GRADUATE MEDICAL EDUCATION COMMITTEE

POLICY REGARDING THE LEARNING AND WORKING ENVIRONMENT FOR GME TRAINEES

- PATIENT SAFETY
- QUALITY IMPROVEMENT
- SUPERVISION AND ACCOUNTABILITY

Purpose: This policy is aimed at creating and supporting a learning and working environment for medical and dental residents and fellows that promotes excellence in the safety and quality of care rendered to patients by trainees and faculty during their participation in a University of Iowa Hospital and Clinics (UIHC) Graduate Medical Education (GME) program. Incorporating the importance of quality and safety into our GME programs goes beyond the present as we recognize that carrying forward that excellence into our learners' future practices is critically important to the patient care they will provide when they are unsupervised and themselves responsible to effect quality improvement measures.

In this policy, the terms learner, trainee, house staff member, resident and fellow may be used interchangeably.

I. Patient Safety. GME at UIHC actively promotes patient safety, with both the learner and the faculty supervisor sharing responsibility for patient safety and the quality of patient care. The continuous overriding focus is on the safety, individual needs and humanity of the patients being cared for. Supervision, knowledge, skills and abilities factor into that focus. In that regard, practitioners must understand the limits of their knowledge and experience and seek assistance as required to provide optimal patient care. It is critical that residents and fellows, along with faculty members, work consistently in a well-coordinated manner with other health care professionals to achieve patient safety goals. Our GME learners must be able to demonstrate the ability to analyze the care they provide, understand their roles within the health care team, and play an active role in system improvement processes, carrying it forward into their unsupervised future practices. Programs must document that the following occur:

   A. *Safety Culture*. UIHC's mission includes an ongoing willingness to deal with safety vulnerabilities. Through each program, UIHC has formal mechanisms in place which the programs document, such as assessments of the knowledge, skills and attitudes of our learners. Learners and faculty must communicate any needed areas of improvement.

   B. *Education on Patient Safety*. Each residency and fellowship program at UIHC must provide formal educational activities that promote patient safety related goals, tools, and techniques. The program must tailor these activities appropriately for their learners and document and retain learner participation at the program level.

   C. *Patient Safety Events*. Trainees, along with faculty and other health care team members, must know their responsibilities in reporting and how to report adverse events, near misses, and unsafe conditions at the clinical site; UIHC makes available to these individuals a summary of patient safety reports that occur. Additionally, learners must be involved in real or simulated interprofessional patient safety activities, including but not limited to root cause analyses that formulate and implement actions.

   D. *Resident Education and Experience in Disclosure of Adverse Events.* Through its Compliance Office, UIHC discloses to patients (and, as necessary, families) when an adverse event has occurred. Residents must be included as participants in real or simulated disclosure events.

II. Quality Improvement. Within each program, the following must be documented:

   A. *Education in Quality Improvement*. Residents and fellows must receive training and gain experience in the quality improvement process, including an understanding of health care disparities. This means that the program must provide quality-related goals, tools, and techniques for learners to achieve quality improvement goals, especially those related to health care disparities that affect their patients.

   B. *Quality Metrics*. In order to prioritize care activities and evaluate the success of improvement efforts, trainees and faculty member must have access to and therefore receive data on quality metrics and benchmarks related to their patient population.

   C. *Engagement in Quality Improvement Activities*. For learners to develop the ability to identify and institute sustainable systems-based changes to improve patient care, they must have the opportunity in their training program to participate in interprofessional quality improvement activities, which should include activities aimed at reducing health care disparities.

III. Supervision and Accountability.

A. *Definition and Structure*. Supervision is required to provide safe and effective care to patients. It also ensures the learner's development of the skills, knowledge and attitudes required to enter the unsupervised practice of medicine and establishes a basis for continued professional growth. The attending is ultimately responsible for the care of the patient; still, every physician shares a responsibility and is accountable for their efforts in providing patient care. The training program, along with UIHC, defines, communicates and monitors a structured chain of responsibility and accountability as it relates to the supervision of all patient care at any training site. The policies of UIHC regarding supervision and accountability apply to all institutions to which a trainee rotates and are subject to ACGME and individual RRC requirements and/or other applicable accrediting or certifying bodies. Each program, regardless of accreditation, is required to follow such standards as applicable.

1. Attending: Each patient must have an identifiable and appropriately credentialed and privileged physician or licensed independent practitioner (as specified by the applicable RRC), who is responsible and accountable for the patient's care.
2. Information Available about Attending: The identity of the attending must be available to each trainee, faculty member, other health care team members and patients.
3. Roles: Each patient must be informed by the learner and faculty member as to their roles in providing the patient with care.

B. *Classification and Methods of Supervision*. The program must be able to demonstrate that the appropriate level of supervision exists for all learners, based on each learner's level of training and ability, as well as patient complexity and acuity. Teaching staff members determine the level of responsibility accorded to each trainee. On-call schedules for teaching staff and more advanced house staff members are structured to ensure that direct supervision is readily available to those on duty who require it.

Initially, PGY-1 residents must be supervised either directly or indirectly with direct supervision immediately available, as described in this policy (respectively, III.B.1 and III.B.2.a, below) and as further defined by the applicable RRC. As appropriate to the situation, the following classifications of supervision must be used to promote oversight while providing for graded authority and responsibility:

1. Direct: The supervising physician is physically present with the learner and the patient.
2. Indirect:
   a. Direct supervision is immediately available, meaning the supervising physician is physically within the hospital or other patient care site and is immediately available to provide Direct Supervision.
   b. Direct supervision available, meaning the supervising physician is NOT physically present within the hospital or other patient care site but IS available immediately by telephone or other electronic modality, and is available to provide Direct Supervision.
3. Oversight: The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

C. *Assignment of Roles*. The Program Director and faculty must assign each learner the roles of progressive authority and responsibility, conditional independence, or a supervisory role in patient care. This means:

1. Evaluation of each learner guided by milestones must be performed by the Program Director.
2. Delegation of portions of care to the trainee, based on the needs of the patient and skills of the learner, must be done by the supervising physician.
3. Supervision by senior learners of junior learners must reflect the senior learner's progress toward independence, while it considers the needs of each patient and the skills of the individual residents or fellows involved.

D. *Guidelines*.

1. Communication Required: Programs must set guidelines describing events and circumstances when a learner must communicate with the supervising faculty member.
2. Limits on Learner's Scope of Authority: Each learner must know the limits of his/her scope of authority and under what circumstances action with conditional independence is permitted.
3. Duration of Faculty Supervisory Assignments: A faculty member's supervisory assignment must be of sufficient duration to assess the knowledge and skills of each learner and to delegate to the learner the appropriate level of patient care authority and responsibility.

Reviewed/Approved by the Graduate Medical Education Committee	6/6/2017