



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

**Department of Medicine General Medicine Wards, Medical Intensive
Care Unit (MICU) and Coronary Care Unit (CCU)**

**Supervision of Residents
December 14, 2012**

Residency training is an educational experience designed to offer residents the opportunity to participate in the clinical evaluation and care of patients in a variety of patient care settings to include the general medicine wards, the MICU, and the CCU. All aspects of patient care rendered by resident physicians must receive close supervision.

All aspects of patient care are ultimately the responsibility of the supervising physician. Supervising physicians have the right to prohibit resident and medical student participation in the care of their patients without penalty, and when allowing care of their patients by residents do not relinquish their rights or responsibilities to: examine and interview; admit or discharge their patients; write orders, progress notes; and discharge summaries; obtain consultations; or to correct resident medical record entries deemed to be erroneous or misleading.

When a resident is involved in the care of a patient it is their responsibility to communicate effectively with their supervising physician regarding the findings of their evaluation, physical examination, interpretation of diagnostic tests, and intended interventions.

The supervising physician is defined as that physician who has immediate oversight responsibility of all aspect of patient care rendered by the residents and may be a staff or fellow.

1. Admissions

Second and third year residents (PGY2 and PGY3) can admit patients to the general medicine wards and the intensive care units. Any admission to the ICUs must be discussed with the ICU fellow or staff at the time of initial evaluation. Residents on the ICU service must evaluate any ICU admission within 30 minutes of arrival. The supervising fellow or staff must be notified within 2 hours of an ICU admission. Ward attending staff must be notified of all patients admitted to the wards.

2. History and Physicals / Consultations

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Residents may perform history and physical examinations and consultations without the supervising physician being physically present. It is the responsibility of the resident to discuss their findings with the supervising physician. The supervising physician must evaluate the patient, review the history and physical, and write/enter a separate note of concurrence with the admission treatment plan, history, and physical exam within 24 hours of admission. For admissions to critical care units, there must be documentation of notification of the admission and concurrence of the supervising physician with trainee health care plans within four hours of admission. Medical students may write/enter the official history and physical for their patients with prior approval of the supervising physician. A resident must co-sign their documentation and indicate that they have independently evaluation the patient.

3. Rounds

General Medicine Wards:

Each team will consist of a second or third year senior resident (PGY2 or PGY3) and 2 first year residents (interns, PGY1), and up to three medical students supervised by a staff physician. Occasionally a team will consist of 2 senior level residents supervised by a staff physician. The role of the senior resident is to supervise and direct the interns and medical students in the daily management and care of the patients on their service. They should provide teaching on specific patient problems as well as formulate a management plan under the supervision of the staff physician. The senior residents should round a minimum of once daily with the interns and medical students. The senior resident or covering staff when the senior resident has the day off must see each patient every day. Further informal rounding with the interns for the purpose of teaching or updating a patient's condition is encouraged but left to the discretion of the resident. Formal rounds with staff should occur no less frequently than three times per week. However, the senior resident is responsible for reporting the status of the team daily to the staff physician. More frequent, less formal rounding with the staff is encouraged and is left to the discretion of the staff and the senior resident.

CCU:

The CCU team will consist of two Cardiology fellows, one second or third year senior resident (PGY2 or PGY3), one to two first year residents (interns, PGY1), occasionally a second or third year Emergency Medicine resident, up to three medical students all supervised by a staff Cardiologist. The senior resident should round a minimum of once daily with the interns, medical students and the Emergency Department resident at the bedside. Daily rounds with the staff and fellow are mandatory. More informal checkout rounds with the staff or fellow is encouraged daily and is left to the discretion of the staff and the senior resident.

MICU:

The MICU team will consist of a Critical Care fellow, a second or third year medicine senior resident (PGY2 or PGY3), one to two first year residents (interns, PGY1), occasionally a second or third year Emergency Medicine resident, and up to three medical students all supervised by a critical care staff member. The senior resident should round a minimum of twice daily with the interns, Emergency Medicine resident and medical students once in the morning and again later in the day prior to check out.

Daily rounds with the staff and/or fellow are mandatory. More informal check out rounds with the fellow is not required but highly recommended.

