Superiority Policy

1) This policy is in compliance with the following rules and regulations:
   a) SAMMC Bylaws
   b) SAUSHEC Resident Supervision Policy
   c) ACGME Emergency Medicine RRC
   d) Program policy for performance of procedures: The residency has created an electronic system that allows providers, nurses and administrative personnel to verify the procedure competence of each individual resident. We use the New Innovations residency tracking system to accomplish this task.

2) This policy applies to all physician residents and interns, PA residents and medical students performing patient care in the SAMMC Department of Emergency Medicine under the supervision of the faculty (attending) emergency physician or faculty EMPA.

3) It is SAUSHEC policy that any resident involved in a medico-legal or Risk Management (RM) case will notify the program director. In most cases, this can be through routine notification. The purpose is to ensure that the medico-legal or RM case is conducted in the context of the residency program and that the resident’s due process rights are protected.

4) Levels of Supervision. Proper supervision is a key concept of patient safety, resident education, and patient care. It is a system that allows graded authority and responsibility for the resident. Because of the volatile nature of emergency medicine practice, an attending physician is always in the ED 24/7; thus, direct supervision is always immediately available in person. As you progress in training and meet your milestones, supervision will become more indirect.
   a) Direct: the supervising physician is physically present with the resident and patient
   b) Indirect but immediately available: the supervising physician is within the hospital and immediately available by phone or person.
   c) Indirect but available: the supervising physician is not within the hospital
   d) Oversight: the supervising physician is available to provide a review of encounters with feedback provided after care is delivered.

5) Presenting patients: Generally speaking, all EM residents will present patients directly to staff. Medical student and off-service resident rotators will present their patients to the EM3. The EM3 will supervise a minimum of two rotators and no more than 3.
   a) Medical Students: Medical students will be directly supervised by the senior resident. Medical students can perform the initial H&P for educational purposes; however, the H&P must be repeated and documented by the senior resident as if the medical student never evaluated the patient. This is for patient safety, medico-legal, and coding/reimbursement reasons. Medical students will present all their patients to the
senior resident early on in the patient evaluation. If the patient is seriously (or potentially) ill, the student should immediately present the patient to the senior or faculty. Medical students cannot write orders. Students will discuss orders and review all lab and X-ray results with the senior residents. Faculty will provide indirect supervision with direct supervision immediately available for the senior resident. There will only be one assigned senior resident per pod, and the senior resident is responsible for orienting the medical student on rounds before shift. The medical student must disclose their student status to ALL PATIENTS.

b) EM1 Residents will present all their patients to the faculty early on in their evaluation of the patient. EM1’s will practice under direct supervision from the faculty member for the first half of their intern year, but supervision may become indirect with direct supervision immediately available during the second half of the year if they are meeting all of the level 1 milestones and a majority of level 2 milestones (as defined by the EM Clinical Competency Committee). If the patient is (or potentially is) seriously ill, the EM1 should immediately present the patient to the faculty. EM1 residents can write orders but should discuss with the faculty prior to ordering. Generally speaking, if the EM1 resident presents the patient to the faculty, he/she should direct all further management questions, results, etc. to the same faculty. This allows for continuity of care. For C pod shifts, there will be two supervising faculty physicians. Because of the size of the C pod and patient acuity, one C pod staff supervises patients seen in beds C22-29 and T5-7, and the other C pod staff supervises patients in beds 30-37 and T3-5. The EM1 will staff patients with the faculty assigned to these respective beds. This will be announced at board rounds at the beginning of shift. For B pod and A pod shifts, there will only be one staff providing supervision, and the EM1 will staff directly with them.

c) The EM2 and EM3 will be under indirect with direct supervision immediately available. The transition occurs as the resident meets all level 1 milestones and the majority of level 2 milestones as defined by the EM Clinical Competency Committee. EM2 and EM3 Residents may present their uncomplicated patients to the faculty physician when the final treatment plan and disposition are being formulated. The EM2 and EM3 should continually update the faculty during changes in the medical management of the patient. Complicated patients or potentially unstable patients should always be brought to the attention of the faculty early in the ED course. Because of the size of the C pod and patient acuity, one C pod staff supervises patients seen in beds C22-29 and T5-7, and the other C pod staff supervises patients in beds 30-37 and T3-5. The EM2 and EM3 will staff patients with the faculty assigned to these respective beds. This will be announced at board rounds at the beginning of shift. For B pod and A pod shifts, there will only be one staff providing supervision, and the EM2 and EM3 will staff directly with them.

