Department of Medicine

Faculty Responsibilities

Inpatient Medicine Wards and Intensive Care Unit

Supervision Policy

I. Overview

a. The residency program is required to be in compliance with the rules and regulations set forth by the Accreditation Council for Graduate Medical Education (ACGME). The program and institution is reviewed on a regular basis by the ACGME appointed Residency Review Committee (RRC) and the ACGME appointed Clinical Learning Environment Review (CLER) group, respectively. This policy is made in conjunction with the Housestaff Supervision Policy found on the Olive View-UCLA Medical Center intranet under GME.

b. Teaching faculty member are responsible for reviewing the following ACGME document:
   i. Appendix 1

II. Level of Supervision and Availability of Supervising Physicians

a. Supervising physicians will direct the care of the patient and provide the appropriate level of supervision based on the complexity of care and the experience, judgment and level of training of the resident physician being supervised.

b. Supervising physicians have the responsibility to enhance the knowledge of the resident physician and to ensure the quality of care delivered by any resident physician. This responsibility is exercised by observation, consultation and direction. It includes the imparting of the supervising physician's knowledge, skills and attitudes to the resident physician and assuring that care is delivered in an appropriate, timely and effective manner. Fulfillment of such responsibility requires personal involvement with each patient and each resident physician who is providing care. Supervising physicians should act professionally and as a role model for resident physicians. (UCLA GME Faculty Supervision Policy)

c. To ensure oversight of resident physician supervision and graded authority and responsibility, the following classifications of supervision are used:
   i. *Level 1/Direct Supervision*: The supervising physician is physically present with the resident physician and patient during the clinical encounter. The supervising physician may be a credentialed house officer or faculty (attending physician).
   ii. *Level 2A/Indirect Supervision*: Defined as immediate availability from on-site supervising physicians.
   iii. *Level 2B/Indirect Supervision:* Defined as immediate availability from off-site supervising physicians. In this role the supervising physician must be immediately available for consultation by phone and must be able to be on-site within 1 hour.
   iv. *Level 3/Oversight*: Defined as non-immediate availability of the supervising physician to provide review of clinical encounters after care is delivered. In this role supervision is typically delivered through presentation and discussion or documentation review.

d. Resident physicians must be supervised according to level of training (following the specific recommendations of their RRC), and based upon the needs of the patient and skills of the resident.

III. Inpatient Wards

a. Operation Mechanics

i. 8AM-4PM

1. Attending physicians of record are expected to be available for Level 2B/Indirect Supervision as of 8AM and on-site for Level 1/Direct Supervision and Level 2A/Indirect Supervision as of 9AM.
2. Attending physicians of record are expected to provide supervision according to the Ward Attending Guidelines document (Appendix 4).
3. If the attending physician of record is unable to fulfill the above requirements it is his/her responsibility to find the appropriate coverage.

ii. 4PM-12AM

1. Attending physicians of record are not required or expected to act in a supervisory role once daily duties have been completed except on the long call day.
2. An attending physician will be on-site to serve as back up for all patients but the long call team. This physician may not be the physician of record for a given patient.
3. Attending physicians serving as back up on-site are expected to provide Direct/Level 1 and Indirect/Level 2A Supervision.
4. Long call attending physicians of record are expected to be available for Level 2B/Indirect Supervision for the 24 hour period of the call day, 8AM to 8AM. They are expected to evaluate as many new admissions as possible on the day of long call though it is not required to evaluate every patient until the following (post-long call) day.
5. If the attending physician of record or attending physician serving as back up is not able to fulfill the above requirements, he/she must ensure that there is another attending physician member that can supervise their team.

