Plastic & Reconstructive Surgery

Supervision Policy

E. Supervision

1. Plastic & Reconstructive Surgery Policy

The supervision of plastic surgery residents is in accordance to the guidelines established by the University of Nebraska Medical Center, College of Medicine and fulfills the requirements established by the Accreditation Council of Graduate Medical Education. These guidelines are distributed to all plastic surgery faculty and residents. Faculty supervises the residents during each year of the Program with the goal of graduated responsibility and action.
Residents have access to beeper numbers, home telephone numbers and cellular phone numbers so that the attending physician is always available.

Patient Care

i. In-patients:

A. The resident will always be in communication with the responsible attending physician with regards to all in-patient matters.
B. The resident will have progressive responsibility in patient care and decision making. However, final decision making and responsibility is that of the attending physician.
C. The resident will call the attending physician
    1. Prior to any invasive procedure.
    2. On admission of any patient to the hospital.
    3. Upon any patient seen in consultation for another service.
D. For critical care patients the attending physician will evaluate the patient and write a note on the chart within 12 hours of admission.
E. For non-critical care admissions the attending will write a note within 24 hours of admission.
F. There must be daily attending input on all critically ill patients or more frequently if necessary.
G. The attending physician must make preoperative notation in the medical record of all patients undergoing elective surgery.
H. In an emergency situation to preserve life and prevent serious impairment of health, residents shall be permitted to implement life support services and notify the attending as soon as possible. The attending will evaluate the patient and write a note at the first opportunity.

I. The care of all patients is the responsibility of the attending physician and should be reflected by the medical record.
J. The attending physician must be present in the Operating Room on all cases. The residents will have progressively increased involvement and responsibilities during operative procedures commensurate with their skill. The attending physician will be present for all key and critical portions of the operation. In addition, the attending physician will be responsible for identifying the correct patient and operative site.
K. If a resident requests physical assistance or attendance of the faculty in any situation, the attending physician will respond without question.

ii. Out-patients:

A. A written consultation is required for every patient seen in the Emergency Room by the Plastic Surgery resident. This consultation must be reviewed by the attending physician within 24 hours for review and documentation of appropriateness of care. With the exception of minor injuries or lacerations the resident will call the attending physician to discuss the plan of care of the patient.
B. The attending physician will evaluate all patients prior to scheduling surgery.
C. Although the residents will participate in the outpatient clinical setting, final decisions and responsibility is the attending physician.
D. All telephone conversations with patients with regarding their care will be documented in the medical record and the resident will review the telephone conversation with the attending physician within 24 hours.
E. If the resident requests assistance or attendance with any aspect of ambulatory care the attending physician will respond.

iii. Fatigue and Work Hours:

The faculty will ensure resident compliance with the work hours outlined in the Resident Work Hours and Call Policy (Supplement 7) to prevent fatigue. Faculty and residents are educated to recognize fatigue and the potential negative consequences. This education is accomplished through didactic presentation, a web based curriculum (resident) and discussion.

iv. Admission History and Physicals/Consultations:

Residents may perform history and physical examinations, and consultations without the attending being physically present. It is the responsibility of the resident to discuss their findings with the attending physician upon completion of their examination. The attending physician must confirm the key portions of the history and physical examination, make additions and corrections in the documented history and physical,

and co-sign the resident's documentation. It is the attending physician's responsibility to document within the appropriate teaching physician guidelines.

v. Daily Progress Notes:

Residents may evaluate patients and write daily progress notes without the attending physician being physically present. It is the responsibility of the resident to discuss their findings and treatment plans documented in their progress note with the attending physician on a daily basis, or more often as described above, when a patient's condition changes, or prior to initiating changes in the a patient's treatment. The attending physician must perform the key portions of the exam and confirm the resident's documentation in the progress note on a daily basis to maintain compliance with documentation guidelines for teaching physicians. Attending and consulting physicians must make additions and corrections in the daily progress notes and signify these with initials and a date and time of the additions to the medical record. All documentation by house staff and attending physicians must be legible to those who use the medical record, including signatures. All entries must be dated and signed.

vi. Daily Orders:

Residents may write daily orders on patients on whom they are participating in the care. These orders will be implemented without the co-signature of an attending or consulting physician. It is the responsibility of the resident to discuss their orders with the attending or consulting physician. Attending and consulting physicians may write orders in the patient's chart on all teaching cases. Residents should notify the appropriate nursing or support staff of orders entered into the chart to facilitate timely patient care. Residents are encouraged to evaluate all patients for whom they are initiating orders. However, if it is clinically appropriate, residents are allowed to place "verbal orders" over the phone. All phone orders must be signed, dated and timed within 24 hours.

vii. Procedures:

Minor procedures performed at locations other than the operating room (eg. Ward, clinic, emergency room, and intensive care unit) may be performed by the plastic surgery resident with the attending physicians knowledge and approval. These procedures are listed below.