6) Patient notification of the supervising physician: A whiteboard is mounted in all ED patient rooms. At the beginning of every shift, the nurse assigned to those beds will update the supervising physician’s name on the board and the supervising physician will ensure accuracy.

7) Co-signature:
   a) All charts of patients seen by medical students must have a complete H&P written by the senior resident supervising the case. The medical student may work as a scribe for the
EM3 provided the EM3 completed all elements of the H&P themselves. All student charts must be signed by the senior resident and faculty prior to the patient’s disposition.

b) All charts of patients seen by EM1 must be reviewed and have a note written by the faculty prior to the patient’s disposition.

c) Off-service intern rotators must have their orders co-signed by the senior resident or faculty before the clerk will place the order.

d) All charts of patients seen by EMPA residents will be cosigned either by the supervising faculty EMPA or faculty physician.

e) Residents are not privileged providers and can only provide patient care under the supervision of a privileged provider. For example, residents are not authorized to prescribe medications for anyone unless the patient is evaluated under the supervision of an attending physician and a formal chart is generated.

f) Residents who choose to practice any form of medicine outside of the program/institution (e.g., curbside treatment of your next-door neighbor while at home: strictly prohibited), whether for pay or not, are considered to be moonlighting. SAUSHEC GME and DOD Policy prohibit resident moonlighting.

g) The faculty physician will review all charts of patients seen by residents and students (all types), and the faculty of record will be noted on the chart. The faculty will attest to the level of supervision, the clinical findings, and the treatment plan. The level of supervision may vary by case complexity, milestone progression of the resident, and faculty comfort level. It is very important that the faculty attest to their level of involvement in the case. This may range from chart review and discussion of case (ie EM3 and/or lower complexity case), to completion of only critical elements of the H&P and discussion with resident (ie EM2), to completion of all elements of the H&P (new EM1 or student).

h) Residents are required to complete the documentation on the front and back of the first T-sheet. Residents are also required to write their medical decision-making on the left side of the faculty supervisor T-sheet. It is the resident’s responsibility to present the chart to the faculty in a timely manner for their review and signature. Faculty will review for any documentation deficiencies and provide feedback for improvement.

8) For patient safety reasons, it is the resident’s responsibility to notify the senior resident and faculty immediately:
   a) Upon the arrival of any critically ill patients
   b) Upon notification of any patient arriving by ambulance.
   c) Upon the arrival of any patient from another clinic or location
   d) Upon the need for sedation or administering vasoactive medications
   e) Critical findings on X-rays or EKG’s
   f) Prior to calling the consultant for admission
   g) Prior to any invasive procedures
   h) Prior to transfer to another facility
   i) Concerning any patient that refuses medical care or wishes to leave AMA
   j) Concerning any patient that has an adverse reaction or complication
   k) About all patients that are dissatisfied or disappointed with their ED treatment

9) Progression of Responsibility (See progression matrix below and summary sheet):
   a) Medical Students:
i) Medical students are always directly supervised. Depending on faculty discretion, the medical student may be directly supervised by a senior resident or attending physician. The supervising physician must complete all elements of the H&P themselves and document their findings.

ii) All patient encounters and significantly invasive procedures and exams (e.g., pelvic exam) performed by medical students assigned to the ED will be directly supervised by the senior resident on duty or the faculty physician.

iii) During each patient encounter the Medical Student will use the hospital two patient identifiers with each patient encounter. The student is also required while introducing him/herself to identify their role in the treatment team (eg. Medical Student (name))

iv) All orders will be reviewed and approved by the supervisor prior to implementation by the nursing staff.

b) Off-Service Rotators:

i) Off-Service Rotators (with exception of the pediatric pod R2) are at intern level of training; thus, the EM3 or the attending physician will always provide direct supervision.

