Policies and Procedures

Section: **School of Medicine**		*NO.*				
Chapter: **Cardiovascular Disease Fellowship**	*Issued:* ***10/18/2019***	*REV. A 7/21/2023*	*REV. B*	*REV. C*		
Policy: Fellow Supervision		***Page 1 of 5***				

PURPOSE

The GMEC must monitor programs' supervision of residents and fellows and ensure that supervision is consistent with:

a. Provision of safe and effective patient care;
b. Educational needs of residents;
c. Progressive responsibility appropriate to residents' level of education, competence, and experience; and,
d. Other applicable Common and specialty/subspecialty-specific Program requirement

SCOPE

This policy applies to all Creighton University **Cardiovascular Disease Fellows**.

DEFINITIONS

To promote appropriate fellow supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:

Direct Supervision: The supervising physician is physically present with the fellow during the key portions of the patient interaction; or, the supervising physician and/or patient is not physically present with the fellow and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.
Indirect Supervision: The supervising physician is not providing physical or concurrent visual pr audio supervision but is immediately available to provide appropriate direct supervision.
Oversight Supervision: The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

The program must define when physical presence of a supervising physician is required.

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

Programs must set guidelines for circumstances and events in which fellows must communicate with the supervising faculty member(s).
Each fellow must know the limits of their scope of authority, and the circumstances under which the fellow is permitted to act with conditional independence.

Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each fellow and to delegate to the fellow the appropriate level of patient care authority and responsibility.

Fellows and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. This information must be available to fellows, faculty members, other members of the health care team, and patients.

POLICY

In a health care system where patient care and the training of health care professionals occur together, there must be a clear delineation of responsibilities to ensure that qualified practitioners provide patient care, whether they are trainees or full-time staff. As residents and fellow trainees acquire the knowledge and judgment that accrue with experience, they are allowed the privilege of increased autonomy in patient care.

Our training program follows the institutional requirements of the Accreditation Council for Graduate Medical Education (ACGME).

a. The ACGME states that the Residency/Fellowship Program Director and faculty are responsible for providing house staff with direct experience in progressive responsibility for patient management.
b. The process of progressive responsibility is the underlying educational principle for all graduate medical and professional education, regardless of specialty or discipline.
c. The responsibility of the attending is to enhance the knowledge of house staff while ensuring patient safety and quality care.
    - Such responsibility is exercised by observation, consultation, and direction, and includes the imparting of knowledge, skills, and attitudes/behaviors to the residents and fellows and the assurance that care is delivered in an appropriate, timely, and effective manner.
    - Supervision may be exercised in many ways including face-to-face contact with house staff in the presence of the patient, face-to-face contact in the absence of the patient, and through consultation via the telephone or other HIPAA-compliant communication devices. If on-site supervision is not necessary, the staff physician must be able to arrive at the health care site within a reasonable period of time.
    - Each program is responsible for training their clinician supervisors in their roles and responsibilities. Incumbent on the clinician educator is the appropriate supervision of the residents and fellows as they acquire the skills to practice independently.

Responsibilities: The provisions of this policy are applicable to patient care services including, but not limited to inpatient care, outpatient care, emergency care, and the performance and interpretation of diagnostic (invasive/non-invasive) and therapeutic procedures.

a. Supervising physicians are responsible for the care provided to each patient and they must be familiar with each patient for whom they are responsible. Fulfillment of that responsibility requires personal involvement with each patient and each resident or fellow who is participating in the care of that patient. Each patient must have a supervising physician whose name is identifiable in the patient record. Faculty members functioning as supervisors should delegate portions of care to residents based on the needs of the patient and the skills of the residents. Other supervising physicians may at times be delegated responsibility for the care of the patient and the supervision of the residents and fellows involved. It is the responsibility of the supervising physician to be sure that the residents and fellows involved in the care of the patient are informed of such delegation and can readily access a supervising physician at all times.

b. Within the scope of the training program, all residents and fellows must function under the supervision of supervising physicians. Because our service provides 24-hour, 7-day a week fellow and faculty coverage, our call schedule (delineating fellow and attending physician) must be provided to the medical center administration and all concerned labs. This call schedule is available to administrators and patient care teams via tigerconnect.com for the fellows and QGenda for faculty.

