SCOPE OF PRACTICE and SUPERVISION POLICY

Internal Medicine – Pediatrics Residency

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**Background**

The combined practice of Internal Medicine – Pediatrics (Med Peds) is a discipline encompassing the medical care of male and female patients from the newborn through the geriatric age groups. It involves the promotion of health, disease prevention, anticipatory guidance, well care and treatment of acute disease states through all phases of illness. Intrinsic to the discipline are scientific knowledge, the scientific method of problem solving, evidence-based decision making, a commitment to lifelong learning, and an attitude of caring that is derived from humanistic and professional values. Residency is clinical training in a supervised environment where the trainee is given graded responsibility based on their attainment of the knowledge, skills, and abilities needed to safely manage patient care and other clinical responsibilities. As such, supervision of residents and ongoing assessment of their clinical skills is of prime importance during residency training.

This document pertains to Resident rotations under the auspices of the Internal Medicine – Pediatrics Residency at Tampa General Hospital, James A. Haley Veterans Hospital, Moffitt Cancer Center, Johns Hopkins All Children’s Hospital and their associated outpatient clinical sites as well as USF Health outpatient clinical sites. 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.

**Purpose**

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. The program director evaluates each resident’s abilities based on specific criteria, guided by the Milestones. Faculty members functioning as supervising physicians delegate portions of care to the residents based on the patient's needs and each resident's skills.

The program follows the ACGME 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.

**Direct Supervision**: the supervising physician is physically present with the resident during the key portions of the patient interaction or 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 but must be immediately available to be physically present.

**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.

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

PGY-1 and residents in the first 4 months of their PGY-2 year have either direct supervision or indirect supervision with direct supervision immediately available on all rotations. PGY-2,3,and 4 residents have more autonomy as they progress through residency training and will always have an oversight level of supervision at minimum. For procedures specifically, please refer to the scope of practice for the level of supervision needed to perform procedures. Finally, each rotation also has the level of supervision for each level resident listed in the goals and objectives.

**Program Director Responsibilities**

The Program Director must:

* Assign appropriate clinical responsibilities, such as patient caps, for each resident based on their demonstrated competence as well as the severity and complexity of patient conditions and available support services.
* Ensure direct supervision of residents at all times, with appropriate documentation.
* Ensure that faculty physician schedules are structured to provide residents with continuous and appropriate supervision and consultation.
* Set faculty supervision to a sufficient duration to assess the knowledge and skills of each resident.
* Ensure that residents know which supervisor is on call and how to reach them.
* Evaluate each resident’s ability based on Milestone-guided criteria.

**Faculty Responsibilities**

Faculty must:

* Be responsible for teaching, evaluating and supervising the residents.
* Routinely review the resident’s documentation in the medical record, attesting clinical documentation with the faculty’s own assessment.
* Ensure compliance with institutional requirements such as updating problems lists, performing medication reconciliation, and maintenance of accurate and timely medical record-keeping.
* Serve as role models of professionalism, providing exemplary patient care and demonstrating excellent communication skills.
* The faculty supervisor(s) assigned for each rotation or clinical experience (inpatient or outpatient) must provide to the Program Director a written evaluation of each resident’s performance during the period that the resident was under their supervision. Supervisors will also provide residents with formative feedback in real-time as appropriate.

**Circumstances for which Supervising Attending Physician Must be Contacted/Communication Required**

1. For all critical changes in a patient’s condition such as code scenario, death, transfer to the intensive care unit.
2. If any trainee feels that a situation is more complicated than he/she can manage.
3. At the request of any ancillary staff, patient or patient family.
4. For any discharge from the hospital or transfer to another unit should also be discussed with the attending.

The residency program has a curriculum for providing knowledge and performance competence that includes (procedure training, simulation, number of procedures that need to be completed before obtaining indirect supervision). 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.