iii. 12AM-9AM

1. Attending physicians of record are not required or expected to act in a supervisory role once daily duties have been completed except on the long call day.
2. An attending physician will be off-site to serve as back up for all patients but the long call team. This physician may not be the physician of record for a given patient.
3. Attending physicians serving as back up off-site are expected to provide Level 2B/Indirect Supervision and Level 3/Oversight Supervision. If resident physicians does not feel comfortable with a patient situation and requests help, back up physicians must be able to provide Level 1/Direct Supervision within a one hour time period.
4. Long call attending physicians of record are expected to be available for Level 2B/Indirect Supervision for the 24 hour period of the call day, 8AM to 8AM. They are expected to evaluate as many new admissions as possible on the day of long call though it is not required to evaluate every patient until the following (post-long call) day.
5. If the backup attending physician is not able to fulfill the above requirement, he/she must ensure that there is another attending physician that can and directly communicate the supervisory needs to that attending physician.

b. Back Up Supervision:

i. Resident physicians are expected to call their designated back up attending physician according to the Must-Call List (Appendix 1) or as needed in any other circumstance in which they feel supervision is needed.

ii. Attending physicians serving as back up on-site are expected to provide Direct/Level 1 and Indirect/Level 2A Supervision.
    1. Attending physicians serving as back up off-site are expected to provide Level 2B/Indirect Supervision and Level 3/Oversight Supervision. . If resident physicians does not feel comfortable with a patient situation and requests help, back up physicians must be able to provide Level 1/Direct Supervision within a one hour time period.

iii. The attending physician serving as back must be accessible by pager via www.amion.com.
iv. If the backup attending physician is not able to fulfill the above requirement, he/she must ensure that there is another attending physician that can and directly communicate the supervisory needs to that attending physician.

c. **Documentation Supervision:**
    i. Attending physicians are expected to provide Level 3/Oversight Supervision for documentation pertaining to patient care according the Ward Attending Guidelines document (Appendix 4).

d. **Procedure Supervision**
    i. Medical procedures performed by non-competent resident physicians must be done with Level 1/Direct Supervision by a supervising physician.

IV. Medical Intensive Care Unit

a. Operation Mechanics

i. 8:30AM-12:00PM

1. Attending physicians should start daily rounds in ICU conference room. New admissions should be staffed first, initially by the night ICU intern then followed by the post-call day intern. The night float intern can be excused after presenting new cases.
2. Attending physicians are expected to start bedside rounds after all new admissions have been presented. The post-call team patients should be seen first to allow the post-call resident to leave by 11:00am.
3. All patients will be seen daily by the ICU attending
4. Attending physicians should attend radiology rounds with team and radiology attending daily at 11:30am.
5. All procedures performed in ICU will be supervised by the attending or fellow depending on the level of competency of housestaff as well as fellow. (Any time of day)
6. All patients must have an attending H&P note/addendum within 24 hours of admission. Attendings will document evidence of direct examination of the patient, interaction with housestaff in formulating the management plan, and their assessment/plan.
7. There must be at least one daily note written on every patient. Housestaff notes will be reviewed by the attending and appropriate feedback will be provided.
8. All new admissions arriving after 6:30AM will be staffed by the ICU attending for that day.

ii. 1:00PM-5:00PM

1. Attending physicians should attend Collaborative Care Rounds on Thursdays at 1pm or assign the fellow to attend.

iii. 5:00PM-8:30AM

1. The on-call ICU attending will be available for oversight (Level 3) supervision. They are expected to respond within 15 minutes of receiving a page.

2. The on-call ICU attending should check in with the on-call resident at least once overnight to answer questions and discuss any new admissions.

V. Night Resident Physician Supervision

a. While we encourage resident physician autonomy, we must be mindful of situations that could bring about adverse patient outcomes. For this reason our guidelines require the night resident physician to notify the attending physician, whether in-hospital or off-site backup, for any of these situations. While this list is not exhaustive, the situations listed in Appendix 2 would mandate contacting the supervising physician.

b. Further documentation may also be required by the night resident physician in order to maintain continuity of care during transitions of care. Please see Appendix 3 for situations that require additional night float documentation. Attending physicians responsible for the supervision of the night resident should review cases to ensure proper documentation has occurred.