Repair of lacerations

Incision and drainage of wounds

Debridement of wounds

Placement of central venous access lines

Placement of chest tubes

Application of casts and splints

Dressing changes

Suture removal

Drain removal

Foley catheter insertion

Nasogastric intubation

Peripheral venous access

Skin Biopsy

Aspiration fluid collection

Swann Ganz Catheter insertion

viii. Duty Hours / Op Logs

In accordance to the ACGME regulations residents are required to log their Duty Hours and Op Logs in New Innovations on a daily basis and all procedures completed are required to be completed by the end of any given work week. If logs are not updated within 7 days, the resident and program coordinator will receive a reminder notification from New Innovations data system. A reminder email (1st notification) will be sent from the PC to the residents. If logs are still not updated within 14 days a 2nd reminder email will be sent. If after 21 days the logs are still not updated a notification will be sent to the resident and the Program Director for further action.

All residents and faculty are provided a copy of the guidelines for faculty supervision of residents. Each resident is given a copy of these guidelines when they start the program along with other policies, schedules, etc. General UNMC campus resident

information is provided by the GME office, resident handbook at New Resident Orientation prior to the July 1 start date. Additionally, the information is available online via a shared network folder.

2. Graduate Medical Education Policy

Graduate medical education in the United States has evolved into a highly formalized system requiring that programs meet the requirements of the Accreditation Council for Graduate Medical Education (ACGME) and that house officers are prepared to meet the certification requirements of those specialty Boards approved by the American Board of Medical Specialties. The Hospitals in which these programs are housed are members of the Council of Teaching Hospitals of the Association of American Medical Colleges. These teaching hospitals, in general, provide high quality care, admit patients with more severe conditions, and provide more care to medically indigent persons than non-teaching hospitals. Over time, the system of residency education in this country has surpassed that of all others and is recognized as the international leader.

The philosophy of education that has pervaded this system is evolved has included graduated responsibility for all house officers culminating in the final year in which a high level of individual responsibility is achieved prior to graduation. Supervision and education are provided by faculty who may be full-time academicians in schools of medicine, highly qualified practitioners who voluntarily contribute their time and knowledge to the program, or combinations of the two. Supervision and education are also provided by the house officer one to another as they progress through their program with a major responsibility shouldered by the senior house officers or chief residents in their final year.

While the need for graduated responsibility in the provision of patient care is an important tenant in the educational system, it is critical that the education of house officers be accomplished in a high quality, expeditious and cost-effective manner.

University of Nebraska Medical Center house officers are physicians with an M.D. or D.O. degree and who have, at a minimum, a Nebraska Temporary Education permit which permits practice in the training program, and many have unrestricted Nebraska licenses. They enter with basic medical knowledge and continue to add special skills and knowledge that will allow them to become fully certified in a medical or surgical specialty. The house officers utilize their superiors as consultants as their ability to assume more responsibility is developed and the need for direct supervision declines. They become competent to make judgments of increasing complexity and to perform procedures of increasing difficulty throughout their house officer training. The outcome of this philosophy of education produces a physician who has had responsibility for self-

learning, for teaching, for graded responsibility in patient care, and for obtaining consultation when appropriate.

The supervisory relationships that exist between faculty and house officers can be at several levels.

A. Inexperienced house officers require a greater level of supervision the physical presence of the faculty member in the role of either the "attending physician" or the "consulting physician" to insure that patients are receiving optimal care.

The term "house officer" as it appears in this document refers to any intern, resident or clinical fellow in training at the University of Nebraska Medical Center.

In order to qualify as an "attending physician", the teaching physician must at a minimum:

1. review the patient's history, the record of examinations and tests in the institution, and make frequent reviews of the patient's progress; and
2. personally examine the patient or see the patient; and
3. confirm or revise the diagnosis and determine the course of treatment to be followed; and
4. either perform the physician's services required by the patient or supervise the treatment so as to assure that appropriate services are provided by house officers, and that the care meets a proper quality level; and
5. be present and ready to perform any service that would be performed by an attending physician in a non-teaching hospital setting when a surgical or medical procedure is performed; and
6. be recognized and/or accepted by the patient as his/her personal or responsible physician, or a member of the personal physician's group, and be personally responsible for the continuity of the patient's care, at least throughout the period of illness or hospitalization.

Some specialists provide their services to patients from a site which is remote from where direct patient care is rendered. These "consulting physicians" provide expertise that is critical to the successful provision of patient care by the "attending physician".

In order to qualify as a "consulting physician", the teaching physician must, at a minimum:

1. either perform the consulting physician's services required by the patient

or supervise the procedure so as to assure that appropriate services are provided by house officers and that the care meets a proper quality level; and

2. be present and ready to perform any services that would be performed by a consulting physician in a non-teaching setting when a surgical or medical procedure is performed.

B. As house officers progress satisfactorily in their training, they must be granted graded responsibility commensurate with their abilities. In this setting, house officers may provide patient care under the supervision of, but without direct participation, although full responsible for the care of the patient, is considered fulfilling an administrative/educational role.

C. Participation, for the purposes of this document, is defined as the attending physician being physically present on site during the delivery of health care. Participation includes supervision. On the other hand, a faculty member does not have to be physically present to supervise a house officer and, therefore, supervision does not imply participation. The faculty cannot bill a patient for services rendered unless there is participation in patient medical care.

