


**CAROLINAS MEDICAL CENTER
DIVISION OF MEDICAL EDUCATION
POLICY FOR RESIDENT SUPERVISION**

Created: 1986

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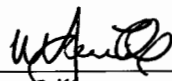
1. The institution and its educational departments will conform to the current Institutional and applicable Program Requirements as published by the Accreditation Council for Graduate Medical Education as well as additional requirements as set by the Executive Committee of the Medical Staff.
2. Faculty supervision assignments will 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.
3. The following departments/units have 24/7 coverage by one or more in-house attending physicians: Emergency Medicine, Obstetrics & Gynecology, in-patient pediatrics, pediatric intensive care unit (PICU), neonatal intensive care unit (NICU), trauma intensive care unit (TICU), medical intensive care unit (MICU).
4. There will be an attending call list for each training program that will allow 24-hour consultations. Each department will have a formal backup mechanism in case the primary consulting attending is not available.
5. To ensure oversight of resident supervision and graded authority, each residency program will confer a specific program policy which incorporates the four levels of supervision as well as their respective ACGME review committee requirements. A template is attached which may be adapted for use by individual residency programs.
 - a) Direct Supervision – the supervising physician is physically present with the resident and patient.
 - b) 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 to provide Direct Supervision.
 - c) 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.
 - d) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.



Mary N. Hall, M.D.
DIO, Deputy Chief Academic Officer
Division of Medical Education

6.19.12

Date



Spencer Lilly
Interim President
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6-29-12

Date

**CAROLINAS MEDICAL CENTER
DIVISION OF MEDICAL EDUCATION
POLICY FOR RESIDENT SUPERVISION**

XXX Residency Program

A. SUBJECT: Resident Supervision Policy

B. EFFECTIVE DATE:

C. POLICY:

The **XXX Residency Program** recognizes and supports the importance of graded and progressive responsibility in graduate medical education. This policy outlines the requirements to be followed when supervising residents. The goal is to promote assurance of safe patient care, and the resident's maximum development of the skills, knowledge, and attitudes needed to enter the unsupervised practice of medicine.

D. DEFINITIONS:

Supervising Physician: A faculty physician, or a more senior resident/fellow.

(NOTE: check your RRC's specialty-specific requirements, VI.D.1 – to determine if your RRC permits residents to be supervised by non-physician licensed independent practitioners. If so, add the specific information here.)

Supervision:

Four levels of supervision are recognized. They are:

•**Direct:** The supervising physician (or "**supervisor**" if your RRC permits supervision by non-physicians) is physically present with the resident and the patient. ***(Some programs will choose to add: "...and prepared to take over the provision of patient care if/as needed." That would apply, for example, to a supervising faculty surgeon being scrubbed in the operating room.)***

•**Indirect:** There are two types of indirect supervision:

➤**Indirect supervision with direct supervision immediately available:**

The supervising physician is present in the hospital (or other site of patient care) and is immediately available to provide Direct Supervision. The supervisor may not be engaged in any activities (such as a patient care procedure) which would delay his/her response to a resident requiring direct supervision.

(NOTE: A qualified supervisor must be in house 24/7 whenever a resident potentially requiring Direct Supervision or Indirect Supervision with direct supervision immediately available is on duty.)

➤**Indirect supervision with direct supervision available:** The supervising physician is not required to be present in the hospital or site of patient care, or may be in-house but engaged in other patient care activities, but is immediately available through telephone or other electronic modalities, and can be summoned to provide Direct Supervision ***(you may wish to add your own defined response time – e.g., "within 15 minutes.")***

•**Oversight:** The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

E. PROCEDURE:

The principles which apply to supervision of residents include:

•***The XXX Residency Program*** establishes schedules which assign qualified faculty physicians, residents, or fellows ***(or appropriate other licensed independent practitioners as permitted by the RRC)*** to supervise at all times and in all settings in which residents of the **XXX Residency**

Program provide any type of patient care. The type of supervision to be provided is delineated in the curriculum's rotation description.

- The minimum amount/type of supervision required in each situation is determined by the definition of the type of supervision specified, but is tailored specifically to the demonstrated skills, knowledge, and ability of the individual resident. In all cases, the faculty member functioning as a supervising physician should delegate portions of the patient's care to the resident, based on the needs of the patient and the skills of the resident.

- Senior residents and fellows serve in a supervisory role of junior residents in recognition of their progress toward independence.

- All residents, regardless of year of training, must communicate with the appropriate supervising faculty member, according to these guidelines:

(Add your own program-specific guidelines for the specific circumstances when the resident MUST call the supervising physician, based on program requirement VI.D.5. Include information about what the resident is to do if that individual does not respond in a timely manner.)

- All PGY-1 residents are supervised either directly or indirectly with direct supervision immediately available until:

(Add your own program-specific guidelines, based on the RRC's specialty specific guidelines – in program requirements VIII.D.5.a).(1)

- In every level of supervision, the supervising faculty member must review progress notes, sign procedural and operative notes and discharge summaries.

- Faculty members must be continuously present to provide supervision in ambulatory settings, and be actively involved in the provision of care, as assigned.

(Check all program requirements – especially those specific to the unique nature of your medical specialty – and add other RRC requirements related to supervision here.)

(Call schedule: (in-house/at-home) May want to add how supervision is determined, where the information is located. Who is contacted next if the person fails to respond? Etc.)

(In turn, some programs may also opt to add whom fellows or residents may be responsible for supervising, such as medical students, junior residents, rotating residents not from program, etc.)

Signed: *XXX Residency* Program Director

(Template adopted from UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES)