

**Orthopaedic Surgical Service
Brooke Army Medical Center
Resident Supervision Policy**

INTRODUCTION

The Resident Supervision Bylaws, as approved by the Medical Staff at Brooke Army Medical Center, represent BAMC's commitment to both medical education training and a commitment to providing quality care to patients with appropriate levels of supervision by privileged/credentialed staff. The Resident Supervision Bylaws define the rules, regulations, and process for supervision by a licensed independent practitioner with appropriate clinical privileges of each participant in the program in carrying out patient care responsibilities. Resident supervision must meet specific standards as specified by JCAHO and policies must specify the process of resident supervision in carrying out their patient care responsibilities. The clinic service chiefs and the program directors are responsible for the clinic and ward supervision policies and their application to residents, interns, and medical students.

GENERAL POLICY REGARDING PATIENT CARE

Quality, compassionate patient care is the heart of the medical profession. All clinical activities involving residents should be conducted with the well being of the patient uppermost. Teaching staff members are expected to act as role models in setting the standard for patient care, and residents are expected to adhere to these standards.

Technical competence and scientific knowledge do not, by themselves, constitute quality patient care. Quality involves communicating with the patient and family. Addressing questions and concerns raised, treating the patient with dignity and respect, and taking responsibility to assure appropriate follow-up and continuity of care. Throughout their training program, residents will be evaluated on their interpersonal skills as well as their knowledge and technical competence.

RESIDENT SUPERVISION POLICY

The Orthopaedic Service at BAMC believes that residency training is an educational experience designed to offer residents the opportunity to participate in the clinical evaluation and care of patients in variety of patient care settings. The goal of residency training is to develop resident physicians into independent practitioners by allowing increasing responsibility in the assessment of patients and in the development and implementation of therapeutic strategies. All aspects of patient care rendered by resident physicians must receive close supervision. All residents, as participants in graduate medical education, are supervised in their patient care responsibilities by a licensed independent practitioner who has been granted clinical privileges through the medical staff process. All patients under the care of the Orthopaedic Surgery Service have a staff orthopaedic surgeon who is ultimately responsible for the care of that patient. The staff

orthopaedic surgeon, as the licensed independent practitioner, will be physically present or immediately available during the patient encounter. **Under no circumstances is the resident to proceed on a path of patient care and management in which he/she is unclear, without first discussing the management with the supervising staff physician.**

All aspects of care are ultimately the responsibility of the staff orthopaedic surgeon and involved consultants. Staff orthopaedic surgeons have the right to prohibit resident participation in the care of their patients without penalty, and when allowing care of their patients by residents do not relinquish their rights and responsibilities to: examine and interview, admit and discharge their patients; write orders, progress notes, and discharge summaries; obtain consultations; or to correct resident medical record entries deemed to be erroneous or misleading.

When a resident is involved in the care of a patient, it is the resident's responsibility to communicate effectively with their supervising physician regarding the findings of their evaluation, physical examination, interpretation of diagnostic tests, and intended interventions on a continuous basis. As the resident acquires knowledge, experience, and surgical skill, they will be allowed increasing responsibility with appropriate supervision.

The role, responsibilities, progression, and patient care activities of participant's in professional graduate education (fellows, residents, interns, and medical students) on the orthopaedic service will be communicated in written form to the medical staff. Progressive involvement and independence in specific patient care activities by participants in professional graduate education will be determined by the participant's supervisor, Orthopaedic Surgery Residency Program Director and the senior Orthopaedic surgeon, typically the Chairman, Department of Orthopaedics and Rehabilitation. The mechanism by which a participant will be judged will include: interim formative evaluations of participants, end of rotation evaluations, accomplishment of rotation specific objectives, demonstrated levels of technical skill and surgical judgment, demonstration of competence, and meeting specific credentialing criteria. The competency of each participant will be documented as training progresses. Supervising staff will provide constructive feedback on medical care, documentation, and professional issues to those in training.