VI. Statement on resident physician supervision

a. All activities, including those performed by credentialed resident physicians, are always under some level of supervision by the responsible attending physician; it is the attending physician's responsibility to determine what level of supervision is necessary.

Appendix 1

Must Call List:

1. Considering escalation in level of care to the ICU, but unsure or disagreement between teams
2. Significant response to treatment that is unexpected (for example, hemodynamic instability that is not stabilizing, or anaphylactic reaction to a medication)
3. Significant change in vital signs or mental status that is not easily correctable or explained
4. Failure to achieve an urgent treatment plan (for example, urgent MAC transfer, diagnostic study or important consult)
5. Unexpected morbidity or death
6. Medical error resulting in significant harm or clinical intervention (always consider submitting an SI report)
7. New Heme/Onc patients when acute leukemia or thrombotic thrombocytopenic purpura (TTP) is seriously considered (call H/O fellow or attending directly)
8. Anytime you are uncertain about patient care or the next step in diagnosis or management

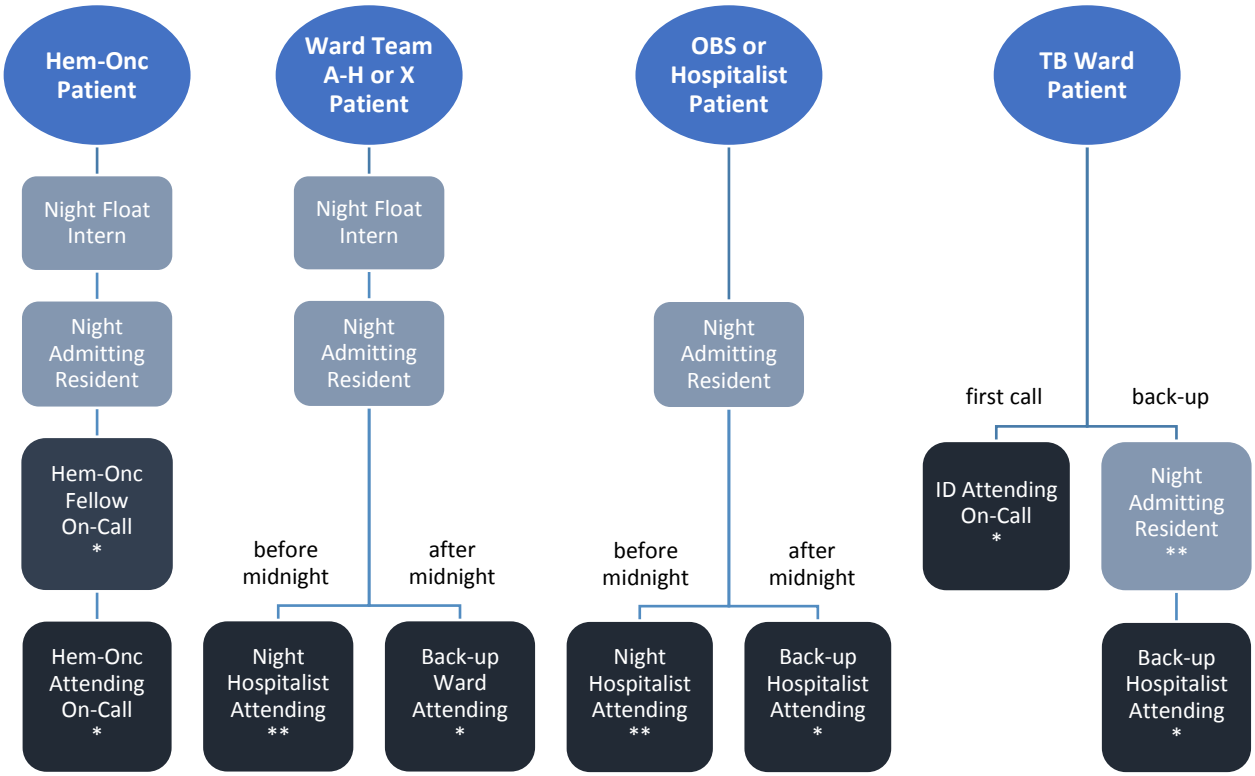
Appendix 2

Must Document List:

