

SAUSHEC Pediatric Residency

General Supervision Policy AY 2014-2015

Goal: The purpose of this document is to provide a broad but comprehensive policy to guide the supervision of residents working within the SAUSHEC Pediatric Residency to ensure adequate patient safety and quality of care while providing the maximal potential for resident education within the military medical system. Further details relating to specific job descriptions can be found within the “SAUSHEC Pediatric Resident Job Description Addendum” and “SAUSHEC Pediatric Residency Transitions of Care Policy” located on the programs “New Innovations” webpage or on the programs shared drives. Additionally, information related to each resident’s current procedural competency is regularly updated and can be found on these same sources as well as the SAUSHEC main page under “Pediatric Supervision Policies”

1. All supervision policies and the attendant documentation will meet ACGME, SAUSHEC, SAMMC and WHASC minimal requirements.
2. All patient encounters rendered within the SAUSHEC Pediatric Residency Program occur with the over-site of a specific, credentialed, licensed, and privileged attending provider who is ultimately responsible for all decisions and patient care rendered during that encounter.
3. Specific and detailed expectations for each year of house-staff training are detailed in the “SAMPC Pediatric Job Description Policy” (addendum 2) and fall under this general supervision policy as detailed below.
4. The program has adopted the following “levels of supervision” in order to provide progressive independence to for the residents and to provide appropriate over-site during early portions of training.
 - A. **Direct Supervision** – the supervising physician is physically present with the resident and patient.
 - B. **Indirect Supervision:**
 - 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.
 - 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.

- C. **Oversight** – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.
 - D. All PL-1 residents will have, at a minimum, “indirect supervision with direct supervision immediately available” through either an upper level resident or staff physician during any patient encounters through their initial year of training.
 - E. Upper level residents (PL-2, PL3) will have, at a minimum, “indirect supervision with direct supervision available” during all patient encounters.
 - F. There are occasions during which care may be rendered with only oversight (i.e. telephone consults). In these situations the resident is responsible for providing the licensed staff with the details of any recommendations relayed or care rendered within 24 hours to ensure that the staff physician has time to appropriately review and provide feedback as necessary.
 - G. Each resident’s specific procedural competency stages will be posted (<http://www.new-innov.com>) under Privileging Reports and available to be reviewed by house staff, attending physician, and provided to nursing as needed (Example Addendum 4).
 - H. The Residency will track progression of each resident’s procedural competency to allow for a staged towards more independent levels of care. This is facilitated through “mid-year” and “end-of-year” evaluations during which specific progressive milestones are reviewed and documented for progressive competency (see Addendum 5).
5. **Outpatient Visits:** All outpatient visits provided by trainees will be done under the supervision of a staff provider. This staff provider will interview and examine the patient at the staff’s discretion, at the trainee’s request, or at the patient’s request. The staff doctor has full responsibility for care provided, whether or not he/she chooses to personally verify the trainee interview, examination or laboratory data. However, resident physicians can reasonably be expected to provide treatment for patients commensurate with their level of training and as directed by the attending physician.
- A. The name of the responsible supervising staff will be clearly recorded in the patient or clinic records. The attending should review each patient seen by the PL-1 resident during the first half of the academic year before the patient leaves the clinic area. In keeping with appropriate and measured increasing independence as practitioners, PL-1’s in the second half of the year may, at their supervisors discretion, complete a patient evaluation independently and submit the written encounter documentation to their supervisor at the end of the half-day. At the end of the first year of residency, if supported by teaching staff consensus, the resident will be held to the staffing requirements of second and third year residents (see addendum 5).

6. **ED Consults:** All cases will be staffed with the on-call staff physician before the consult result or recommendations are considered valid. Care will be documented in writing with the name of the responsible staff recorded and will be co-signed by the same. The responsible staff consultant must be notified verbally by the trainee performing the consult within six (6) hours of time for routine consults and immediately for any high risk or ICU consults.

