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| *Section:* **School of Medicine (Phoenix)** | | *NO.* | | | | |
| *Chapter:* **Emergency Medicine (Phoenix)** | *Issued: 3/11/20* | *REV. A 11/2/2020* | *REV. B* | *REV. C* | | |
| *Policy:* **Resident Supervision** | | *Page 1 of 16* | | | | |

**PURPOSE**
In compliance with the ACGME Institutional and Common Program Requirements, it is the goal of Creighton University to outline the types of leave available to the residents and fellows of Creighton University.

**SCOPE**
This policy applies to all Creighton University School of Medicine (Phoenix) residents in the Emergency Medicine Residency Program..

**DEFINITIONS**
To ensure oversight of resident supervision and graded authority and responsibility, the program uses the following classification of supervision:

- Direct Supervision – the supervising physician is physically present with the resident and patient.
    - This applies to all patients seen within the emergency department.
- Indirect Supervision 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.
    - This applies to the majority of patients seen outside of the emergency department.
- Indirect Supervision 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 provide direct supervision.
- Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.
- Resident in Charge (RIC) – senior resident providing a supervisory experience with graduated responsibility as needed for educational development of emergency medicine residents

**OVERVIEW**
Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

Supervision may be exercised through a variety of methods (e.g. more advanced resident or fellow). However, within the ED, the supervising attending is immediately available 24 hours a day.

Structured Chain of Responsibility for Supervision

In the clinical learning environment of the emergency department, each patient has an identifiable, appropriately credentialed and privileged attending physician (or licensed independent practitioner)

*In the event of any discrepancies between program policies and the GME policy, the GME policy shall govern.*

who is ultimately responsible for that patient's care. However, every physician shares in the responsibility and accountability for their efforts in the provision of care.

- All residents must function under the direction of an attending physician. Herein, the "team" seeing the patient is composed of the resident and board eligible/certified attending physician.
    - Within the ED this information is available to residents and faculty members at change of shift within the physician's documentation area (i.e. "doc box"), and patients through dry erase boards which are present within different treatment areas of the department.
    - Residents and faculty must inform the patient (whenever possible) of their role in the patient's care.
    - Each resident must know the limits of his/her scope of authority and the circumstances under which he/she is permitted to act with conditional independence as outlined in the policy.
    - The attending is to direct patient care and provide the appropriate level of supervision based upon the patient's condition, the likelihood of major changes in the management plan, the complexity of the care and the experience and judgment of the resident being supervised.
    - Attending physicians are encouraged to delegate portions of care to residents, based on the needs of the patient and the skills of the residents provided that this does not interfere with work hour requirements or cause excessive work demands during clinical shift.
    - Resident responsibility is graduated. Residents are given progressive responsibilities in both the clinical as well as the didactic curriculum based on level of training outlined at the end of this section.
    - The attending physician has the ultimate responsibility for the patient and their care provided.

**POLICY**

The Resident Supervision Policy is outlined below, along with a link to access Creighton University policy.

## PROGRESSIVE RESPONSIBILITY & SUPERVISION POLICY

Overview:

The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident physician to assume personal responsibility for the care of individual patients. For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept--graded and progressive responsibility--is one of the core tenets of graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.

- Supervision shall be provided for all residents in a manner that is consistent with proper patient care, the educational needs of residents, and the applicable with the Accreditation Council of Graduate Medicine Education (ACGME) and Emergency Medicine Residency Review Committee Program Requirements (EM-RRC).
- Program-specific policies are in compliance with the institutional policy outlined herein as well as standards outlined by the EM-RRC.

- The program director is responsible for communicating the written description of supervisory lines of responsibility to all residents and all members of the teaching staff at all clinical training sites. Such communication should be done annually.
- The program director is responsible for reviewing the level of resident responsibilities at least annually with each resident at the time of the semi-annual review. Changes in the level of responsibility and exceptions to standard responsibilities shall be documented in the resident's departmental file.
- The program director is responsible for ensuring that each resident is appropriately supervised regardless of the training site to which the resident is assigned.

