

The University of Alabama Hospital Graduate Medical Education Policy and Procedure Supervision Policy	GMEC Approved Date: May 6, 2025
	Next Review Date: Spring 2026

PURPOSE:

This policy establishes supervision guidance in accordance with ACGME and the GMEC for residents at The University of Alabama Hospital.

SCOPE:

This policy applies to all GME programs at the University of Alabama Hospital. All are expected to adhere to the following standards to optimize patient care and the educational experience. Supervision takes place in all facets of training and during all rotations.

Progressive Authority and Responsibility: 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.

Levels of Supervision

1. Direct Supervision:
 - a. the supervising physician is physically present with the resident during the key portions of the patient interaction; or
 - i. PGY-1 residents must initially be supervised directly
 - b. the supervising physician is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.
2. 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.
3. Oversight:

The supervising physician is available to provide a review of procedures/encounters with feedback provided after care is delivered.

POLICY STATEMENT:

- Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate the appropriate level of patient care authority and responsibility.
- Each program is responsible for developing descriptions of the level of responsibility accorded to each resident by rotation and Post-Graduate Year (PGY). These descriptions must include identification of the mechanisms by which the participant's supervisor(s) and program director make decisions about each resident's progressive involvement and independence in specific patient care activities. In particular:
 - The program director must evaluate each resident's abilities based on specific criteria established by the faculty. These criteria shall be guided by national standards-based criteria when such are available.
 - Supervising faculty members will delegate patient care activities to residents based on the needs of the patient and the demonstrated abilities of the resident.
 - Senior residents should serve in a supervisory role of junior residents with appropriate patients, provided the junior residents have demonstrated progress in the training program.

- General
 - All patient care must be supervised by a qualified faculty and member of the medical staff.
 - Each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner) who is ultimately responsible for that patient's care at all clinical sites utilized for education of residents/fellows.
 - The program must define when physical presence of a supervising physician is required.
 - This information should be available to the residents/fellows, faculty members, other members of the health care team and patients.
 - Residents/fellows and faculty members should inform patients of their respective roles in each patient's care.
 - On-call and clinical assignment schedules must be available at all clinical service locations so that residents, nursing staff, and ancillary personnel can easily identify the assigned resident and their faculty supervisor.
 - PGY-1 level residents must be supervised either directly or indirectly. If indirect supervision is provided, such supervision must be consistent with RC policies, and PGY-1 residents must meet established criteria to be eligible for indirect supervision.
 - Residents/fellows can report inadequate supervision and accountability in a protected manner that is free from reprisal by following the GME Procedures for Submitting Concerns or Complaints.

- Faculty Responsibilities
 - Oversees all clinical decisions, is available for the performance of the procedure to ensure patient safety and optimal educational experience.
 - The attending physician is responsible for all patient care decisions and will be immediately available to the resident.
 - Routinely review resident's documentation in the medical record.
 - Be attentive to compliance with institutional requirements such as problem lists, medication reconciliation, and additional field-defined document priorities.
 - Provide residents with constructive feedback as appropriate.
 - Serve as a role model to residents in the provision of patient care that demonstrates professionalism and exemplary communication skills.

- Resident Responsibilities
 - Each resident is responsible for knowing the limits of the scope of authority and the circumstances under which the resident is permitted to act with conditional independence.
 - In recognition of the responsibility to the institution and commitment to adhere to the highest standards of patient care, residents must routinely notify the responsible attending physician based on the above, as well as any additional circumstances identified in program-specific supervisory policy.

- Attending Notification Policy
 - There will be circumstances in which all residents, regardless of level of training and experience, must verbally communicated immediately with appropriate supervising faculty. At a minimum, these circumstances will include:
 - In case of patient death
 - Any time there is unexpected deterioration in the patient's medical condition
 - Patient is in need of invasive operative procedures
 - Instances where patient's code status is in question and faculty intervention is needed

- A patient is transferred to or from a more acute care setting (floor to ICU and vice versa)
 - A patient's condition changes requiring MET/CHAT team activation
 - Any other clinical concern whereby the resident/fellow feels uncertain of the appropriate clinical plan
 - Each program may further define elements for escalation of care and attending notification.
 - Timeliness of Attending Notification: It is expected that the resident will notify the attending as soon as possible after an incident has occurred. Notification of the attending should not delay the provision of appropriate and urgent care to the patient. If despite the best efforts, the resident cannot reach the assigned attending, then they should notify the program director, medical director of the service or the chair of the department for guidance.
- **Bedside Procedures**

This policy applies to all bedside procedures performed by GME trainees on patients seen at University Hospital. Surgical procedures performed by GME trainees on patients in the operating rooms are not covered by this policy as there are already policies covering these situations. This policy does not apply to central venous line procedures. The UAB Hospital policy for CVL must be followed (Appendix 14).

Bed Side Procedures and Level of Training:

PGY 1 Resident: Direct supervision by upper level resident, fellow, or faculty for all invasive procedures until proficiency demonstrated in established quantity, this number can vary by training program.

PGY 2 and Higher Resident: Direct supervision by peer upper level resident, fellow, or faculty for all invasive procedures until proficiency demonstrated in established quantity, this number can vary by training program.

1. It is the policy of University Hospital that all GME PGY1 trainees performing a bedside procedure discuss the clinical appropriateness of the procedure with the senior resident, fellow or attending. PGY2 and higher GME trainees should discuss the clinical appropriateness of a bedside procedure with the fellow or attending as needed.
2. The attending physician is responsible for determining the appropriate level of supervision required for performing a bedside procedure, the appropriate indication for the procedures, discussion of risk-benefit with residents and patients (as necessary), assessing the risk of the procedure, determining the qualification of the resident performing the procedure and providing adequate support to the trainee performing the procedure.
3. It is expected that a resident shall inform the faculty member or upper level resident when he/she does not feel capable of performing a bedside procedure.
4. The resident performing a procedure should make sure that there is adequate backup (such as senior resident, fellow, attending, interventional services, surgical services) before performing the procedure.
5. The resident should attempt the procedure no more than three times before stopping and re-evaluating the clinical situation and asking for a senior resident, fellow, attending, interventional service, or surgical service to take over the performance of the procedure.

6. The resident should call the senior resident, fellow or the attending if he/she has attempted the procedure three times unsuccessfully before attempting the procedure again.
7. The procedure should be aborted and alternate plans discussed with the attending when the risk of the procedure including discomfort to the patient outweighs the benefit of repeated attempts beyond three.
8. In case of emergency, greater than three attempts can be made but should be justified with clear documentation of the need to do so in the procedure note.