7. **Inpatient Management:** The primary management and care for all hospitalized patient falls under the staff physician assigned to the Ward/PICU/NICU/Nursery. Residents are expected to operate as primary medical personnel for all admitted patients under the SAUSHEC residency. PL-1 residents are primarily responsible for the daily management of such patients (admissions, daily notes, rounds, discharges, and procedures) to be carried out under the direct supervision of a senior resident (PL-2 or PL-3). All admissions or discharges are to be staffed prior to final disposition and require a staff co-signature indicating acceptance of the patient. Specific supervision policies related to PL-1 residents on inpatient rotations are as follows:
 - A. Ward: All PL-1 medication and IVF orders written during the first 6 months of the PL-1 year will require co-signature from a supervisory resident or a staff physician.
 - B. NICU: All PL-1 medication and IVF Orders require a co-signature from either a supervisory resident or a staff physician.
 - C. All procedures conducted by a PL-1 resident require a supervisor's oversight prior to be signed off as "competent to perform without direct supervision". Documentation of such competency is located on the programs "New Innovations" webpage or can be found on any of the various shared drives used within the program. Residents are responsible for providing proof of competency to perform such procedures when questioned by patients, other house-staff, or other members of the medical team.

8. **Escalations of Care/Codes:** The program recognizes that there may be occasions during which a patient has an acute change in care that requires immediate intervention by a house-staff member. Under such conditions (i.e. Code, escalation of care with transfer to the ICU, etc) the resident (PL1) should immediately notify their supervising resident while taking appropriate life saving actions for the patient. Supervising residents (PL2 or PL3) should initiate contact with their supervisory staff as soon as possible or delegate other ancillary staff to help make contact while they continue to stabilize the patient.

9. **End-of-Life Care:** Due to the highly complex nature of caring for Pediatric End-of-Life care concerns, the primary responsibility for initiation and completion DNR's is solely the responsibility of the attending staff; however resident participation in the discussion of these decisions is encouraged when feasible. All end-of-life care should have direct supervision by a licensed staff member.

10. **Staff Oversight:** The primary assignment of competence for each resident is determined by the "Clinical Competency Committee" run by the Program Director. This Committee

reviews the recommendations of the supervisory staff, rotation evaluations, performance on procedural workshops, and the number of successful procedures rendered under direct supervision to assess competency. The program utilizes two week inpatient staff rotations to ensure that the resident receives an adequate amount of staff continuity to track progression through the ACGME core competencies as well as procedural competency. Within the clinic the residents are assigned a primary evaluator who integrates the shared experiences of the entire clinic staff into an overall evaluation of the residents performance, both as it relates to the six core competencies, as well as procedural progression, and progression into higher supervisory roles.

11. **Staff discretion:** Occasions may arise when it is in the program's, patient's, or resident's best interest to temporarily increase the level of supervision. The designated staff may, at any time, declare that staffing requirements for a particular type of patient, clinic session, or resident panel for that session has changed as long as these changes reflect closer supervision rather than less.

A. If it is felt, because of academic or clinical deficiencies, that continued close supervision of a particular resident may be required, this should be coordinated with the program director, chief resident, and the resident's "Training Officer" to allow for appropriate due process.

12. **Support Staff Verification of Procedural Competence:** (see also Addendum 4)

- i. 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.
- ii. 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. As needed, the Privileging Report can also be pulled for each individual resident at <http://www.new-innov.com>.

13. Rotating Residents from other Residency Programs: As all rotating residents are only in the Outpatient Setting, they will be treated with regards to supervision level the same as a SAUSHEC Pediatric PL-1 resident as detailed in section 5 above (e.g., All outpatient visits provided by trainees will be done under the supervision of a staff provider., etc) at a minimum.

14. Rotating Medical Students: The program will adhere to the SAUSHEC Institutional Policy on Supervision of Medical Students.

Addendum 1:

2011 ACGME SUPERVISION STANDARDS

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

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.

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.

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.

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.

Addendum 2:

SAUSHEC Pediatric Resident Job Description 2014-2015

Residents working within the SAUSHEC Pediatric Residency are expected to practice patient care in a variety of educational settings. This means interns and residents, who are not fully trained, credentialed, boarded or licensed often, are the first Health Care Provider (HCP) to see a patient. In fact, our training mission makes it critical that trainees are allotted the opportunities to be the first individual who sees, evaluates and develops a plan for their patients. We also believe that it is important for trainees to take a graduated approach to patient care responsibility with progressively less supervision required over their 3 year residency. This will ensure that on June 30th of their PL-3 year they are ready to take full, unsupervised, responsibility for their patients to carry out their respective military missions.

Within this setting we must also insure that our patients receive state of the art care that is no different from that delivered by a non-GME health care organization. As such, the ultimate responsibility for every patient encounter that occurs within the program will always reside upon a licensed, credentialed staff pediatrician. In all our patient care areas, a staff physician is assigned to supervise resident activities related to patient care and they are ultimately responsible for any care rendered. As such, it is critical that residents keep supervisory staff informed of all patient care issues.

