Name of Policy:	**GME: Resident Supervision**	
Policy Number:	**3364-86-025-00**	
Approving Officer:	**Dean, College of Medicine and Life Sciences**	**Effective date: 5/21/2024**
Responsible Agent:	**Director, Graduate Medical Education**	**Original effective date**: **02/1997**
Scope:	**UT College of Medicine Residents**	

____	New policy proposal	X	Minor/technical revision of existing policy
____	Major revision of existing policy	____	Reaffirmation of existing policy

POLICY

Graduate Medical Education (GME) exists to provide an organized educational program with guidance and supervision of the resident, facilitating the resident's ethical, professional and personal development while ensuring safe and appropriate care for patients.

PURPOSE

GME sponsored programs must provide appropriate supervision for all residents that is consistent with proper patient care, the educational needs of the residents, and the applicable program requirements.

PROCEDURE

All residents joining GME program at The University of Toledo will participate in an institutional orientation program and a program specific orientation. This orientation must provide the entering resident with:

- Institutional GME policies and procedures
- Program specific policies and procedures
- Information about all associated/affiliated institutions in a program.

Supervision of residents is expected in all areas of all GME sites to assure consistently high standards of patient care.

Supervision of Residents

In the clinical learning environment, residents 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, 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 is based on each resident'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.

Appropriate supervision is essential for patient safety and high-quality teaching. Supervision is also

contextual. There is tremendous diversity of resident-patient interactions, education and training locations, and resident skills and abilities, even at the same level of the educational program. The degree of supervision for a resident is expected to evolve progressively as the resident gains more experience, even with the same patient condition or procedure. The level of supervision for each resident is commensurate with that resident'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.

Faculty and other members of the healthcare team can view a resident or fellow's privilege levels at any time via ePriv (ProMedica) or iPriv. (UTMC).

- ePriv can be accessed in the ProMedica Apps on MyProMedica. Anyone with a PHS log in has access
- iPriv can be accessed via https://epriv.asm-cloud.com/app-4/uoftoledo/#/home

Levels of Supervision

To promote appropriate resident 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 Review Committee may further specify]. PGY-1 residents must initially be supervised directly. [The Review Committee may describe the conditions under which PGY-1 residents progress to be supervised indirectly]

The supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology. [The RC may choose not to permit this requirement. The Review Committee may further specify]

Indirect Supervision – The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident 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.

Oversight with Delegated Teaching: The resident/fellow may be delegated by the attending teaching physician to provide Direct or Indirect supervision to another resident/fellow.

The program must define when 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 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.

Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.

Senior residents or fellows 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

or fellow.

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.

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.

Circumstances Requiring Faculty Notification

The following circumstances require documentation in the medical record and faculty notification by the residents/fellows:

Immediate Notification

- Unexpected death
- Suicide attempt
- All admissions and inpatient consultations
- Cardiac or Respiratory Arrest, or Rapid Response Team called
- Unplanned intubation, worsening gas exchange requiring significant escalation of FiO2 or PEEP, or ventilator support (e.g. BiPAP, CPAP)
- Unexpected cardiovascular support (e.g. addition of vasoactive drugs, anti-arrhythmic)
- Admission to or unplanned transfer to the ICU or more monitored setting (e.g. escalating care/increased severity of illness)
- Any procedure or treatment that requires informed consent (e.g. residents and fellows will follow the informed consent process as per the institutional/facility policy in which they are practicing)
- Development of any clinical problem that requires invasive procedure/operation for treatment
- Iatrogenic event: serious complications from medical and/or surgical interventions
- Development of significant neurologic changes (e.g. mental status changes, suspected CVA, seizure, new onset paralysis)
- New significant bleeding (e.g. requiring or contemplating transfusion or requiring fluid resuscitation)
- At another physician/provider request
- At care team member request/recommendation
- At patient or family request
- Patient falls
- All emergency department consultations
- Prior to all procedures and/or developments

Notification By the Conclusion of Resident's Shift

- All discharges
- Signing out against medical advice (AMA)
- Initiation of restraints

Intimate Exams

- Procedural consent must be obtained in all circumstances and clearly documented in the medical records per Institutional/facility policy. Preoperatively, patients are to be told who is participating in the surgery and provide at least verbal permission for participation.

- Anesthetized patients are not to undergo additional sensitive location exams (e.g.: Pelvic exams, Rectal

exams, Breast Exams) by learners uninvolved with the actual performance of the procedure. Those directly involved in the care of the patient may only perform sensitive location exams if it is required as part of the procedure itself or to assess procedural technical success. Consent for performance of sensitive location exams should be obtained prior to the onset of anesthesia.

Programs may set additional guidelines for circumstances and events in which resident/fellows must communicate with appropriate supervising faculty members that are specific to the program.

Clinical Responsibilities

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.

[Optimal clinical workload will be further specified by each Review Committee.]

Teamwork

Residents must care for patients in an environment that maximizes effective communication and promotes safe, interprofessional, team-based care in the specialty and larger health system.

[Each Review Committee will define the elements that must be present in each specialty.]

Each Residency program must be in compliance with its own RRC requirements for resident supervision.

Approved by: /s/ Shaza Aouthmany, M.D. Chair, Graduate Medical Education Committee /s/ Christopher Cooper, M.D. Dean, College of Medicine & Life Sciences Review/Revision Completed by: *Graduate Medical Education Committee*	Policies Superseded by This Policy: *None* Initial Effective Date: 02/1997 Revision/Review Date: *Reviewed 5/03, Revised 5/05, Reviewed 2/06/07, Reviewed 2/3/09, Revised 4/5/11, Reviewed 4/2/13, Revised 3/4/14, Revised 11/3/15, Revised 6/6/17, Revised 6/4/19, Reviewed 8/3/21, Revised 8/1/23, 5/21/2024* Next Review Date: 5/2026