**TRAINING PROGRAM SUPERVISION AND ACCOUNTABILITY POLICY**
**Neurocritical Care**

**Harborview Medical Center, University of Washington Medical Center Montlake**

## 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 the attending schedule (Neurology, PCCM, and Anesthesiology Qgenda) to fellows, faculty members, other members of the health care team, and patients.

The Neurocritical Care 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:
    a. the supervising physician is physically present with the 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 fellow and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology. When fellows are supervised via telecommunication technology, the supervising physician and fellow interact with each other to identify the key elements relevant to the case, and agree upon the management plan.

2. Indirect Supervision:

the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the fellow for guidance and is available to provide appropriate direct supervision within 10 minutes.

3. Oversight: the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

**Fellow 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**

**Fellows**

Fellows may be *directly or indirectly supervised*. They may provide direct patient care, supervisory care or consultative services, with progressive graded responsibilities as merited. Fellows should serve in a supervisory role to medical students, junior and intermediate residents in recognition of their progress towards independence, as appropriate to the needs of each patient and the skills of the 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 | Fellow Level | Location | Supervision Level |
|---|---|---|---|
| Intensive Care Unit Rotations | PGY-4-7* | Intensive Care Unit | Direct during rounds, direct & indirect after rounds. |
| Stroke Rotation | PGY-4-7* | Emergency Department, | Indirect via the 'stroke phone', with in-person check-ins |

| | | | |
|---|---|---|---|
| | | inpatient wards, telestroke | |
| Central venous access | PGY 4-7* | Intensive Care Unit | Direct for the first 5 procedures, then indirect if signed off by PD and deemed proficient |
| Bronchoscopy | PGY 4-7* | Intensive Care Unit | Always direct |
| Endotracheal Intubation | PGY 4-7* | Intensive Care Unit or operating room | Always direct |
| Brain Death Declaration | PGY 4-7* | Intensive Care Unit | Always Direct |
| Chest tube placement | PGY 4-7* | Intensive Care Unit | Always Direct |
| Tracheostomy placement | PGY 4-7* | Intensive Care Unit | Always Direct |

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

-when making decisions about withdrawal of life-sustaining treatments
-when a patient acutely deteriorates and requires urgent procedures
-when a patient requires BLS or ACLS
-For determination of death by neurological criteria
-Before administering thrombolytic therapy or initiating mechanical thrombectomy

**Supervision of Consults**

N/A— fellows are always primary providers during their rotation.

**Emergency Procedures**

It is recognized that in the provision of medical care, unanticipated and life-threatening events may occur. 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 weeklong 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 Handoffs**

Fellows conducting hand-offs are expected to use structured verbal and electronic processes for patient transfers between services and locations. Fellows may be supervised directly or indirectly when conducting hand-offs. Faculty must assess fellow readiness to move from direct to indirect supervision when conducting hand-offs and patient transfers using direct observation. During day-night transitions, fellows usually have an AM touchpoint with the supervising physician on relevant updates from overnight, and a dedicated PM list-run discussion all pertinent/active issues on every patient they cover.