To provide an overall framework for expectations for all house-staff within the SAUSHEC Pediatric Residency the executive committee has developed the following statements that outline the scope of normally delegated responsibilities in different care settings at each level of training as well as the expected level of supervision. The Program, SAUSHEC and Wing Supervision Policy can be found on the Residency Program's New Innovations Main Page (<http://www.new-innov.com/pub/>). Each Resident's level of "certification" or procedural competence is posted on the Program's Comprehensive Educational Website (<http://www.new-innov.com>) . Should any member of the medical staff (nursing, physician, etc) have questions regarding procedural competency, they can ask any Pediatric Resident or Faculty to access this password protected area to review resident specific procedural certification.

Inpatient Settings

PL-1- Inpatient Setting: PL-1 residents always care for patients under the supervision of a PL-2 and/or PL-3 resident and a credentialed staff provider. The PL-1 resident on inpatient services is expected to function as the primary physician for all inpatients assigned to his/her care (including surgical patients). This responsibility necessitates a comprehensive knowledge of the status, lab data and a plan for those patients at all times. The PL-1 has a central role in the formulation, implementation and documentation of health care as well as communication of information to patients/family, supervisors and to other involved providers. Responsibilities include:

- a. Complete all assigned patient evaluations to include any service specific required written documentation in the required format on the day of admission.
- b. Complete routine daily patient evaluation and record daily progress notes in inpatient records of assigned patients. These notes should include all available new data and amendments to impressions. Newborns admitted for maternal reasons are excluded from the daily progress note requirement.
- c. Discuss routine patient care issues on daily scheduled rounds.

d. Immediately notify supervisor(s) of any significant change in patient status and document such changes in the inpatient record.

e. Perform indicated procedures after obtaining informed consent (written if necessary). Seek assistance and direct supervision for any procedure that they have not had adequate experience with or if they are not authorized to perform that procedure independently (See Addendum #4 for guidance or website). Procedure notes should be written for all procedures requiring written informed consent. A proper timeout should be done and documented for all procedures requiring written informed consent.

f. Participate in emergent responses to acute events as directed by supervisor or necessitated by situation. Assume an increasing role in emergent situations as skill and experience develops.

g. Complete a discharge narrative summary in the required format on all assigned patients at time of discharge that includes an appropriate follow-up plan. Provide the summary for review to senior resident or staff supervisor prior to patient discharge. In the ICU settings, discharge summaries must be reviewed by staff.

h. Maintain appropriate and, at a minimum, daily communication and rapport with the parents of assigned pediatric inpatients.

i. Teach and supervise medical students assigned to the ward, read and countersign their notes and participate in their evaluation.

j. Provide general pediatric consultation to the Emergency Department and non-pediatric services alongside the PI-2, PI-3 or staff. Consultations on ED or non-pediatric services that occur on call must be reviewed with attending staff the next morning or sooner if there is any concern about the patient's condition or uncertainty about how to proceed diagnostically or therapeutically. Appropriate documentation in the form of an AHLTA T-con must be completed for any patient dispositioned to home from the ED and will be reviewed and co-signed by the ward staff physician on duty within 24 hours. Primary response to the ER and outside referrals for admission/consultations are the responsibility of the PL-3. However, the PL-1 will be expected to participate in the evaluation and admission process to include completing all required administrative actions.

k. When appropriate, conduct inpatient follow-up for patients recently discharged from the hospital. All patient encounters from the follow-up will be staffed by the PL-3 or staff supervisor physician prior to disposition from the inpatient unit. The ward attending will review and co-sign the written note acknowledging documentation and concurrence with the plan.

1. Keep senior resident supervisors and staff informed of the condition of all patients on their team.

PI-2 or PI-3 Inpatient Supervisory Resident

PL-2 and PL-3 residents provide a primarily supervisory role on the inpatient service; however they must be ready to provide primary, first line care (all of the duties of a PL-1) when necessary. This is likely to occur when PI-1 residents are off the ward in continuity clinic, engaged in a patient transport or whenever workload dictates in order to maintain quality of care.

Specific PL-2 and PL-3 duties include:

- a. Conduct a comprehensive assessment of all new admissions and complete a Resident Admit Note (or equivalent) in the required format summarizing the H&P including relevant differential diagnostic considerations on the day of admission. In the NICU, only a single admit note is required from either the intern or the supervisory resident.

