

CLER Focus: Supervision Policy

BLUF

- Interns require direct supervision or a supervisor in house on all procedures.
- Junior residents (PG2-3) will present ALL patients to the chief resident (PG4-5) on-call
- Chief residents will determine timing of faculty contact
- ENT sees ALL consults. If the referral service wants a “routine” consult seen immediately, that consult will be seen immediately.
- **All residents will inform patients that they are a trainee and who is their attending of record. Residents should at some point during an interview inform patients of their role in the care and how the attending is supervising.**
- If a consultant is giving a resident a hard time, do not argue! Ask for the consultant to call your attending. Walk away and relax.

Introduction

Faculty are assigned to cover each and every clinic and operating room such that all resident clinical activities have on-site supervision. **All outpatients are assigned a specific appointment with a specific ATTENDING physician at a specific time thus it is ABSOLUTELY CLEAR which faculty is in charge of a patient’s healthcare. Additionally, the INFORMED CONSENT CLEARLY STATES who is the ATTENDING SURGEON for all surgeries.** However, all patients understand that in our academic facility, supervised resident participation will be an integral portion of the care they will receive. The degree of resident participation will be commensurate with the abilities, knowledge and experience of the particular resident as well as the clinical complexity of the particular situation.

Direct faculty supervision, while ever present, is allocated in a fashion appropriate to the resident’s level of training. In the outpatient clinic, attending staff physicians are assigned to each clinic, and are responsible for the quality and appropriateness of patient care. Documentation of all patient encounters by an attending is required per institutional guidelines. This includes the supervision of medical students, interns, and residents. Faculty physicians are available to the residents at all times and are ultimately responsible for all care delivered in the ambulatory setting. On the inpatient wards, an attending staff is assigned to each patient admitted. This staff will be noted on the admission orders and it is the responsibility of the admitting resident to notify the attending staff in a timely manner. An attending staff note will be written for each admission. In the operating room, an attending staff will be present for each operation. This includes nights and weekends. During the night and weekends, the on-call attending staff is responsible for the supervision of all medical students/interns and residents assigned to the service. It is the responsibility of the first call resident to keep the Chief resident and attending staff informed.

LEVELS OF SUPERVISION

- **Direct Supervision (DS)**–
 - The supervising physician is physically present with the resident and patient.
- **Indirect Supervision (IS):**
 - with direct supervision **immediately available (IS-I)**
 - The supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
 - with direct supervision **available (IS-A)**
 - 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.
- **Oversight (OS)**
 - The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

SUMMARY OF SUPERVISION INSTRUCTIONS

<u>PATIENT CONTACT</u>	<u>SUPERVISION GUIDELINES</u>
Emergent or Urgent Consultations	Discuss with Faculty immediately
Operating Room Procedures	Discuss with Faculty immediately
Major Procedures in Clinic and Hospital	Discuss with Faculty immediately
Admissions to Otolaryngology Service	Discuss with Faculty immediately
End of Life Discussions/Decisions	Discuss with Faculty immediately
Trauma Consultations	Discuss with Faculty within 24 hours
Routine Hospital Consultations	Discuss with Faculty within 24 hours
Walk-in Clinic Patients	Discuss with Faculty within 24 hours

PROGRESSION OF RESIDENT RESPONSIBILITIES

The otolaryngologist in training will be supervised and instructed by staff surgeons. When more senior residents are present on service, a hierarchical system will prevail with the junior resident reporting to a more senior resident or Chief resident who in turn reports to staff. It is expected that, until delegated more authority, the junior resident will discuss all clinical care issues with the Chief resident or attending staff. All residents are assigned to a staff in clinic on a one-on-one basis for teaching and supervision. Clinics are booked directly under the primary staff for the duration of residency. PG4 residents rotating at the MD Anderson will follow their assigned faculty mentor and rotate in clinic with that staff. While on their rotation at MD Anderson/Darnell Army Medical Center/Audie Murphy VA/Methodist Hospital, all SAUSHEC residents are in the operating room acting first as assistant surgeons then advancing to the role of the primary surgeon with direct or indirect attending supervision. Delegation of authority and responsibility for patient care will increase as the resident demonstrates increased competence in delivery of safe, effective and compassionate care. The otolaryngology faculty will formally assess the resident during the quarterly residency review and give real time feedback as well. Resident education and feedback will be documented in the Self-Directed Resident Portfolio. The Portfolio will be reviewed quarterly by the Program Director and by the Training Committee. The SAUSHEC Otolaryngology resident supervision policy is clearly outlined in the SAUSHEC website. All faculty and residents are aware of the policy and of the website.

