MONITORING OF RESIDENT SUPERVISION

1. **PURPOSE**: The purpose of this circular is to define the responsibilities and procedures for the monitoring of resident supervision at Fargo VA Medical Center (VAMC).

2. **POLICY**: The goal of monitoring resident supervision is to foster a system-wide environment of peer learning and collaboration. The monitoring process involves all settings of care. The monitoring of resident supervision involves medical record review processes and the use of other performance improvement data. Documents and data arising from the monitoring are confidential and protected under Title 38 U.S.C 5705.

3. **ACTION**:

A. **Responsibilities:**

1) The Chief of Staff (COS) is responsible for ensuring an appropriate resident supervision monitoring process and serves as the leader for Graduate Medical Education programs.

2) The Graduate Medical Education Director is the designated institutional officer who has the authority and responsibility for the oversight and administration of the University of North Dakota School of Medicine and Health Sciences (UNDSMHS) Accreditation Council for Graduate Medical Education (ACGME)-accredited program and for ensuring compliance with ACGME institutional requirements.

3) Service Line (SL) Directors and Medical Directors are responsible for collection of resident supervision data specific to the SL; utilizing the parameters outlined in Section B and the attached Resident Supervision Monitoring worksheet (Attachment A). Collected data should be representative of all residents, with reviews forwarded to the Performance Improvement (PI) Section for compilation of the Medical Center Resident Supervision Report.

4) The PI Section will compile a quarterly Medical Center Resident Supervision report, and present it to the Medical Executive Committee (MEC). The PI Section also will review, and present to the MEC, the results of monitors concerning patient care involving residents including adverse events/near misses, incident reports and tort claims, patient complaints, EPRP, other medical record reviews and locally-derived PI data and reports from accrediting or regulatory bodies.

5) MEC is responsible for review and analysis of the resident supervision report and the directing of identified action needs.

B. **Monitoring Requirements:**

1) SL will monitor resident supervision at least monthly using the Resident Supervision Monitoring form – Attachment A, reporting to PI on a quarterly basis.

2) Admission Notes - The supervising physician has physically met, examined and evaluated the patient within 24 hours of admission including weekends and holidays and has documented findings and recommendations in the form of an independent progress note or addendum to the resident note.

3) Progress Notes - Documentation to evaluate involvement of the supervising physician, no less than every 48 hours or at a frequency appropriate to the patient's level of clinical acuity. In intensive care units, daily or more frequent documentation by the supervising physician is expected. Progress notes may take any of the following forms:

a) Independent progress note

b) Addendum to resident note

c) Counter-signature of resident note

d) Documentation in the resident progress note stating the case was discussed with the supervising physician.

4) Discharge Summaries – Supervising physicians are required to sign all discharge summaries. If a formal discharge summary is not required; e.g., 23-hour observation, the supervising physician's involvement should be documented in the resident disposition note.

5) Transfers

a) From one inpatient service to another or to a different level of care, including transfers into and out of Intensive care - must involve the supervising physician from both the transferring and receiving services, unless the same supervising physician is responsible for the patient across different levels of care. The supervising physician from the receiving service must treat the patient as a new admission and must write an independent note or an addendum to the resident's transfer acceptance note.

b) Intensive Care Unit (ICU) – documentation that the supervising physician has met, examined and evaluated the patient as soon as possible, but no later than 24 hours of transfer, including weekends and holidays and has entered an independent admission note or addendum to the resident's transfer note within one (1) day of admission.

6) Consultations: Inpatient consults must be completed within the timeframe requested. Documentation by any of the four (4) methods stating the case was discussed with the supervising physician is required.

7) Outpatient Care: The supervising physician must be physically present in the clinic area during clinic hours.

a) Patients new to the facility must be seen by or discussed with the supervising physician to be documented by independent note, addendum to the resident note or documentation in the resident progress note stating the case was discussed with the supervising physician. *Co-signature of the resident's note is not considered sufficient documentation of resident supervision.*

b) The supervising physician is expected to be involved in the important diagnostic and therapeutic decisions as well as the decision to discharge the patient from the clinic. In these situations, the resident must discuss the patient with the supervising physician. The supervising physician, in consultation with the resident, ensures that the discharge of a patient is appropriate. Documentation may be any of the four (4) methods.

8) Surgical Cases:

a) For all elective or scheduled surgical procedures conducted in the operating room (OR) or same day (ambulatory surgery), a supervising physician must evaluate the patient and write a pre-procedural note or addendum to the resident's pre-procedural note describing the findings, diagnosis, plan for treatment and/or choice of the specific procedures to be done. This pre-procedural evaluation and note may be done up to 30 days in advance of the procedure. A pre-procedural note may serve as the admission note if it is written within one calendar day of admission by the supervising physician with responsibility for continuing care of the inpatient and if the note meets criteria for both admission and pre-operative notes.

b) Surgical cases coded Level E (Emergency care) and F (Non-OR procedure – routine bedside and clinic procedures) require100% procedure review for appropriateness and outcomes.