- b. Supervise the activities of the PL-1 resident while facilitating acquisition of medical knowledge, critical thinking, time management and decision-making skills. During the PL-1 first inpatient rotation, co-sign all admission and discharge orders for at least the first week or until the staff and senior residents feel the intern has demonstrated competence. Even after competency is demonstrated, all orders and chart entries of the PL-1 will continue to be reviewed for completeness and accuracy. Supervisory residents are also expected to co-sign all PL-1 Medication or IV fluid orders for the first 6 months of residency while on inpatient ward, (or until deemed competent by the pediatric Clinical Competency Committee). In the NICU, supervisory residents are expected to co-sign all PL-1 medication or IV fluid orders until progression to PG-2 status (or when deemed competent by the Clinical Competency Committee and NICU supervisory staff).

- c. Assure proper transfer of clinical information whenever transferring patient care management at the end of the duty period.

- d. Respond to emergent and acute situations and assume team leader role.

- e. Provide supervision and assistance for all procedures conducted by junior residents and medical students.

- f. Supervise all activities of medical students.

- g. Supervision and teaching of procedural skills should be conducted with the objective of providing the PL-1 resident with the technical competence necessary to progress to the supervisory resident level and be in accordance with Pediatric Trainee Supervision Guidelines (Addendum #4), SAUSHEC Supervision Guidelines

- h. Evaluate performance of PL-1 and assure compliance with duties outlined for that level.
- i. Assure appropriate and timely consultations from staff specialists.
- j. Provide general pediatric consultation to the Emergency Department and other

Non-Pediatric services either directly or by supervising the PL-1 during these consults.

k. PL-2/3 resident will serve as the primary pediatric supervisory resident for all pediatric medical admissions and for consultations on surgical admissions. These consultations must be discussed with the pediatric staff supervisor physician prior to the formal consult being placed on the patient's chart. The staff supervisor must review and co-sign the consult indicating concurrence.

l. Routine admissions, with no significant unexplained abnormalities in vital signs or laboratory values and an obvious/clear diagnosis or problem should be reported to supervising staff within a minimum of 6 hours. Admissions or status changes should be reported sooner if there is any question about the patient's condition, diagnosis or uncertainty as to how to proceed diagnostically or therapeutically. ALL PICU admissions must be reported to the attending immediately.

m. PL-2/3 Residents are responsible for efficient bed management of all medical and surgical beds on the Pediatric Ward. This is accomplished by having the PL-2/3 called by all services with all potential ward admissions. The PL-2/3 will constantly monitor the status of bed availability on the ward and coordinate with the ward staff attending physician and the medical director of the ward to resolve any bed availability or ward closure issues. The PL-2/3 will respond to all Emergency Room consults and admissions and discuss with the attending. The PL-1 may go with the PL-2/3 to evaluate the patient, but the Emergency Room response is a primary PL-2/3 responsibility.

PIMS (Procedure, Icu, Monitored unit, Sedation Rotation)

The PIMS resident is expected to function as the primary physician for all inpatients assigned to his/her care (including surgical patients). This responsibility necessitates a comprehensive knowledge of the status, lab data and a plan for those patients at all times. The PIMS resident has a central role in the formulation, implementation and documentation of health care as well as communication of information to patients/family, supervisors and to other involved providers. Responsibilities include:

1. Complete all assigned patient evaluations to include any required written documentation in the required format on the day of admission.

2. Complete routine daily patient evaluation and record daily progress notes in inpatient records of assigned patients. These notes should include all available new data and amendments to impressions.
3. Discuss routine patient care issues on daily scheduled rounds.
4. Immediately notify supervisor(s), of any significant change in patient status and document such changes in the inpatient record.
5. Perform indicated procedures after obtaining informed consent (written if necessary) and performing a timeout if indicated. (See informed consent memo). Seek assistance and direct supervision for any procedure that they have not had adequate experience with or if they are not authorized to perform that procedure independently (See Attachment 1). Procedure notes should be written and a timeout performed for all procedures requiring written informed consent.
6. Participate in emergent responses to acute events as directed by supervisor or necessitated by situation. Assume an increasing role in emergent situations as skill and experience develops.
7. Complete a narrative summary in the required format on all assigned patients at time of discharge or transfer that includes an appropriate follow-up plan. Provide the summary for review to staff prior to patient discharge/transfer.
8. Maintain appropriate, and at a minimum, daily communication and rapport with the parents of assigned pediatric inpatients.
9. Teach and supervise medical students assigned to the PICU, read and countersign their notes and participate in their evaluation.
10. Provide general pediatric consultation to the Emergency Department and non-pediatric services the supervision of PICU staff. Consultations on ED or non-pediatric services that occur on call at night must be reviewed with the attending staff.
11. On call at night and during the weekends, all communication initiated from residents to the attending will be facilitated first through the PGY3. This will require the PGY3 to evaluate the patient and understand the issues well enough on PICU patients to communicate with the PICU attending directly when required.
12. Night Shift PGY3 must attend both Ward and PICU check-out.