- Residents will be supervised by teaching staff in such a way that the residents assume progressively increasing responsibility according to their level of education, ability, and experience. The level of responsibility shall be determined by the program director and teaching staff.

## LEVEL SPECIFIC COMMUNICATION GUIDELINES FOR PATIENT CARE

The following are guidelines for circumstances and events in which residents must communicate activities involved in patient care with the supervising Resident In Charge (RIC), faculty member. This also provides the framework under which the resident is permitted to act with conditional independence.

- EM1: Presentation of patients to RIC and/or supervising attending after evaluation but prior to initiation of diagnostic tests and/or performing procedures
- EM2: Presentation of patients to RIC and/or supervising attending after evaluation and initiation of diagnostic tests and/or performing procedures with the expectation that the RIC and/or attending will review the aforementioned after evaluating the patient.
    - Unstable patients are to be discussed immediately prior to initiation of diagnostic tests and/or performing procedures
- EM3: Presentation of patients to the supervising attending when they are ready to be dispositioned.
    - Unstable patients are to be discussed immediately after initiation of diagnostic tests but before performing procedures

## EM-1 DELINEATION OF RESIDENT RESPONSIBILITIES

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| **SUPERVISION OF JUNIOR LEARNERS** | NONE |
| **PROGRESSIVE RESPONSIBILITY FOR PATIENT MANAGEMENT (CLINICAL)** | |

Perform comprehensive history and physical exam (PC, ICS, P)
Prioritize care based on the patient's level of acuity and/or time within the Department (SBP)
Presentation of patients to EM3 resident or supervising attending after evaluation but prior to initiation of diagnostic tests and/or performing procedures (PC, ICS, P, MK) Assure that the patient has been seen by an attending prior to disposition (SBP)
Understand the pathophysiology and treatment of common emergency medicine complaints (MK)
Learn basic principles governing the emergency management to the undifferentiated patient (PC, MK)
Develop basic technical skills including IV insertion, bladder catheterization, nasogastric tube placement, female genitourinary/pelvic examination, arterial blood gas, wound repair, regional anesthesia, anterior/posterior nasal packing, central venous access, bedside ultrasound, splinting, joint and fracture reductions, arthrocentesis, I & D, lumbar puncture, obstetric delivery, intubations, and slit lamp/tonopen examination (PC, MK).
Document patient encounters on templates (SBP)
Manage ~1.0 patient per hour (on average) (PC, SBP)
Perform vascular access and defibrillation/cardioversion during resuscitations (PC, SBP)

## DIDACTIC RESPONSIBILITY

Develop basic skills in literature review (PBL, MK)
Review emergency medicine literature (PBL, MK)
Attend ≥ 75% of weekly didactic (MK, PBL, SBP, P)
Present assigned lectures as detailed below (MK, PBL, P, SBP, PC, ICS)

The resident will be responsible to present **3 cumulative hours** of lectures during the academic year as assigned by the chiefs/program leadership. This includes but is not limited to M&M, core lecture, Copa Quick Hit, etc.

***Electronic copies of each lecture will be submitted to the Program Director & Associate Program Director (Dr. Narang) for review 1 week prior to the assigned lecture.

- Failure to submit the lecture for review 1 week in advance will result in a letter of deficiency being placed in the resident file.
    - Continual lack of adherence to this will result in the resident being placed on professional concern and the matter referred to the graduate medical education committee and designated institutional officer.

- A final electronic copy will be submitted to the Program Coordinator for archival for the RRC.
- Residents will also be required to submit ECG's and radiographs each month to the Chief Resident for ECG Rounds and Radiology rounds.

## ADMINISTRATIVE RESPONSIBILITIES

Be evaluated on daily shift evaluation card (MK, PBL, P, SBP, PC, ICS)
Be evaluated on the clinical competencies of headache, procedural competency of central venous insertion (MK, PBL, P, SBP, PC, ICS)
Complete end of rotation evaluation and peer evaluations (P, ICS)
Complete institutional mandates (P, SBP)
Participate in resident recruitment lunches/dinners (ICS)
Participate in resident meetings (ICS, SBP)
Complete PBLI log (PBL)
Maintain accurate and complete procedure and resuscitation logs (PC, P)
Report duty hours into web based program and notify Program Director of any potential violations (P)
Contact program director/chief resident if sick to allow for sick call coverage (P)
Complete annual program, ACGME, and faculty evaluations (P)
Take ABEM in-service examination (MK)
Attend a minimum of 4 quality improvement/patient safety meetings (PC, ICS, SBP)
Initiate a Quality Improvement & Patient Safety (SBP) ●

Identify project and begin active involvement.

