	POLICY AND PROCEDURE	
DEPARTMENT: **Graduate Medical Education**	**Title:** **Resident Supervision & Scope of Practice Policy**	**Original Date: 11/11/2009** **Revisions: 10/2021, 2/2023, 3/2024**

SCOPE: All Family Medicine Residents

PURPOSE: To provide clear understanding of levels of supervision and scope of practice for resident physicians.

POLICY: Resident Supervision & Scope of Practice

PROCEDURE:

This document pertains to resident rotations under the auspices of the USF/MPM Family Medicine Residency at Morton Plant Hospital and Mease Countryside Hospital. All Accreditation Council of Graduate Medical Education (ACGME), Joint Commission (JC), Agency for Health Care Administration (AHCA), and CMS guidelines pertaining to graduate medical education apply to this scope of practice.

The purpose of this policy is to ensure that residents are provided adequate and appropriate levels of supervision during the course of the educational training experience and to ensure that patient care continues to be delivered in a safe manner. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident is assigned by the program director and faculty members to ensure effective oversight of resident supervision.

Each resident and faculty must inform each patient of their respective roles in patient care. Residents 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 must communicate with the supervising faculty on hospital admission or when a patient decompensates and/or requires transfer to a higher level of care such as an ICU. Residents must reach out to faculty when providing emergency care, unexpected patient death or event reporting, patient or staff request to speak to attending or if the trainee is harmed or threatened.

Routine communication on patients with no unexpected changes in status should occur before the end of each patient care shift/session.

Supervision may be provided by more senior residents in addition to attendings. However, all patient care must be provided under a credentialed and privileged attending physician. Residents are authorized to perform any activity assigned while under the direct supervision of a credentialed and privileged attending physician. The attending physician is ultimately responsible for management of the individual patients and the supervision of the residents involved in the care of the patient. Supervision must be documented in the medical record in accordance with the USF/MPM Family Medicine Residency compliance guidelines.

Residents and faculty can report concerns regarding inadequate supervision on the GME website or the hospital reporting system. Any reports will be protected from reprisal. This document is available on the GME website for all residents, faculty, other team members, and patients.

The program follows the ACGME classification of supervision as noted below. The supervising physician can refer to a faculty, fellow, or resident who has been given supervisory privilege. These supervisory levels are used throughout the Scope of Practice document.

Direct Supervision
The supervising physician is physically present with the Resident during the key portions of the patient interaction.

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.

Indirect Supervision
The supervising physician does not provide physical or concurrent visual or audio supervision but is immediately available to the Resident for guidance and is available to provide appropriate direct supervision.

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

The residency program has a curriculum for providing knowledge and assessing performance competence that includes didactic lecture series, symposia/procedure training, competency testing, simulation, number of procedures that need to be completed before obtaining indirect supervision status and reviewing evaluations. Annual decisions about competence are made by the program's clinical competency committee to ensure a successful transition and preparation for the next PGY level. All residents need to maintain current ACLS training.

	Supervising Physician present (Direct)	**Supervising Physician is not providing physical or concurrent visual or audio supervision but is immediately available (Indirect)**	**Supervising physician is available to provide a review of procedures/encounters with feedback after care is delivered (oversight)**			
Designated Levels	1	2	3	See below level of supervision required for each procedure and year of training.		
CORE PROCEDURES				**PGY-1**	**PGY-2**	**PGY-3**
• Admit patients and complete inpatient H&P • Perform patient care and procedures in inpatient setting • Perform patient care and procedures in outpatient setting				1	2	3

• In hospitals with open ICU, admit patients to ICU and complete H&P for ICU level of care • Evaluate, diagnose, and treat common medical conditions • Make referrals and request consultations • Provide consultations within the scope of his/her privileges • Render appropriate care in a life-threatening emergency			
PROCEDURES	**PGY-1**	**PGY-2**	**PGY-3**
• Abscess I&D	1	2	2
• Arterial blood gas	1	2	2
• Arterial line placement	1	1	1
• Arthrocentesis	1	2	2
• Aspirations and injections, joint or bursa	1	2	2
• Bladder catheterization	1	2	2
• Bone marrow aspiration	1	1	1
• Burn care	1	2	3
• Cardioversion, emergent	1	3	3
• Cardioversion, elective	1	1	1
• Casting and splinting	1	2	3
• Central venous catheterization	1	1	1
• Chest tube placement	1	1	1
• Circumcision, neonatal	1	1	1
• Colposcopy with biopsy	1	1	1
• Cryotherapy	1	2	3
• ECG interpretation, emergent	1	3	3
• ECG interpretation, elective	1	3	3
• Endometrial biopsy	1	1	1
• Excisions of skin tags	1	3	3
• Excisions of skin and subcutaneous lesions	1	2	2
• Feeding tube placement (nasal or oral)	1	1	1
• Gastric lavage and aspiration	1	1	1
• Implantable contraceptive device insertion/removal	1	1	1
• I&D hemorrhoid	1	1	1
• IUD insertion	1	1	1
• IUD removal, strings visible	1	2	2
• IUD removal, strings not visible	1	1	1
• Local anesthesia	1	3	3
• Lumbar puncture	1	1	1
• Major surgical assist	1	1	1
• Manage minor closed fractures	1	2	2
• Manage uncomplicated dislocations	1	2	2
• Nasal packing	1	2	2
• Pap smear	1	2	2
• Paracentesis	1	1	1

• Pericardiocentesis (emergent)	1	1	1
• Peripheral nerve blocks	1	2	2
• Peripheral IV placement	1	3	3
• Pulmonary function test interpretation	1	3	3
• Routine low-risk obstetrical care to include:			
1. scalp electrode placement	1	1	1
2. IUPC placement	1	1	1
3. induction of labor	1	1	1
4. vaginal deliveries	1	1	1
5. mgmt. of episiotomies & 1^{st}-3^{rd} degree lacerations	1	1	1
• Suprapubic bladder aspiration	1	1	1
• Suturing -simple lacerations	1	3	3
• Suturing -multilayer closures	1	2	2
• Tendon/joint injections	1	2	2
• Thoracentesis	1	1	1
• Tracheal intubation, emergent	1	2	2
• Ultrasound	1	1	2
• Vasectomy	1	1	1
• Venipuncture	1	3	3

Medical Staff Communication:

The medical staff will be apprised of resident performance, patient safety issues and quality of patient care as it pertains to graduate medical education. The medical staff is also provided with written descriptions of the roles, responsibilities and patient care activities of residents as denoted in the scope of practice statements that are maintained in the graduate medical education office and on the BayCare Intranet under Policies and Procedures. The Family Medicine Residency Program Director is a standing member of the Graduate Medical Education Committee of the sponsoring University and regularly reports on these areas to the medical staff through the following vehicles. The residency program director will report no less than semiannual updates to the Medical Executive Committee of Morton Plant Hospital. This information is reported both up to the governing board and down to the corresponding departments within the medical staff as appropriate. The program will have a regular report to the department of Family Medicine. Where indicated by the medical staff, ad hoc committees (such as the joint practice committee of the departments of Ob/Gyn and Family Medicine) will be convened to address issues relevant to resident supervision, medical records, resident performance, patient safety, and quality patient care.

REFERENCES: USF GME Policies, ACGME requirements