13. Conduct patient transport between healthcare facilities under the supervision of PICU staff.

Staff Attending's Responsibilities in Inpatient Settings

1. The inpatient staff supervisor is ultimately responsible for all patient care by residents and medical students on his/her team. He/she will be actively involved in all aspects of patient care and needs to be kept informed of all significant patient care issues (admissions, status changes, complaints, etc.)
2. The staff supervisor or their designee should be present at all patient care rounds when patient care decisions are being made.
3. The staff supervisor will be readily available for supervision on the ward. The staff supervisor is subject to recall to the hospital in a timely manner after contact by beeper or telephone. The ward staff supervisor may designate an alternate if the ward staff supervisor is going to be unavailable for a brief period but this should be kept to a minimum.
4. The ward staff supervisor should be constantly aware of the functioning of the ward team, noting the strengths and weaknesses of the house staff and nursing support. She/he should be available to help with ward care if there is an unexpected patient care responsibility, which may lead to resident fatigue and/or jeopardize patient care.
5. The staff supervisor will examine all patients admitted to their service (Ward, NICU, PIMS, and Nursery) for medical care and discuss the admission with parents. Staff will examine all babies admitted to the nursery prior to discharge. In the nursery, staff is required to co-sign either the admission or discharge physical signifying that they agree with the resident's exam, assessment and plan. If the staff's examination or assessment/plan differs significantly from the resident's or if the staff has anything to add, the staff will make the appropriate changes or include an addendum.
6. The staff supervisor will assure that the parents/patient admitted to their service for medical care is adequately informed of patient status and progress.
7. The staff supervisor will write a brief note on each patient within 24 hours of admission. Additional notes should be written at a minimum of every 3 days or anytime there is a major change in the clinical status of the patient (except healthy newborns without complications or medical issues for whom no attending note is required).
8. The staff supervisor must review, sign, and date the intern/resident history and physical. All subsequent resident/medical student progress notes need to be reviewed and co-signed daily, and orders should periodically be reviewed for completeness and accuracy. All comments and

signatures require a corresponding stamp with provider number unless automatically added by the EMR.

9. Staff supervisor physicians are responsible for “Do not resuscitate” orders. These orders will be renewed at least every 3 days and will be accompanied by a daily staff note in the chart after discussion with parents to confirm their desire to continue the order in keeping with policy patient and the patient’s parents were counseled and concur with the orders. (STAFF SUPERVISORS MUST TIME, DATE, and SIGN ALL ENTRIES).

10. The staff supervisor physician is responsible to ensure that the patient’s referring and/or primary physician is kept informed as to the patient’s clinical status, and is informed at the time of the patient’s discharge that plans for long term follow-up have been made with the referring physician.

11. The staff supervisor will ensure that each patient has appropriate outpatient follow-up arranged at discharge.

12. The staff supervisor will review and countersign the work copy of the inpatient record cover sheet, discharge summary, and resident history and physical forms, etc.

13. The staff supervisor is responsible for countersigning all consultations to other services performed by the pediatric house staff on the ward team or on call. This includes both consultations performed in the Emergency Department and on patients admitted to other services on the pediatric ward. Consultations performed on admissions to services other than the Pediatric or Hematology/Oncology services must have a staff signature on the consultation or in the inpatient chart. The attending is also responsible for countersigning the encounter sheets (i.e. T-cons) from any ward follow-ups.

14. The staff supervisor should observe each resident taking a history and doing a physical examination at least once during the rotation. They will also be responsible for and regularly reviewing each resident’s progression through the ACGME Six Core Competencies of patient care, medical knowledge, professionalism, systems based practice, practice-based learning and interpersonal and communications skills. In addition, the staff physician is expected to provide formal written feedback at the completion of each block that is specific to these six ACGME Core Competencies.

15. Finally, as referenced in the SAMPC “Transition of Care” policy, the attending physician is expected to be present for a minimum of one of the two daily patient hand-off sessions between day and night teams.