Operating Room and Emergency Center Supervision

Our requirements dictate that all patients must be supervised by an attending. Operating room supervision by an attending surgeon must, at a minimum, be present in the hospital. Certain procedures in the operating room require the attending to be present in the operating room but not scrubbed and certain procedures require the attending surgeon to be scrubbed during the case (see SAUSHEC Otolaryngology Surgery Supervision Policy for Operating Room Procedures). In order to assure that residents are observed sufficiently from faculty, a Procedure Evaluation Form will be used to evaluate the performance of index cases and then tracked in the Resident Portfolio. Certain procedures can be performed without direct faculty presence, once the resident is deemed "proficient". In such circumstances, the attending faculty on call must first be notified prior to the initiation of the procedure in the clinic after hours or in the emergency room. Additionally, the Program Director will review the current Resident Case Log quarterly during the Resident Portfolio evaluation. This review will determine whether the caseload and the case mix are being distributed equally among residents. If a residents in found to be performing too few index cases compared with his peer group, then he will be declared "**Red**" for those cases and be given the highest priority to scrub on those specific cases. If he is found to be trending toward too few cases, then he will be declared "**Yellow**" for those cases and given a higher priority to scrub on those cases. If his case mix is adequate, the he will be declared "**Green**" for those cases. Additionally, the Program Director may adjust resident rotation schedules to better "equalize" caseload among the SAUSHEC residents.

Major procedures (defined as those procedures not listed in **PROCEDURES WITH INDIRECT FACULTY SUPERVISION** section below) performed in the emergency center and hospital must have direct faculty supervision.

Faculty Call

Designated faculty members are on call 24-hours a day every day of the year, and are always available by telephone or pager. A list of the call schedule, pager numbers and home telephone numbers is provided to all Otolaryngology residents monthly as well as being posted in the departmental office and distributed to the hospital operators. Residents are required to call whenever they have any patient related concerns and are

specifically instructed that they must immediately notify the attending whenever a patient is being admitted to the Otolaryngology - Head and Neck Surgery service or needing to go to the operating room. Since it is a requirement that an attending be present for any surgical procedure, occasionally an emergency may require the surgical intervention to take place prior to the attending actually making it to the operating room suite. This is most likely to occur with airway emergencies, where securing the airway is paramount. Finally, in the event a faculty member ever was unable to be reached, all faculty members are available to help. Also, Anesthesia staff and General Surgery Trauma staff are always in-house and available for immediate consultation. The on-call staff may be contacted 24/7 by support staff to verify procedural competence of residents (see SAUSHEC Supervision Policy Section VIII).

Research Supervision

All faculty are active in mentoring resident research projects. Our Director of Research provides additional supervision and expertise to the resident's research experience.

Resident Supervision according to level/years in the program

PG2-5 OTOLARYNGOLOGY/HEAD AND NECK SURGERY

- All members of the caregiver team will be instructed in:
 - recognition of and sensitivity to the experience and competency of other team members;
 - time management;
 - prioritization of tasks as the dynamics of a patient's needs change;
 - recognizing when an individual becomes overburdened with duties that cannot be accomplished within an allotted time period;
 - communication, so that if all required tasks cannot be accomplished in a timely fashion, appropriate methods are established to hand off the remaining task(s) to another team member at the end of a duty period;
 - signs and symptoms of fatigue not only in oneself, but in other team members;
 - compliance with work hours limits imposed at the various levels of education; and,
 - team development.
- Above topics will be reviewed/explored in the Grand Round schedule in May/June of each academic year
- All residents will be assigned to surgical teams consisting of attending surgeons, senior(PG4/5), intermediate (PG2/3), PG1, and medical students.

PG1 OTOLARYNGOLOGY INTERNSHIP

Ultimate oversight of resident supervision is provided by the Program Director from the SAUSHEC Department of Otolaryngology. The PG1 year will be spent at SAUSHEC performing multiple subspecialty rotations. PG1 residents do not take call and may never be in a situation where their supervisor is not in house during a procedure.