9) Non-OR Procedures:

a) Routine bedside and clinic procedures including skin biopsies, line placement, lumbar puncture, incision and drainage (I&D), etc., will be supervised as appropriate to the location in which they are done and the competency of the resident. Documentation must clearly identify the supervising physician and must follow setting specific guidelines. For internal medicine and psychiatry residents, no procedures may be done without the physical presence of the attending physician/preceptor.

b) Non-routine, non-bedside diagnostic or therapeutic procedures; e.g., endoscopy, invasive radiologic procedures, bronchoscopy, chemotherapy, etc. require a pre-procedural note. The supervising physician must be physically present in the procedure area for the therapeutic portion of all procedures. Documentation of supervision may be by one (1) of the four (4) methods.

c) For chemotherapy, the supervising physician must be present during the treatment planning (i.e., choice of modality and regimen), dosage or dosimetry determinations, and writing of chemotherapy orders. The supervising physician and resident need not be present during administration of the chemotherapy since delivery is a function of a registered nurse.

C. **Reporting of Monitoring**: A Medical Center report on resident supervision will be presented quarterly at the Organizational Performance Council (OPC) and at the MEC. The review will also be sent to the Graduate Medical Education Committee. The MEC is responsible for review of the resident supervision monitoring, the directing of identified action needs, and to act on recommendations from the OPC.

D. Review of quality improvement data (protected by 38 U.S.C 5705 and revised implementing regulations and current VA policy) will be conducted in accordance with Network policy.

E. **Annual Report on Residency Training Program (RCN-10-0906)**: Results of the Annual Report on Residency Training Programs (RCN 10-0906), and review of residents' comments related to their VA experience, will be provided annually to the VA Residency Site Directors, the MEC and the Graduate Medical Education Committee, for identification of opportunities of improvement in resident supervision and creation of action plans.

4. **REFERENCES**:
VHA Handbook 1400.1, *Resident Supervision*, dated July 27, 2005
Network Policy V23-CMO-028, *Resident Supervision/Monitoring of Resident Supervision*, dated February 15, 2006
Circular MS-01, *Supervision of Resident Physicians*, dated February 19, 2009

5. **RESPONSIBILITY**: The Office of the Chief of Staff (11) is responsible for the contents of this circular.

6. **RESCISSIONS**: Circular MS-11 dated February 22, 2007

7. **REVIEW DATE**: March 2012

/s/
JEFFREY W. SKOGEN, MD
Acting Chief of Staff

/s/
ROBERT P. McDIVITT, FACHE
Medical Center Director

Distribution: Q drive

Attachment A

INDEX:
RESIDENTS
Supervision, Monitoring

Fargo VAMC
Resident Supervision Review FY09

SERVICE: _____Medicine ____ Surgery ____ Psychiatry	**FY Quarter ____ 1st ____ 2nd ____ 3rd ____ 4th**

SAMPLE SIZE = 10. If less than 10 occurrences sample all occurrences.

Patient Initial/Last 4 SSN											Total %
	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	
ADMISSION: **Documentation: independent note or addendum to resident note.**											
Supervising MD has physically met, examined, and evaluated patient with 24 hours of admission with documentation by end of the calendar day following admission. (This includes weekends and holidays.)	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	
PROGRESS NOTES: **Documentation: independent note, addendum to resident note, co-signature of resident note or documentation in resident note that case discussed with attending MD.**											
ICU: Documentation of supervising MD involvement is present daily.	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	
Med/Surg/Psych: Documentation of supervising MD involvement is present every 48 hours.	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	
TRANSFERS: (sample size of 5) **Documentation: independent note or addendum to resident note.**											
Transfer between services/level of care- whether receiving or transferring. Documentation of attending involvement. (Supervising MD must treat as new admission.)	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	
Transfer ICU: Transfer In: Supervising MD must physically meet, examine and evaluate within 24 hours as new admission, including weekends and holidays. Transfer Out: Transfer between services/level of care.	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	

Patient Initial/Last 4 SSN											Total %
DISCHARGE:											
Documentation in resident note, where discharge disposition noted, that discussed with attending MD.	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	
Co-signature of resident discharge summary by end of next working day after transcribed dictation received.	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	
INPATIENT CONSULTS: **Documentation: independent note, addendum to resident note, co-signature of resident note or documentation in resident note that case was discussed with supervising MD.**											
Consult completed in requested time frame, as noted by completed progress note or consult note. Date/Time requested: Date/Time completed:	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	
Documentation by attending MD by end of next calendar day of consult completion.	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	
OUTPATIENT CONSULTS: (This reflects New patients as seen in specialty medicine/surgery clinic) **Documentation: independent note, addendum to resident note, co-signature of resident note or documentation in resident note stating case discussed with attending MD.**											
NEW patient to clinic will be seen or discussed with attending MD to demonstrate involvement.	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	
URGENT CARE **Documentation: independent note, addendum to resident note or documentation in resident note stating case discussed with attending MD.**											
Attending MD contacted while patient in urgent care with evidence of involvement.	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	
OR SURGERY : **Documentation: Pre-procedural note and co-signature of operative report.**											
OR surgery: Attending MD pre-procedural note up to 30 days in advance of procedure. Note to include- dx, findings, plan of treatment and choice of procedure.	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	

Patient Initial/Last 4 SSN											Total %
Date of Procedure: Date of Pre-procedural note by attending MD.											
Operative Note co-signed by attending MD by end of next calendar day of resident signing.	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	
NON-OR PROCEDURES: Documentation: independent note, addendum to resident note, co-signature of resident note or documentation in resident note stating case discussed with attending MD.											
Non routine/ non beside/clinic procedures- i.e., Special procedural areas- GI procedures, invasive radiology, invasive cardiac. Documentation of attending MD physically present.	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	