UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE JACKSONVILLE
Office of Educational Affairs

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Approved by: ACGME & TJC	SUPERVISION PROTOCOLS FOR RESIDENTS/FELLOWS	**Revised Date**: 5/26/09; 2/11/11
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This standard is numbered MS.04.01.01 in The Joint Commission 2011 Comprehensive Accreditation Manual for Hospitals (CAMH). [Effective January 1, 2011]

Standard MS.04.01.01

In hospitals participating in a professional graduate education program(s), the organized medical staff has a defined process for supervision by a licensed independent practitioner with appropriate clinical privileges of each member in the program in carrying out his or her patient care responsibilities.

Rationale for MS.04.01.01

This standard applies to participants registered in a professional graduate education program when the graduate practitioner will be a licensed independent practitioner. The management of each patient's care, treatment and services (including patients under the care of participants in professional graduate education programs) is the responsibility of a licensed independent practitioner with appropriate clinical privileges.

Elements of Performance for MS.04.01.01

1. The organized medical staff has a defined process for supervision by a licensed independent practitioner with appropriate clinical privileges of each participant in the program in carrying out patient care responsibilities.
2. Written descriptions of the roles, responsibilities, and patient care activities of the participants of graduate educational programs are provided to the organized medial staff and hospital staff.
3. The descriptions include identification of mechanisms by which the supervisor(s) and graduate education program director make decisions about each participant's progressive involvement and independence in specific patient care activities.
4. Organized medical staff rules and regulations and policies delineate participants in professional education programs who may write patient care orders, the circumstances under which they may do so (without prohibiting licensed independent practitioners from writing orders), and what entities, if any, must be countersigned by a supervising licensed independent practitioner.
5. There is a mechanism for effective communication between the committee(s) responsible for professional graduate education and the organized medical staff and the governing body.
6. There is responsibility for effective communication (whether training occurs at the organization that is responsible for the professional graduate education program or in a participating local or community organization or hospital).
    a. The professional graduate medical education committee(s) (GMEC) must communicate with the medical staff and governing body about the safety and quality of patient care, treatment, and services provided by, and the related educational and supervisory needs of, the participants in professional graduate education programs.
    b. If the graduate medical education program uses a community or local participating hospital or organization, the person(s) responsible for overseeing the participants from the program communicates to the organized medical staff and its governing body about the patient care, treatment, and services provided by, and the related educational and supervisory needs of, its participants in the professional graduate education programs. NOTE: The GMEC can represent one or multiple graduate education programs depending on the number of specialty graduate programs within the organization.

7. There is a mechanism for an appropriate person from the community or local hospital or organization to communicate information to the GMEC about the quality of care, treatment, and services and educational needs of the participants.
8. Information about the quality of care, treatment, and services and educational needs is included in the communication that the GMEC* has with the governing board of the sponsoring organization.
9. Medical staff demonstrates compliance with residency review committee citations.

* Graduate medical education programs accredited by the Accreditation Counsel on Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), or the American Dental Association's Commission on Dental Accreditation are expected to be in compliance with the aforementioned requirements; the hospital should be able to demonstrate compliance with any residency review committee citations related to this standard.

ACGME Institutional Requirements

I.B. Commitment to Graduate Medical Education (GME)

I.B.1. The Sponsoring Institution must provide graduate medical education (GME) that facilitates residents' professional, ethical, and personal development. The Sponsoring Institution and its GME programs, through curricula, evaluation, and resident supervision, must support safe and appropriate patient care…

III.B. GMEC Responsibilities: The GMEC must establish and implement policies and procedures regarding the quality of education and the work environment for the residents in all programs. These policies and procedures must include:
…Resident supervision: Monitor programs' supervision of residents and ensure that supervision is consistent with:

III.B.4.a) Provision of safe and effective patient care;

III.B.4.b) Educational needs of residents;

III.B.4.c) Progressive responsibility appropriate to residents' level of education, competence, and experience; and,

III.B.4.d) Other applicable Common and specialty/subspecialty-specific Program Requirements.

ACGME Common Program Requirements (effective 7/1/11)

VI. Resident Duty Hours in the Learning and Working Environment…

VI.D. Supervision of Residents

VI.D.1. 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) who is ultimately responsible for that patient's care.

VI.D.1.a) This information should be available to residents, faculty members, and patients.

VI.D.1.b) Residents and faculty members should inform patients of their respective roles in each patient's care.

VI.D.2. The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients. Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate

availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident delivered care with feedback as to the appropriateness of that care.

VI.D.3. Levels of Supervision

To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:

VI.D.3.a) Direct Supervision – the supervising physician is physically present with the resident and patient.

VI.D.3.b) Indirect Supervision:

VI.D.3.b).(1) 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.

VI.D.3.b).(2) 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.

VI.D.3.c) Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

VI.D.4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.

VI.D.4.a) The program director must evaluate each resident's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.

VI.D.4.b) Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.

VI.D.4.c) 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.

VI.D.5. Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.

VI.D.5.a) Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

VI.D.5.a).(1) In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available. [Each Review Committee will describe the achieved competencies under which PGY-1 residents progress to be supervised indirectly, with direct supervision available.]

VI.D.6. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.