- The resident may participate in existing departmental health care delivery projects or may provide a written proposal for a new project.
- All new projects require the approval of the quality improvement and/or program director.

Scholarship (PBL, SBP, MK)

- Identify a scholarly project, establish role in project, present status of project at residency conference and provide documentation to file.

| **EM-2 DELINEATION OF RESIDENT RESPONSIBILITIES** | |
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| **SUPERVISION OF JUNIOR LEARNERS** | Supervise fourth year medical students during last six months of academic year (PC, P, MK, ICS) in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident. |

| **PROGRESSIVE RESPONSIBILITY FOR PATIENT MANAGEMENT (CLINICAL)** |
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| Obtain history and physical exams in a complete and efficient manner (PC, ICS, P)<br>Self-assign patients and prioritize patient care according to acuity and time (SBP) Presentation of patients to EM3 resident or supervising attending after evaluation and initiation of diagnostic tests and/or performing procedures (PC, ICS, P, MK) with the expectation that the senior resident and/or attending will review the aforementioned after evaluating the patient (SBP)<br>Perform invasive procedures during emergency department resuscitations (PC)<br>Understand the pathophysiology and treatment of common emergency medicine complaints (MK)<br>Develop skill in the evaluation and management of the emergency management of the undifferentiated patient (PC, MK)<br>Develop skill in the simultaneous management of multiple patients, including critically ill (SBP)<br>Assure that the patient has been seen by an attending prior to disposition (SBP)<br>Develop advanced technical skills including endotracheal intubation (including the use of adjunctive modalities), pericardiocentesis, thoracentesis, tube thoracostomy,<br>cricothyroidotomy, conscious sedation, central venous lines for central venous pressure measurement and hemodialysis (PC, MK)<br>Develop and understand factors affecting the efficient function of the emergency department (SBP)<br>Manage ~1.5 cases per hour (on average) (PC, SBP)<br>Perform airway management during resuscitations (PC) Dictate<br>medical records (SBP) |

## DIDACTIC RESPONSIBILITY

Develop basic skills in literature review (PBL, MK)
Review emergency medicine literature (PBL, MK)
Attend ≥ 75% of weekly didactic (MK, PBL, SBP, P)
Present assigned lectures as detailed below (MK, PBL, P, SBP, PC, ICS)

The resident will be responsible to present **3 cumulative hours** of lectures during the academic year as assigned by the chiefs/program leadership. This includes but is not limited to M&M, core lecture, Copa Quick Hit, etc.

***Electronic copies of each lecture will be submitted to the Program Director & Associate Program Director (Dr. Narang) for review 1 week prior to the assigned lecture.

- Failure to submit the lecture for review 1 week in advance will result in a letter of deficiency being placed in the resident file.
    - Continual lack of adherence to this will result in the resident being placed on professional concern and the matter referred to the graduate medical education committee and designated institutional officer.
- A final electronic copy will be submitted to the Program Coordinator for archival for the RRC.
- Residents will also be required to submit ECG's and radiographs each month to the Chief Resident for ECG Rounds and Radiology rounds.

