

**WAKE FOREST BAPTIST MEDICAL CENTER**  
**RESIDENT/FELLOW SUPERVISION POLICY**

**Prepared by:** Chair, Graduate Medical Education Committee and  
the Director of Physician and House Staff Services

**SUBJECT:** Resident/Fellow Supervision Policy

**I. POLICY OVERVIEW:**

This policy establishes the minimum requirements for resident/fellow supervision at WFBMC. Individual training programs may also have additional requirements for their medical staff and residents/fellows.

The WFBMC medical staff has overall responsibility for the quality of the Professional services provided to patients, including patients under the care of the Residents/fellows. It is, therefore, the responsibility of the medical staff to ensure that each resident/fellow is supervised in his/her patient care responsibilities by a LIP (licensed independent practitioner) who has clinical privileges at WFBMC through the medical staff credentialing process.

It is the responsibility of individual program directors to establish detailed written policies describing resident supervision at each postgraduate year for their residency programs. These written descriptions of resident supervision must be distributed annually and/or made readily available (e.g. electronic format) to all residents/fellows and medical staff for each residency program.

At all times, patient care will be the responsibility of a licensed independent practitioner with appropriate clinical privileges. The requirements for on-site supervision will be established by the program director for each residency program in accordance with ACGME requirements and will be monitored through periodic departmental reviews, with institutional oversight through the GMEC internal review process. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. 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.

Careful supervision and observation are required to determine the resident's/fellow's abilities to perform technical and interpretive procedures and to manage patients. Although they are not licensed independent practitioners, residents/fellows must be given graded levels of responsibility while assuring quality care for patients. Supervision of residents/fellows should be graded to provide gradually increased responsibility and maturation into the role of a judgmentally sound, technically skilled, and independently functioning credentialed provider.

The type of supervision (physical presence of attending physicians, home call backup, etc.) required by residents at various levels of training must be consistent with the requirement for progressively increasing resident responsibility during a residency program and the applicable program requirements of the individual Residency Review Committee, as well as common standards of patient care.

The decision about how each resident's/fellow's progressive involvement and independence in patient care activities is determined by the program director. 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 program faculty. In addition, the policy for each program must be in compliance with applicable Joint Commission standards, summarized below:

- At all times, patient care will be the responsibility of a licensed independent practitioner with appropriate clinical privileges in that health care system.
- Written descriptions of the roles, responsibilities, and patient care activities of the residents/fellows, by level, are available to medical and health care staff.
- The descriptions identify mechanisms by which the program director and program faculty make decisions about an individual resident's/fellow's progressive involvement and independence. Those parameters may include but may not be limited to: a given number of successfully performed, observed procedures; a total number of procedures or processes performed; the general impression of competence and professionalism perceived by faculty, etc.
- Delineation of order-writing privileges, including which orders if any must be countersigned.

## **II. PRACTICE**

The practice implication is to establish supervision standards, roles, responsibilities and patient care activities of all participants in professional graduate medical and dental education programs of Wake Forest Baptist Medical Center (WFBMC).

## **III. DEFINITIONS**

The following definitions are used throughout the document:

Licensed Independent Practitioner (LIP) – a licensed physician, dentist, podiatrist, or optometrist who is qualified, usually by board certification or eligibility, to practice his/her specialty or subspecialty independently.

Medical Staff – a LIP who has been credentialed to provide care in his/her specialty or subspecialty by a hospital.

Resident/Fellow – a professional post-graduate trainee in a specific specialty or subspecialty.

GMEC (Graduate Medical Education Committee) – a committee tasked with establishing and implementing policies and procedures regarding the quality of education and the work environment for the residents/fellows in all programs. The committee is chaired by the Associate Dean for Graduate Medical Education and its membership includes representative program directors, department chairs, and residents/fellows.

#### IV. PROCEDURES

A. All residents'/fellows' patient care activities are ultimately supervised by credentialed providers ("staff attendings") who are licensed independent practitioners on the medical staff of WFBMC. The staff attendings must be credentialed in that hospital for the specialty care and diagnostic and therapeutic procedures that they are supervising. In this setting, the supervising staff attending is ultimately responsible for the care of the patient.

By exception, supervision of residents/fellows may be performed by physician extenders (e.g., physician assistants or nurse practitioners) with particular expertise in certain diagnostic or therapeutic procedures, if so designated by the program director. Ultimate responsibility for the residents'/fellows' patient care, in this case, will rest on the credentialed staff who oversees the physician extender's practice.

Each program director will define the policies in his/her program to specify how residents/fellows in that program progressively become independent in specific patient care activities while still being appropriately supervised by medical staff. A program's resident supervision policies must be in compliance with The Joint Commission policies on resident supervision. The policy will delineate the role, responsibilities and patient care activities of residents/fellows and will delineate which residents/fellows may write patient care orders, the circumstances under which they may do so (e.g., "all situations"), and what entries if any must be countersigned by a supervisor.