1. Anytime you discuss a case with a supervising physician (please note, includes unexpected morbidity or death of any patient)
2. Change in the patient's plan of care. This includes new medications or new recommendations from a consultant. (Exception: if the primary team's note or sign out already states medication to be administered prn [such as IV furosemide based on I/O], then not considered change in plan of care)
3. Critical vital sign notifications
4. Anytime you go to the bedside to evaluate a patient
5. Any escalation in level of care
6. RRT/Code Blue

Appendix 3

NIGHT FLOAT CHAIN OF COMMAND



* Call Hospital Operator or check AMION to identify the attending or fellow on-call

** Medicine On-Call Pager

USE THE AFTER-HOURS CHAIN OF COMMAND FOR:

1. Any question or uncertainty about patient care, *i.e.* any time you are not completely sure of what to do in a clinical situation
2. Other examples of important calls to an attending:
   - Unexpected upgrade in level of care (to SDU or ICU), or RRT/Code Blue that is not transferred
   - Unexpected clinical response to treatment (*e.g.* hemodynamic instability that is not correcting quickly, anaphylactic reaction)
   - Failure in achieving an urgent treatment plan (*e.g.* delay in urgent consult, diagnostic study, urgent medication, MAC transfer, *etc.*)
   - New Hem-Onc patient where acute leukemia or TTP is seriously considered in the differential (always call H/O Fellow or Attending)
   - Unexpected transfusion (*e.g.* more than 2 units)
   - Unexpected morbidity or death
   - Medical error resulting in significant harm or clinical intervention

and document In ORCHID

Examples of appropriate events to document:

- Whenever patient care was discussed with a supervising resident, fellow, or attending
- Whenever the level of care was changed
- Whenever the management plan was changed (*e.g.* recommendations of consultants, new findings prompting action)
- Any issue that the team or other healthcare providers need to know

Use the Internal Med Inpt Progress Note type with a title of “Cross-cover Event” and free-text template

Forward notes for attending co-signature:

- to the attending the case was discussed with (back-up attending), or
- to the primary ward attending of record if not discussed with the back-up attending

Appendix 4

DEPARTMENT OF MEDICINE

OLIVE VIEW-UCLA MEDICAL CENTER

WARD ATTENDING GUIDELINES

(Updated June 26, 2018)

WARD SCHEDULE:

1. Welcome to the Olive View wards. To plan your first day on service, contact the attending you are taking over for prior to your start date. You can see your daily schedule at www.amion.com (password: ov im).

2. There are 3 types of call days: **Long** (10 pts), **medium** (6 pts) and **short** (4 pts). Call days are scheduled on an 8 day cycle: **Long** – Post-long – no call – **Short** – no call – **Medium** – no call – no call – **Long**.

3. Per new RRC duty hour restrictions, interns are no longer limited to 16 hours, but our program goal is still for them to leave by 10pm. Meet with your team on long-call days for new patient rounds in the afternoon (usually 3-6pm) and finish by no later than 8pm so the interns can get their work done and leave by 10pm. Residents stay overnight on long-call days, and must leave the hospital by 11:00am the following day. On post-long call, prioritize sickest and dischargeable pts (plus resident-admitted pts) early so you can excuse your resident by 11:00am. You will then work with the interns, who will sign out at 4-5pm when the night float intern arrives. On non-call days, attending rounds should start at 9:00am and finish by 11:30am.

4. On Short and Medium call days, discuss with your resident when the best time for rounds would be (usually late morning or early-mid afternoon). Attending physicians are expected to personally see all new admissions prior to leaving the hospital.

