PURPOSE:

The Psychiatry residency program recognizes and supports the importance of graded and progressive responsibility in graduate medical education. This policy outlines the requirements to be followed when supervising residents. The goal is to promote assurance of safe patient care, and the resident’s maximum development of the skills, knowledge, and attitudes needed to enter the unsupervised practice of medicine.

The Psychiatry Residency will supervise residents in a manner consistent with the ACGME Program Requirements in Psychiatry.

POLICY:

A: DEFINITIONS:

Supervising Physician: A faculty physician, or a more senior resident/fellow.

Supervision:

To ensure oversight of resident supervision and graded authority and responsibility to be compliant with ACGME’s Common Program Requirements, the Program must use the following classification of supervision.

Four levels of supervision are recognized. They are:

- **Direct**: The supervising physician is physically present with the resident and the patient.
- **Indirect**: There are two types of indirect supervision:
  - Indirect supervision 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.

- Indirect supervision 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

- **Oversight**: The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

### B: PROCEDURE:

1. Per Common Program Requirement.

   - All PGY-1 residents are supervised either directly or indirectly with direct supervision immediately available until demonstrated competence in:
     - The ability and willingness to ask for help when indicated;
     - Gathering an appropriate history;
     - The ability to perform an emergent psychiatric assessment; and,
     - Presenting patient findings and data accurately to a supervisor who has not seen the patient.

   - The Psychiatry program establishes schedules which assign qualified faculty physicians, residents, or fellows to supervise at all times and in all settings in which residents provide any type of patient care. The type of supervision to be provided is delineated in the curriculum’s rotation description.

   - The minimum amount/type of supervision required in each situation is determined by the definition of the type of supervision specified, but is tailored specifically to the demonstrated skills, knowledge, and ability of the individual resident. In all cases, the faculty member functioning as a supervising physician should delegate portions of the patient’s care to the resident, based on the needs of the patient and the skills of the resident.

   - Senior residents and fellows serve in a supervisory role of junior residents in recognition of their progress toward independence.

   - All residents, regardless of year of training, must communicate with the appropriate supervising faculty member, according to these guidelines:

     - In every level of supervision, the supervising faculty member must review progress notes, sign procedural and operative notes and discharge summaries.

     - Faculty members must be continuously present to provide supervision in ambulatory settings, and be actively involved in the provision of care, as assigned.

2. Progression of Independence from Supervision.

   Progressive independence from supervision occurs with the advancement through the PGY1-PGY4
years. At the beginning of training all cases are directly discussed and checked out with a supervisor. As the resident progresses through the PGY2 year, uncomplicated cases can be managed by the resident without immediately checking out the case with the supervisor on site. Continued graduated progression of less supervision, if so approved by the Program Director and after feedback from faculty, occurs with an increasing number of cases during PGY3-PGY4 years, wherein an increasing percentage of patient cases are allowed to depart from the treatment site before direct review by the site attending. The approved process for residents to see patients independently will be depicted and monitored locally by directly informing the site supervisor and ancillary site personnel.

**Notification of Attending Physician**

- The supervising attending needs to be informed by the resident: a) when the patient's condition deteriorates unexpectedly; b) when additional information puts the working diagnosis in doubt or questions the treatment plan; c) when information is obtained that raises concerns regarding the patient's risk for self-harm or harm to others; d) when the patient or family members disagree with the treatment plan; e) when there are serious disagreements or conflicts within the treatment team or with other services or providers; f) when decisions need to be made that have major clinical or legal implications, such as decisions not to hospitalize suicidal or homicidal patients.

- The resident will notify the on-call attending when: a) the resident has any questions or concerns about the patient or the care provided; b) when patients decide to leave AMA; c) when the resident intends not to hospitalize a patient seen in the ER who has expressed ideas of self-harm or harm to others; d) when the resident intends to turn down a request for admission; e) when the resident plans to send home from the ER a patient who has had a rapidly deteriorating clinical course (e.g. recent onset of mania, anorexia with significant recent weight loss). The resident will also call the on-call attending to review all consults.

**Supervision of invasive procedures**

- *Direct supervision required by a qualified member of the medical staff*
  - Electroconvulsive therapy (ECT)
- *Indirect supervision required with direct supervision available by a qualified member of the medical staff*
  - Intravenous line insertion
- *Oversight required by a qualified member of the medical staff*
  - Phlebotomy and Suture removal

**Emergency Procedures**

It is recognized that in the provision of medical care, unanticipated and life-threatening events may occur. The resident may attempt any of the procedures normally requiring supervision in a case where death or irreversible loss of function in a patient is imminent, and an appropriate supervisory physician is not immediately available, and to wait for the availability of an appropriate supervisory physician would likely result in death or significant harm. The assistance of more qualified individuals should be requested as soon as practically possible. The appropriate supervising practitioner must be contacted and apprised of the situation as soon as possible.

**Supervision of Consults**
Residents performing consultations on patients are expected to communicate verbally with their supervising attending as soon as possible after seeing the patient and certainly within 24 hours or (for night float and on call residents) within the same call or night float shift. Any resident performing a consultation where there is credible concern for patient’s life, requiring the need for immediate intervention, MUST communicate directly with the supervising attending as soon as possible prior to intervention or discharge from the hospital, clinic or emergency department. If the communication with the supervising attending is delayed due to ensuring patient safety, the resident will communicate with the supervising attending as soon as possible. Residents performing consultations will communicate the name of their supervising attending to the services requesting consultation.

**Residents Notification Principles**

Residents should seek supervisor (attending or senior resident) input using the SAFETY acronym.

1. Seek attending input early
2. Active clinical decisions: Call the supervising resident or attending when you have a patient whose clinical status is changing and a new plan of care should be discussed. Supervising physician should be called when transferring a patient to the Intensive Care Unit (ICU).
3. Feel uncertain about clinical decisions: Seek input from the supervising physician when you are uncertain about your clinical decisions.
4. End-of-life care (in psychiatry, including risk assessment) or family/legal discussions: Always call your attending when a patient is suicidal, homicidal, gravely disabled, or at imminent risk, or when there is concern for a medical error or legal issue. Supervising attending should be called when entering a ‘Do not Resuscitate Order.’
5. Transitions of care: Always call the attending when the patient becomes acutely ill and you are considering transfer to another service, facility, or level of care.
6. Help with system/hierarchy: Call your supervisor if you are not able to advance the care of a patient because of system problems or unresponsiveness of consultants or other providers.
7. If attending physician is unavailable, the resident should contact the on-call attending physician. If the on-call attending physician is unavailable, the resident will contact the Program Director or Associate Program Director for any issues above.