4. Daily Progress Notes

Residents may write/enter daily progress notes. It is the responsibility of the resident to discuss their findings and treatment plans documented in their progress note with the supervising physician on a daily basis, or more often when a patient's condition changes, or prior to initiating significant changes in a patient's treatment plans. The residents must notify the supervising fellow or staff of any significant deterioration in a hospitalized patient's condition within 2 hours of recognition of that deterioration. Supervising ward and ICU physicians must write/enter a daily staff note. At the end of a rotation the supervising physician is encouraged to write/enter a note which will include a brief summary of that patient's condition and identifies the new supervising physician who will be accepting responsibility for that patient. Medical students may write/enter progress notes but they must be co-signed by a resident. The resident co-signing the note is responsible for the content of these notes and should meticulously evaluate and critique each note. An intern or senior resident should never co-sign a student note without having seen and examined the patient.

5. Orders

Residents may write/enter orders on patients for whom they are participating in their care. These orders will be implemented without the co-signature of an attending or consulting physician. Residents are encouraged to evaluate all patients for whom they are initiating orders. However if it is clinically appropriate, residents are allowed to place "verbal" orders over the phone. All phone orders must be signed, dated, and timed within 24 hours. **Medical students may write orders but they must be co-signed by a resident prior to implementation. Medical students are not allowed to give verbal orders at any time.**

6. Discharge Summaries/Transfer Summaries

Residents may write/enter the discharge summary/transfer summary on patients for whom they are participating in their care. It is the responsibility of the resident to discuss discharge plans with the attending or consulting physician prior to discharging the patient. The resident will inform the supervising physician of all discharge plans before the patient is discharged or transferred to another provider, service or facility. The name of the supervising staff will be annotated on the summary. Medical students may write/enter discharge summaries with the prior approval of the supervising physician. Their documentation must be co-signed by a resident.

7. Occurrence Reports:

If the situation occurs where a resident is called upon to fill out an occurrence report on a patient, the resident will not refer to submission of the report in the progress notes, or in any portion of the medical record.

8. Procedures:

The supervising staff must be notified before any procedure requiring consent is performed. Residents performing procedures that they are not certified to perform unsupervised should be supervised by the physical presence of the physician certified to perform the procedure independently. In general all first year residents will be certified at the start of the academic year to perform venopuncture, peripheral IV line placement, arterial puncture and nasogastric tube placement unsupervised. The following is a list of additional procedures that are both required for residency training and that are tracked. The number needed is given and the number requiring bedside supervision by a more experienced physician is in parentheses:

- abdominal paracentesis 3 (3)
- arthrocentesis of a joint 3 (3)
- central venous line placement
 - femoral line 5 (5)
 - subclavian line 5 (5)
 - internal jugular line 5 (5)
- lumbar puncture 5 (5)
- thoracentesis 5 (5)
- treadmill test 25 (50)
- endotracheal intubation 5 (5)
- Swan-ganz catheter placement 5 (5)*

Individuals may be certified to perform these procedures unsupervised by the program director only after they have successfully completed the minimum number of required supervised procedures and when a supervising physician has documented that they are competent to perform the procedure. Occasionally a resident has done sufficient numbers of other procedures to be allowed to do them unsupervised (flexible sigmoidoscopy 15 (15), bone marrow biopsy 5 (5), transvenous pacer 5 (5)* etc). These will also be tracked and require certification by the program director. It is the resident's responsibility to document all their procedures in the New Innovations procedure logbook in order to receive credit. All procedures except for venopuncture, peripheral IV line placement, nasogastric tube placement, arterial puncture, or those procedures performed during an emergency such as a code require prior notification of the supervising physician. An electronic and hard copy record of the resident's procedure certification will be maintained on file in the Internal Medicine Residency office. A copy will be given to all the clinics and wards. A written record of certification will be sent with the residents doing away rotations. Medical students are not allowed to perform any procedures unsupervised.

9. Progression:

Residents progress in responsibilities by year group (PGY level). Progression to the next year group will depend upon continued demonstration that the resident has achieved the expected competence in each of the six key areas patient care, medical knowledge, practice-based learning and improvement, systems based practice, professionalism, and communication and interpersonal skills. This will be accomplished using a variety of competency based assessment tools to include direct observation by the attending staff, by resident chart review, satisfactory completion of the mini-clinical

evaluation exercise, 360 degree rotation evaluations, skills stations, portfolios and by formal rotation evaluations.. The progress of every resident is formally reviewed every six months by the Internal Medicine Residency Clinical Competency Committee. A written record of the residents' progress is on file in the Internal Medicine residency administrative office.

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Program Director
SAUSHEC Internal Medicine

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Chairman, Department of Medicine