5. Good sign outs/hand offs are critical. When your resident is gone (off, or post-long call) review the sign-outs with the interns before they sign out for the day, which the resident would normally do.

6. Housestaff have one scheduled day off per week. You will need to cover for your resident during his/her days off. When the interns have the day off the resident will cover, but please help out (especially for large services).

7. For after-hours questions, let your team know if they should contact you, or the "chain of command" attending. You need to be available by phone/pager after hours on your long-call day.

8. Morning Report is scheduled 8:15-9:00am in the Conference Dining Room (CDR) on Mon, Tue and Fri. All teams are required to attend, except the post-long call team. Attending rounds should start after morning report on non-call days. Do not round after 11:30; all housestaff should go to noon lecture (please respect their time!). Weekend rounds are more flexible, depending on the schedule and needs of the team.

9. Hours and timecards: For those who can code for overtime (OT), you are allowed a maximum of 12 hrs/week of preapproved OT (actually, 6 hours per each weekend or holiday day in your pay period). Flex your hours as much as possible, but if you request more OT complete an "Emergency OT Request" form from Alicia. This form must be signed by your supervisor and Dr. Wali before your timecard is completed.

Code 701 ($) or 705 (comp time) for OT (each with reason code 843). Code 531 (standby) when you are on long-call at home.

PATIENT CARE, DOCUMENTATION AND OTHER RESPONSIBILITIES:

1. The attending physician is responsible for the welfare of the patients, and thus needs to be involved in all major decisions. However, attendings should also encourage the resident to be the team leader and make management decisions. Commenting on these decisions is a more useful educational style than making your own decisions without the resident's involvement.

2. All patients must have an **attending H&P note/addendum within 24 hrs of admission**, defined from the time the "Request for Admit" order is placed in ORCHID. Attending H&P notes are required on all patients including holdovers admissions and ICU transfers.
    a. Your admission H&P can be written as an addendum to the intern's H&P note. If you want to write a separate admission note, please use the "History & Physical" note type, and state "see separate attending H&P note" in the addendum of the intern's H&P. Daily progress notes can be signed w/o an addendum.
    b. Interns also must complete their H&P w/in 24 hrs of admission. There must be at least one note written every day. This can a separate attending note, the intern H&P, the MRAN, or an intern progress note.
    c. Your Attending note must give evidence of (a) direct exam of the pt, (b) interaction with Housestaff in formulating management plan, and (c) your assessment/plan.
3. Daily progress notes should be reviewed for accuracy of documentation of the physical exam, correct use of abbreviation and reason for hospitalization. These do not require an addendum.

4. For ORCHID PowerChart training, excellent YouTube videos are on: www.uclaoliveview.org/orchid/training/.

5. You should help the team anticipate early and "next-day" discharges. All discharges must be approved by the Attending, and housestaff should document this agreement in the discharge summary.

6. Utilization Review and Documentation (for questions contact the UR Dept. at x73414, or Dr. Glen Pearlstein):
7. Appropriate documentation is essential for the hospital to obtain reimbursement. Document the severity of illness and intensity of services needed for inpatient care (e.g., "pt requires continued stay for frequent nebulizer txs, IV abx, IV analgesic, persistent hypoxia, etc"), and teach trainees to do the same.
8. Also teach trainees to link diagnoses when appropriate (e.g., HTN and CKD → consider documenting "CKD secondary to HTN" to capture the severity of illness).
9. **Collaborative Care Rounds**: CCR rounds will meet with your team for 15 minutes daily, between 10:00 and 11:00. You and/or the resident must attend.
10. Foreign visitors (including non-L.A. County residents) are only eligible for emergent inpatient care. Outpatient f/u visits (including PDC) are not allowed. Refer these pts for care in their own county or country.
11. Procedures done by Housestaff must be supervised directly by an Attending, unless the Resident is "competent" to perform/supervise the procedure. Housestaff competency is documented on the Intranet. Contact the Procedure Service (pager on AMION) during regular hours to supervise the housestaff or complete the procedure independently. If you supervise a procedure, the resident will send you an electronic doc to sign via MedHub.