ii) Orders from Off-Service rotators are required to be cosigned by either the EM3 or faculty.

c) EM1:

i) Provide patient care under the direct supervision of the faculty. EM1’s have a responsibility to keep the faculty informed immediately of all patient encounters. As the EM1 progresses to the intermediate resident level on milestone assessments, the supervision level may become indirect with direct supervision immediately available.

ii) Manage the airway on selected non-trauma resuscitations with direct senior/faculty supervision as appropriate and determined by the faculty. EM1’s will also be allowed to manage Routine Trauma airways when an appropriate level of experience has been documented via completed airway procedures (as documented in the procedure logger), or completion of an anesthesia rotation. However, the EM2 is always the resident responsible for the airway in MAJOR trauma activations.

iii) During each patient encounter the EM1s and R1s will use the hospital two patient identifiers with each patient encounter. Each resident is also required to identify their role in the treatment team while introducing him/herself to the patient.

d) EM2:

i) Will staff patients with the attending physician. The EM2 ED rotations are designed to allow progressive responsibility in the ED while under the indirect supervision of the EM faculty. Triage, patient flow patterns, and disposition decisions will be emphasized. Additional emphasis will be placed upon multiple simultaneous patient evaluations and construction of the foundation of the supervisory/administrative aspects of managing an ED. Direct supervision will be immediately available in person 24/7.

ii) The EM2 resident will update the EM3 and/or faculty on the clinical status of seriously ill patients and immediately bring administrative problems to the attention of the EM3 or faculty.

iii) During the second half of the academic year, the EM2 may be asked to assume the role of an EM3 with responsibility for junior resident supervision and the overall
functioning of their respective department pod. (See EM3 below for roles and responsibilities.)

iv) EM2’s may directly supervise medical students at the discretion of the attending physician if there is no EM3 assigned to that pod or the EM3 is saturated with more than 3 learners.

v) Manage the airway for major trauma resuscitations.

vi) If certified on the SAUSHEC EM EKG examination, EM2’s are authorized to interpret triage EKGs for the presence or absence of STEMI. The EM2 should also immediately report ischemic EKG’s that may be consistent with NSTEMI to the attending physician.

vii) During each patient encounter the EM2 will use the hospital two patient identifiers with each patient encounter. Each resident is also required to identify their role in the treatment team while introducing him/herself to the patient.

e) EM3:

i) During the EM3 year the resident is expected to take on increasing responsibility of running the ED. The role of the senior resident is to learn how to manage ED flow, supervise and teach junior learners, and to keep the faculty informed. The expectation is that by the end of their year they will have the ability to work independently in an emergency department. This responsibility includes direct supervision and instruction of at least 2 of the following providers; junior residents, off-service rotators or medical students. This generally includes directly supervising the off-service and medical student rotators. The EM3 should not supervise more than 3 learners on a single shift. At the beginning of every shift, the EM3 is expected to meet with the attending and discuss the supervision plan for junior residents and students. If there are too few learners on a particular shift for the EM3 to directly supervise, the EM3 is expected to see more patients on their own.

ii) The EM3 resident will serve as the team leader during the initial evaluation and stabilization of all critically ill patients. The ED faculty will directly supervise and provide a critique of all major resuscitations performed in the ED. Areas of critique include pre-code organization, management of resources, and maintenance of control and proper sequencing of therapeutic/diagnostic steps. He/she will be ready to assume technical procedures if difficulty is encountered by more junior house staff. As resuscitation leader, the EM3 will directly supervise the junior house staff in procedures, maintain overall responsibility for the patient, and provide a post resuscitation report and critique to all involved.

iii) The EM3 will function as the overall manager of the resident/student provider team in their pod. The EM3 is expected to know the status of all patients in the ED at any time. The EM3 will keep the faculty informed of all patient dispositions, whether it is discharge, consultation, or admission.

