Petaluma Valley Hospital
ST. JOSEPH HEALTH SYSTEM

ST. JOSEPH HEALTH SYSTEM
SONOMA COUNTY

TITLE: RESIDENT PHYSICIAN POLICY

POLICY # _____

MANUAL: MEDICAL STAFF Page 1

Effective Date: 8/26/08 Approval: Anthony Kosinski, M.D.
Medical Staff President

Reviewed/Revised: 3/11, 4/13, 12/16

PURPOSE/EXPECTED OUTCOMES

It is the policy of Petaluma Valley Hospital to specify the mechanisms by which residents are supervised by members of the Medical Staff.

The management of each patient's care is the responsibility of a member of the Medical Staff with clinical privileges. This policy is intended to guide the activities of admitting/attending physicians and resident physicians in insuring that patient care activities in which residents participate are appropriately supervised and documented during the course of resident rotations based at PVH. This supervision should begin with each resident's initial contact with the attending physician and the patient, continue through the daily contact with the patient, and with the attending physician, and be completed when all the documentation of the hospital stay has been recorded in the patient's medical record.

DEFINITIONS

Following are the definitions of terms used throughout this policy:

Resident: A resident is a medical doctor or doctor of osteopathy in a residency-training program, approved by the Accreditation Council for Graduate Medical Education. For the purpose of this policy, the Residency Training Program is one that has an education affiliation agreement with Petaluma Valley Hospital through the University of California-San Francisco.

Supervising Physician: A supervising physician is a member of the PVH Medical Staff, in good standing, who has agreed to take responsibility for the activities performed by resident(s) and has been specifically designated by the Residency Program to serve as a supervising physician. All supervising physicians must have proof of liability coverage issued by the residency program (minimum coverage required is 1 million per occurrence / 3 million aggregate).

Site Coordinator(s): The coordination of the scheduling and supervision of the residents will be the responsibility of the physician(s) appointed as Site Coordinator(s) for the service(s) to which the residents are assigned. The site coordinator(s) will work with the Medical Director of the program who will have responsibility for ensuring that residents are provided appropriate backup support when patient care responsibilities are especially unusual, difficult, or prolonged.

POLICY:

1. Residents shall not hold Medical Staff appointment and shall not be entitled to the rights, privileges, and responsibilities of appointment to the Medical Staff. Residents must submit a resident information form along with a copy of current licensure (if applicable), controlled substance registration (if applicable), and appropriate health screening. The employer, Santa Rosa Family Medicine Residency Consortium, will be responsible for confirming the identity of each resident and will attest that this has been done (e.g., by attesting that an I-9 form was completed) and for supplying evidence of the required malpractice, liability, and Workers' Compensation coverage.

2. Residents shall identify themselves as residents and shall wear name badges that include the designation of "resident physician" as well as name, medical degree, and clinical specialty.

3. Residents may be invited to attend specific Medical Staff or Hospital Committees by the Medical Staff President for the purpose of participating in review of patient care in which the residents were involved. For this reason, resident physicians are required to sign agreements to protect the confidentiality of peer review/patient care information.

4. Residents may be granted access to electronic patient information provided they have signed the confidentiality agreement that is required for such access.

5. Activities performed by residents shall be under the supervision of a Medical Staff member (supervising physician). Clinical activities shall be limited to those of the clinical privileges granted to the supervising attending physician and agreed upon by the hospital, residency training program and the supervising Medical Staff member.

6. Residents shall not be granted specific clinical privileges but will operate according to a matrix of supervision and competency requirements specific to their level of training. The matrix of supervision and competency requirements shall be specific about what the resident can do according to medical specialty; year(s) in training; level of experience and degree of independence. (See 10a through d)

7. In addition to performance of procedures, participation in any care not included in the matrix of supervision and competency requirements requires the physical presence of a supervising physician as outlined in the document. If there are specific patient care activities for which the Medical Staff requires documentation of knowledge, training, or experience (e.g., procedural sedation requiring a passing score on a test), the resident must meet the criteria established by the Medical Staff in order to participate in that specific patient care activity. In addition, the issuing of DNR or restraint orders will be limited to those that have been countersigned by the attending or admitting physician.

8. Medical Staff Services shall maintain a list of all residents currently working at the facility and their job descriptions, which will be accessible to hospital staff.