Each program director will complete a listing of resident/fellow clinical activities that are permitted by level of training, the required level of supervision for each activity, and any requirements for performing an activity without direct supervision. Program directors will submit their listing of clinical activities by postgraduate year to the Office of Graduate Medical Education (GME) for review.

B. Levels of supervision must be defined as follows:

1. Direct Supervision: the supervising physician is physically present with the resident and patient.
2. Indirect Supervision:
  - a) 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.
  - b) 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.
3. Oversight: the supervising physician is available to provide review of the procedures/encounters with feedback provided after care is delivered.

C. Each program director should annually review the residents'/fellows' clinical activities by level and make changes as needed. Program directors will submit the new job descriptions and their updated listing of clinical activities by postgraduate year to the Office of Graduate Medical Education (GME) for review.

D. The program director will ensure that all supervision policies are distributed to and followed by residents/fellows and the medical staff supervising the residents/fellows. Compliance with the resident supervision policy will be monitored by the program directors.

E. Annually, or more frequently as indicated, the program director will determine if residents can progress to the next higher level of training. The requirements for progression to the next higher level of training will be determined by standards set by each program director. This assessment will be documented in the annual evaluation of the residents/fellows.

## **V. SUPERVISION OF RESIDENTS/FELLOWS IN THE INPATIENT SETTING**

**VI.** All lines of responsibility and authority for inpatient care delivered by inpatient unit or ICU teams are directed to a credentialed staff provider. Residents/fellows should write daily orders on inpatients for which they are participating in the care. These orders will be implemented without the co-signature of a staff physician. It is the responsibility of the resident to discuss their orders with the attending staff physician. Attending staff may write orders on all patients under their care. Residents/fellows will follow all local teaching hospital policies for how to write orders and notify nurses and will follow the “verbal orders” policies of each patient care area.

B. Medical staff supervision of care for hospitalized patients must be documented in the inpatient record. Documentation requirements for inpatient care are outlined next.

C. Documentation, in writing, by medical staff must be in accordance with hospital policies. This documentation includes especially: concurrence with the admission, history, physical examination, assessment, treatment plan; orders concurrence with major interventional decisions; concurrence when any major change occurs in the patient’s status, such as transfer into or out of an intensive care unit or changes in “Do Not Resuscitate” status. Documentation, in writing, by residents/fellows must also be in accordance with hospital policies.

## **VI. SUPERVISION OF RESIDENTS/FELLOWS ON INPATIENT CONSULT TEAMS**

All inpatient consultations performed by residents/fellows will be documented in writing, with the name of the responsible staff consultant recorded. The responsible staff consultant must be notified verbally by the resident/fellow doing the consult within an appropriate period of time as defined by the particular consulting service. The consulting staff is responsible for all the recommendations made by the consultant team.

## **VII. SUPERVISION OF RESIDENTS/FELLOWS IN OUTPATIENT CLINICS**

All outpatient visits provided by residents/fellows will be conducted under the supervision of a staff provider. This staff provider will interview and examine the patient at the staff’s discretion, at the resident’s/fellow’s request, or at the patient’s request. The staff provider has full responsibility for care provided, whether or not he/she chooses to verify personally the interview or examination.

## **VIII. SUPERVISION OF RESIDENTS/FELLOWS IN THE EMERGENCY DEPARTMENT**

The responsibility for supervision of residents/fellows providing care in the Emergency Department (ED) to patients who are not admitted to the hospital will be identical to that delineated for outpatient supervision above. The responsibility for supervision of

residents/fellows who are called in consultation on patients in the ED will be identical to that delineated for consultation supervision above. Consulting staff should be notified appropriately of ED consultations.

#### **IX. SUPERVISION OF RESIDENTS/FELLOWS IN INTERPRETIVE SETTINGS**

It is the responsibility of each training program/department in these areas to establish supervisory regulations in compliance with The Joint Commission, ACGME, RRC, and other specialty and subspecialty board requirements.

#### **X. SUPERVISION OF RESIDENTS/FELLOWS PERFORMING PROCEDURES**

A resident/fellow will be considered qualified to perform a procedure if, in the judgment of the supervising medical staff and his/her specific training program guidelines, the resident/fellow is competent to perform the procedure safely and effectively. Residents/fellows at certain year levels in a given training program may therefore be approved to perform certain procedures without direct supervision, based upon specific written criteria set forth and defined by the Program Director. However, the resident's/fellow's medical staff of record will be ultimately responsible for all procedures on inpatients.

In addition, residents/fellows may perform emergency procedures without prior medical staff approval or direct supervision when life or limb would be threatened by delay. All outpatient procedures will have the medical staff of record documented in the procedure note, and that medical staff will be ultimately responsible for the outpatient procedure.

Residents/fellows who require the direct presence of a supervisor to perform procedures may be supervised by either medical staff or, instead, by more senior residents/fellows, when those latter are also approved by the program to perform the procedure independently.

#### **References:**

Joint Commission Hospital Accreditation Standards, 2011  
Accreditation Council on Graduate Medical Education, 2011