CONEMAUGH MEMORIAL MEDICAL CENTER
GRADUATE MEDICAL EDUCATION POLICY

SUPERVISION POLICY

Purpose

The Conemaugh Memorial Medical Center (CMMC) Residency/Fellowship Programs follow the principle that resident/fellow supervision is required at all levels in order to insure optimal educational benefit as well as patient safety. As medical educators, we recognize the need for graduated responsibility and opportunity to make decisions in order to develop judgment by residents/fellows at every level. The principle of graduated responsibility under supervision begins in the PGY-1 year with resident/fellow credentialing in basic patient evaluation and care skills and progresses from specific to general supervision. As residents/fellows gain knowledge, proficiency in manual and problem solving skills and begin to demonstrate good judgment, the intensity of supervision decreases to foster independent decision-making. Patient safety remains our primary concern followed by the facilitation of education and learning.

Principles

A. Each patient must have an identifiable, appropriately-credentialed and privileged attending physician who is ultimately responsible for that patient's care.

B. Clinical responsibilities must be conducted in a carefully supervised and graduated manner, allowing housestaff to assume progressively increasing responsibility in accordance with their level of education, ability, and experience.
   1. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident or fellow must be assigned by the program director and faculty members after assessment of relevant competencies.
   2. The program director must evaluate each resident's abilities based on specific criteria. When available, evaluation should be guided by specific criteria or milestones.
   3. Senior residents or fellows should be given the responsibility for supervising 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.

C. Supervision of residents and fellows should foster humanistic values by demonstrating a concern for each housestaff member's well-being and professional development.
   1. Supervision must include timely and appropriate feedback and residents and fellows must be provided with rapid, reliable systems for communicating with supervising faculty.
   2. Supervision assignments should be of sufficient duration to assess the knowledge and skills of each trainee and delegate to him/her the appropriate level of patient care authority and responsibility.

D. Faculty members functioning as supervising physicians should delegate portions of care to residents and fellows, based on the needs of the patient and the skills of the resident or fellow. Residents, fellows and faculty members should inform patients of their respective roles in each patient's care.

E. Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care,

the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident delivered care with feedback as to the appropriateness of that care.

Policy

The CMMC Residency/Fellowship Programs recognize the ACGME's three classifications or levels of supervision:

A. **Direct Supervision** - the supervising physician is physically present with the resident/fellow and patient

B. **Indirect Supervision**:
   1. **With direct supervision immediately available** - the supervising physician is physically within the confines of the 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 confines of the site of the patient care, but is immediately available via phone and/or electronic modalities and is available to provide Direct Supervision.

C. **Oversight (Informal Supervision) -** the supervising physician is available to provide review of procedure/encounters with feedback provided aftercare is delivered.

Procedure

A. Each Program sponsored by CMMC shall develop and maintain appropriate supervision policies, compliant with ACGME/AOA Program Requirements, including an explicit description of the supervision for each activity or rotation and for each level.

B. The following site-specific faculty supervision requirements are applicable.
   1. Inpatient Services: A patient care team that may include medical students, interns, residents and fellows, under the supervision of a faculty physician, shall care for patients admitted to the service. Decisions regarding diagnostic tests and therapeutics, although initiated by housestaff, shall be reviewed with the responsible faculty member during patient care rounds.

      Patients shall be seen by the responsible attending and their care shall be reviewed at appropriate intervals. The attending shall document his/her involvement in the care of the patient in the medical record. Housestaff members are required to promptly notify the patient's faculty physician in the event of any controversy regarding patient care or any serious change in the patient's condition.

      Faculty members or their designees (covering physicians) are expected to be available, by telephone or pager, for housestaff consultation 24 hours per day for their term on service, on-call day or for their specific patients.

2. Emergency Departments: In the Emergency Departments, a faculty member must be on-site 24 hours per day.
3. Clinics and Consultation Services: In clinics and consultation services, a faculty member must review overall patient care rendered by housestaff.
4. Intensive Care Units: In intensive care units, housestaff decisions regarding patient care, including admission, discharge, treatment decisions, performance of invasive procedures and end-of-life decisions are to be discussed and reviewed by faculty.
5. Supervision of Housestaff in Operating Suites: In the operating suites, a surgical faculty member is responsible for the supervision of all operative cases. A surgical faculty member shall be present in the operating room with housestaff during critical parts of the procedure. For less critical parts of the procedure, a surgical faculty member must be immediately available for direct participation.

Monitoring Compliance

A. The quality of housestaff supervision and adherence to supervision guidelines and policies shall be monitored through annual review of the housestaff's evaluations of their faculty and rotations, review of ACGME surveys and the GMEC's internal reviews of programs. When necessary, during the Special Reviews of programs, the GMEC shall request that each program provide a description of the procedures to ensure supervision in the program's clinical settings (including nights and weekends), an explanation as to how the program monitors compliance with its supervision policies, a description as to how the program becomes aware of and responds to exceptions or critical instances of breakdown of supervision and the mechanisms the program has in place to ensure accessibility and availability of faculty.

B. For any significant concerns regarding housestaff supervision, the respective program director shall submit a plan for its remediation to the GMEC for approval and the program director may be required to submit progress reports to the GMEC until the issue is resolved.

References

CR-VI.A (Supervision and Accountability)
IR-IV.I (Supervision)

GMEC Revised: 1/2016, 3/2018
GMEC Reviewed: 5/2013, 4/2018
Approved: 7/2013, 4/2018