

**UNIVERSITY OF WASHINGTON CHILD AND ADOLESCENT PSYCHIATRY
RESIDENCY PROGRAM
SUPERVISION POLICY**

Roles, Responsibilities and Patient Care Activities of Residents

Definitions

Child and Adolescent Psychiatry Resident:

A physician who is engaged in a graduate education program in child and adolescent psychiatry (CAP), and who participates in patient care under the direction of attending physicians (or licensed independent practitioners) as approved by the Psychiatry Review Committee of the ACGME. *Note: The term “resident” includes all residents who participate in our approved subspecialty graduate medical education program who historically have also been referred to as “fellows.”*

As part of their educational program, residents are given graded and progressive responsibility according to the individual resident’s clinical experience, judgment, knowledge, and technical skill. 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. Residents are responsible for asking for help from the supervising physician (or other appropriate licensed practitioner) for the service they are rotating on when they are uncertain of diagnosis, how to perform a diagnostic or therapeutic intervention, or how to implement an appropriate plan of care.

Attending of Record (Attending): An identifiable, appropriately-credentialed and privileged attending physician, or licensed independent practitioner, who is ultimately responsible for the management of the individual patient and for the supervision of residents involved in the care of the patient. The attending delegates portions of care to residents based on the needs of the patient and the skills of the residents.

Supervision

To ensure oversight of resident supervision and graded authority and responsibility, indirect levels of supervision are provided as defined:

1. **Indirect Supervision:**
 - a) *with direct supervision immediately available* – the supervisor 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 supervisor 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 come to the site of care in order to provide Direct Supervision.
2. **Oversight** – the supervising physician is available to provide review of patient care with feedback provided after care is delivered.

Clinical Responsibilities

The clinical responsibilities for each resident are based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services. The specific role of each resident varies with their clinical rotation, experience, duration of clinical training, the patient's illness and the clinical demands placed on the team. The following is a guide to the specific patient care responsibilities by year of clinical training. Residents must comply with the supervision standards of the service on which they are rotating unless otherwise specified by their program director.

PGY-4, and above (Senior Residents) Senior residents may be directly or indirectly supervised. They may provide direct patient care, supervisory care, or consultative services, with progressively graded responsibilities, as merited. They must provide all services ultimately under the supervision of an attending physician. Senior residents may serve in a supervisory role of medical students, junior, intermediate, and (in the case of fellows) PGY-3 or PGY-4 residents, in recognition of their progress towards independence, as appropriate to the needs of each patient and the skills of the senior resident; however, the attending physician is ultimately responsible for the care of the patient. When a senior resident is supervising a more junior resident, both residents should inform patients of their respective roles in that patient's care.

Attending of Record

In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged **primary attending physician** who is ultimately responsible for that patient's care. The attending physician is responsible for assuring the quality of care provided and for addressing any problems that occur in the care of patients, and thus must be available to provide direct supervision when appropriate for optimal care of the patient. The availability of the attending to the resident is expected to be greater with less experienced residents and with increased acuity of the patient's illness. The attending must notify all residents he/she supervises of when he or she should be called regarding a patient's status. In addition to situations the individual attending would like to be notified of, the attending should include in his or her notification to residents all situations that require attending notification, per program policy. These are as follows:

- 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
- During on-call duty, 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 or prior to previously scheduled discharge date; c) when the

resident intends not to hospitalize a patient seen in the ER; 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, or patients who were recommended for admission and whose families have chosen to wait at home for the available bed). The resident will also call the on-call attending to review all consults and whenever they admit a patient.

The *primary* attending physician may at times delegate supervisory responsibility to a *consulting* attending physician if a procedure is recommended by that consultant. This information should be available to residents, faculty members, and patients.

The attending may specifically delegate portions of care to residents based on the needs of the patient and the skills of the residents and in accordance with hospital and/or departmental policies. The attending may also delegate partial responsibility for supervision of junior residents to senior residents, but the attending must assure the competence of the senior resident before supervisory responsibility is delegated. The attending remains responsible for assuring that appropriate supervision is occurring and is ultimately responsible for the patient's care. Residents and attendings should inform patients of their respective roles in each patient's care.

The attending and supervisory residents are expected to monitor the competence of residents through direct observation, rounds, individual and group supervision sessions, and review of the medical records of patients under their care.

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.

Supervision of invasive procedures

In a training program, as in any clinical practice, it is incumbent upon the physician to be aware of his/her own limitations in managing a given patient and to consult a physician with more expertise when necessary. When a resident requires supervision, this may be provided by a qualified member of the medical staff or by a resident who is authorized to perform the procedure independently. In all cases, the attending physician is ultimately responsible for the provision of care by residents. When there is any doubt about the need for supervision, the attending should be contacted.

Procedures that psychiatry residents can perform on neurology rotations, and the required level of supervision, should be as specified by supervision policies of those programs and departments, as appropriate to the resident's level of training, experience, technical skill, the procedure, and the clinical situation. The following procedures may be performed on psychiatry rotations with the indicated level of supervision:

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

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 may provide consultation services under the direction of attendings or supervisory residents, including fellows. The attending of record is ultimately responsible for the care of the patient and thus must be available to provide direct supervision when appropriate for optimal care. The availability of the attending and supervisory residents or fellows should be appropriate to the level of training, experience and competence of the consult resident and is expected to be greater with increasing acuity of the patient's illness. Information regarding the availability of attendings and supervisory residents or fellows should be available to residents, faculty members, and patients. Residents performing consultations on patients are expected to communicate verbally with their supervising attending within 24 hours or (in the case of consults seen during call) as soon as possible after seeing the patient and certainly within the same call 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.

Supervision of Hand-Offs

Residents, attendings, and other primary providers on psychiatry services must provide structured verbal and electronic handoffs when transferring care of a patient, and must be available to receive handoffs when taking over the care of a patient. Residents may be supervised directly or indirectly, by an attending or supervisory resident, in giving and receiving handoffs. Residents should be directly supervised in giving and receiving handoffs initially, to establish competence. The attending physician remains responsible for assuring that appropriate handoffs are occurring and is ultimately responsible for the patient's care.

Resident Competence & Delegated Authority

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. The program director must evaluate each resident's abilities based on specific criteria. In psychiatry, these criteria include:

- a) Satisfactory peer evaluations of residents by training call residents (supervisory residents evaluating junior residents) or by trainees (more junior residents evaluating supervisory residents)
- b) Clinical rotation evaluations
- c) Clinical skills assessments
- d) Demonstration of supervisory capability by CAP residents.

Guidelines around Supervision and Progressive Responsibility

Attendings and residents should adhere to the SUPERB-SAFETY model in providing and seeking supervision, as follows:

Attendings should adhere to the SUPERB model when providing supervision. They should

1. **Set Expectations:** set expectations on when they should be notified about changes in patient's status.
2. **Uncertainty is a time to contact:** tell resident to call when they are uncertain of a diagnosis, procedure or plan of care.
3. **Planned Communication:** set a planned time for communication (i.e. each evening, on call nights).
4. **Easily available:** Make explicit your contact information and availability for any questions or concerns.
5. **Reassure resident not to be afraid to call:** Tell the resident to call with questions or uncertainty.
6. **Balance supervision and autonomy.**

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. Be prepared to present the situation, the background, your assessment and your recommendation.
3. **Feel uncertain about clinical decisions:** Seek input from the supervising physician when you are uncertain about your clinical decisions. Be prepared to present the situation, the background, your assessment and your recommendation.
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.

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.

Approved by CAP RESC 10/6/23.