c. Our training program encourages residents and fellows to assume increasing levels of responsibility commensurate with the ACGME milestones experience, skill, knowledge, and judgement. The Clinical Competency Committee of each program defines the levels of responsibilities for each milestone of training by submitting a description of the types of clinical activities each trainee may perform under what type of supervision. The Fellowship Program Director ensures that this list of graduated levels of responsibility is available electronically to the health care site who will distribute it to other appropriate staff. Note that this is the minimum level of supervision required by the trainee: more intensive supervision may be provided at the discretion of the supervising fellow and/or faculty member.

d. In order to ensure patient safety and quality patient care while providing the opportunity for maximizing the educational experience of the fellow in the ambulatory setting, it is required that an appropriately privileged supervising physician is physically present for supervision during clinic hours. Supervising physicians are responsible for ensuring the coordination of care that is provided to patients.

e. The faculty physician needs to be directly supervising all invasive diagnostic and therapeutic procedures, including TEE, coronary angiogram and EP procedures.

f. The faculty physician needs to be immediately available within the facility for supervising non- invasive procedures with significant risk, such as stress tests.

g. The faculty physician needs to be immediately available for supervising by phone or electronic means for non-invasive procedures with minimal risk, such as transthoracic echocardiogram, reviewing EKG's or monitor strips, etc.

h. For the care of patients in the unit and consultative service, the physician should be immediately available by phone or electronic means for providing supervision.

i. There are circumstances in which all fellows, regardless of level of training and experience, must verbally communicate with their appropriate supervisor (i.e., fellow to attending physician).

j. Each resident/fellow must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence, and he/she should seek supervision as appropriate.

Circumstances in which the resident MUST contact the supervising fellow/faculty:

a. Anytime questions arise regarding patient care
b. At the request of the bedside nurse
c. Every cardiology admission
d. General ward consultations for urgent conditions
e. Transfer of any patient to a higher level of care
f. Code Blue Team activation
g. Change in DNR status
h. Patient/family dissatisfaction or request for a care meeting
i. Patient requesting discharge AMA
j. EVERY procedure
k. Patient death
l. Initiation of vasopressors
m. Any issues arising in a post-procedure patient

Circumstances in which the first-year fellow MUST contact the supervising attending:

a. Anytime questions arise regarding patient care
b. Every cardiology admission
c. General ward consultations for urgent conditions
d. Code Blue Team activation

e. Patient/family dissatisfaction or request for a care meeting
f. Patient requesting discharge AMA
g. Any procedure not credentialed by the Clinical Competency Committee
h. Patient death
i. Any procedure related complications
j. Any decision on proceeding with an invasive test, such as coronary angiography, TEE or cardioversion

Circumstances in which the second/third-year fellow MUST contact the supervising attending:

a. Every urgent/non-elective cardiology admission
b. Code Blue Team activation
c. Patient/family dissatisfaction or request for a care meeting
d. Patient requesting discharge AMA
e. Any procedure not credentialed by the Clinical Competency Committee
f. Patient death
g. Any procedure related complications
h. Any decision on proceeding with an invasive test, such as coronary angiography, TEE or cardioversion

Critical diagnoses/emergencies when all house staff MUST contact the supervising attending:

a. Patient suspected of STEMI
b. Unstable ACS patient with ongoing symptoms
c. Suspected cardiogenic shock
d. Any ascending aortic dissection
e. Any patient with complete or advanced heart block
f. Any large pericardial effusion
g. Any post procedure bleeding access site issues
h. Unstable arrhythmias, such as ventricular fibrillation or ventricular tachycardia

REFERENCES

https://www.acgme.org/

AMENDMENTS OR TERMINATION OF THIS POLICY

Creighton University reserves the right to modify, amend or terminate this policy at any time.

The GME policy supersedes all program level policies regarding this area/topic. In the event of any discrepancies between program policies and the GME policy, the GME policy shall govern.