9. Residents may attend patients in the Emergency Department, OB, and General Surgery (will be expanded as necessary).

Patient services that a resident may provide under the supervision of attending physicians include the following:

a. perform initial and ongoing assessment of patient's medical, physical, and psychosocial status;
b. perform history and physical (attending physician required to sign and assume full responsibility for the recorded history and physical);
c. develop assessment and treatment plan;
d. perform rounds;
e. order tests, examinations, medications, and therapies;
f. arrange for discharge and aftercare;
g. write/dictate admission notes, progress notes, procedure notes, and discharge summaries;
h. provide patient education and counseling covering health status, test results, disease processes, and discharge planning; and
i. perform procedures under direct supervision, as outlined in the matrix of supervision and competency requirements and
j. assist in surgery.

10. Following are the general guidelines by under which residents will function when performing the above-listed duties:

a. Admitted Patients: The resident will contact the attending physician directly for all admissions. This discussion will be recorded in the patient's chart indicating that the discussion took place, its outcome and the time and date of the call. The attending physician has the responsibility to decide whether personal view of the patient is indicated at that time.

b. Emergency Department Patients: For the Emergency Department, the resident will discuss all patients directly with the attending physician before discharge or admission of a patient.

c. Patients Whose Status Changes for the Worse: A similar contact with the attending physician by the resident will take place whenever a patient's condition unexpectedly changes for the worse requiring transfer to Intensive care Unit, or placement on a respirator or deterioration of vital signs consistent with an unexpectedly bad outcome.

d. All resident orders and progress notes must be co-signed by the attending within 24 hours, but such countersignature shall not be required prior to execution of any order except for DNR and restraint orders. Orders for controlled substances must be signed before execution for residents who do not have a DEA certificate that includes controlled substances.

e. All admissions or non-emergent negative status changes occurring during the night will also be discussed with the attending physician during the morning report. (Emergent negative status changes would have been discussed with a member of the Medical Staff at the time.)

11. All resident care is supervised, and the attending physician is ultimately responsible for care of the patient. The proximity and timing of the supervision, as well as the specific tasks delegated to the resident physician, depend on a number of factors including:

a. the level of training (i.e., year in residency) of the resident,
b. the skill and experience of the resident with the particular care situation,
c. the familiarity of the supervising physician with the resident's abilities, and
d. the acuity of the situation and the degree of risk to the patient.

12. The key responsibilities of the supervising physician are as follows:

a. Evaluate of the appropriateness of each patient's admission to the hospital or service.
b. Evaluate of the patient to confirm the resident's subjective and objective findings, review the differential diagnosis, and discussion of the plan of care.
c. On a daily basis, review the progress of the patient and modification of the plan of care.
d. Provide direct supervision of the resident while performing any procedure delegated to the resident by the supervising physician.
e. Review the patient's medical record for completeness and accuracy of the medical record.
f. In all instances, it is the responsibility of the attending physician to keep abreast of the care of his or her patients at all times, which means periodic contact with the resident if the contact has not been made by the resident.

13. The quality of care provided by the residents shall be monitored through the Medical Staff committee and department structure and reported to the Executive Committee and Board of Trustees on a quarterly basis.

14. Concerns or problems that may arise regarding a resident in the program shall be reported to the site coordinator(s) in a timely fashion for resolution. If satisfactory resolution is not reached, the issue may be taken to the Executive Committee.

15. A resident-specific report will be made at the end of each cycle to the Director of the Residency Training Program and to the Executive Committee regarding the safety, quality of patient care, and treatment and services provided by, and the related educational and supervisory needs of, the participants in the program. The report shall include an evaluation of general observation, clinic evaluation, interpretation, test procedures and the independent procedure of performance and if each rotation has been completed successfully or non-successfully**.** Each resident will be responsible for compiling a list of procedures completed during each evaluation period.

Author/Department: Katie Santy/Medical Staff Services Supervisor	
References: JCAHO Standards, ACGME Standards, and the agreement between UCSF and SMCSR	
Reviewed/Revised:	
Approvals: Medicine Executive Committee- 7/29/08 Surgery Executive Committee- 7/11/08 Executive Committee- 7/15/08, 3/15/11, 12/20/16 Board of Trustees- 8/26/08, 3/22/11, 1/24/17	Distribution: