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SCOPE OF PRACTICE

Neurological Surgery Residency
Director of Program: Mark S. Greenberg, MD, FAANS
USF Health Morsani College of Medicine
University of South Florida

This document pertains to resident rotations under the auspices of the Neurological Surgery Residency Training Program at Tampa General Hospital, James A. Haley VA, Moffitt Cancer Center, and Johns Hopkins All Children's. 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 AND POLICY

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 in the following circumstances, when faced with critical situations or uncertainties in patient care. These situations include, but are not limited to, instances involving patient upgrade to higher level of care, unexpected patient death, unexpected complication or event report, patient or staff request to speak with attending, or if the resident is harmed or threatened. 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. 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 Neurological Surgery Residency Program at the University of South Florida compliance guidelines.

Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.

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.

LEVELS OF SUPERVISION

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

Direct Supervision

1) The supervising physician is physically present with the Resident during the key portions of the patient interaction.
2) 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 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 after care is delivered.

RESIDENT ASSESSMENT AND EVALUATION

The residency program has a curriculum for providing knowledge and performance competence that includes direct procedural training, surgical training, and clinical training which is overseen by neurosurgical attendings. Due to the nature of the seven-year residency program, it is expected that residents will advance in the various competencies at different rates. Ultimately the overseeing attending is responsible for determining a resident's level of competence on a case-by-case basis, and the appropriate balance of oversight and autonomy specific to each patient care situation.

Annual decisions about competence are made by the program's clinical competency committee and Program Director to ensure a successful transition and preparation for the next PGY level. Residents will be evaluated based on the ACGME Neurological Surgery Milestones 2.0 on a semiannual basis, to give a general indication of personal abilities and achievements. However, these Milestones are meant to be used as a broad evaluation tool, and achievement of certain Milestones does not negate the necessity for oversight that is appropriate for the trainee and in the best interest of the patient. Residents should be able to identify and contact a responsible attending surgeon for a given patient at all times.

It is important that residents demonstrate an evolving level of knowledge, skill, judgement and autonomy over the course of their training, and attendings are encouraged to cultivate an environment that offers growth for trainees, while ensuring patient safety is the utmost priority. If at any time an attending determines that a resident is not performing, in a manner that is safe and consistent with expectations, that attending is responsible for following up with the program director to immediately relay any concerns and/or deficiencies. At that time, the Program Director may elect to adjust

that resident's training and/or oversite as needed to ensure patient safety. Changes in oversite should be brought to the attention of any faculty who may be supervising that resident, so they are aware and can adjust their supervision as needed.

All neurosurgery rotations, including outpatient clinics, are considered sites in which a resident may be actively involved in advanced life support, as either the lead physician or a participant. As such, all residents are required to maintain current ACLS and BLS certifications.

	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 for level of supervision required for each procedure and year of training					
Patient Management Competencies				**PGY-1**	**PGY-2**	**PGY-3**	**PGY-4**	**PGY-5**	**PGY-6**	**PGY-7**
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				1	1	2	2	3	3	3
Pre-operative evaluation and management, including history and physical examination, formulation of a plan of therapy, and specification of necessary tests				1	1	2	2	3	3	3
Evaluation and management of post-operative patients, including the conduct of monitoring, specifying necessary tests to be carried out, and preparing orders for medications, fluid therapy, and nutrition therapy				1	2	2	3	3	3	3
Transfer of patients between hospital units or hospitals				1	2	2	3	3	3	3
Discharge of patients from hospitals				1	2	2	3	3	3	3
Interpretation of laboratory results				1	2	2	3	3	3	3

