

RESIDENT HANDBOOK

SECTION V: SUPERVISION

RESIDENT SUPERVISION

PURPOSE

To outline guidelines for supervision for residents and fellows at the Kirk Kerkorian School of Medicine at UNLV training programs.

POLICY

Each program will be responsible for the development of a specific policy for its program which includes the principles stated in this document and outlines specific supervision issues distinctive to the individual training program. All supervision situations will be specialty-specific and meet the requirements of the review committee of that discipline. Programs may adopt these guidelines as appropriate to their specialties.

PROCEDURE

I. General Principles

- a. In the clinical learning environment, each patient must have an identifiable, appropriately credentialed, and privileged attending physician (or licensed, independent practitioner as approved by each review committee) for each clinical encounter involving a resident.
- b. The attending physician is responsible for the care provided to assigned patients.
- c. The program director and/or individual attending must determine the level of supervision required to provide appropriate training and to assure quality of patient care.
- d. Supervision of residents must be documented.
- e. Program directors direct and supervise their program and their trainees.
- f. With the exception of a life or death emergency, at no time can a resident be supervised by a relative. The term "relative" is defined by state statute and university policy as any person who is within the third degree of consanguinity or affinity. Consanguinity is a blood relationship within a family of the same descent. Affinity is a marriage or other legal relationship (such as adoption) formally recognized by the State of Nevada. Relationships within the third degree of consanguinity or affinity are defined as:
 - i. The employee's spouse, child, parent, sibling, half-sibling, or step-relatives in the same relationship
 - ii. The spouse of the employee's child, parent, sibling, half-sibling, or step-relative
 - iii. The employee's in-laws, aunt, uncle, niece, nephew, grandparent, grandchild, or first cousin.

II. Key Supervision Issues

- a. Attending physician/staff practitioner responsibilities:
 - i. Inpatient:

1. Attending physician is identified in the chart
 2. Meet with the patient within 24 hours of admission
 3. Document supervision with progress note by the end of the day following admission
 4. Follow local admission guidelines for attending notification
 5. Ensure discharge is appropriate
 6. Ensure transfer from one inpatient service to another inpatient service is appropriate
- ii. Outpatient:
1. Attending physician is identified in the chart
 2. Discuss patient with resident during initial visit; document attending involvement by either an attending note or documentation of attending supervision in the resident progress note.
 3. Countersign note
- b. Emergency/Department
- i. An attending physician must always be physically present
- c. Consultation
- i. Discuss with resident doing consultation within 24 hours
 - ii. Document supervision of consultation by the end of the next working day
- d. Surgery/Procedures
- i. Attending physician notified
 - ii. Attending meets with the patient before procedure/surgery
 - iii. Documents agreement with surgery/procedures
 - iv. Countersigns procedure note
- e. Sign initial Do Not Resuscitate (DNR) orders and document compliance with local DNR policies
- f. Program director responsibilities
- i. Establish and write a program-specific supervision policy that includes:
 1. Standards for direct and indirect supervision and oversight for all trainees
 - a. PGY1 residents should be supervised either directly or indirectly with direct supervision immediately available.
 2. Progressive authority and responsibility, conditional independence, and supervisory role for each level of training
 3. Guidelines for circumstances and events in which residents/fellows must communicate with appropriate supervising faculty members (i.e. transfer of a patient to a higher level of care or end of life decisions)

- ii. Determine faculty supervision assignments so that they are a sufficient duration to assess the knowledge and skills of each resident/fellow and delegate to him/her the appropriate level of patient care authority and responsibility.
- iii. Review with each resident the limits of his/her scope of authority and the circumstances under which he/she is permitted to act with conditional independence.
- iv. Evaluate each resident's/fellow's abilities based on specific criteria, when available, the evaluation should be guided by specific national standards-based criteria.
- v. Assign to each resident/fellow the privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care based on individual assessments and input from the faculty.
- vi. Ensure that senior residents and/or fellows serve in a supervisory role of junior residents in recognition of their progress towards independence, based on the needs of each patient and the skills of the individual resident or fellow.
- vii. Review the supervision policy with trainees (residents and fellows) at least annually
- viii. Educate faculty about the supervision policy, their roles, and responsibilities.
- ix. Implement the policy with frequent review and follow up to determine any modifications needed.

Approved by Graduate Medical Education Committee April 2017