

Four types of documentation of resident supervision are allowed:

1. Attending progress note
2. Attending addendum
3. Co-signature
4. Resident documentation

Refer to scenarios on this card to determine the appropriate type of documentation.

Observation Patients

The level of supervision depends upon the unit where the patient is being held (i.e. ICU, inpatient ward, or emergency department). Residents will contact the attending on-call for patients being discharged before seeing the attending.

Documentation: A summary of the discussion between the resident and attending must be documented in the resident's note (for those patients not seen by the attending prior to release). An independent note or addendum to a resident note is required when the attending is able to evaluate the patient in person.

Home Visits

Residents must have training in handling emergency situations and home health policies. PGY-1 residents must be accompanied by an attending. For other PGY-level residents, the attending must be readily available via phone.

Documentation: Any of the 4 types of documentation: attending's name and degree of involvement must be documented.

Telemedicine/Telehealth

Real-time Videoconferencing: The attending must be in the general vicinity and available to the resident for direct supervision without delay, as if the patient were being seen in a clinic.

Store and forward telehealth: The resident reviews the material with or without the attending present, and the attending reviews the same material. The interpretations and reports on all images and pathology specimens must be verified by the attending.

Home telehealth: Attendings are expected to exercise general oversight of the care provided by residents. Residents must consult with the supervising practitioner regarding any changes in a home telehealth patient's status or proposed changes in the treatment plan.

Documentation: Any of the 4 types of documentation: supervising practitioner's name and degree of involvement must be documented.



Reference:

VHA Handbook 1400.1 Resident Supervision - www.va.gov/vhapublications
Veterans Health Administration, Office of Academic Affiliations

IB: 10-196
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Resident Supervision Attending Practitioner Responsibilities

"Supervising Practitioner" (synonymous with "Attending"):

Responsible for all care in which interns, residents or fellows are involved.

"Resident" is used to apply to physician, dentist, optometrist, and podiatrist residents and fellows, regardless of training level.

Documentation of all patient encounters must identify the supervising practitioner (attending) and indicate the level of involvement.

Four types of documentation of resident supervision are allowed:

1. **Attending's progress note** or other entry into the patient health record.
2. **Attending's addendum** to the resident admission or progress note.
3. **Co-signature** by the attending implies that the attending has reviewed the resident note or other health record entry, and absent an addendum to the contrary, concurs with the content of the resident note or entry. Use of CPRS function "Additional Signer" is **not acceptable** for documenting supervision.
4. **Resident documentation** of attending supervision. [Includes involvement of the attending and the attending's level of supervision or oversight responsibility (e.g., "I have seen and discussed the patient with my attending, Dr. 'X', and Dr. 'X' agrees with my assessment and plan"), at a minimum, the responsible Attending should be identified (e.g., "The Attending of record for this patient encounter is Dr. 'X'")]

Inpatient: New Admission

Attending must see and evaluate the patient within 24 hours of admission.

Documentation: An attending admission note or addendum documenting findings and recommendations regarding the treatment plan within 24 hours of admission (no exceptions for weekends or holidays). First post-graduate year (PGY-1) residents must have on-site supervision at all times by either an attending or a more advanced resident, with an attending being available on-call (also applies to Night Float and 'Over Cap' Admissions).

Inpatient: Continuing Care

Attending must be personally involved in ongoing care.

Documentation: Any of the 4 types of documentation, at a frequency consistent with the patient's condition and principles of graduated responsibility.

Inpatient: ICU Care (includes SICU, MICU, CCU, etc.)

Because of the unstable nature of patients in ICUs, attending involvement is expected on admission and on a daily or more frequent basis.

Documentation: Admission documentation requirements (see Inpatient: New Admission above) plus any of the 4 types of documentation daily. An admission note or addendum to the resident's admission note is required within 24 hours of admission.

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Inpatient: Discharge or Transfer

Attending must be personally involved in decisions to discharge or transfer the patient to another service or level of care (including outpatient care).

Documentation: Co-signature of the discharge summary or discharge/transfer note. If patient is transferred from one service to another, the accepting attending should treat the patient as a New Admission. If the same attending is responsible for the patient across different levels of care, transfer documentation is not required.

Outpatient: New Patient Visit (includes Emergency Department visits)

Attending must be physically present in the clinic. Every patient who is new to the facility must be seen by or discussed with an attending.

Documentation: An independent note, addendum to the resident's note, or resident note description of attending involvement. Co-signature of resident note by attending alone is not sufficient documentation.

Outpatient: Return Visit

Attending must be physically present in the clinic. Patients should be seen by or discussed with an attending at a frequency to ensure effective and appropriate treatment.

Documentation: Any of the 4 types of documentation. The attending's name must be documented.

Outpatient: Discharge

Attending will ensure that discharge from a clinic is appropriate.

Documentation: Any of the 4 types of documentation.

Surgery / OR Procedures

Except in emergencies, the attending surgeon must evaluate each patient pre-operatively.

Documentation: Attending must write a pre-procedural note or an addendum to the resident's pre-procedure note describing findings, diagnosis, plan for treatment, and/or choice of procedure to be performed (may be done up to 30 days pre-op). May be combined with attending admission note or addendum, if within 24 hours of admission and before the OR procedure. Use appropriate note title. Informed Consent must be obtained according to policy. Attending level of involvement is documented in the VistA Surgical Package. Post-op documentation per Joint Commission requirements and local medical center bylaws.

Radiology/Pathology:

Documentation: Radiology or pathology reports must be verified by the radiology or pathology attending.

VistA Surgery Package Codes

Level A: Attending Doing the Operation Attending performs the case, but may be assisted by a resident.

Level B: Attending in OR, Scrubbed Attending is physically present in OR, or procedural room, and directly involved in the procedure. The resident performs major portions of the procedure.

Level C: Attending in OR, Not Scrubbed Attending is physically present in OR or procedural room, observes and provides direction to resident.

Level D: Attending in OR Suite, Immediately Available Attending is physically present in OR or procedural suite and immediately available for supervision or consultation as needed.

Level E: Emergency Care Immediate care is necessary to preserve life or prevent serious impairment. Attending has been contacted.

Note: Emergency (non-elective) surgery with an attending present should be coded as A-D with respect to the appropriate level of supervision.

Level F: Non-OR Procedure Routine bedside or clinic procedure done in the OR. Attending is identified.

Consultations

(Inpatient, Outpatient, Emergency Department)

When residents are involved in consultation services, the consultant attending is responsible for supervision of these residents.

Documentation: Any of the 4 types of documentation; use of consult management package is highly encouraged.

Emergency Department (ED):

The ED attending must be physically present in the ED, and is the attending of record for all ED patients. The ED attending must be involved in the disposition of all ED patients.

Documentation: An independent note, addendum to the resident's note, or resident note description of attending involvement. Co-signature by the Attending alone is not sufficient.

Routine Bedside & Clinic (Non-OR) Procedure (e.g., LPs, central lines, centeses)

Setting-dependent supervision and documentation; principles of graduated responsibility apply.

Documentation: Resident writes procedure note that includes the attending's name. Any of the 4 types of documentation are acceptable.

Non-routine, Non-bedside, Non-OR Procedure (e.g., cardiac cath, endoscopy, interventional radiology)

The attending must authorize the procedure and be physically present in the procedural area.

Documentation: Any of the 4 types of documentation: attending's name and degree of involvement must be documented