responsibility of attending physicians is to enhance the knowledge of residents while ensuring patient safety and quality care. Such responsibility is exercised by observation, consultation, and direction, and includes the imparting of knowledge, skills, and attitudes/behaviors to the residents and the assurance that care is delivered in an appropriate, timely, and effective manner.
- n. **Graduated Level of Responsibility.** The progressive responsibility given to a resident for the care of patients based on the resident’s clinical experience, judgment, knowledge, and technical skills and balanced with the specific complexity of each individual patient for which patient care is delegated by the attending anesthesiologist. As part of medical training, residents must be given progressive responsibility for the care of patients. The determination of the individual resident’s ability to provide care to patients without a supervisor present or act in a teaching capacity will be based on documented evaluation of the resident’s clinical experience, judgment, knowledge, and technical skills. Ultimately, it is the decision of the attending physician as to which activities the individual resident will be allowed to perform within the constraints of the program directors assigned levels of responsibility. The overriding consideration must be the safe and effective care of the patient.

## 6. RESPONSIBILITIES

Resident training occurs in the context of different disciplines and in a variety of appropriately structured clinical settings. The administrative organization and titles may vary but the following functions must be assigned.

- a. **Attending Physician (Anesthesiologist).** The attending physician is responsible for, and must be personally involved in the care provided to individual patients. When a resident is involved in the care of a patient, the responsible attending physician must continue to maintain a personal involvement in the care of the patient. Ultimately, it is up to the individual attending anesthesiologist to determine what procedures and patient care their assigned resident may perform under their supervision. Additionally, the attending physician is expected to fulfill the following supervisory responsibilities:

- 1) Attending anesthesiologists may supervise no more than two resident operating rooms at the same time. Additional attending responsibilities should occur only during emergent trauma cases or other unplanned emergent cases during which the request for additional attending help should be requested through either available in-house attending anesthesiologists or the Late Home Call (LHC) anesthesiologist.
- 2) Attending anesthesiologists must be knowledgeable of the graduated levels of responsibility for residents. In accordance with SAUSHEC and SAMMC policy, attending anesthesiologists need to be aware of their residents' procedural competence and the level of supervision required for each of the various clinical activities. Please see below (8. Levels of Supervision) for definitions and further discussion regarding direct v/s indirect supervision.
- 3) Anesthesia services must be rendered with attending physician supervision of residents readily available or be personally delivered by the attending physicians themselves. Confirmation of resident supervision will be documented in progress notes entered by the attending physician or reflected within resident notes.
- 4) Attending anesthesiologists will provide their residents(s) with their preferred mode of communication during their particular duty assignment together. This should include (but is not limited to): pagers, cell phones, VOIP phones, etc.
- 5) Attending anesthesiologists will provide their resident(s) with clear expectations regarding responsibilities of specific patient care to include (but not limited to): clear intraoperative goals, when to page the attending during the intraoperative portions of the case, whether or not the attending desires to be present for intubation or extubation, what procedures or how many attempts at a procedure the resident may perform without the presence of the attending, etc.
- 6) Attending anesthesiologists will provide timely feedback and written evaluations for the residents with whom they work.
- 7) Attending anesthesiologists will immediately communicate any significantly concerning resident performance issues to the resident's respective Associate Program Director or the Program Director. Attending anesthesiologists may be requested to provide the feedback in writing as well.
- 8) When transitioning care of a patient to another attending anesthesiologist, the initial attending will ensure that the resident is aware of the transition and will provide chart documentation detailing the time of transition. At the first opportunity, on-coming attending anesthesiologists will conduct a transfer of care meeting with the resident to review their specific plans, patient goals and contact information with the resident and answer any questions the resident may have regarding care of the patient.

- 9) Attending anesthesiologists will ensure that the patient is clear on who the attending anesthesiologist and who the resident anesthesiologist is in each clinical setting.
  - 10) Attending anesthesiologists will make every effort to directly support and supervise their residents when responding to all codes in the hospital. Attending anesthesiologists can use their clinical judgment if they are actively engaged in the care of another patient during this time.
  - 11) Attending anesthesiologists are expected to respond to all MAJOR trauma admissions unless they are unable to due to the supervisory demands of other concurrent patient care responsibilities.
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- b. **Designated Institutional Official (DIO).** The DIO is responsible for oversight and administration of GME programs. The Directors of Medical Education (DME) may assist the DIO in carrying out these responsibilities.
  - c. **Institutional Clinical Authority (ICA).** The ICA is responsible for the quality of care provided by attending and residents at the teaching institute.
  - d. **Institutional Governing Body (IGB).** The IGB is responsible for addressing GME program needs and obligations on planning and decision-making and making necessary resources available to respective programs to ensure that appropriate resident supervision is provided at the teaching institution. For example, this may be the MTF Commander or other similar authority.
  - e. **Program Director.** The Program Director is responsible for the quality of the overall education and training program in a given specialty and for ensuring that the program is in substantial compliance with the policies of the respective accrediting or certifying body. The Program Director defines the levels of responsibility for each year of training by preparing a document describing the types of clinical activities that residents may perform and those for which residents may act in a teaching capacity for more junior residents. The assignment of graduated levels of responsibility will be made available to staff as appropriate and maintained on file at the service/department and the GME office. This information will also be provided annually to each resident and documentation of receipt must be maintained in training file. Annually, at the time of promotion, or more frequently as appropriate, this document will be provided to the relevant service chiefs, along with a list of residents assigned to each year or level of training. The residency Program Director must ensure that individual residents are prepared for advancement to the next higher level of post-graduate medical education and that any exceptions for individual residents are made as applicable.