Outpatient Setting

Residents

1. Residents will provide direct patient care in the outpatient setting. The resident will evaluate and treat outpatients with proper consultation and supervision by staff preceptors in accordance with their level of experience, level of skill and judgment of the staff. The staff supervisor will interview and examine the patient themselves to confirm findings at either the staff's discretion, the trainee's request or at the patient's request.
2. All patient encounters will be documented in the required format, with an AHLTA entry for each patient seen. The resident will assign the appropriate staff as the supervising staff within AHLTA. Resident will assure medical charts have completed growth charts and problem sheets and meet Joint Commission standards.
3. PL-1 residents during the first 6 months of the academic year will present each patient encounter to a preceptor. They will complete AHLTA record and electronically assign their preceptors for review after each patient visit. In keeping with appropriate and measured increasing independence as practitioners, PL-1's in the second half of the year may, at their supervisors discretion, complete a patient evaluation independently and submit the written encounter documentation to their supervisor at the end of the half-day. For all resident encounters, patients are not to be discharged from the clinic until the primary problem is addressed, treated and adequate follow-up is arranged. When there is any doubt or question about the diagnosis or treatment of a patient, the resident should discuss the patient with the staff preceptor before the patient leaves the clinic.
4. Under normal conditions, all Residents are to complete and turn in patient records with the encounter note to the staff preceptor for review and signing on the day the patient is seen. When call duty or other compelling circumstances arise, the records can be turned in no later than 48 business hours following the encounter. This is to ensure that attending physicians have enough time to co-sign the encounter within the 72-hour business hour time period dictated by hospital and military policy.
5. Residents must document all unscheduled patient encounters and patient telephone consults (T cons) in the required format. These should be reviewed by an appropriate staff supervisor.
6. Residents should daily review their new radiology and laboratory results. All abnormal laboratory results must be reviewed with the appropriate staff supervisor. Documentation of the results, assessment and plan should be made in AHLTA, assigning the co-signature to the staff with which you discussed the results.
7. Residents will assume increasing independence in these activities depending on their clinical experience, demonstrated skill and as deemed warranted by their supervisory staff.

8. All communications occurring through electronic media that directly involves patient management should be reviewed and co-signed by an appropriate staff supervisor. This includes but is not limited to E-mails, telephone encounters, or other forms of electronic communication.

Staff Attendings in Outpatient Settings

1. The attending is ultimately responsible for all patient care by residents and medical students that he/she is precepting. He/she will be actively involved in all aspects of patient care and needs to be kept informed of all significant patient care issues.

2. The attending will be readily available for supervision in the clinic.

3. There will be an adequate ratio of supervisory staff to educational learners (i.e. medical students, residents, or fellows) to ensure adequate patient safety and learner education. The program as a whole has decided that a ratio of 1:3 of supervisors to learners should be maintained to meet this goal.

3. The attending should be constantly aware of the experience and skill level of the residents under their supervision. He/she should observe each resident taking a history and doing a physical examination. They will also be responsible for and regularly reviewing each resident's progression through the ACGME Six Core Competencies of patient care, medical knowledge, professionalism, systems based practice, practice-based learning and interpersonal and communications skills. In addition, the staff physician is expected to provide formal written feedback at the completion of each block that is specific to these six ACGME Core Competencies.

4. The attending or senior resident will be expected to verify the examination and history after each patient encounter with a student. The attending should review each patient seen by the PL-1 resident during the first half of the academic year before the patient leaves the clinic area. In keeping with appropriate and measured increasing independence as practitioners, PI-1's in the second half of the year may, at their supervisors discretion, complete a patient evaluation independently and submit the written encounter documentation to their supervisor at the end of the half-day. Review is acknowledged by the staff signing the AHTLA encounter. Co-signs should address whether the patient was seen by the staff, whether the staff discussed the patient with the resident, but didn't examine the patient, or if the staff simply reviewed the note and agrees: examples:

a) "I saw and evaluated the patient. Discussed with resident and agree with resident's findings and plan as documented in the resident's note."

b) As the clinic supervisor I was available for consultation and discussed the pt. with the resident prior to disposition. I have reviewed this record and agree with the documentation with the following exceptions: none

c) As the clinic supervisor I was present but not consulted by the resident on this patient prior to disposition. I have reviewed this record and agree with the documentation with the following exceptions: none

5. The staff supervisor will interview and examine the patient themselves to confirm findings at the staff's discretion, the trainee's request or at the patient's request.