	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 for level of supervision required for each procedure and year of training						
Initial evaluation and management of patients in the urgent or emergent situations, including urgent consultations, trauma, and emergency department consultations				1	1	2	2	3	3	3
evaluation and management of post-operative complications, including hypotension, hypertension, oliguria, anuria, cardiac arrhythmias, hypoxemia, change in respiratory rate, change in neurologic status, and compartment syndromes				1	1	2	2	3	3	3
Patient Management Competencies (continued)				**PGY-1**	**PGY-2**	**PGY-3**	**PGY-4**	**PGY-5**	**PGY-6**	**PGY-7**
evaluation and management of critically-ill patients, either immediately postoperatively or in the intensive care unit (ICU), including monitoring, ventilator management, specification of necessary tests, and orders for medications, fluid therapy, and enteral/parenteral nutrition therapy				1	1	2	2	3	3	3
management of patients in cardiac arrest (ACLS required)				1	1	2	2	3	3	3
Procedural Competencies				**PGY-1**	**PGY-2**	**PGY-3**	**PGY-4**	**PGY-5**	**PGY-6**	**PGY-7**
carry-out of basic venous access procedures, including establishing intravenous access				1	1	2	2	3	3	3

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Designated Levels	1	2	3	See below for level of supervision required for each procedure and year of training						
placement and removal of nasogastric tubes and Foley catheters				1	2	2	2	3	3	3
arterial puncture for blood gases				1	2	2	2	3	3	3
carry-out of advanced vascular access procedures, including central venous catheterization, temporary dialysis access, and arterial cannulation				1	1	2	2	3	3	3
repair of surgical incisions of the skin and soft tissues				1	1	2	2	3	3	3
repair of skin and soft tissue lacerations				1	1	2	2	3	3	3
excision of lesions of the skin and subcutaneous tissues				1	1	2	2	3	3	3
tube thoracostomy				1	1	2	2	3	3	3
paracentesis				1	1	2	2	3	3	3

Procedural Competencies (continued)	**PGY-1**	**PGY-2**	**PGY-3**	**PGY-4**	**PGY-5**	**PGY-6**	**PGY-7**
Advanced airway management (DC26) a) endotracheal intubation b) tracheostomy	1	1	2	2	3	3	3
Arterial line placement (DC27) -	1	1	2	2	3	3	3
Cervical Spine Traction (DC23)	1	1	2	2	3	3	3
CVP Line Placement (DC25)	1	1	2	2	3	3	3
External Ventricular Drain (DC21)	1	1	2	2	3	3	3

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Designated Levels	1	2	3	See below for level of supervision required for each procedure and year of training						
ICP Monitor Placement (DC20)				1	1	2	2	3	3	3
VP Shunt Tap/Programming (DC22)				1	1	2	2	3	3	3

Operative Procedures

For surgical cases done in the operating room, all PGY-1 residents require direct observation for the full duration of the case. For PGY-2 through PGY-7, level of oversight will be determined by the attending surgeon on a case-by-case basis based on the specific procedure, acuity of the patient, and other critical factors. At a *minimum*, there must be indirect supervision with direct supervision available.

Attending surgeons must be present pre-operatively for key points as defined by the current safety practices of that specific site, *e.g.* marking the patient, safety 'time-out', multi-disciplinary huddle, etc. *The exception to this would be emergent situations in which the attending physician is indirectly supervising and is en-route for direct supervision but has not yet arrived. In this instance, if it is determined that the patient requires immediate intervention prior to the attending physician's arrival the following should be clearly communicated between resident and physician: the patient's current status; the need for immediate intervention; and the surgical plan, including any critical point(s) that the resident should stop and wait for direct supervision.*

For instances where the attending surgeon will be providing indirect supervision throughout any portion of the case, the attending should clearly define for the resident the surgical plan and expectations, including the critical portions of the operation that the attending should be present to provide direct supervision.

Senior and Chief residents are expected to have a level of increasing autonomy that will generally require very little direct supervision, in order to prepare them for independent practice. However, it is still important that the critical portions of the case are clearly identified, and it is explicitly said whether or not the attending will be there for those portions of the case.

Residents are supervised by teaching staff in such a way to ensure that residents assume progressively increasing responsibility according to each residents' level of training and ability, as well as patient complexity and acuity. Faculty call schedules are structured to assure that support and supervision are readily available to residents on duty and all residents have direct access to attending pager, cell phone and home phone numbers. The quality of resident supervision and adherence to the above guidelines are monitored through annual review of the residents' evaluations of their faculty and rotations.

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Mark S. Greenberg, MD, FAANS
Program Director, Department of Neurosurgery

Date