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USF HEALTH

Resident Supervision & Scope of Practice Policy
Interventional Radiology
Integrated Residency Program
At the University of South Florida College of Medicine

Resident supervision policy:

Aim: The aim of the resident supervision policy is to define terms and framework for resident supervision for resident physicians engaged in training and patient care in the Department of Radiology at the University of South Florida Morsani College of Medicine.

Definitions:

Resident: A physician in training in a post graduate medicine program who participates in patient care under the direction of teaching faculty. The term "resident" includes all post graduate physicians engaged in a training program at USF and includes resident physicians and subspecialty fellows. In post-graduate training, residents are given progressive responsibility based upon the knowledge, skill, training level and experience of each individual resident physician. Each resident is expected to recognize their ability and limits of their ability and seek assistance, when necessary, in providing patient care.

Faculty: An attending physician is a physician designated by the training program as capable and qualified to supervise and teach residents. The faculty physician must be identifiable and appropriately credentialed, licensed and certified to provide care at the site of patient care. The attending physician is ultimately responsible for the care of the patient and the supervision of the resident physicians involved in their care. The faculty physician supervises and delegates patient care tasks to the resident physicians according to the needs of the patient and the skill, knowledge and experience of the residents involved in that patient's care.

The goal of the resident and attending relationship during the period of resident training is the acquisition of the skills, knowledge and experience needed to practice the specialty of diagnostic radiology and interventional radiology independently.

Supervision

To ensure oversight of resident supervision and graded authority and responsibility, the following levels of supervision are recognized:

1. Direct Supervision: The supervising physician is physically present with the resident and patient. This level of supervision is preferred for the majority of procedural and diagnostic training encountered in the vascular and interventional radiology program.

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. This level of supervision is the least frequent level of supervision encountered in the vascular and interventional radiology program but may be appropriate in certain on call and emergency diagnostic radiology situations.

Responsibilities

Residents: Residents are responsible for providing patient centered care and recognizing that the individual patient needs required variable levels of supervision. Residents must recognize they are part of a team and may participate in all facets of patient care if the demonstrate the appropriate level of knowledge, skill, experience, and judgment. The resident must also recognize the limitations of their ability and seek the guidance of the attending physician. Each member of the team must provide the highest level of care for any given patient. Residents should also strive to become independent and demonstrate their knowledge level, procedural skill, and professionalism by engaging in patient care and increasing their responsibility as they progress through training.

Attending physicians: Attending physicians are ultimately responsible for the care of the individual patient. In providing quality care, the attending physicians are obligated to delegate patient care tasks to the resident physicians according to the ability, knowledge, and experience of the resident in a variety of patient circumstances. This requires the attending physician to continuously assess the needs of the patient and the competence and ability of the resident during all phases of patient care. The attending physician must recognize the appropriate level of supervision and must provide that supervision to care for the patient and educate the resident. The attending physician is also obligated to document the resident physician role in diagnostic and therapeutic invasive procedures and appropriately direct the informed consent of patients prior to procedures.

Supervision requires communication and designation of supervisory roles. The roles of the attending physician and resident physician must be communicated to the patient and all members of the patient care team. The attending physician and facility are responsible for publishing and updating an accurate call schedule according to hospital and site service obligations. The call schedule will be published and accessible for the resident physicians, attending physicians, nurses, and other members of the health care team.

Residents are not permitted to perform independently in the residency until their PGY-3. Residents will not be scheduled on independent diagnostic radiology call until that time. The resident must be cleared

by the PD and CCC for independent overnight call by demonstrating competency in the interpretation of commonly performed imaging procedures and medical knowledge of common conditions encountered on overnight diagnostic radiology call. If the CCC/PD feel a resident is not prepared, the resident will be notified during semiannual reviews. A learning plan will be developed, and call schedule delayed until the CCC/PD indicates the resident is prepared for independent call.

Residents will not be permitted to take independent IR call until evaluated by faculty and PD/APD. Independent IR call will not occur until the PGY-5 year during TGH IR rotations. If the CCC and/or PD feel a resident is not prepared, the resident will be notified during semiannual review. A learning plan will be developed, and call schedule delayed until the CCC/PD indicates the resident is prepared for independent call.

Attending notification: Faculty should be notified if the following occur:

- Degradation of patient clinical status – change from floor to ICU admission
- Code Blue or patient death in patient post-procedure that was unexpected
- Complication following procedure that is unexpected
- Potential transfer of patient from outside facility to TGH for Radiology/Interventional Radiology care
- Emergent situation when other clinical services are not available for decision making
- Ambulatory patient referred to ER post procedure
- Ambulatory patient being admitted for inpatient care following recent procedure
- Ambulatory patient or faculty requesting to speak to on-call physician with unexpected complication

Emergency situations: In life threatening emergency situations, the primary obligation is to the immediate care of the patient and all physicians should provide emergency care within their ability. Supervision may not be immediately available in these unforeseen circumstances, and the resident physician may attempt life and limb saving procedures when supervision is not available. The resident and attending physician team should anticipate emergency circumstances and attending assistance should be available as soon as possible. In the event of emergency care rendered by residents, the attending physician must be notified of the situation as soon as possible.