- f. **Residents.** Residents are responsible for the care of the patients they are assigned and for coordinating that care with the licensed attending anesthesiologist that is supervising the care of the patient. Residents must not attempt to provide clinical services or do procedures outside of the graduated level of responsibility for which they are trained. Any uncertainty a particular resident may have regarding the acceptable boundaries of patient care under their particular attending anesthesiologist should be clarified and verified before rendering any additional care. Additionally, each resident must make all efforts to communicate to the attending physician any significant issues as they relate to patient care. Such communication should be documented in the medical record. Failure to function within graduated levels of responsibility may result in adverse reaction in accordance with SAUSHEC and SAMMC policy. Additionally, residents are expected to:
- 1) Write orders related to patient management based on overall plans discussed with the attending physician responsible for that patient.
  - 2) In the pre-operative setting, coordinate all pre-operative evaluations for patients deemed to be ASA Class III or higher with an attending physician, and documentation of this discussion will be annotated on the record.
  - 3) Verify that their assigned attending anesthesiologist is aware that they have been assigned to work with the resident.
  - 4) Verify that their attending anesthesiologist has had an opportunity to see and evaluate the patient prior to a procedure or going to the operating room, if possible.
  - 5) Notify their attending anesthesiologist or the Anesthesia Floor Coordinator (916-6705) IMMEDIATELY for any of the following:
    - a. Changes in the patient's intraoperative condition
    - b. Suspected medication errors
    - c. Initiation of ACLS protocol
    - d. Hemodynamic instability
    - e. Unexplained rise in end tidal CO<sub>2</sub>
    - f. Changes in blood pressure, heart rate, heart rhythm, oxygenation, peak airway pressures outside acceptable ranges (as discussed with their attending) or concerning for any reason to the resident
    - g. Acute blood loss or total blood loss exceeding planned transfusion thresholds

- h. New or concerning intraoperative physical exam findings, to include (but not limited to): decreased/absent breath sounds, absent of a pulse, change in pulse quality, bleeding from sites of intervention (airway, venous/arterial access), obstructed flow thru laryngeal mask airway, skin color changes to face/extremities, etc.
  - i. Unintended dural punctures during placement of epidural catheters
  - j. Equipment malfunction, concerning changes to invasive lines/monitors, to include (but not limited to): loss of airway, loss or dampening of arterial waveform, inability to draw back from invasively line, loss of venous access, ANY issues with the electronic medical record, etc.
  - k. Administration of any of the following medications/fluids:
    - i. Blood products
    - ii. Heparin
    - iii. Protamine
    - iv. Methergine
    - v. Hemabate
    - vi. Vasoactive medication infusions
    - vii. Recombinant Factor 7a
  - l. ALL new consults (pain, intravascular access, airway management, operative cases)
  - m. Increased dosing of pain management medications for patients on the Acute Pain Service (to include PO, IV and catheter delivered medications)
  - n. Significant surgical course changes during operative procedures, to include (but not limited to):
    - i. Change in patient positioning (prone, supine, lateral)
    - ii. Conversion to open procedure from a laparoscopic procedure
    - iii. Aortic cross-clamping
    - iv. Initiation/cessation of cardiopulmonary bypass
- 6) Verify that the attending anesthesiologist is aware of any emergency codes that the resident is responding to in the hospital.
- 7) Verify that the attending anesthesiologist is aware of any trauma admissions that the resident is responding to in the trauma bay.
- 8) Notify their attending anesthesiologist if they are requested to perform any procedure outside of the operating room environment to include (but not limited to) intubations, central line placements, arterial line placements, etc.