**Position Descriptions**

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| **TITLE** | **Post Graduate Year-1 and first 4 months of PGY -2 (Intern)** |
| **REPORTS TO** | Program Director, Attendings, Chief Medical Resident, Fellow, or Senior Level Resident |
| **POSITION SUMMARY** | An intern (or PGY-1and first 4 months of PGY-2) is a highly supervised medical school graduate who serves as the immediate manager of up to 10 patients in the inpatient or outpatient settings. The intern also assists in teaching assigned medical students on the general floors and makes daily rounds with the medical students. |
| **COMPETENCIES AND ESSENTIAL FUNCTIONS** |  |
| **Inpatient**  **Responsibilities** | * The intern performs a comprehensive admission history and physical examination on all patients admitted to the service. These are recorded in a written or computerized medical record. * The intern develops an assessment and plan and reviews these with the Attending physician and supervising resident. * The intern writes admission and subsequent orders with approval by the supervising resident. * The intern writes prescriptions for hospital pharmacy filling for post- hospital care with approval from the supervising resident and Attending physician. * The intern assists with arranging appropriate follow-up care of patients. * The intern may also write discharge summaries for hospitalized patients. * The intern performs inpatient procedures under direct supervision * The intern will, at minimum, notify supervisors of situations (1) for all critical changes in a patient’s condition such as code scenario, death, transfer to the intensive care unit (2) if any trainee feels that a situation is more complicated than he/she can manage (3) at the request of any ancillary staff or patient, and (4) for any discharge from the hospital or transfer to another unit should also be discussed with the attending. |
| **Outpatient Responsibilities** | * The intern performs history and physical exams on all ambulatory patients. * Develops assessments and plans. * Writes prescriptions as appropriate with review by an Attending physician. * Performs outpatient procedures and schedules follow-up under the direct supervision of an Attending physician. |
| **SUPERVISORY RESPONSIBLITIES** | * Medical Students |

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| **TITLE** | **Post Graduate Year–2 (after first 4 months), 3 and 4 Resident** |
| **REPORTS TO** | Program Director, Faculty, Chief Medical Resident, or Fellow |
| **POSITION SUMMARY** | A PGY-2 (after first 4 months), 3, or 4 resident is a supervised trainee who serves as inpatient team leader, consultant, or outpatient physician with all levels of supervision (oversight, direct supervision or indirect supervision) based on rotation or procedure. PGY-2 (after first 4 months), 3 and 4 residents are responsible for supervising two PGY-1 residents, one to two third-year medical students, and   * up to 20 patients on inpatient teams. The resident may make independent assessments and decisions about treatment under indirect supervision or oversight status in the inpatient setting. In the outpatient setting, all patient care is provided under the direct or indirect supervision of attendings. All residents will, at minimum, notify supervisors of situations where care is escalated, a complication or unexpected outcome has occurred, for all deaths and end of life decisions. |
| **COMPETENCIES AND ESSENTIAL FUNCTIONS** |  |
| **Inpatient**  **Responsibilities** | * The resident writes admission notes on each patient. * In conjunction with the attending, manages the ongoing care of hospitalized patients. * Supervises interns and medical students. * Arranges follow up and placement for hospitalized patients in conjunction with case management. * Writes discharge summaries on all patients admitted to his or her team. * The resident will, at minimum, notify supervisors of situations (1) for all critical changes in a patient’s condition such as code scenario, death, transfer to the intensive care unit (2) if any trainee feels that a situation is more complicated than he/she can manage (3) at the request of any ancillary staff or patient, and (4) for any discharge from the hospital or transfer to another unit should also be discussed with the attending. |
| **Outpatient Responsibilities** | * In the outpatient setting, residents perform patient care and outpatient procedures under the direction or indirect supervision of an Attending physician |
| **KNOWLEDGE, SKILLS AND ABILITY** | The PGY-2 (after first 4 months), 3 and 4 residents may perform procedures with indirect supervision if given supervisory status as per residency rules described in text below.  The following procedure must at all times be performed with direct supervision unless this is a code blue situation:   * Insertion of right heart/pulmonary artery catheters * Endotracheal intubations |
| **SUPERVISORY RESPONSIBLITIES** | * PGY-1 Residents and Medical Students |

**Procedure Competency Requirements**

Safety is the highest priority when performing any procedure on a patient. It is also expected that a Resident will be thoroughly evaluated and credentialed as competent in performing a procedure before he or she can perform a procedure unsupervised. In order to perform a procedure under direct supervision, Residents must:

* Demonstrate competence in medical knowledge relevant to procedures through the candidate’s ability to explain indications, contraindications, patient preparation methods, sterile techniques, pain management, proper techniques for handling specimens and fluids obtained, and test results;
* Recognize and manage complications; and
* Clearly explain to a patient all facets of the procedure necessary to obtain informed consent.
* Be able to initiate a standardized preparation beforehand including hand washing, donning of sterile gloves, preparation of the procedural field, and application of some form of anesthetic.

