**Supervision Policy #0.12**

## I. Purpose

This policy is set forth to ensure the appropriate level of supervision is in place for all residents/fellows based on their level of training and ability, as well as patient complexity and acuity.

## II. Definition

To promote appropriate resident/fellow supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:

- **Direct Supervision**: The supervising physician is physically present with the resident/fellow during the key portions of the patient interaction; or, the supervising physician and/or patient is not physically present with the resident/fellow and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology. PGY-1 residents must initially be supervised directly.
    - For Internal Medicine, a supervising physician must be immediately available to be physically present for PGY-1 residents on inpatient rotations who have demonstrated the skills sufficient to progress to indirect supervision.
    - For Otolaryngology-Head and Neck Surgery, the program must define those physician tasks for which PGY-1 residents must be supervised directly until they have demonstrated competence as defined by the program director, and must maintain records of such demonstrations of competence. Also, the program must define those physician tasks for which PGY-1 residents may be supervised indirectly with direct supervision available, and must define "direct supervision" in the context of the individual program. Supervision through telecommunication technology must be limited to residents at the PGY-2 level and above.
    - For Psychiatry, the PGY-1 residents should progress to being supervised indirectly with direct supervision available only after demonstrating competence in: the ability and willingness to ask for help when indicated; gathering an appropriate history; the ability to perform an emergent psychiatric assessment; and, presenting patient findings and data accurately to a supervisor who has not seen the patient. Also, when a resident requiring direct supervision provides remote care, the supervising physician must be physically present with the resident.
    - For Surgery, the program must define those physician tasks for which PGY-1 residents may be supervised indirectly, with direct supervision available, and must define "direct supervision" in the context of the program. The program must define those physician tasks for which PGY-1 residents must be supervised directly until they have demonstrated competence as defined by the program director, and must maintain records of such demonstrations of competence.

- **Indirect Supervision**: The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident/fellow for guidance and is available to provide appropriate direct supervision.
- **Oversight**: The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

## III. Policy

Each ACGME-accredited KCU GME program must establish a written policy for supervision that defines resident/fellow supervision classifications.

The program supervision policies shall incorporate all ACGME specialty-specific program requirements related to resident/fellow supervision. It is the responsibility of the PD to keep an updated version of the program supervision policy on file in New Innovations accessible to residents/fellows, faculty, and the KCU GME Department.

Residents/Fellows and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. This information must be available to residents/fellows, faculty members, other members of the health care team, and patients.

The program must demonstrate that the appropriate level of supervision in place for all residents/fellows is based on each resident's/fellow's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation.

The program must define when the physical presence of a supervising physician is required.

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident/fellow must be assigned by the program director and faculty members. The degree of supervision for a resident/fellow is expected to evolve progressively as the resident/fellow gains more experience, even with the same patient condition or procedure. The level of supervision for each resident/fellow is commensurate with that resident's/fellow's level of independence in practice; this level of supervision may be enhanced based on factors such as patient safety, complexity, acuity, urgency, risk of serious safety events, or other pertinent variables.

The program director must evaluate each resident's/fellow's abilities based on specific criteria, guided by the Milestones.

Faculty members functioning as supervising physicians may delegate portions of care to residents/fellows based on the needs of the patient and the skills of each resident/fellow.

Senior residents or fellows should serve in a supervisory role to 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.

The program must set guidelines for circumstances and events in which residents/fellows must communicate with the supervising faculty member(s).

Each resident/fellow must know the limits of their scope of authority and the circumstances under which the resident/fellow is permitted to act with conditional independence.

Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident/fellow and to delegate to the resident/fellow the appropriate level of patient care authority and responsibility

Faculty members are responsible for the following:

- Be ultimately responsible for the care of the patient.
- Provide appropriate levels of supervision to promote patient safety.
- Have a role in the supervision of residents/fellows.
- Delegate resident/fellow responsibilities for patient care, progressive responsibility of patient management, and graded supervision.
- Provide residents/fellows with constructive feedback when appropriate.
- Adhere to all ACGME specialty, institutional, and common program requirements regarding supervision.
- Be familiar with program-specific levels of responsibility and teach residents/fellows according to the level that is commensurate with training, education, and demonstrated skill.
- Supervise operative, invasive, and/or other high-risk procedures. The level of supervision required for the performance of a particular procedure by an individual resident/fellow is determined by the faculty member but will include at a minimum, all key portions of the procedure. During non-supervised portions of the procedure, the faculty member remains available for consultation and/or returns to the operating room.
- Be continually present and actively involved when providing supervision in ambulatory settings.

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