A formal evaluation process exists whereby the residents are evaluated as to knowledge, skills, and overall performance on a semi-annual basis. The teaching faculty will complete a standard evaluation from on a quarterly basis. This evaluation covers performance in cognitive, affective, and psychomotor domains. The teaching staff member comments on the individual's performance strengths and weaknesses. The results of these evaluations are discussed formally with the resident during semiannual counseling sessions. The resident is allowed to review the evaluation and make any comments regarding the evaluation on the standardized form. Finally, the resident is required to sign the evaluation acknowledging its content and form. The evaluation session is also utilized for the program director to obtain direct feedback from individual

residents regarding the current teaching faculty, academic program, and overall residency program. A brief synopsis of the resident's six month performance is then dictated and added to the permanent resident file.

Residents are also formally evaluated using standard forms and format after each outside rotation. The teaching staff at the respective outside institution completes these evaluations. Evaluations are discussed with the individual residents and are forwarded to the program director for inclusion in the permanent resident file. Upon completing all outside rotations, a formal counseling session is conducted whereby the program director obtains feedback from the resident regarding his/her experience during the outside rotation.

Resident performance is an agenda item at the bi-weekly staff meetings. Problems with individual resident performance are discussed at these meetings. Recurrent problems with individual residents may necessitate formal counseling statements that are placed in the individual's residency file.

Residents also receive formal Department of the Army evaluation reports annually. These are completed by the program director and are forwarded to the Department of the Army for inclusion in the resident's permanent Army file. A final written evaluation is completed for each resident who finishes the Orthopaedic Residency Training Program at Brooke Army Medical Center. This evaluation includes a review of the resident's performance during the final period of training and verifies that the resident has demonstrated sufficient professional ability to practice competently and independently. This evaluation is maintained as a permanent part of the individual's record and is maintained by both the Orthopaedic Residency Training Program as well as The Graduate Medical Education Department at Brooke Army Medical Center.

Rotating interns and medical students on the Orthopaedic Surgery Service also receive performance evaluations at the completion of their rotation. Standardized evaluation forms approved by the Institutional Graduate Medical Education Committee are used. The individual is counseled as to their performance during the rotation and is allowed to make comments regarding the evaluation. The intern or student is then required to sign the evaluation acknowledging its content and form. Finalized evaluations are forwarded to the Graduate Medical Education Office for inclusion into the student's education file.

Evaluation of the teaching staff and the academic program is conducted on a semi-annual basis (December and June). Each resident completes standardized forms for each full time teaching faculty member. To ensure anonymity, the forms are given to the Administrative Chief Resident. The Chief Resident compiles the information and transfers the information to a single evaluation form. This form is given to the residency secretary, who types the evaluation and forwards the completed evaluation to the program director. The program director then discusses the results of the evaluation with each of the respective teaching faculty members.

Residents are encouraged to discuss problems as they occur with the chief resident or program director with regards to the teaching environment and the residency program in general. Certainly, an “open door” policy exists whereby the residents can approach the program director at any time and express concerns and problems.

Residents and rotating interns or students have unlimited access to their own resident files and can review them at any time. The program director authorizes access to an individual’s file. He/she may review their file at any time. Access to other resident’s files is not permitted.

We remain committed to the education of these residents and therefore believe the evaluation process to be an integral adjunct to the resident’s education. Residents are advanced to positions of higher responsibility only on the basis of their satisfactory progressive scholarship and professional growth.