6. Staff will review all charts within 72 business hours from when the patient is seen and acknowledge their review and concurrence by signing the encounter sheet.

OFF-SITE ROTATIONS

1. While attending off-site rotations, all residents will adhere to the respective program specific GME supervision policies at the site of the rotation. In the event that the residents are rotating through a site that does not have direct GME oversight (i.e. an independent practitioner in the community) the above stated SAUSHEC supervision policy will be applied.

2. The attending should be constantly aware of the experience and skill level of the residents under their supervision. He/she should observe each resident taking a history and doing a physical examination. They will also be responsible for and regularly reviewing each resident's progression through the ACGME Six Core Competencies of patient care, medical knowledge, professionalism, systems based practice, practice-based learning and interpersonal and communications skills. In addition, the staff physician is expected to provide formal written feedback at the completion of each block that is specific to these six ACGME Core Competencies.

Addendum 3:

ACGME STANDARDS COMPLIANCE WITHIN SAUSHEC PEDIATRIC RESIDENCY SUPERVISION 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.

(See III.1. Staff Attending in Inpatient Settings and V.1. Staff Attending in Outpatient Settings)

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

(See I. A. PL-1- Inpatient Setting, I. B. PI-2 or PI-3 Inpatient Supervisory Resident, II. PIMS (Procedure, Icu, Monitored unit, Sedation Rotation), III.1. Staff Attending in Inpatient Settings and V.1. Staff Attending in Outpatient Settings)

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.

(See III.1. Staff Attending in Inpatient Settings and V.1. Staff Attending in Outpatient Settings) – Direct supervision is in place in both inpatient and outpatient settings

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.

(See III.1. Staff Attending in Inpatient Settings and V.1. Staff Attending in Outpatient Settings) – “With Direct supervision immediately available” is in place in both inpatient and outpatient settings. This occurs primarily in the outpatient setting while residents see patients in clinic but have staff immediately available. Inpatient attendings provide primarily direct supervision during duty hours.

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

(See III.1. Staff Attending in Inpatient Settings and II. PIMS (Procedure, Icu, Monitored unit, Sedation Rotation) – Occurs primarily in inpatient settings after hours via on call staff assigned to the unit. Depending on the circumstance the attending may be physically available for direct supervision. Guidelines in our policy state criteria for resident communication with attending and role of attending oversight.

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

(See III.1. Staff Attending in Inpatient Settings and V.1. Staff Attending in Outpatient Settings) – Occurs primarily in outpatient setting and occasionally in the inpatient setting when the inpatient team is consulted to the ED. For both circumstances, our policy delineates the attending notification and verification process and timelines.

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.

(See III. Staff Attendings in Inpatient Settings and V. Outpatient Setting Residents) – the policy delineates the progressive responsibility and independence of residents through the various year levels in both inpatient and outpatient settings.

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.

(See III.9. Staff Attendings in Inpatient Settings and III. Staff Attendings in Inpatient Settings) – our policy delineates criteria and guidelines for contacting attending as well as process for “do not resuscitate” orders

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.

(See I. B. Pl-2 or Pl-3 Inpatient Supervisory Resident)

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

(See I. A. PL-1- Inpatient Setting and V. Outpatient Setting Residents) – our policy delineates the role of the PL-1 in these settings and the availability of supervision by an attending or supervisory resident at all times.

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.

In our program attending schedules and clinic supervisory assignments assure compliance with this requirement.

Addendum 4:

House Staff Supervision Progression

Specialty: Pediatrics

Nothing in this report restricts the provision of emergency care required during a life-threatening event. These aspects of supervision are in addition to those specified in the individual residency program statement, the Professional Staff Rules and Regulations, and other applicable policies. The list below is not designed to be an exhaustive list of all procedures performed by residents in the program. Procedures which are similar but not identical to those listed may be performed with the level of supervision specified for the like procedure.