| **ADMINISTRATIVE RESPONSIBILITIES** |
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| Be evaluated on daily shift evaluation card (MK, PBL, P, SBP, PC, ICS)<br>Be evaluated on the clinical competencies of abdominal pain, procedural competency of endotracheal intubation, and resuscitation (MK, PBL, P, SBP, PC, ICS)<br>Complete end of rotation evaluation and peer evaluations (P, ICS)<br>Complete institutional mandates (P, SBP)<br>Participate in resident recruitment lunches/dinners/tours (ICS)<br>Participate in resident meetings (ICS, SBP)<br>Complete PBLI log (PBL)<br>Contact program director/chief resident if sick to allow for sick call coverage (P)<br>Maintain accurate and complete procedure and resuscitation logs (PC, P)<br>Report duty hours into web based program and notify Program Director of any potential violations (P)<br>Complete annual program, ACGME, and faculty evaluations (P)<br>Take ABEM in-service examination (MK)<br>Attend a minimum of 4 quality improvement/patient safety meetings (PC, ICS, SBP)<br>Implement quality improvement/patient safety project (SBP) ●<br>Active involvement in the implementation of project.<br>Scholarship (PBL, SBP, MK)<br>● Complete topic review draft with a complete bibliography of scholarly project ●<br>Alternatively, selection and participation in the national CPC competition. |

| **EM-3 DELINEATION OF RESIDENT RESPONSIBILITIES** | |
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| **SUPERVISION OF JUNIOR LEARNERS**<br><br>**RIC GUIDELINES** (please see below) | Supervise fourth year medical students, EM-1's, and rotating junior residents from other services (PC, P, MK, ICS) in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident. |
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**PROGRESSIVE RESPONSIBILITY FOR PATIENT MANAGEMENT (CLINICAL)**

Coordinate patient flow through the department (SBP)
Direct the majority of resuscitations (MK, PC)
Demonstrate a high level of skill and efficiency in the performance of all ED procedures (PC)
Supervise junior residents as they perform procedures (MK, PBL, PC, P, ICS)
Demonstrate the ability to function semi-independently, directing and supervising all aspects of patient care (SBP, PC, MK, ICS, P)
Assure all patients are presented to and seen by an attending prior to discharge (SBP)
Broaden and enhance knowledge base in all aspects of EM, both clinical and nonclinical (MK, PBL)
Understand the pathophysiology and treatment of common emergency medicine complaints (MK)
Develop knowledge of education and teaching principles and demonstrate skills of clinical teaching (P, ICS, MK, PBL)
Develop knowledge of ED administrative principles and demonstrate ability to perform common administrative responsibilities of an emergency physician (SBP)
Manage ~2.0 cases per hour on average
Demonstrate proficiency of dictation of medical records (SBP)

**DIDACTIC RESPONSIBILITY**

Expand knowledge of research principles (PBL, MK)
Develop knowledge of education and teaching principles and demonstrate skills of clinical teaching (P, ICS, MK, PBL)
Present medical student lectures (MK, ICS, P)
Attend ≥ 75% of weekly didactic (MK, PBL, SBP, P)
Present assigned lectures as detailed below (MK, PBL, P, SBP, PC, ICS)

The resident will be responsible to present **3 cumulative hours** of lectures during the academic year as assigned by the chiefs/program leadership. This includes but is not limited to M&M, core lecture, Copa Quick Hit, etc.

***Electronic copies of each lecture will be submitted to the Program Director & Associate Program Director (Dr. Narang) for review 1 week prior to the assigned lecture.

- Failure to submit the lecture for review 1 week in advance will result in a letter of deficiency being placed in the resident file.
    - Continual lack of adherence to this will result in the resident being placed on professional concern and the matter referred to the graduate medical education committee and designated institutional officer.
- A final electronic copy will be submitted to the Program Coordinator for archival for the RRC.
- Residents will also be required to submit ECG's and radiographs each month to the Chief Resident for ECG Rounds and Radiology rounds.

## ADMINISTRATIVE RESPONSIBILITIES

Be evaluated on daily shift evaluation card (MK, PBL, P, SBP, PC, ICS)
Be evaluated on the clinical competencies of chest pain and procedural competency of FAST examination (MK, PBL, P, SBP, PC, ICS) and resuscitation. Complete end of rotation evaluation and peer evaluations (P, ICS)
Complete institutional mandates (P, SBP)
Participate in resident recruitment lunches/dinners/tours (ICS)
Participate in resident meetings (ICS, SBP)
Complete PBLI log (PBL)
Contact program director/chief resident if sick to allow for sick call coverage (P)
Maintain accurate and complete procedure and resuscitation logs (PC, P)
Report duty hours into web based program and notify Program Director of any potential violations (P)
Complete annual program, ACGME and faculty evaluations (P)
Take ABEM in-service examination (MK)
Attend a minimum of 4 quality improvement/patient safety meetings (PC, ICS, SBP) Present a previously approved, completed quality improvement/patient safety project with suggestions for future improvements to the project (ICS, SBP)
Scholarship (PBL, SBP, MK)