LEVELS OF COMPETENCE FOR ORTHOPAEDIC SURGERY RESIDENTS

1. The competency process is an ongoing process designed to facilitate the attainment of the goals and objectives of the Orthopaedic Surgery Residency Training Program and to document the progression in training. Although the credentialing process is largely based on graduated levels of technical skill and surgical judgment, appropriate levels of physical examination and other diagnostic skills, information gathering, and health care planning, as well as professional and personal ethics required for appropriate and complete patient care, are implied essential components of the process. A graduating resident should have attained the clinical judgment and technical skills required for staff credentialing (level 4b). Credentials will be maintained throughout the training period and will be forwarded to the appropriate Health Care Facility upon completion or termination of residency training.
2. Procedure competence will be based on general categories of procedures rather than performance of a specific operative procedure or number of specific procedures performed because of the very large number of separate procedures within the specialty of Orthopaedic Surgery and differences in individual training and case material. The performance levels will be used by the appointed staff supervisor in deciding the appropriate level of supervision required for a particular operation or procedure in addition to the actual experience of the resident in a particular procedure.
3. In general there are five (5) levels of competence, roughly paralleling the four (4) residency training years, with two (2) subdivisions for each level: a) performance with direct supervision, and b) without direct supervision. Performance without direct supervision would normally constitute credentialing for a supervisory role for the level of competence. Ability and experience of the individual resident will be used to determine the progress of individual residents rather than the year in training per se.

4. Levels of competence and typical procedures:

a. Level one: Arthrocentesis; wound debridement and closure; skin grafting; closed fracture manipulation; minor surgical procedures such as carpal tunnel release; simple arthrotomy; minor osteotomy/ostectomy; open reduction and or fixation of minor fractures; extensor tendon or partial tendon repair; and tendon or minor joint release.

b. Level two: Arthrotomy; arthroscopy of knee or ankle; major fracture reduction; open reduction and internal fixation of extremity fractures; ligament repair or reconstruction; tendon repair; osteotomy or ostectomy; joint manipulation; small joint arthroplasty or fusion; local soft tissue coverage procedures; and bone grafting.

c. Level three: Arthroscopy of upper extremity; hand, wrist, or foot arthroplasty or fusion; tendon transfers; nerve repair; distant soft tissue coverage procedures; major osteotomies or fusions; spine fusion without instrumentation; and open or needle biopsy.

d. Level four: Major joint arthroplasty; spinal fusions with instrumentation; open reduction and internal fixation of complex fractures such as the distal femur or proximal humerus; complex arthroscopic reconstruction and procedures; posterior decompression of the spine; arterial or venous repair; and nerve or tendon grafts.

e. Level five: These include procedures that are considered exceptions to the normal credentialing for Staff Orthopaedists at Brooke Army Medical Center. Residents under the direct supervision of properly credentialed staff physicians may perform these. An individual resident may have sufficient experience to be credentialed in one to these procedures by the end of training to be fully credentialed such as lumbar disc surgery, revascularization/replantation, and free tissue transfers.

Exceptions: Individual cases may be assigned to residents by staff supervisors as exceptions. An example would be lumbar disc excision. An individual resident might gain sufficient experience to be credentialed in a specific procedure but not at the higher level of overall credentialing.

The resident competency grid provides general guidelines to the levels of training and supervision and training considered generally appropriate for various procedures. ([Click here supervision grid](#))

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SURGICAL LOG

All residents are required to maintain a surgical log of all surgeries, closed manipulations of fractures, and soft tissue procedures in which they have participated. These are maintained on the ACGME database and include ICD-9 and CPT codes. The data collected should include patient name, hospital number (or SSN), date of the

procedure, procedure performed, attending physician, and whether the resident served as first or second assistant. All surgeries will be entered in the orthopaedic surgery data base. Failure to maintain the surgical log may result in sanctions, including suspension of surgical privileges.

For all emergency and inpatient consultations, the resident on call will initially evaluate individual patients. The care and management of the patient will be then discussed with the chief resident or teaching staff physician on call. If the chief resident evaluated the patient, ultimate care decisions must be discussed with the on call teaching staff physician prior to initiating treatment. The teaching staff physician will quickly respond to the hospital if required.