POST-DISCHARGE F/U:

1. For patients who have a PCP/medical home (at OV or elsewhere), schedule post-discharge f/u with the PCP.
2. For assistance with Discharge planning, discuss in your daily CCR rounds or call the UR department at x73414.
3. For patients who **do not have** a PCP/medical home:

4. If patient needs a face-to-face appt → schedule with CCC-PDC clinic by calling the Urgent Care clerks or the CCR Discharge coordinator. Teach interns and residents to clearly state at the end of the discharge summary what needs to be followed.
5. If patient needs a test/study/telephone f/u but doesn't require a face-to-face appt → schedule an NP telephone f/u (team contacts the inpatient NPs; they have a logbook for this purpose in their office).
6. Please NERF these patients and have the intern document this in the discharge summary.

TEACHING RESPONSIBILITIES:

1. **Bedside rounds** are an opportunity for you to role model physician/patient interactions, teach physical exam skills, and obtain real time historical and physical examination data. Resident learners prefer bedside rounds[1] and believe they are better for patient care[2]. Bedside rounds are preferred by patients as well[3,4]. For these reasons bedside teaching is required by attendings, and housestaff will expect them (on not all, but some patients).

2. Respect your teams' time constraints, be brief and teach while you help manage patient care. Limit Attending rounds as much as possible. Query your housestaff and explain your thought processes as much as you can, and let the entire team become active participants. You should also observe your housestaff do at least part of a H&P when on-call and give them pointers. Take this opportunity to complete a "mini-CEX".

3. You are responsible for attending Morning Report at least 2 times per week. Morning Report is scheduled 8:15-9:00am in the Conference Dining Room (CDR) on Mon, Tue and Fri.

4. Plan specific days to meet and give feedback to your housestaff; daily continuous feedback is also appreciated. You also need to complete written evaluations for your team members at the end of the rotation, using our web-based MedHub evaluation system. Contact the Medicine Dept. (x73205) for questions.

5. **EBM teaching:**
    a. Two landmark articles will be available every month. Attending physicians are responsible for coordinating that these articles are presented by someone on the team. The articles are on our residency website and hardcopies are in the workrooms.
    b. Attending physicians should ensure that at least one article is reviewed per 8 day call cycle while on the inpatient medicine service.

MEDICAL STUDENTS:

1. **Meet separately with the 3rd year student at least weekly** to provide feedback, as well as review a case or an approach to being a better physician. You should review 1-2 written H&Ps with the student and provide detailed feedback. Also observe the student examine at least 1 patient during the rotation and give feedback on his/her examination skills. The students also have a UCLA requirement for you to observe a Hx and PE.
2. Students are scheduled one day off per week. They have a separate day off scheduled every other week for their "Doctoring" course on a Tue or Thur. They also have required lectures at OVMC on Mon, Wed and Fri afternoons.
3. We have IMGs who act as 3rd year students through a special UCLA Family Medicine training program. They can do everything except: (1) sign notes/orders, and (2) perform procedures or "invasive" exams (pelvics, rectals).
4. If you are unable to perform your ward attending duties due to illness or emergency, please contact Gus Chavez in the Dept. of Medicine office as soon as possible. If you have an expected absence it is your responsibility to make arrangements for someone to cover for you. If you have any questions, or have concerns about a team member, please contact the Program Director, Associate Program Directors or the Chief Residents. Thank you and enjoy the OV wards!

References: 1 – Williams et al, Acad Med 2008
2 – Gonzalo et al, JGIM 2010
3 – Lehman et al, NEJM 1997
4 – Rogers et al, Acad Med 2003