Consultative patient care: Residents engaged in vascular and interventional radiology are expected to provide consultative care under the direction of faculty attending physicians and with the assistance of attending designated practitioners (i.e., Nurse Practitioners; APRNs and Physician Assistants: PAs). The attending physician responsible for the patient consultative service must consider the training level, experience and skill of the resident physician involved in the consultation and provide the appropriate level of supervision based upon the acuity of the patient problem.

Patient Hand-off and transfer of care: Transfer of patient care responsibility must be done according to site specific requirements. In general, the attending physician should be involved in the hand off process whenever possible and should supervise novice residents in the transfer of patient care. Call schedules, rotation schedules and procedure schedules should be created with an emphasis of minimizing patient hand-offs whenever possible.

Review of Resident Supervision: Supervision of residents and assessment of resident capability is a continuous process. Attending physicians are expected to give daily feedback to resident physicians and

continuously determine the resident capability for progressive independence in providing excellent patient care. The program will also use formal mechanisms to include global end of rotation evaluations, semi-annual review of progress, milestone assessment and multifaceted feedback mechanisms such as 360-degree evaluations. Review of resident progress and promotion to the next level of training will be assessed by the program director and clinical competence committee. If the resident is not meeting expectations, the resident will be notified of their underperformance and will be subject to remediation, formal and informal discipline, and dismissal according to USF GME policy.

Scope of Practice in Procedural Rotations of the Integrated IR residency

The purpose of this policy is to ensure that residents are provided adequate and appropriate levels of supervision during 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/fellow is assigned by the program director and faculty members to ensure effective oversight of resident supervision.

Each resident must know the limits of their scope of authority and the circumstances under which they are permitted to act with conditional independence. Residents are responsible for asking for assistance from the supervising physician when they are dealing with a complex clinical scenario, when they are dealing with a severely ill patient with an acute medical issue, when their procedural skills are insufficient for the task at hand or if they are unsure of the optimal treatment plan. All patient care must be provided under 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 University of South Florida compliance guidelines.

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

IR procedures

For interventional radiology procedures performed in the IR department and suites, all procedures require an attending physician to perform the “time-out” prior to the procedure. Therefore, all procedures in the IR labs require at least a supervision level of 1/2.

All IR Residents will require direct supervision (level 1) for the first two months in the IR suites during procedures – which occurs as a PGY-4 resident in the current block schedule. Independent home IR call will not begin until PGY-5 year. As confidence in the abilities of the resident by the faculty increases, the supervision level will increase to level 2 for all procedures. Procedures should not begin without an attending physician in the department – nor should “time out” be permitted without attending present by current TGH guidelines.

Low risk procedures, which are only performed on the floor, can be performed with Indirect Supervision or Oversight after demonstrating competency with these procedures during Level 1 supervision. Informal and formal evaluations will be given to notify residents of their capabilities for these low-risk procedures.

The following procedures can be performed by IR residents after normal hours after faculty have given feedback the resident is prepared to perform them on the floor (Oversight). The faculty on-call should be made aware if any of these procedures are being performed:

- Central venous catheter manipulation (tunneled or non-tunneled)
- GI tube manipulation (G tube, GJ tube, J tube)
- Tunneled central venous catheter removal

Inpatient consults

Inpatient consults will be performed without attending physicians present; however, all stat consults will be reviewed with the faculty immediately after the evaluation of the patient either in person or by phone. Routine consults can be reviewed daily and rounding performed when clinical schedule permits.

	Supervising Physician present (Direct)	Supervising Physician immediately available (Indirect)	The trainee may perform the procedure without supervising Attending/ resident (Oversight)		
Designated Levels	1	2	3	See below for level of supervision required for each procedure and year of training	
CORE PROCEDURES				**PGY-3-5**	**PGY-6**
Perform patient care and procedures in outpatient setting				2	2
Admit patients and complete inpatient H&P for general ward service				3	3
Remove or manipulate central venous catheters				3	3
Admit patients to ICU and complete H&P for ICU level of care				2	2
Treat and manage common medical conditions				3	3
Make referrals and request consultations				2	3
Provide consultations within the scope of his/her privileges				2	3
Initiate and manage mechanical ventilation for 24 hours				1	1
Perform any procedures in the IR procedural suite				1,2	1,2
SEDATION					
Conscious Sedation				1	1
Local anesthesia				2,3	2,3

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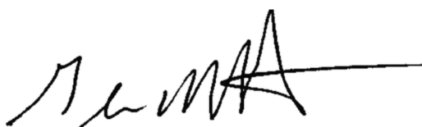
Designated Levels	1	2	3	See below for level of supervision required for each procedure and year of training	
Specific Procedures				**PGY-3-5**	**PGY-6**
Image guided drainage abscess/fluid				1,2	2
Arterial access/angiogram				2	2
Arterial embolization/stenting				1	2
Removal of existing drains/biliary/nephrostomy				3	3
Fistulagram and intervention				1	1,2
Suprapubic and gastric tubes				2	2
Venous access/venogram				2	2
Venous intervention (stent/embolization)				1,2	2
Non-vascular visceral access (biliary/renal)				1,2	1,2
Biopsy – Image guided				2	2
Central venous catheter placement				1,2	2
Arterial/Venous thrombolysis				1	1,2
Portal Intervention (TIPS/variceal embolization)				1	1,2
Delivery of transarterial radiopharmaceuticals and chemoembolics				1	1,2
Removal of tunneled catheters				2,3	3
IVC filter placement/removal				1	1



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