

**TRAINING PROGRAM SUPERVISION AND ACCOUNTABILITY POLICY**

Please reference complete [UW GME Institutional Supervision and Accountability Policy](#) for additional definitions and background.

**UW Boise Psychiatry Residency Training Program**

**Responsibilities and Accountability**

Each patient must have an identifiable and appropriately credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care. This information will be available through posting in the electronic health record, and work schedule documents available to residents, faculty members, other members of the health care team, and patients.

The UW Boise Psychiatry Residency Training Program residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care.

The program will provide the appropriate level of supervision for each resident based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation.

As part of their education program, residents are given graded progressive responsibility according to the individual's clinical experience, judgment, knowledge, and technical skill. Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence.

**Supervision Definitions**

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

1. Direct Supervision:
  - a. the supervising physician is physically present with the resident and patient during the key portions of the patient interaction; or,
    - i. PGY-1 residents must initially be supervised directly with the supervising physician physically present during the key portions of the patient interaction; or,
      - a. PGY-1 Residents must initially be supervised directly, only as described in 1.i. above.
      - b. PGY1 residents should progress to being supervised indirectly with direct supervision available only after demonstrating competence in:

- ii. the ability and willingness to ask for help when indicated;
- iii. gathering an appropriate history;
- iv. the ability to perform an emergent psychiatric assessment; and,
- v. presenting patient findings and data accurately to a supervisor who has not seen the patient.

b. the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.

i. When a resident requiring direct supervision provides remote care, the supervising physician must be physically present with the resident.

2. Indirect Supervision:

a. the supervising physician 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

3. Oversight: the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

### **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, guided by the Milestones.

Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident.

### **Clinical Responsibilities by PGY-Level**

#### **PGY-1 Residents**

PGY-1 residents are initially directly supervised (see definitions above).

- 1) PGY-1 residents should progress to being supervised indirectly with direct supervision available only after demonstrating competence in:
  - a. the ability and willingness to ask for help when indicated
  - b. gathering an appropriate history
  - c. the ability to perform an emergent psychiatric assessment
  - d. and, presenting patient findings and data accurately to a supervisor who has not seen the patient.

- 2) When a resident requiring direct supervision provides remote care, the supervising physician must be physically present with the resident.
  - a. Once a PGY1 residents has demonstrated competence in the areas outlined in A-D above, the supervising physician can concurrently monitor patient care through appropriate telecommunication technology when the patient is not physically present with the resident.

**PGY-2 Intermediate Residents**

Intermediate residents may be *directly or indirectly supervised* by an attending physician or fellow but will provide all services under supervision. They may supervise PGY-1 residents and/or medical students; however, the attending physician is responsible for the care of the patient.

**PGY-3, PGY-4 Senior Residents**

Senior residents may be *directly or indirectly supervised*. They may provide direct patient care, supervisory care or consultative services, with progressive graded responsibilities as merited. Senior residents or fellows should serve in a supervisory role to medical students, junior and intermediate 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 responsible for the care of the patient.

**Levels of Supervision for Common Specialty Clinical Activities and Invasive Procedures**

Please list each clinical activity/procedure by PGY-level, with specific CPR Level of Supervision language:

Clinical Activity/Procedure	Resident Level (PGY)	Location	Supervision Level
Inpatient Psychiatry	PGY1, 2	VA, Saint Alphonsus, State Hospital South	Direct and indirect
Emergency Psychiatry	PGY1	VA	Direct and indirect
Forensic Psychiatry	PGY1	Idaho State Correctional Institute	Direct
VA Night float	PGY 2, 3, 4	VA	Indirect
Consult Psychiatry	PGY2	St. Luke’s Hospital	Direct and indirect
Addiction Psychiatry	PGY2	VA	Indirect
Child Psychiatry Inpatient Consults and Outpatient	PGY3	St. Luke’s Hospital	Direct and indirect
Outpatient Psychiatry	PGY3,4	VA, St. Luke’s Hospital, Boise State University Student Health, Saint Alphonsus	Direct and indirect

### **Circumstances and Events in which Supervising Faculty Member (s) MUST be Contacted**

The supervising attending needs to be informed by the resident: 1) 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, including suicidal behavior on the inpatient unit; 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; c) when the resident intends not to hospitalize a patient seen in the ER who has expressed ideas of self-harm or harm to others; 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). The resident will also call the on-call attending to review all consults.