- Submission to resident file of a completed manuscript (including CPC case manuscript), that is approved by the research director and the program director.
- **One adequate scholarly project, approved by the research director/program director, is required for graduation** .

## RESIDENT IN CHARGE (RIC) GUIDELINES

### Role Description

The overall goal of the Resident in Charge (RIC) role is to provide a supervisory experience with graduated responsibility as needed for educational development of emergency medicine residents and required by the emergency medicine Residency Review Committee.

**Coverage**: 24/7 (protected during conference)

### RIC Checklist

- Arrive early to assist the R2 to check front room supplies.
- Write your name on the whiteboard in front of the HUC and assume responsibility for the x8656 ASCOM.
    - At the beginning of shift, the RIC is to meet with the charge physician, triage physician (if applicable), CRL and front room nurses to make those individuals aware that they are the RIC for the shift and to discuss department flow and strategy.
- The RIC is also responsible to meet with the CRL at the midpoint of their shift. The expectation is that your communication will be ongoing rather than occurring at discrete intervals so as to assume primary responsibility for the department.
- Manage departmental flow, assign front room patients to junior residents, identify cases for medical students, work collaboratively with the Teach resident, and maintain continuous contact with the attendings and CRL.
- Ensure trauma packets are signed and submitted.
- Meet with oncoming RIC regarding departmental strategy and amend if necessary.

### Responsibilities of RIC

- Oversee all patients in the front/trauma room and help with overflow and issues in ED. With time, experience, and flow the scope of oversight will grow (i.e. primarily staff patients, monitoring of back patients).
- Front room / critical care patients
    - RIC will perform the front room check to ensure all equipment is ready for critical
    - patients.
    - They will have the option of seeing patient primarily or assigning a PGY-1/2 as primary resident - PGY-2 will have first pass at patient.
        - Medical students may be involved in the cases for education (but not as primary).
        - **PGY-1 Primary**– RIC will directly supervise the case including presentation, plan, and management. RIC will communicate plan with

the front room attending. RIC will be responsible for teaching to PGY-1. Additionally, attending will teach 1 point about case with PGY-1.

- **PGY-2 Primary** – RIC will receive frequent updates from the PGY-2 but PGY-2 will present and communicate directly with attending. RIC will assist with procedures as needed; some procedures may be designated to the RIC instead of the PGY-2 at the attending discretion (e.g., known difficult airways). This will be similar to a teach role.
- **RIC/PGY-3 Primary** – RIC will function as primary provider. RIC may handoff procedures to junior resident, and involve others for educational purposes.
  - Documentation is to be done by primary resident (except for procedure notes)
  - Procedures are to be performed by primary resident except in rare circumstances where a specific resident is specifically designated by the front room attending

- Trauma activations
  - Captain/Survey Days (even calendar days after 6:00 AM) – RIC will captain or will designate a PGY-2 to captain; RIC will appoint survey resident (usually a PGY-1 or PGY-2). RIC will oversee case and help PGY-2 with plan and management, but PGY-2 will present and communicate directly with attending. RIC will assist with procedures as needed. This will be similar to a teach role
  - Procedure Days (odd calendar days after 6:00 AM) – RIC will act as procedure resident or will designate a PGY-2 to act in this role
  - Green Traumas – RIC will act as captain or will designate a PGY-2 to captain; RIC will appoint survey (usually a PGY-1 or PGY-2). RIC will oversee case and help PGY-2 with plan and management, but PGY-2 will present and communicate directly with attending. RIC will assist with procedures as needed. This will be similar to a teach role.
    - Documentation: Designated Captain is in charge of ensuring that all trauma paperwork is complete and will follow up all results and dispo the patient
    - Procedures: Designated Captain (exception: rare circumstances where a more senior resident is designated by the attending)