Ultimate responsibility in the operating room again rests with the teaching staff physician. The closeness of staff supervision in the operating room is determined by a number of factors, including: the resident's year of postgraduate training the skill and knowledge of the resident, the complexity of the patient's medical condition, and the difficulty of the procedure being performed. The attending teaching staff physician will have the responsibility of determining, on a case-by-case basis, the degree of independence exercised by a resident. Regardless of how much or how little independence is permitted, the final responsibility for all aspects of the patient's care remains with the teaching staff physician. The teaching staff physician responsible must be present in the operating suite for all operative cases under his/her care.

Further lines of responsibility for residents are discussed under resident expectations and goals for each year level of training and under descriptions of outside resident.

MEDICAL RECORDS/DOCUMENTATION

Part of the training of an orthopaedic surgery resident includes becoming proficient in documentation. The residents should make a concentrated effort to provide accurate, legible, and timely documentation of patient care provided. This includes admission notes, progress notes, discharge summaries, operative reports, and clinic notes. Every effort should be made to record patient care data in a consistent, coherent, and concise manner. Operative dictations must be completed within 24 hours of the operative procedure. Discharge summaries must be completed within 72 hours of the time of discharge from the hospital. Failure to complete medical records in a timely fashion may result in disciplinary actions to include suspension of clinical privileges.

The following is the minimum standard for inpatient documentation by staff members(LIP):

- The admission and history will edited and cosigned within 24 hours of admission
- A staff note will also be written when a significant change in occurs that affects patient care
- A staff note will be written prior to operative procedures
- A staff note will be written when complications occur
- Staff will sign discharge summaries, operative summaries, and the chart cover sheets

The following is the minimum standard for inpatient documentation by house staff:

- Medical students will be directly supervised. All inpatient medical record entries, including orders, will be signed immediately by house staff supervisor or by the supervising staff. The medical record should reflect house staff and supervising staff involvement in daily care of patient. For example “ patient seen with or discussed with (name of BAMC staff).
- Interns and Physician Assistants will be supervised by house staff working within their competency guidelines and by supervising staff. All orders must be cosigned immediately and all medical record entries must be cosigned within 24 hours by appropriate house staff or supervising staff. The medical record should reflect staff involvement in daily care of patient. For example “ patient seen with or discussed with (name of BAMC staff).
- Residents working within their competency guidelines, may write orders and make medical record entries under indirect supervision of a LIP (supervising staff member). The medical record should reflect staff involvement in daily care of patient. For example “ patient seen with or discussed with (name of BAMC staff).

The following is the minimum standard for outpatient documentation by staff members:

- All new consults will be seen or discussed with supervising staff. Medical records will reflect direct staff involvement in patient care either with a note from the staff member, or at least staff signature.

The Following is the minimum standard of outpatient documentation by house staff:

- Medical students will have direct supervision by house staff or supervising staff. All documentation will be cosigned by supervising staff and must reflect direct supervision. Example “ patient seen with and discussed with “ Dr. (name of house staff or staff).
- Interns and Physician Assistants will have direct supervision by house staff or supervising staff. All documentation will be cosigned supervising staff and must reflect direct supervision.
- Residents will have evidence of direct or indirect supervision documented on all clinical records for that visit. New visits will show evidence for direct staff involvement . Follow-up visits, if no complications or changes in stated care plan are present, may receive indirect supervision by supervising staff. All notes will be cosigned by supervising staff.

ORTHOPAEDIC OUTPATIENT CLINIC

The fracture clinic is staffed by a resident under the supervision of a teaching faculty member. The resident is expected to evaluate each patient and formulate an initial plan for the management of the patient’s condition. The plan is documented in the patient’s chart and the can be modified if the need arises depending on teaching staff input or progress of the patient. The resident has ample opportunity to perform closed manipulation of fractures, apply and remove casts, perform minor procedures, and manage a variety of acute injuries to the musculoskeletal system.

Subspecialty clinics are under the direct supervision of the assigned staff. Residents from all levels are involved in these clinics with graduated levels of responsibility.