- 9) Notify their attending anesthesiologist or program leadership if they are at risk of violating duty hours.
- 10) Notify their attending anesthesiologist if they do not feel they can adequately perform their clinical duties for that particular day (i.e. due to illness, sleep deprivation, excessive stress, etc.)
- 11) Notify their attending anesthesiologist if they are pregnant so that adequate precautions can be made to minimize exposure to known operating room hazards
- 12) Notify their attending anesthesiologist of any mandatory appointments that will conflict with their performing clinical duties.
- 13) Ensure that a post-operative note is completed (within 24 hours) for patients cared for in the operating room or on the labor and delivery ward that remain in the hospital for at least one night.
- 14) Inform the patient that they are the resident anesthesiologist and specifically state the name of their attending anesthesiologist so the patient is clear on their role in the patient's care.

## **7. RESIDENT JOB DESCRIPTIONS & DUTY HOUR IMPLICATIONS**

- a. **1<sup>st</sup> year Clinical Anesthesia Resident (CA-1).** A CA-1 resident has completed an ACGME-approved clinical base year (CBY or PGY-1 year) or previous training in another specialty that satisfies the requirements of the CBY for anesthesiology.
- b. **2<sup>nd</sup> year Clinical Anesthesia Resident (CA-2).** A CA-2 resident has successfully completed the requirements of the CA-1 year and has received credit for 12 months of satisfactory clinical competence from the American Board of Anesthesiology (ABA).
- c. **3<sup>rd</sup> year Clinical Anesthesia Resident (CA-3).** A CA-3 resident has successfully completed the requirements of the CA-2 year and has received credit for 24 months of satisfactory clinical competence from the ABA.
- d. **Intermediate-Level Resident.** An Intermediate-Level resident is any CA-1, CA-2, or CA-3 resident who has not yet achieved the goals and objectives of all core rotations, nor fulfilled all minimum case requirements. Intermediate –level residents should have 10 hours—and must have eight hours—free of duty between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.

- e. **Resident in the Final Years of Education.** A resident in the final years of education is a CA-3 resident who has achieved the goals and objectives of all core rotations and fulfilled all minimum case requirements. The program director monitors resident case logs and rotation schedules to determine residents who have achieved this distinction. Such residents are presented to the Clinical Competence Committee for formal acknowledgment of their achievement.
  - 1) Residents in the final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. These circumstances must be monitored by the program director.
  - 2) This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards.

## 8. LEVELS OF SUPERVISION

- a. According to the ACGME, supervision of residents may be exercised in one of the following ways:
  - 1) **Direct supervision.** The supervising physician is physically present with the resident and the patient.
  - 2) **Indirect supervision 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.
  - 3) **Indirect supervision with direct supervision available.** The supervising physician is not physically within the hospital (or other site of patient care) but is immediately available by means of telephone and/or electronic modalities and is available to provide direct supervision.
  - 4) **Oversight.** The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.
- b. In the SAUSHEC Anesthesiology Residency Program, all resident supervision is either direct or indirect (with direct supervision immediately available). Supervising faculty anesthesiologists are always present in the hospital and available for the appropriate level of supervision.
- c. Hospital support staff needing to confirm the procedural competence of a SAUSHEC Anesthesiology resident may do so at any time of day or night by calling the Anesthesia Floor Coordinator (attending anesthesiologist on call) at (210) 916-6705.

## 9. DOCUMENTATION OF SUPERVISION OF RESIDENTS

- a. The medical record must clearly demonstrate the active involvement of the attending physician. Documentation requirements for evaluation and management and ongoing care for inpatients and outpatients must be included in departmental policies appropriate to specialty needs.
- b. Some diagnostic or therapeutic procedures require a high-level of expertise in their performance and interpretation. Although gaining experience in performing such procedures is an integral part of the education of the resident, such procedures may be performed only by residents who possess the required knowledge, skill, and judgment and under an appropriate level of supervision by attending anesthesiologists. Attending physicians will be responsible for authorizing the performance of such procedures, and such procedures should only be performed with the explicit approval of the attending physician.
- c. Attending physicians will provide appropriate supervision for the patient's evaluation and management decisions and for procedures. For elective or scheduled procedures, the attending anesthesiologist will evaluate the patient and write a pre-procedural note describing the findings, diagnosis, plan for treatment, and/or choice of specific procedures performed.
- d. All preoperative evaluations which are completed by residents will be reviewed and co-signed by Late Home Call (LHC) attending anesthesiologist or the attending physician who is responsible for the patient's care in the OR suite. This documentation will be in the medical record and completed the same day of the evaluation.
- e. All intra-operative records will be signed by the attending physician. If supervision is delegated to another attending physician, the change in supervision must be clear to the resident and documented in the anesthesia record.