### **Supervision of Consults**

Residents performing consultations on patients are expected to communicate verbally with their supervising attending as soon as possible after seeing the patient and certainly within 12 hours or (for night float and on call residents) within the same call or night float 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.

### **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.

### **Faculty Supervision Assignment**

Faculty supervision assignments are typically one-week to several month's duration for inpatient settings (e.g. inpatient, consultation-liaison, and emergency psychiatry rotations) and 6-12 months for outpatient psychiatry rotations and therefore are of sufficient length to assess

the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. In inpatient settings, assignments may in some cases be shorter.

### **Supervision of Handoffs**

Residents conducting hand-offs are expected to use structured verbal and electronic processes for patient transfers between services and locations. Residents use handoff tools in the patient record. Residents may be supervised directly or indirectly when conducting hand-offs. PGY-1 residents should initially be directly supervised when conducting hand-offs. Faculty must assess resident and fellow readiness to move from direct to indirect supervision when conducting hand-offs and patient transfers after being observed providing thorough and appropriate hand-offs on at least three occasions by the supervising psychiatrist.

### **Expectations Regarding Supervision**

Supervision is designed to help residents learn the principles and practice of Psychiatry. Residents are supervised throughout residency, as part of every clinical experience. Beginning residents have close, daily supervision. As residents progress through the residency, they will generally be supervised less closely and less frequently. Residents will be given increasing responsibility for patient care, in a graduated manner, appropriate to their level of training and skills. In addition, senior residents are expected to supervise junior residents (with attending backup) during training call and on some elective rotations. The program's policies regarding supervision are outlined in the Supervision Policy above. The following Expectations Regarding Supervision constitutes an addendum to the Supervision Policy and covers more detailed and specific requirements for types of supervision at each PGY level, as well as general expectations regarding supervisory relationships in our residency program.

### **Overview of Specific, Required Types of Supervision by PG-year:**

#### PGY-1 year

- Daily supervision with inpatient and forensic psychiatry attending on rounds, as well as daily supervision with the emergency psychiatrist during patient care.
- During psychiatry rotations, one hour a week of supervision with the inpatient attending (apart from rounds)
- One hour per week "off ward" supervision (on psychiatry inpatient rotations) with a faculty member other than your inpatient attending. This faculty member is also your Faculty Advisor/Mentor. You can use this time to present and discuss cases, work on case formulation, interview patients with your supervisor, review literature, etc. as well as discuss topics like transitioning to residency, managing work-life balance, etc. This time is confidential and not evaluated. The program does not hear about your interactions during this time unless there is a safety concern.
- Attending supervision when on daytime call (please see below for guidelines about on call supervision); night call is not permitted for PGY-1 residents on psychiatry rotations

### PGY-2 year

- Daily supervision with inpatient/consult/addiction attending on rounds and during patient care
- One hour a week of supervision with inpatient/consult/addiction attending (apart from rounds)
- One hour per week of psychotherapy supervision (assigned)
- Caseload supervision in clinic (i.e. supervision of your patient caseload by an on-site faculty member responsible for the patient care you provide)
- Back up attending supervision when on call and night float

### PGY-3 year

- Daily supervision with inpatient/consult/ER attending, as relevant
- One hour/week of supervision with inpatient/consult/ER attending (apart from rounds), as relevant
- Caseload supervision in every clinic (one hour per clinic day; may be in team/group format)
- At least one hour per week of psychotherapy supervision
- Back up attending supervision during clinic days and when on call and night float

### PGY-4 year

- Caseload supervision in every clinic (one hour per clinic day)
- At least one hour per week of psychotherapy supervision
- Back up attending supervision during clinic days and when on call and on night float

### **Expectations Regarding Supervision**

Interactions between residents and supervising faculty attendings are governed by the following principles:

