

TRAINING PROGRAM SUPERVISION AND ACCOUNTABILITY POLICY

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Please reference complete UW GME Supervision Policy for additional definitions and background at:

<https://www.uwmedicine.org/education/gme/policies-and-procedures/supervision>

ADVANCED HEART FAILURE AND TRANSPLANT CARDIOLOGY (AHFTC) FELLOWSHIP

UNIVERSITY OF WASHINGTON MEDICAL CENTER

Responsibilities and Accountability

Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care. This information will be available through Qgenda, Epic, and/or the UW Page Operator to residents/fellows, faculty members, other members of the health care team, and patients.

The AHFTC fellows and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care.

The program will provide the appropriate level of supervision for each fellow based on each fellow's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation.

As part of their education program, fellows are given graded progressive responsibility according to the individual's clinical experience, judgment, knowledge and technical skill. Each fellow must know the limits of their scope of authority, and the circumstances under which the fellow is permitted to act with conditional independence.

Supervision Definitions

To promote oversight of fellow supervision while providing for graded authority and responsibility, the following levels of supervision are recognized:

1. Direct Supervision – the supervising physician is physically present with the fellow and patient.
 - a. the supervising physician is physically present with the <resident/fellow> and patient during the key portions of the patient interaction; or,
 - b. 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.
2. Indirect Supervision:
 - a) *with direct supervision immediately available* – the supervising physician is physically within the hospital or other site of patient care and is immediately available to provide Direct Supervision within 10 minutes.

- b) *with direct supervision available* – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities and is available to come to the site of care in order to provide Direct Supervision.
- 3. Oversight – the supervising physician is available to provide review of procedures/ encounters with feedback provided after care is delivered.

Resident Competence & Delegated Authority

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members.

The program director must evaluate each fellow’s abilities based on specific criteria, guided by the Milestones.

Faculty members functioning as supervising physicians must delegate portions of care to fellows based on the needs of the patient and the skills of each fellow.

Clinical Responsibilities by PGY-Level

PGY 7/8 - Advanced Heart Failure/Transplant Cardiology (AHFTC) Fellows

AHFTC Fellows are considered senior fellows and may be *directly or indirectly supervised*. They may provide direct patient care, supervisory care or consultative services, with progressive graded responsibilities as merited. Senior fellows should serve in a supervisory role to medical students, junior and intermediate residents, and junior fellows in recognition of their progress towards independence, as appropriate to the needs of each patient and the skills of the senior fellow; however, the attending physician is responsible for the care of the patient.

Levels of Supervision for Common Specialty Clinical Activities and Invasive Procedures

Please list each clinical activity/procedure by PGY-level, with specific CPR Level of Supervision language:

Clinical Activity/Procedure	Resident level (PGY 7/8)	UWMC	Supervision Level
Endomyocardial biopsies	PGY 7/8	UWMC	Direct supervision required by a qualified member of the medical staff
Intra-aortic balloon pump placement	PGY 7/8	UWMC	Direct supervision required by a qualified member of the medical staff
Percutaneous left/right ventricular assist	PGY 7/8	UWMC	Direct supervision required by a qualified

devices (e.g., Impella, TandemHeart, ECMO)			member of the medical staff
Pulmonary artery catheterization	PGY 7/8	UWMC	Indirect supervision required with direct supervision available by a qualified member of the medical staff
Central line and arterial line placement	PGY 7/8	UWMC	Indirect supervision required with direct supervision available by a qualified member of the medical staff
Pharmacologic stress testing	PGY 7/8	UWMC	Oversight required by a qualified member of the medical staff
Cardiopulmonary exercise testing	PGY 7/8	UWMC	Oversight required by a qualified member of the medical staff

Circumstances and Events in which Supervising Faculty Member (s) MUST be Contacted

When there is any doubt about the need for supervision, the attending should be contacted.

Supervision of Consults

Residents rotating on the cardiology service may provide consultation services under the direction of the supervisory fellow. The attending of record is ultimately responsible for the care of the patient and thus must be available to provide direct supervision when appropriate for optimal care and/or as indicated by individual program policy. The availability of the attending and supervisory fellow should be appropriate to the level of training, experience and competence of the consult resident and is expected to be greater with increasing acuity of the patient's illness. Information regarding the availability of attendings and supervisory fellows should be available to residents, faculty members, and patients.

Residents or fellows performing consultations on patients are expected to communicate verbally with their supervising attending at regular time intervals every day and page the supervising attending for all emergency consults. Any resident or fellow performing a consultation where there is credible concern for patient's life or limb requiring the need for immediate invasive intervention MUST communicate directly with the supervising attending as soon as possible prior to intervention or discharge from the hospital, clinic or emergency department so long as this does not place the patient at risk. If the communication with the supervising attending is delayed due to ensuring patient safety, the resident or fellow will communicate with the supervising attending as soon as possible. Residents or fellows performing consultations will communicate the name of their supervising attending to the services requesting consultation.

Additional specific circumstances and events in which residents or supervisory fellow performing consultations must communicate with appropriate supervising faculty members include:

1. All Patients: Hemodynamic instability including cardiogenic or vasodilatory shock
2. All Patients: Brady or tachyarrhythmias causing potential or actual hemodynamic instability

3. All Patients: Acute coronary syndrome with hemodynamic consequences
4. Heart Transplant Patients: Suspected cardiac rejection causing potential or actual hemodynamic instability.
5. MCS/LVAD Patients: Suspected device thrombosis or malfunction.

If the supervising individual does not respond in a timely manner, another faculty member or the section chief should be notified.

Emergency Procedures

It is recognized that in the provision of medical care, unanticipated and life-threatening events may occur. The fellow may attempt any of the procedures normally requiring supervision in a case where death or irreversible loss of function in a patient is imminent, and an appropriate supervisory physician is not immediately available, and to wait for the availability of an appropriate supervisory physician would likely result in death or significant harm. The assistance of more qualified individuals should be requested as soon as practically possible. The appropriate supervising practitioner must be contacted and apprised of the situation as soon as possible.

Faculty Supervision Assignment

Faculty supervision assignments are of 2-week duration and therefore are of sufficient length to assess the knowledge and skills of each fellow and to delegate to the fellow the appropriate level of patient care authority and responsibility.

Supervision of Hand-Offs

For the inpatient UWMC clinical services, fellows must provide verbal and written sign-out in a face-to-face discussion with the Cardiology nocturnist faculty member prior to leaving the hospital. Similarly, when arriving to the inpatient services, fellows must receive verbal/written sign-out in a face-to-face discussion with the Cardiology nocturnist faculty member upon arriving to the hospital. If fellows leave clinical services during the work day (conferences, ambulatory clinics, etc.), appropriate care hand-offs should occur with clinical care team members or providers to ensure continuity of care (i.e. nocturnist, ARNP or PA, co-fellow, resident) As documented in the ACGME's common program requirements, programs must design clinical assignments to minimize the number of handoffs and must ensure and monitor effective, structured handoff processes to facilitate both continuity of care and patient safety. Fellows must be competent in communicating with team members in the hand-off process.