

Supervision and Accountability Policy

Background

Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth. Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care.

Personnel Definitions

Fellow: An individual who is enrolled in an ACGME-accredited training program (in this case, Pediatric Hematology & Oncology), and who participates in patient care under the direction of attending physicians or licensed independent practitioners. Fellows have completed training in pediatrics (or joint training in internal medicine and pediatrics).

As part of their training program, fellows are given graded and progressive responsibility according to the individual fellow's clinical experience, judgment, knowledge, and technical skill. 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. Fellows 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 procedure, or how to implement an appropriate plan of care.

Attending of Record (Attending): In the clinical learning environment, an identifiable, appropriately credentialed and privileged primary attending physician or licensed independent practitioner who is responsible and accountable for that patient's care, and for supervision of the fellows involved in the care of the patient.

Fellows and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. This information is available to patients, trainees, faculty members and other members of the health care team via the medical record. The schedules for fellows and faculty are also available to one another and other members of the division.

Supervision Definitions

To promote oversight of resident supervision while providing for graded authority and responsibility, the following levels of supervision are recognized:

A. Direct Supervision

1. The supervising physician/practitioner is physically present with the resident during the key portions of the patient interaction; or,
 2. The supervising physician/practitioner and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.
- B. Indirect supervision
1. The supervising physician/practitioner is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.
- C. Oversight
1. The supervising physician/practitioner is available to provide review of procedures/encounters with feedback provided after care is delivered.

Policy

Clinical Responsibilities for Fellows

Fellows may be directly or indirectly supervised. They may provide direct patient care, supervisory care or consultative services, with progressive graded responsibilities as merited. Fellows should serve in a supervisory role to medical students, junior and intermediate residents in recognition of their progress towards independence, based on the needs of each patient and the skills of the individual fellow; however, the attending physician is ultimately responsible for the care of the patient.

Fellow Competence and Delegated Authority

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. The program director must evaluate each fellow's abilities based on specific criteria, guided by the Milestones. Each fellow will meet with the PD every 6 months to review their progress across the milestones.

Faculty Duration of Assignments

Faculty supervision assignments are typically 7-14 days in duration and therefore are of sufficient duration to assess the knowledge and skills of each fellow and delegate to the fellow the appropriate level of patient care authority and responsibility.

Reporting Adverse Events

The fellow must report any complication, near miss, or patient problem/safety issue to the supervising faculty. In addition, fellows and faculty are strongly encouraged to utilize the eFeedback institutional reporting system for Seattle Children's Hospital. Patient Safety Net (PSN) or other relevant institutional event reporting system. UW Medicine's Patient Safety team triage all patient-related incident reports every business day, and identifies reports that either result in high patient harm, or represent significant systems-related risk points in our organization's safety systems. The Patient Safety team ensures that incident reports are completed and routed appropriately to local leaders and subject matter experts, which review the reports. Incidents involving serious outcomes of care that may qualify as adverse events and require further review via Root Cause Analysis (RCA) are identified, processed, and reported to senior leadership. The Risk Management department

receives automatic notification of events that are assigned a harm score of 6 or higher and reviews incident reports for possible reportable or reviewable events. They take immediate steps to investigate and mitigate situations involving patient harm, including consideration for patient and healthcare professional well-being. In recognition of our patients' rights to autonomy in making healthcare decisions and to improve our culture of safety by demonstrating accountability for patient harm, UW Medicine is increasing its transparency with patients and their families when harm occurs.

Levels of Supervision for Common Specialty Clinical Activities and Invasive Procedures

Clinical Activity/Procedure	Resident level (PGY)	Location	Supervision Level
Inpatient Consultation	4, 5, 6	Seattle Children's	Indirect Supervision
Outpatient Consultation	4, 5, 6	Seattle Children's	Indirect Supervision
Invasive Procedures*	4, 5, 6	Seattle Children's	Direct Supervision
Minimally Invasive Procedures**	4, 5, 6	Seattle Children's	Oversight
Telephone Consultation	4, 5, 6	Seattle Children's	Oversight

*Bone marrow aspirate, bone marrow biopsy, bone marrow harvest, lumbar puncture (diagnostic and/or with intrathecal chemotherapy), skin biopsy

** Suture removal, swabs of external lesions for infectious studies

Supervision of Consults

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 and/or as indicated by individual program policy. Fellows performing consultations on patients are expected to communicate verbally with their supervising attending within 1 hour.

Circumstances in Which Supervising Practitioner MUST Be Contacted

The appropriate supervising faculty member must be contacted for all circumstances and events which require emergent evaluation, new oncologic diagnoses, admission to the hospital, transfer from the acute to the intensive care unit, and any patient death.

Supervision of Hand-Offs

The table below describes expectations of supervision with each type of hand-off situation. General guiding principles for hand-offs include: the number of hand-offs should be minimized, hand-offs should ideally occur in person or via telephone, using standardized electronic medical record tools with the electronic medical record available and with time for each party to ask questions; continuity of patient care and patient safety are of paramount importance.

The process for hand-offs is detailed below. Hand-offs occur as needed with indirect supervision of the supervising attending, with direct supervision available as needed.

Hand-Off Procedure:

Inpatient Hematology/Oncology Service

- A. Evening sign-out (Fellow to Acute Care Oncologist):
 - 1. Fellow will hand off to the Acute Care Oncologist in person, or in rare situations, when necessary, by phone. Components to include patient name, age, diagnosis, reason for admission, acuity, active problem list, problems keeping the patient in the hospital, overnight tasks requiring follow-up, and relevant social issues.
 - 2. Elaboration of well-known patients or uncomplicated chemotherapy admissions will be only if requested.
 - 3. Note, the Acute Care Oncologist has access to daily progress notes and Epic, and will call the attending as needed to solve problems overnight.
- B. Morning sign-out (Acute Care Oncologist to fellow):
 - 1. The Acute Care Oncologist will discuss complicated overnight events or sick patients with immediate concerns with the fellow in person.
 - 2. The Acute Care Oncologist will send the fellow an email update for simple overnight events for active patients. Not every patient requires a sign-out.
- C. Fellow to outpatient team at discharge:
 - 1. Each patient will have discharge summary prepared by the residents and cosigned by the attending. This is available to the primary team at discharge summarizing inpatient stay.

Inpatient BMT Hand-Off

- A. Evening sign-out (fellow to Acute Care Oncologist):
 - 1. Fellow will hand off to the Acute Care Oncologist in person. Components to include patient name, age, diagnosis, reason for admission, days post-BMT, BMT type, acuity, active problem list, problems keeping the patient in the hospital, overnight tasks requiring follow-up, and relevant social issues.
 - 2. Elaboration of well-known patients or uncomplicated admissions will be only if requested.
 - 3. Note, the Acute Care Oncologist has access to daily progress notes and Epic and will call the attending as needed to solve problems.
- B. Morning sign-out (Acute Care Oncologist to fellow):
 - 1. The Acute Care Oncologist will give sign-out to the fellow in person summarizing overnight events on all patients.
- C. Fellow to outpatient team at discharge:
 - 1. Each patient will have a formal discharge summary dictated to the outpatient team summarizing inpatient stay, with verbal sign-out to the outpatient primary team.

Outpatient Hematology/Oncology Clinic Hand-Offs

- A. Clinic documentation serves as primary hand-off. For complex patient issues, email or in-person discussion of patients will occur.
- B. For admissions, clinic History and Physical will be entered in patient's chart prior to admission and verbal sign-out given to the inpatient team.