UW GME Approved Supervision Policy

Revised 03/10/2022

TRAINING PROGRAM SUPERVISION AND ACCOUNTABILITY POLICY

[Last updated: 3.26.2026]

Please reference complete UW GME Institutional Supervision and Accountability Policy for additional definitions and background.

Colon and Rectal Surgery Fellowship Program

University of Washington Medical Center-Montlake/Northwest, FHCC

Responsibilities and Accountability

Each patient must have an identifiable and appropriately credentialed and privileged attending physician who is responsible and accountable for the patient's care. This information will be available through the electronic medical record, team list, and call schedule to residents, faculty members, other members of the health care team, and patients. If the attending of record is not available in a timely manner, the attending of the day or on-call attending may be contacted.

The colon and rectal surgery 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 the 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 skills. 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.

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Supervision Definitions

To promote appropriate resident supervision while providing for graded authority and responsibility, the following classification of supervision is recognized:

1. Direct Supervision:

   a. The supervising physician is physically present with the resident during the key portions of the patient interaction.

   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.

   c. PGY-1 residents must initially be supervised directly, only as described in the above definition.

2. Indirect Supervision:
   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.

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

4. Direct Supervision:

   a. The supervising physician is physically present with the resident during the key portions of the patient interaction.

   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.

   c. PGY-1 residents must initially be supervised directly, only as described in the above definition.

5. Direct Supervision:

   a. The supervising physician is physically present with the resident during the key portions of the patient interaction.

   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.

   c. PGY-1 residents must initially be supervised directly, only as described in the above definition.

6. Indirect Supervision:
   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.

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

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

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 and/or other performance evaluations.

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.

Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s).

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.

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<u>PGY1</u>

Residents may be *directly* or *indirectly supervised*. They may provide direct patient care, supervisory care, or consultative services, with progressive graded responsibilities as merited. Residents 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 resident; however, the attending physician is ultimately responsible for the care of the patient.

Levels of Supervision for Common Specialty Clinical Activities and 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. The activities and procedures below mostly center on clinic, ward and ICU locations. Supervision in the OR for surgical specialties is governed by Medicare supervising physician teaching rules and those rules should be referenced for all items below. 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.

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I. Specialty Specific

Clinical Activity/Procedure	Resident level (PGY)	Location	Supervision Level
Patient Evaluation & Management (Basic): a) evaluation and management of a patient admitted to hospital, including initial history and physical examination, formulation of a plan of therapy, and necessary orders for therapy and tests b) pre-operative evaluation and management, including history and physical examination, formulation of a plan of therapy, and specification of necessary tests c) evaluation and management of post-operative patients, including the conduct of monitoring, and orders for medications, testing, and other treatments d) transfer of patients between hospital units or hospitals e) discharge of patients from the hospital f) interpretation of laboratory results	Colorectal Resident	All settings (clinic, ward, ICU) *For OR, see section note above	*Indirect Supervision, with direct supervision available* (supervising physician not physically present but available by phone/text/email discussion)
Patient Evaluation & Management (Basic): a) initial evaluation and management of patients in the urgent or emergent situation, including urgent consultations, trauma, and emergency department consultations (ATLS required)	Colorectal resident	All settings (clinic, ward, ICU) *For OR, see section note above	*Indirect Supervision, with direct supervision available (supervising physician not physically present but available by phone/text/email discussion)*

b) evaluation and management of post-operative complications, including hypotension, hypertension, oliguria, anuria, cardiac arrythmias, hypoxemia, change in respiratory rate, change in neurologic status, and compartment syndromes c) evaluation and management of critically ill patients, either immediately post-operatively or in the intensive care unit, including the conduct of monitoring, and orders for medications, testing, and other treatments d) management of patients in cardiac or respiratory arrest (ACLS required)			
Procedures (Basic): a) Emergency department fracture reduction and splinting b) Dressing removal or change c) Suture removal;	Colorectal resident	All settings (clinic, ward, ICU) *For OR, see section note above	*Indirect Supervision, with direct supervision available* (supervising physician not physically present but available by phone/text/email discussion)
Procedures (Intermediate): a) Basic venous access procedures, including establishing intravenous access b) Placement and removal of nasogastric tubes and Foley catheters c) Arterial puncture for blood gases d) Central venous catheter removal e) Incision and drainage of abscesses	Colorectal resident	All settings (clinic, ward, ICU) *For OR, see section note above	*Indirect Supervision, with direct supervision available* (supervising physician not physically present but available by phone/text/email discussion)

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Clinical Activity/Procedure	**Resident level (PGY)**	**Location**	**Supervision Level**
Key and critical portions of surgical procedures	Colorectal resident	OR	Direct supervision is required by a qualified member of the medical staff
Flexible sigmoidoscopy/ colonoscopy	Colorectal resident	All settings (clinic, ward, ICU) *For OR, see section note above	Direct supervision is required by a qualified member of the medical staff
Sedation for procedures following successful completion of the UW Medicine Conscious Sedation module	Colorectal resident	All settings (clinic, ward, ICU *For OR, see section note above)	*Supervised indirectly, with direct supervision available* (supervising *physician not physically present but available by phone/text/email discussion)*

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

The Department of Surgery Attending Call Triggers are specific circumstances and events in which residents must communicate with appropriate supervising faculty members. If the supervising practitioner does not respond in a timely manner, the resident is to attempt to contact the supervising practitioner by cell or home phone via paging operator. If the supervising physician still does not respond, the resident is to contact the on-call attending physician.

Department of Surgery Attending Call Triggers

An Attending must be called if:

- Any change in patient status
- Admission or Discharge AMA
- Complex decision-making requiring initiation of a therapy or procedure for Dx or Tx (e.g. IR, CT scan, abx, new hemodialysis, bronchoscopy)
- Device dysfunction (i.e. VAD, ECMO)
- Immunosuppression related issue
- Intubation or institution of NIPV
- Life threatening event (i.e. cardiac arrest, death)
- Limb threatening event (i.e. loss of pulses, concern for compartment syndrome)
- Medication/treatment error requiring intervention
- Need for blood transfusion
- New vital sign instability or unstable arrhythmia
- Pt transferred to ICU or Telemetry
- Significant neuro changes (cva, seizures)
- Unplanned loss of a drain
- Wound dehiscence/evisceration
- If nurse or other physician requests attending notification
- If a Direct Supervision person is called for any reason

All triggers should be documented with an event note

Supervision of Consults

Residents performing consultations on patients are expected to communicate verbally with their supervising attending preferably on the same day and within 1 hour of seeing the consult, but no later than the following morning. If the supervising physician does not respond in a timely manner, the attending of the day or on-call attending may be contacted.

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 exist for the duration of the rotation and therefore are of sufficient length to assess the knowledge and skills of each resident/fellow and to delegate to the resident/fellow the appropriate level of patient care authority and responsibility.

Supervision of Hand-Offs

Residents conducting hand-offs are expected to use the UW GME IPASS structured verbal process and Epic HER electronic processes for patient transfers between services and locations.

Residents are supervised directly or indirectly when conducting hand-offs. PGY-1 residents are initially directly supervised when conducting hand-offs. Faculty assess resident readiness to move from direct to indirect supervision when conducting hand-offs and patient transfers using the assessment method of direct observation. Refresher courses in the IPASS hand-off method are provided throughout the year for all resident levels.

Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. Programs must ensure that residents are competent in communicating with team members in the hand-over process.