- Back room patients
  - RIC will be responsible for seeing back patients primarily as needed to maintain flow. Expectation will be that if there is a need the RIC will see *at least* 1-2 back patients for every front patient they supervise.
- Medical student patients
  - If no teach is available, RIC will directly supervise medical student patients or appoint a PGY-2 or PGY-3 resident to assist the medical student for the day (e.g., multiple medical students)

- RIC will help identify patients for medical students to see.
- When there is NOT a Teach resident,
  - Student will present to RIC and attending
  - RIC and attending will provide teaching and plan to student
  - Student and attending will write notes in Epic
  - RIC will write a brief supervision note as well as document all procedures
  - Procedures will all be done with attending, RIC or designee
  - RIC and attending will be responsible for orders and discharge paperwork

- Triage
  - During Triage Attendings Hours (weekdays 9a-9p, weekends 1p-9p)
    - RIC will work with triage attending to evaluate EKGs and place patients
  - No Triage Attending Hours
    - RIC will serve in some of the triage functions
      - Evaluate EKGs
      - Help with placement of patients
      - Leveling of Traumas
      - They will *not* function as the triage doc to see every patient
- Off-service rotators
  - RIC will directly supervise the case including presentation and plan and management
  - RIC will communicate plan with the attending. RIC will be responsible for teaching to off-service rotator (when there is not a Teach resident)
  - Additionally, attending will try to teach 1 point about case with off service rotator
  - Documentation: to be performed by the off service rotator
- Flow
  - RIC will be responsible to manage flow and volume with oversight of the front room attending
  - RIC will work with charge nurse (clinical resource leader, CRL) to help troubleshoot flow and throughput issues
  - RIC will meet at least twice per shift with CRL to help troubleshoot flow and throughput issues
    - Meet with CRL at 7:15 AM & 7:15 PM, as well as half-way through resident shift
  - High flow/surge volume: Trigger for this will be flexible but more than 5 patients in room waiting an hour for primary provider or more than 8 patients in rack

- Options include:
  - RIC assigning resident primary providers (i.e., handing out charts)
  - RIC changes to a primary provider role as front room resident who helps by also seeing patients in the back as well
  - RIC triggers the D1 resident into "fast track mode" to clear out fast-track patients
- All issues with flow and RIC: Dr. Epter should be notified by email with details of events

- Documentation
  - RIC will write notes all patients they serve as primary and all procedures they perform as primary
  - RIC will write brief supervision notes on all medical student cases in addition to notes written by attendings supervising the medical students
    - Supervision note will consist of brief MDM section with relevant H&P elements as needed.
    - Example
      - 21 y/o G2P1 at 11 WGA by U/S 2 weeks ago, presenting vaginal bleeding for 3 days, VSS, abd non tender, os closed, US show IUP with FHR 140, hgb WNL, will d/c with OB follow up
- Communication
  - At the start of each shift, update whiteboard by back nursing desk with roles
  - RIC will hold the x8656 phone at all times
  - RIC and CRL will communicate frequently (see above)
- Transitions of Care/Sign Out
  - RIC to RIC
    - Primary to Primary
- Evaluation of RIC
  - Faculty will provide feedback of residents to PD/APD
  - PD/APD will provide rotation evaluation

The policy and 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.

- The program director must evaluate each resident's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.

*In the event of any discrepancies between program policies and the GME policy, the GME policy shall govern.*

- Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.
- 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.

Programs must set guidelines for circumstances and events in which **residents must communicate with appropriate supervising faculty members,** such as the transfer of a patient to an intensive care unit, or end-of-life decisions.

- Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.
    - In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.

Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.

**REFERENCES**

American Board of Emergency Medicine: https://www.abem.org/public

ACGME
Creighton University GME Policy link:
https://medschool.creighton.edu/sites/medschool.creighton.edu/files/gme-resident-supervision.pdf

**AMENDMENTS OR TERMINATION OF THIS POLICY**

Creighton University reserves the right to modify, amend or terminate this policy at any time.