- Intern roles that may be performed without Direct Supervision or IS-I after establishing competency by a faculty or a resident supervisor include***:
 - Patient Management Competencies*
 - evaluation and management of a patient admitted to the hospital, including initial history and physical examination, formulation of a plan of therapy, and necessary orders for therapy and tests
 - pre-operative evaluation and management, including history and physical examination, formulation of a plan of therapy, and specification of necessary tests
 - evaluation and management of post-operative patients, including the conduct of monitoring, specifying necessary tests to be carried out, and preparing orders for medications, fluid therapy, and nutrition therapy
 - interpretation of laboratory results
 - *Procedural Competencies*
 - carry-out of basic venous access procedures, including establishing intravenous access
- ***Indirect supervision will be allowed only after PG1 resident is supervised directly performing above tasks by the PG2-5 residents and the staff surgeons. When competency in those tasks are documented by the Program Director in the Resident Portfolio, indirect supervision of the above tasks will be allowed.

- Direct supervision (DS) is required until competency is demonstrated for:
 - *Patient Management Competencies*
 - transfer of patients between hospital units or hospitals
 - discharge of patients from the hospital
 - initial evaluation and management of patients in the urgent or emergent situation, including urgent consultations, trauma, and emergency department consultations (ATLS required)
 - evaluation and management of post-operative complications, including hypotension, hypertension, oliguria, anuria, cardiac arrhythmias, hypoxemia, change in respiratory rate, change in neurologic status, and compartment syndromes
 - evaluation and management of critically-ill patients, either immediately post-operatively or in the intensive care unit, including monitoring, ventilator management, specification of necessary tests, and orders for medications, fluid therapy, and enteral/parenteral nutrition therapy
 - management of patients in cardiac arrest (ACLS required)
 - *Procedural Competencies*
 - See bedside procedural list at the end of this section.
- ***As noted previously, competency in those supervised tasks listed above are documented by the Program Director in the Resident Portfolio. Interns may not perform any bedside procedures EVEN AFTER COMPETENCY HAS BEEN ESTABLISHED without direct or IS-I supervision per ACGME requirement. PGY-2 year is the first time IS-A supervision is permitted in residency.

PG2 Otolaryngology/Head and Neck Surgery

The year begins with a two-week intense introductory course (approximately 20 hours/wk) to Otolaryngology. This course covers a broad variety of topics including basic sciences, audiology, otology, head and neck cancer, trauma, radiology, rhinology, cadaver dissection, and emergency topics.

The PG2 year is spent on the Otolaryngology services at SAUSHEC. On the Otolaryngology service residents divide their time approximately equally between the clinic and the operating room. During clinics, residents work one-on-one with a full time faculty member under close supervision, learning the elements of otology-neurotology, head and neck surgery, including endocrine surgery of the head and neck, Plastic and Reconstructive Surgery, Laryngology, Otolaryngologic Allergy, Pediatric Otolaryngology, and general Otolaryngology.

Surgical experience in the PG2 year begins with relatively simple cases and moves to progressively more complex cases, under close supervision. This year includes training in use of lasers (both hand-held and endoscopic) and flexible and rigid per-oral endoscopy. In this year and each succeeding year, residents spend every Friday morning in conferences related to the targeted areas (allergy, immunology, pathology, radiology, otology, neurology, neurotology, audiology, rhinology, laryngology, facial plastic and reconstructive surgery, head and neck oncology, and endocrinology). PG2s take first call in rotation with PG3s and make daily rounds at their respective institutions. During this year, the resident must have chosen, in consultation with the Research Coordinator, a research topic and faculty research preceptor during their one-month research rotation.

PG3 Otolaryngology/Head and Neck Surgery

Each resident rotates at SAUSHEC, Darnell AMC, and MD Anderson Hospital. Additionally, each resident will spend one month doing research. In each setting, residents begin to evaluate patients independently in the outpatient setting, with supervision by chief residents and faculty. Surgical skills continue to develop, and residents follow their patients in continuity from the clinic to the operating room and then to the clinic again for post-op follow-up. Duties include complete history and physical examinations on all admissions, routine patient care orders, operative reports and discharge summaries on all patients that they have operated upon, discharge summaries of patients who have been admitted for non-operative therapy or those private patients not operated upon by the senior resident, attendance in all clinics; participation in surgery, and first call. Residents during their research rotations are able to optimize their time to accomplish their required research project, which had been set up during the PG2 year. They are required to provide written updates as to the progress of their research project until completed and submitted in a fashion acceptable for publication.

