Resident Supervision
Attending Practitioner Responsibilities
For all care in which interns, residents or fellows are involved

Department of Veterans Affairs

Documentation of all patient encounters **must identify the supervising practitioner and indicate the level of involvement.**

Four types of documentation of resident supervision are allowed:

1. Attending progress note or other entry into the medical record.

2. Attending addendum to the resident's note.

3. Co-signature by the attending implies that the supervising practitioner has reviewed the resident note, 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 (e.g., "*I have seen and discussed the patient with my supervising practitioner, 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.
Documentation: An attending admission note or addendum documenting findings and recommendations regarding the treatment plan within one calendar day of admission. (No exceptions for weekends or holidays).

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.

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 – see above.

Outpatient: New Patient Visit
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 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.

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.

Surgery / OR Procedures

Except in emergencies, attending surgeon must evaluate each patient pre-operatively.
Documentation: Attending must write a pre-procedural note describing findings, diagnosis, plan for treatment, and/or choice of procedure to be performed (may be done up to 30 days pre-op). **Informed Consent** must be obtained according to policy. Attending level of involvement is documented in the VistA Surgical Package. Post-op documentation per JCAHO requirements and local medical center bylaws.

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.

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

Consultations (Inpatient, Outpatient, Emergency Department)

Attending physician must supervise all consults performed by residents.
Documentation: Any of the 4 types of documentation; use of consult management package is highly encouraged.

Radiology/Pathology:

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

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.

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.