## 10. EMERGENCY SITUATIONS

- a. An "emergency" is defined as a situation where immediate care is necessary to preserve the life of, or to prevent serious impairment to the health of a patient. In such situations, any resident, consistent with informed consent provisions of the institution, is permitted to do everything possible to save the life of a patient or to save a patient from serious harm. The appropriate attending anesthesiologist will be contacted and apprised of the situation as soon as possible. The resident will document the nature of this discussion in the patient's record.
- b. In situations involving diagnostic or therapeutic procedures with significant risk to the patient, the resident must consult with and obtain approval from an attending physician that will be available to assist or to advise as appropriate. In such cases, the

attending physician will determine, based on the circumstances of the case and the resident's level of experience, whether to be physically present or to be available by telephone or other communication device. If circumstances do not permit the attending physician to write a pre-procedural note, the resident's note will include the name of the responsible attending physician. The note will indicate that the details of the case, including the proposed procedure, were discussed with and approved by the attending physician.

## **12. EVALUATION OF RESIDENTS AND ATTENDINGS**

### **a. Evaluation of residents:**

- 1) Each resident in SAUSHEC Anesthesiology will be evaluated regularly according to the six ACGME core competencies. A resident typically receives multiple written feedback entries over the course of a month. Written feedback entries provide the resident with immediate feedback and serve as the source documents for synthesizing an overall monthly (block) evaluation. It is expected that daily feedback and block evaluations will be discussed with the resident prior to submission within the electronic evaluation software program. Evaluations will be in accordance with the certifying bodies (ABA and ACGME) and institutional policy. Evaluations are maintained in an electronic database ([www.new-innov.com](http://www.new-innov.com)) and are available for review by residents and program leadership.
- 2) The Clinical Competence Committee will review the written evaluations of each resident on a quarterly basis (more frequent as necessary) and determine the suitability of increased responsibility, conditional independence, and supervisory roles for a given anesthesiology resident.
- 3) The Chair of the Clinical Competence Committee and the Program Director will submit semi-annual reports of clinical competence (either "satisfactory" or "unsatisfactory") to the ABA.
- 4) At the end of every academic year, the Clinical Competence Committee and the Program Director will make a specific determination as to whether a given resident is ready for the responsibilities of the next level of training and if there are any exceptions to the level of supervision required. Any such exceptions will be discussed directly with the resident and documented in his/her "Supervision Database".
- 5) If at any time a resident's performance or conduct is judged by the Program Director to be detrimental to the care of a patient(s), action will be taken to ensure the safety of the patient(s). Additional actions will be IAW the institutional due process policy for residents and determined by the SAUSHEC Anesthesiology Clinical Competence Committee.

b. Evaluation of faculty:

- 1) SAUSHEC Anesthesiology residents complete anonymous written evaluations of their individual attending physicians every six months. They also evaluate the overall quality of the teaching faculty in an anonymous annual evaluation of the residency program. In addition to other areas, evaluations will address the adequacy of clinical supervision by individual attending physicians. The Program Director will review the evaluations and provide feedback to individual attending physicians, identifying areas where improvements can be made.
- 2) All evaluations of residents and attending physicians will be kept on file by the residency Program Director, in an appropriate location and for the required timeframe according to the guidelines established by their respective ACGME Residency Review Committee or other accrediting or certifying agencies.

### **13. TRANSITIONS IN CARE**

Faculty anesthesiologists are routinely in the operating room (or other area of clinical responsibility) with their assigned resident(s) during transitions in care. It is ultimately the responsibility of the staff anesthesiologists to ensure that appropriate patient hand-offs occur. If/when inadequate transfers of care are observed, faculty are encouraged to make on-the-spot corrections and submit written evaluations as deemed appropriate.

Please see the SAUSHEC Anesthesiology Transitions in Care Policy for further details.

### **14. MONITORING PROCEDURES**

The IGB is responsible for ensuring that the institution fulfills all responsibilities within this section. Monitoring of appropriate attending supervision will be accomplished in a number of fashions to include:

- a. The Graduate Medical Education Committee (GMEC) will document and discuss any citations regarding resident supervision on all Internal Residency Reviews or Residency Review Committee reports. The GMEC will suggest methods for correction and follow-up for such citations and forward these to the ICA and IGB for review and approval.
- b. The chair of the GMEC will report to the IGB any internal or external review issues regarding resident supervision. This report allows a direct linkage of the GMEC and credentials chairpersons.
- c. The ICA and DIO, along with all other members of the Risk Management Committee, will participate in discussion of all cases involving residents to determine if there are issues of the availability of appropriate levels of supervision or violations

of the graduated levels of responsibilities. The DME or DIO will report pertinent issues to the GMEC.

- d. Program Directors will monitor supervision of diagnostic and therapeutic procedures involving the residents to ensure consistency with the graduated levels of supervision as established by the Program Director.

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