**Program Procedural Preparation**

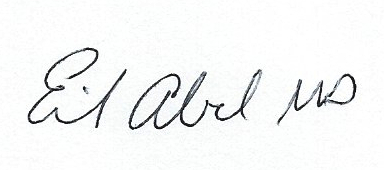
The residency program has a curriculum for providing knowledge and performance competence that is set forth below. All residents need to maintain current ACLS training.

All PGY-1 residents need to pass the GME central line training during orientation. All PGY-1 residents also have a procedure workshop in June of their PGY-1 year. During the PGY-1 year, all residents need direct supervision for the majority of procedures as listed in the table below. At the end of the PGY-1 year, residents have a final training workshop on core bedside procedures. Residents are given supervisory status as a 2nd, 3rd or 4th year resident after they have successfully completed procedure competency training and have completed 5 of the noted procedure. For those procedures that PGY-2, 3 or 4 residents have not achieved supervisory status, PGY-1 procedural guidelines should be applied.

Residents are also instructed to log their procedures in New Innovations (NI). Residents can log their procedures into NI as often as they like, but it must be done at least monthly.

|  | **Supervising Physician present (Direct)** | | **Supervising Physician available by phone or can come in (Indirect but direct supervision available)** | **The trainee may perform the procedure without supervising Attending/ resident (oversight)** |  |  |  |
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| Designated Levels | 1 | 2 | | 3 |  |
| **CORE PROCEDURES** | | | | | | **PGY-1 and first 4 months of PGY-2** | **PGY-2 (after first 4 months),3,4 resident** |
| Admit patients and complete inpatient H&P for wards and ICU | | | | | | 1 | 2 |
| Treat and manage common medical conditions | | | | | | 2 | 2 |
| Make referrals and request consultations | | | | | | 2 | 2 |
| Provide consultations within the scope of his/her privileges | | | | | | 2 | 2 |
| Render any care in a life-threatening emergency | | | | | | 3 | 3 |
| Initiate and manage mechanical ventilation for 24 hours | | | | | | 2 | 2 |

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| **Floor Procedures** | **PGY-1 and first 4 months of PGY-2** | **PGY-2 (after first 4 months),3,4 resident** |
| Abscess drainage | 1 | 2 |
| Arterial blood gas | 1 | 2 |
| Arterial line placement | 1 | 2 |
| Arthrocentesis | 1 | 2 |
| Aspirations and injections, joint or bursa | 1 | 2 |
| Bladder catheterization | 1 | 2 |
| Bone marrow aspiration | 1 | 1 |
| Bone marrow needle biopsy | 1 | 1 |
| Cardioversion, emergent | 1 | 3 |
| Cardioversion, elective | 1 | 1 |
| Central venous catheterization | 1 | 2 |
| Circumcision | 1 | 1 |
| Chest tube placement | 1 | 1 |
| Developmental screening tests | 3 | 3 |
| ECG interpretation panel, emergent | 3 | 3 |
| ECG interpretation panel, elective | 2 | 2 |
| Excisions of skin tags/other | 1 | 2 |
| Feeding tube placement (nasal or oral) | 2 | 2 |
| Flexible sigmoidoscopy | 1 | 1 |
| Gynecologic evaluation and exam | 2 | 3 |
| Injections – subcutaneous, intradermal and intramuscular | 3 | 3 |
| Intraosseous line placement | 1 | 3 |
| Liquid nitrogen therapy for skin lesions | 1 | 3 |
| Lumbar puncture | 1 | 3 |
| Pap smear | 2 | 3 |
| Pain management | 2 | 3 |
| Paracentesis | 1 | 3 |
| Pericardiocentesis (emergent) | 1 | 2 |
| Peripheral IV placement | 3 | 3 |
|  |  |  |
| **Floor Procedures** | **PGY-1 and first 4 months of PGY-2** | **PGY-2 (after first 4 months),3,4 resident** |
| Pulmonary function testing | 1 | 3 |
| Umbilical artery and vein catheterization | 1 | 1 |
| Swan-Ganz catheterization | 1 | 1 |
| Skin biopsy | 1 | 2 |
| Suturing | 2 | 2 |
| Thoracentesis | 1 | 2 |
| Tracheal intubation, emergent | 1 | 3 |
| Transcutaneous pacemaker | 1 | 3 |
| Tympanometry and audiometric interpretation | 3 | 3 |
| Tube thoracostomy | 1 | 1 |
| Venipuncture | 2 | 3 |
| Vision and hearing screen | 3 | 3 |
| Wound care | 2 | 3 |



10/11/23

Program Director Erika Abel, MD Date