A senior level resident on the team is scheduled a dedicated general orthopaedic clinic one day a week. During this clinic the resident has the opportunity to manage a variety of outpatient orthopaedic problems. This clinic allows the resident to have continuity of patient care and participate in the care of patients from preoperative evaluation through postoperative follow-up care. All new patients in the resident clinic are initially evaluated by the resident and a tentative plan is developed. The patient is discussed with the teaching staff assigned to the clinic and a definitive plan is initiated for the care of each patient.

CLINIC OPERATIONS

The physician responsible for overall clinic operations will be the assistant chief of orthopaedic surgery. Daily operations will be delegated to the clinic consultant, who is expected to remain available, and generally in the clinic area, for consultation and management decisions during the regular office hours.

Clinic Consultant Responsibilities:

1. Direct supervision of the intern or physician assistant assigned to carry the orthopaedic trauma call pager, and delegate/triage consults received from outlying clinics or the emergency department. When a patient is admitted, requiring emergent surgery, the clinic consultant will notify the on-call staff physician. Under no circumstances, should the clinic consultant leave his post in the clinic, without a replacement staff consultant.
2. Provide consultative advice/assistance to residents assigned the cast room or general clinics from their respective team, as well as occasional supervision of other team clinics. Additionally, the consultant will be responsible for assisting or advising the orthopaedic physician assistants seeing clinic on the respective days.
3. Provide direct supervision of the orthopaedic wound clinic, when it is available, and appropriate staffing is present (Health Technician, or LVN/RN).

OPERATING ROOM

The residents assigned to operative cases will be the primary surgeons. This privilege assumes that the resident has adequately prepared to perform the procedure. If such is not the case, or if the case is felt to be beyond the resident's capabilities, the teaching staff will perform the procedure and the resident will first assist the teaching staff member. Operative dictations are the responsibility of the resident surgeon, unless specified by the teaching staff member. A supervising staff orthopaedic surgeon will always be in direct supervision of resident staff. Operative dictations are to be dictated as soon as possible following the surgery, and always within 24 hours of surgery.

CONSULTATIONS

Inpatient consultations are the responsibility of the Chief Resident. Inpatient consults, whether emergent or not, have the highest priority and will be evaluated in a timely manner. The Chief Resident, and not his/her designee, is responsible for visiting the inpatient consult within 24 hours of receiving the consult, preferably the same day. Initiation of treatment will take place during this same time period. Inpatient consults will not be referred to a later clinic without an initial assessment of the patient. Outpatient consults will be reviewed by the Staff Orthopaedic Surgeon on call and a determination as to the urgency and timing of evaluation will be made. Patients will then be scheduled appropriately. Inpatient or outpatient consults will not be referred to a different team unless subspecialty expertise is required and the appropriate teaching staff member (Spine, Sports, Hand, Adult Reconstruction, etc.) has accepted the patient in transfer.

WEEKEND ROUNDS

Each inpatient on the orthopaedic surgery service will be seen by a resident from the appropriate team every day, including Saturday, Sunday, and holidays. On weekends and holidays, these patients will be seen no later than 0900 hours. Rounds will always be conducted in appropriate professional dress. Supervision of residents will be both via direct supervision and indirect supervision by a staff orthopaedic surgeon on call or by the physician of record. The call team will conduct morning report at 0700 on weekends and all non regular duty days with the staff on call in attendance and review all cases.

QI ISSUES AND COMMUNICATION TO MEDICAL STAFF AND GME

Daily morning report and weekly chiefs conference are held to address QI issues as they arise. Monthly orthopaedic service QI conference will be held to provide peer review of untoward events. Residents are expected to work within their competency guidelines. Both surgical and administrative events that are significant or sentinel in nature which have quality improvement or risk management implications will be discussed. Significant outlying events associated with resident provided care will be discussed at the monthly department of surgery QI meeting and referred to the medical staff and GME as appropriate. Residents and supervising staff are responsible for completion of the Quality Improvement/Risk Management Document BAMC FORM 1043 in a timely fashion.