PG4 Otolaryngology/Head and Neck Surgery

This year is divided between SAUSHEC, MD Anderson Cancer Center, and Methodist Hospital. During these rotations, outpatient, inpatient, and surgical skills and responsibilities continue to mature. During this rotation at the MD Anderson Cancer Center in Houston, Texas, emphasis is placed on head and neck oncology and endocrine surgery. They are expected to read extensively and mature their head and neck surgical oncology skills. During the MD Anderson rotation, clinical faculty members permit the residents to perform, under supervision, nearly all of the cases by the residents. In addition, during the MD Anderson rotation the residents are given the opportunity to view various aspects of civilian academic practice and acquire some exposure to the business side of a medical practice. The Methodist rotation concentrates on head and neck surgery to include parotidectomies, neck dissections, and flaps. The PG4 year also marks an increasing responsibility in the outpatient, inpatient, and OR setting. PG4 residents along with the PG5s, provide second-line on-call backup to the junior residents (PG2s and PG3s).

PG5 CHIEF RESIDENT OTOLARYNGOLOGY/Head and Neck Surgery

Each Chief Resident spends the year managing one of the SAUSHEC Otolaryngology services. At each site they are responsible for oversight of clinic activities and service administration, with faculty supervision. The process of increasing responsibility continues, along with performance of more complex surgical operations, an active role in medical student education in the clinics, and organization of some of the teaching conferences (collection of cases for radiology, pathology, quality assurance, and tumor board conferences). The Chief Resident will continue to accumulate experience in otology and neurotology, both medical (including evaluation and management of vestibular disorders) and surgical, primarily with the SAUSHEC faculty neurotologists. This year also includes extensive experience in head and neck oncology, thyroid and parathyroid disease with the H&N surgical oncologists. The Chief Resident will also work closely with our pediatric ENT faculty refining their skills in the management of complex pediatric patients, complex sinus-rhinology patients, and complex sleep patients.

Availability of Schedules

A centralized call schedule is created and updated by the program director's office. Any schedule changes are disseminated throughout the residency immediately. The call schedule includes primary, chief, and attending level call responsibilities. IMOUTA will be performed between the junior residents and between the chief residents.

SMALL PROCEDURE LIST: Proficiency for procedures WITHOUT direct faculty supervision

The following small procedures require supervision prior to establishing independent competency. It is expected that all PGY2s and above has established competency in this entire list unless otherwise verbally counselled by the ENT program director. Competency at the intern level is established by performing the COMPETENCE QUANTITY number of cases under the direct supervision of a senior resident or ENT faculty. Interns should independently track the volume of these small procedures to assure COMPETENCE QUANTITY is achieved prior to PGY2 start. Note: The attending faculty must always be notified prior to proceeding with any patient taken to the operating room. Also, any of the below procedures which are not "routine" or "typical" should be discussed with the faculty before the procedure starts.

<u>PROCEDURE NAME</u>	<u>COMPETENCE QUANTITY</u>	<u>RESIDENT</u>	<u>SUPERVISION</u>
Facial lacerations	3	PG 1	DS for 3, then IS-I
Tracheotomy tube change	3	PG 1	DS for 3, then IS-I
Closed reduction of nasal fractures	3	PG 1	DS for 3, then IS-I
Endoscopic Biopsies (Larynx, NP, BOT)	3	PG 1	DS for 3, then IS-I
Arch Bar Removal	3	PG 1	DS for 3, then IS-I
Fat or Paper patch myringoplasty	3	PG 1	DS for 3, then IS-I
Drainage of peritonsillar abscesses	3	PG 1	DS for 3, then IS-I
Incision and drainage of superficial abscesses	3	PG 1	DS for 3, then IS-I
Control of epistaxis	3	PG 1	DS for 3, then IS-I
Removal of nasal/ear foreign bodies	3	PG 1	DS for 3, then IS-I
Fiberoptic laryngoscopy	3	PG1	DS for 3, then IS-I
Minor biopsies of the head and neck	3	PG1	DS for 3, then IS-I
Placement of Nasogastric Tubes and Foley catheters	3	PG1	DS for 3, then IS-I
Arterial puncture for blood gases	3	PG1	DS for 3, then IS-I
Central venous catheterization.	3	PG1	DS for 3, then IS-I
Endotracheal intubation	3	PG1	DS for 3, then IS-I