The UNMC COM and the program in which house officer education is provided each has a responsibility to see the policies and procedures exist that describe the specific levels of supervision required for house officers. They are responsible to ensure that house officers, and that the requirements are re-evaluated on a regular basis. It is not possible to define specific levels of supervision or responsibility that could be applied to all programs and all situations because of variations in the requirements of specialties. Therefore, standards should be determined by each program commensurate with the clinical circumstances and the abilities of the house officer.

Certain principles should guide institutional and programmatic policies:

1. Accreditation Standards: The national standards for house officer supervision as defined by the Accreditation Council for Graduate Medical Education and individual Residency Review Committees must be met as approved and published by the Accreditation Council for Graduate Medical Education.

2. UNMC Commitment:

   A. The UNMC has responsibilities for support of house officers who are physicians engaged in postgraduate study and who provide institutional patient care.

B. The UNMC COM has a responsibility to help meet the cost to implement these guidelines.

3. Progressive Responsibility:

   A. House officer education must continue to be progressively graduated in both experience and responsibility with due attention to the benefit and safety of the patient. Development of mature clinical judgment requires that each house officer be involved in the decision-making process. This process should be determined by each program and individualized commensurate with the clinical circumstance and the abilities of the house officer.

   B. Progressive responsibility for the "first decision" making prior to faculty involvement is important for the maturation of each house officer, whereas "final decision" making after involvement is the province of the faculty. In the process of allowing house officers the opportunity to make the "first decision", the attending physician must insure that the process does not delay the provision of cost-effective and expeditious care.

   C. It is appropriate and desirable that house officers who are more senior have responsibility for supervision and education of those house officers junior to them. House offices' roles and supervisory relationships should be defined in writing by each program.

   D. Faculty must supervise the total care for each hospitalized patient as well as the admission and discharge process and must follow the program policy. There must be documented knowledge of every hospitalized patient as indicated by, at a minimum, initials or signature on the admitting history and physical, daily progress notes, procedure reports and the discharge summary.
   E. Faculty has ultimate authority for patient care; however, both faculty and house officers at all levels have individual responsibility for their actions in patient care.

4. Emergencies: In an emergency situation to preserve life or prevent serious impairment to health, house officers shall be permitted to implement life support services and notify the attending physician as soon as possible. The responsibilities of the attending physician to the patient and to the house officer are not changed by these circumstances.

5. Admissions and Discharge: House officers may admit patients to and discharge them from the hospital under the authority of, and with the consent of, the appropriate faculty member. The only exception is an emergency where delay of permission could result in injury or loss of life. Appropriate

faculty member(s) must be informed of all admissions, transfers and discharges.

6. Quality Monitoring: The overall quality of patient care is the collaborative concern of house officers, faculty, nursing staff and the administration. Clearly defined and carefully reviewed Quality Monitoring should regularly determine that the institutional standards are being met.

7. Critical Decision Areas: In areas of the hospital where rapidity of critical decisions or interventions are common, a supervisory attending will always be available for consultation.

8. Consultation Service: A readily available consultation service should be provided by each department and/or division. All consultations given by house officers must be reviewed by a faculty member in a timely manner and any necessary revisions conveyed promptly.

9. Ambulatory Care: Every house officer must have the opportunity to participate in ambulatory care. Designated faculty must be available on-site, or readily available according to their respective RRC special requirements, for supervision of house officers in such settings.

10. Evaluation: Evaluation is an integral part of supervision. Each department will prepare an evaluation system to monitor the progress of each house officer as he/she progresses through the clinical rotations. At a minimum, a formal written evaluation by a designated supervisory faculty member will be made on each house officer at the completion of each assigned rotation and will be discussed with the house officer. These evaluations will be forwarded to the Program Director who is ultimately responsible for ensuring adequate supervision and evaluation of each house officer within the program. Evaluations, every four months, are required by UNMC, with direct personal review by the Program Director at least every 6 months. Written evaluations must include an assessment of the house officer's progress, performance, dedication, aptitude, capabilities, quality of patient care and qualifications to assume increasing levels of responsibility. If deficit areas are identified, these should be documented in writing by the Program Director who will ensure appropriate remedial action by taken.

    In addition to the above, house officers must have an opportunity to evaluate their faculty in writing.

11. Program Policy: In devising program guidelines for residency supervision, the aspects of supervision listed below should be addressed.

    The development, implementation and enforcement of this policy is the responsibility of the chairpersons and program directors. Oversight for the

compliance of individual programs is the responsibility of the Graduate Medical Education Committee acting on behalf of the Dean of the College of Medicine.

Policies will:

- Define areas of delegated authority.
- Establish degrees of graded responsibility.
- Define acceptable risks.
- Define the endpoint of supervised education.
- Establish a system of accountability.
- Devise policies for transmitting delegated authority or supervision of patients.
- Individualize supervision to the level of house officer maturation.
- Adjust methods of supervision to around-the-clock patient coverage.
- Establish a process to inform hospital units of degree of graded responsibility.