iv) The EM3 will be the primary consultant for, and verify history and physical exam findings of, all junior house staff for which he/she is responsible. He/she will audit and discuss errors or charting techniques on all patient charts that he/she had the responsibility of supervising, and will sign and write a note on these charts. Teaching and supervision of other providers will be performed in close cooperation with the faculty. The senior resident will evaluate junior residents, rotating interns and medical students using the standard shift evaluation form available on New Innovations.
v) The EM3 will assure that SOPs and administrative policies are carried out to include transfer of patients, ambulance, VIPs, etc. The EM3 is responsible for patient complaints during the shift, and should investigate and report them to the faculty on duty.

vi) The EM3 can receive the call for patient transfers from other facilities so long as they complete the transfer sheet and communicate effectively with faculty/charge nurse. The EM3 can provide online medical control for EMS on post.

vii) The EM3 will discuss all admissions first with the faculty and then with the admitting physician and approve movement of patients to the ward or unit. He/she will help coordinate all admissions through the respective service consultants and evaluate their stability for transfer to ICU or CCU.

viii) He/She will monitor patient volume and notify EM faculty when patient volume exceeds capacity.

ix) If the EM3 has passed the EKG competency assessment, they will be entrusted to assess, sign, and time stamp triage EKG’s for STEMI. The EM3 must immediately notify the faculty of all STEMI’s and activate the cath lab. The EM3 must also immediately notify staff of ischemic EKG’s. For any patient in triage with an ischemic EKG, the EM3 and faculty must communicate with the red rover nurse to ensure that patient is placed immediately in a bed.

x) The EM3 will be under indirect supervision with direct supervision immediately available. In order to help the senior resident become prepared for the independent practice of EM, sections of the department may be given to the senior to run independently, but the EM3 should always maintain open lines of communication with faculty.

xi) Because the goal for the EM3 year is to transition to independent practitioner, the EM3 should strive to see at least 2 patients per hour in C and B pod and 3 patients per hour in A pod. This is the community average. So long as the EM3 can practice safely, striving to surpass these community standards is encouraged. The attending physician will ALWAYS be available to assist. In the past, some residents have kept a sticker log to self-assess their progress.

xii) During each patient encounter the EM3 will use the hospital two patient identifiers with each patient encounter. Each resident is also required to identify their role in the treatment team while introducing him/herself to the patient.

Progression Matrix:
Summary of Supervision and Responsibility of Trainees and Supervisors in the ED
[Note that the documentation requirements shown in these tables reflect minimums from a GME and patient safety perspective. Requirements for billing may be different from depicted here.]

<table>
<thead>
<tr>
<th>Level</th>
<th>Key Aspects of Supervision</th>
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<tbody>
<tr>
<td>Medical Student</td>
<td>Early presentation of all patients to senior resident (SR) or faculty</td>
</tr>
<tr>
<td></td>
<td>SR/faculty will repeat all elements of the H&amp;P</td>
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<tr>
<td></td>
<td>All orders cosigned by SR/faculty</td>
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<tr>
<td></td>
<td>SR/faculty will write separate note and sign chart</td>
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<tr>
<td></td>
<td>Faculty to sign attestation statement of H&amp;P findings and cosign all charts</td>
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<table>
<thead>
<tr>
<th>Level</th>
<th>Key Aspects of Supervisory Responsibility</th>
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| Senior Resident (EM3s, and EM2s on selected shifts) | Direct POD resident team to optimize patient care and flow  
Maintain situational awareness of the waiting room and patients with excessive dwell times in the ED  
Maintain situational awareness of all critically ill patients in their POD  
Ensure a structured, safe, and effective handoff during transitions of care  
Supervise and teach juniors at the bedside and in team center  
Keep faculty informed of all patient dispositions  
Communicate effectively with nursing  
Write notes on all patients seen  
Provide feedback to your learners on things they did well and areas for improvement  
Faculty will cosign all charts |
| Faculty | Direct and indirect supervision for all trainees in ED  
Provide excellent bedside teaching to residents (1 minute preceptor model, for example)  
Encourage residents to think critically and allow autonomy commensurate with level of training and experience  
Provide feedback to resident on things they did well and areas for improvement—(written and verbal feedback in a timely manner)  
Assist your residents with administrative issues in order to optimize their learning experience  
Faculty will cosign and review all charts |