Privilege Report



Pediatrics
 Status: Incoming Resident
 Phone: (210) 916-9928
 Pager: 210 513

Procedure:	CPT® Code
Direct Supervision	
Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); other than the prone position *	01991
Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); prone position *	01992
Anesthesia for procedures in lumbar region; diagnostic or therapeutic lumbar puncture *	00635
Anesthesia for procedures on salivary glands, including biopsy *	00100
Anesthesia for procedures on upper anterior abdominal wall; percutaneous liver biopsy *	00702
Application of finger splint; static *	29130
Application of long arm splint (shoulder to hand) *	29105
Application of long leg splint (thigh to ankle or toes) *	29505
Application of short arm splint (forearm to hand); static *	29125
Application of short leg splint (calf to foot) *	29515
Arterial catheterization (A-lines) or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous *	36620
Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); cutdown *	36625
Arterial Puncture *	
Arterial puncture, blood removal or arterial catheterization	36600
Aspiration of bladder; with insertion of suprapubic catheter *	51010
Attendance at delivery (when requested by delivering physician) and initial stabilization of newborn *	99436
Bag Valve Mask Ventilation--Any age	
Biopsy of liver, needle; percutaneous *	47000
Bladder Catheterization (< 3 y/o) *	
Bone Marrow Aspiration	
Bone marrow; aspiration only *	38220
Bone marrow; biopsy, needle or trocar *	38221
Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with bronchial alveolar lavage *	31624
Cardiopulmonary resuscitation (eg, in cardiac arrest) *	92950

Addendum 5:

SAUSHEC PEDIATRIC RESIDENCY

MILESTONES AND PROGRESSION CRITERIA

PGY -1

Milestones (Mid-Year)

Comments

___ Conference attendance \geq 80%

___ USMLE/COMLEX Part 3 Scheduled or Taken

___ Resident deemed appropriate by majority vote at the CCC to write medication/fluid orders on the ward/PICU without co-signature

Progression to PGY-2

Comments

___ Satisfactory Performance in all rotations

___ Conference attendance \geq 80%

___ USMLE/COMLEX Part 3 -- Passed

___ PREP Questions – 1 Year, \geq 50% correct
(turned in by June 1 PGY1 Year)

___ Research mentor/project identified

___ CITI investigator course completed for research in human subjects

<https://www.citiprogram.org/default.asp>

___ Resident deemed appropriate by majority vote at the CCC to write medication/fluid orders in the NICU without co-signature

___ Resident deemed appropriate by majority vote at the CCC to take responsibility for team leadership and resident call

___ Resident deemed to be making appropriate progression in 6 core ACGME competencies and milestones

MILESTONES AND PROGRESSION CRITERIA

PGY -2

<u>Milestones (Mid-Year)</u>	<u>Comments</u>
------------------------------	-----------------

- Conference attendance $\geq 80\%$
- Applied for Medical License
- Research project started
- PREP Questions – 1 Year, $>60\%$ correct
(turned in by Dec 31 PGY2 Year)

<u>Progression to PGY-3</u>	<u>Comments</u>
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- Satisfactory Performance in all rotations
- Passed PL-2 PALS Simulation
- PALS Instructor
- Sedation Certification (complete non-patient related Requirements)
- Completed NICU Transport Course
- Has a valid medical license
- Conference attendance $\geq 80\%$
- PREP Questions – 1 Year, $\geq 60\%$ correct
(turned in by June 1 PGY2 Year)
- Research project making adequate progress
(submit for publication/presentation if ready)
- Resident deemed appropriate by majority vote at the CCC to be making expected progression in 6 core ACGME competencies and milestones

MILESTONES AND PROGRESSION CRITERIA

PGY -3

Milestones (Mid-Year)

Comments

- Conference attendance $\geq 80\%$
- Up to Date on BLS/PALS/NRP
- Scheduled of taken ACLS
- Procedure log on target for credentialing
- Taught at least one PALS course
- Research project completed or near completion
- PREP Questions – 1 Year, $>70\%$ correct
(turned in by Dec 31 PGY3 Year)

Progression to Graduation

Comments

- Satisfactory Performance in all rotations
- Up to Date on BLS/PALS-Instructor/NRP for at least 90 days past graduation
- Conference attendance $\geq 80\%$
- Taught at least one PALS course second half of the year
- Procedure log complete for credentialing
- Sedation Certification (completed all phases)
- PREP Questions – 1 Year, $\geq 70\%$ correct
(turned in by June 1 PGY3 Year)
- Research project completed
(turned in by April 30 PGY3 Year)
- Deemed appropriate by majority vote of the Clinical Competency Committee to practice independently as a Pediatrician as evidenced by expected ACGME core competency proficiency and milestone achievement

*****Failure to comply with milestones and/or progression criteria will result in trainee being presented for academic action at the Clinical Competency Committee*****

Attestation Statement: By signing below, I acknowledge I have read the SAUSHEC Pediatric Residency Program's Supervision Policy. My questions regarding these expectations have been answered to my satisfaction.

Resident Name (Write Name)

Resident Signature

Date