**Name of Hospital**

**Department of \_\_\_\_**

**Name of Residency Program**

**Policies and Procedures**

**Title**: Supervision and Accountability

**Effective Date**:

**Last Reviewed**:

**Last Revised**:

**References**: Name of Institution, GME policy (add # if use numbers) – Resident Supervision and Accountability

**Purpose**

To define the mechanisms for acceptable supervision of residents in the [name of program] residency program.

Definition: You may define a resident or supervisor in this section

**Policy**

1. The residency is an educational experience and is designed to offer structured and supervised exposure to promote learning and strives for an equal balance of service and education. All patient care must be supervised by an identifiable, appropriately-credentialed and privileged attending physician who has ultimate responsibility for patient care. The program director ensures this information is available to residents, other faculty and hospital administration as appropriate. Residents and faculty should inform patients of their respective roles in each patient’s care.
2. Supervision shall be provided on a graduated basis as the trainee progresses through the training program and based on individual evaluation of knowledge and skill. The supervising physician shall be available to the trainee and is responsible for determining the activities the trainee will be allowed to perform within the context of the assigned levels of responsibility. At the same time, the trainee is responsible for seeking consultation and advice when it is clinically indicated or warranted.
3. The following classifications of supervision are utilized:
	1. *Direct supervision* – the supervising physician is physically present with the resident and 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, within 15 [or time your program agrees upon] minutes, to provide direct supervision.
	3. *Indirect supervision 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.
	4. *Oversight* – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.
4. Residents must be provided with rapid, reliable systems for communicating with supervising physicians while at the same time experiencing graduated responsibility, assuming greater and greater levels of responsibility for aspects of the patient’s care as their competencies increase and are documented.
5. 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. Initially, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available. PGY-1 resident must have direct supervision until competence is demonstrated and documented in the following:

[Some programs choose to add a list of patient care activities and/or procedures that PGY 1 residents can be “credentialed” to do on their own after they have demonstrated competence. Check your specialty FAQ’s and requirements for specifics, if applicable]

1. 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.
2. The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services. Regardless of year of training, all [Name of Program] residents **MUST** contact a supervising faculty in the following circumstances:

**THESE ARE EXAMPLES FROM AN INTERNAL MEDICINE PROGRAM!!**

1. Situations where the resident on duty feels he/she needs immediate assistance of the supervising attending physician or has any question regarding the patient’s status or condition
2. Transfer of patient from medical floor to the ICU
3. Any unexpected clinical deterioration on floor or ICU
4. Any transfer of patient from an outside facility to TUH ICU
5. Conditions which require immediate intubation and mechanical ventilation
6. Changes to or new DNR/DNI requests
7. Death
8. If discharge a patient from the ER when in contradiction to ER attending.
9. 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. 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. Supervising physicians should delegate portions of care of residents, based on the needs of the patient and the skills of the residents.
10. Senior residents 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.

[Some programs choose to list specific supervision requirements for specific rotations, particularly if there special or unique situations that are in the hospital. This is optional]