- Interactions between residents and attendings are expected to be respectful, collegial, and focused on the common goal of excellent patient care
- A resident should, at all times, have direct access (in person or by telephone) to a faculty attending. **If you are unable to reach your designated attending in a timely fashion, please call the program director (at the VA) or the site director of the site where you are working. At the VA, please refer to the "VA Supervisor Backup" policy for further details.**
- When the attending is on vacation or otherwise unavailable, a specific covering attending will be designated
- A faculty attending on the clinical service in which patient care takes place is designated as the supervising attending and has the ultimate clinical and legal responsibility for the care provided, although the resident is encouraged (and may be required) to also consult with other clinical or regular faculty supervisors
- Residents will present new cases to the attending on daily rounds on the inpatient, emergency, and consultation-liaison psychiatry services. On outpatient rotations, the resident will present new cases to the attending (caseload supervisor) as soon as

possible, and definitely within one week, and will provide regular updates for ongoing cases (monthly, or whenever the patient is seen if this is less often than monthly)

- Residents on Psychiatry services (i.e. not on Medicine, Pediatrics, or Neurology) will have at least two hours of individual supervision per week (including individual supervision with the inpatient/consult/ER attending, “off ward” supervision, psychotherapy supervision, and/or outpatient caseload supervision, as appropriate: see overview by PG-year, above)
- As a teacher, the supervisor/attending is expected to provide the resident with information, guidance, and choices in patient care. The attending/supervisor needs to keep abreast of clinical issues on the service or with the resident’s patient caseload, and supervision needs to be sufficiently close to allow him/her to notice problems
- The attending/supervisor needs to monitor the resident’s performance and give regular, constructive feedback. The attending/supervisor determines how closely the resident needs to be supervised and how much reporting he/she expects from a particular resident, depending on the resident’s level of training, experience, and skills. The resident is expected to be open to learning, willing to consult, and prepared to fully inform the attending/supervisor about all patient care issues. It is strongly recommended that the expectations, terms, and goals of the supervisory agreement be made explicit in a collegial discussion between the attending/supervisor and the resident at the beginning of the supervisory relationship
- As outlined in the Supervision Policy, 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
- As outlined in the Supervision Policy, during on-call or night float 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; c) when the resident intends not to hospitalize a patient seen in the ER who has expressed ideas of self-harm or harm to others; 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). The resident will also call the on-call attending to review all consults.

Any resident or supervisor who feels uncomfortable with any supervision relationship, for whatever reason, should consult the Residency Director, Associate Residency Director, and/or Chief Resident at the clinical site for help and advice.

## **Protocol for Immediate Supervisor Involvement**

### **UW Boise Psychiatry Residency Program**

- 1- Residents are required to contact their direct supervisor for supervision immediately, either by phone or in person after emergent clinical stabilization, as appropriate, for any of the following:
  - a. Any questions or concerns about the patient or care provided
  - b. Patient requesting immediate (AMA) discharge from ER or an inpatient unit (inpatient psychiatric unit or on medical floor with psychiatric consult)
  - c. Resident intends to not to hospitalize a patient seen in the emergency room
  - d. Resident intends to turn down an ER physician's request for patient admission to inpatient psychiatric unit
  - e. Resident plans to send home from the emergency room a patient with a rapidly deteriorating clinical course
  - f. All inpatient consults
  - g. Rapid Response or Code on the inpatient unit
  - h. When additional clinical information puts the working diagnosis in doubt or questions the treatment plan
  - i. When information is obtained that raises concerns regarding the patient's risk for harm to self or others
  - j. When the patient or family members disagree with the treatment plan
  - k. When there are serious disagreements or conflicts within the treatment team or other services or providers
  - l. When decisions need to be made that have legal implications such as duty to warn concerns or consideration to file a child protective services report
  - m. Instances of violence, threats of violence, as per #2 below
  - n. Suicide attempts in the hospital as per #2 below
- 2- Residents are to report ALL incidents of violence, threats of violence, or harassment directed towards them from patients and staff, no matter how trivial, as well as ALL suicides or suicide attempts by patients. These critical incidents should be reported immediately to the responsible attending supervisor either by phone or in person. In addition, such events should be to the Program Director or Associate Program Director within 24 hours.
  - a. The Program Director will speak with the resident (for minor instances this may be delegated to the Associate Program Director or supervising attending) and will be responsible for seeing that adequate psychological support and supervision are provided.
- 3- If, for any reason, the supervisor cannot be reached, residents should immediately contact the Program Director and/or Associate Program Director by phone.
- 4- Residents will be oriented to the reporting policy upon entering the program and reminded at regular intervals to report critical incidents.
- 5- The Residency Training Office will maintain statistics and report them regularly to the resident group. The Training Office will also identify any patterns involved in these incidents so that these can be addressed.