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Improving Healthcare for the Common Good

Spotlight on Resident Supervision

by Yasmine Gourdain

Major components of the 2003 Accreditation Council for Graduate Medical Education (ACGME) regulations and the 1989 New York State Section 405 regulations deal with enhancing resident supervision, but work-hour limits have long overshadowed the supervision component.[1] The recent findings and recommendations of an Institute of Medicine (IOM) report on resident duty hours pushed supervision to the forefront and forced many to take a more detailed look at post-graduate trainee supervision.[2]

The IOM report found that close supervision led to better patient care and patient outcomes; it recommends more frequent consultation between residents and their supervisors.[2] New York State recently made changes to look more comprehensively at supervision during on-site surveys, and the ACGME established a task force that is currently seeking evidenced-based data with regard to resident supervision and how it affects patient safety.[3]

What constitutes quality supervision for residents? This question can have a myriad of answers. Although the ACGME supports the IOM's recommendations on supervision, it cites that there is little evidenced-based data demonstrating what defines quality supervision; however, the data that have been collected show that residents believe they have too much supervision and attendings believe they need more.[4]

To bridge the gap between resident and attending perceptions, critical success factors to quality supervision must be established. Studies show that clearly defining the role of the supervisor, setting clear expectations, and establishing lines of communication between residents and their attendings have had positive impacts on patient care and the perception of supervision.[5]

A study published in the *Journal of Graduate Medical Education* (March 2010) examined the experiences of residents who had access to an on-site hospitalist and those who only had access to an attending by phone at night. Both the residents and attendings reported positive experiences and better patient outcomes when there was a hospitalist on-site at night.[6]

Although increased supervision for residents might have a positive effect, there might also be some pitfalls. Dr. Frank Iaquinta, a former program director of over 20 years, stated that having more direct supervision by attendings is good for patient care. However, maintaining resident autonomy and the resident hierarchy, the "up-the-ladder" approach of seeking help, is critical to training residents to become competent, well-rounded attendings.

Those tasked with supervising residents must strike a balance between providing adequate oversight and allowing residents to be independent decision-makers without compromising patient care. Allowing residents to make their own decisions is vital to their education and growth as physicians.

Defining quality supervision is a dynamic process. Once defined, the ultimate goal of providing quality education for residents and preserving patient safety is one that can be achieved.

[1]www.ACGME.org accessed 4/19/10; N.Y.C.R.R 10 § 405.4 [2]IOM, 2008 [3]See note 1. [4]Farnan et al, 2009 [5]Farnan et al, 2010 [6]Trowbridge et al, 2010

CURRENT GME RESOURCES AND INFORMATION AT-A-GLANCE

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Share your:

- Questions and comments
- Practical solutions and ideas
- Resident Education concerns and needs
- The types of publications, training, and conferences that would be most helpful to you
- Can IPRO assist with addressing your goals for improvement? Let us know.

Contact IPRO's Hospital Compliance staff at: (800) 233-0360, ext. 119 or egorke@ipro.org

Near Miss Registry Update

by Ethan Fried, MD, MS, FACP, St. Luke's-Roosevelt Hospital, NYC

The Near Miss Registry, the risk-free, anonymous, online tool for collecting information about our patient safety vulnerabilities and the strongest barriers that protect patients from those vulnerabilities, is expanding. But first let's review why tracking near misses is such a powerful patient safety initiative.

Conscientious readers of *Resident Times* will recall that the Near Miss Registry is a project of the New York Chapter of the American College of Physicians supported by the New York State Department of Health Patient Safety Center. The registry is the first statewide, web-based collection system for information about near-miss medical errors. During Phase I (2007-2009) we created an online survey to collect details about near misses and the barriers that prevented these errors from adversely affecting patients. We visited dozens of internal medicine residency programs across the state and trained over 3,000 residents on the impact of medical errors, their anatomy and classification, human factors design and how to safeguard against these classifications, the importance of a risk-free reporting system, and how to interact with the survey.

We collected 285 reports and divided them according to the institution's sophistication level (inferred by the existence of infrastructural features like computerized physician order entry, electronic health records, night float coverage rather than overnight call, and a supervised or electronic sign-out process). We also pulled 23 key words from the error descriptions, effectively capturing all of the data.

We found that medication errors dominated the near-miss reports. Pharmacists and medication reconciliation processes saved many patients. Anticoagulation is potentially one of the most dangerous therapies we use and must be handled carefully. Finally, chaos and distractions put our patients in danger even with access to the most sophisticated computer systems.

In Phase II of the study we will expand the reach of the survey to include users from other specialties and allied healthcare providers. A revised survey will reflect the specific functions of these users. We have already conducted focus groups aided by the Committee of Interns and Residents (the house staff union), the New York City Health and Hospitals Corporation, the Healthcare Association of New York State and the Greater New York Hospital Association.

Soon we will contact Designated Institutional Officials (responsible for oversight of all training programs) and Patient Safety and Chief Operating Officers at hospitals across New York State. We will reintroduce the registry and encourage hospitals to train all personnel in the basic science of patient safety and the use of the Near Miss Registry. Institutions may also invite representatives of the registry to conduct training similar to that given to the internal medicine residents in Phase I. We will use our updated survey to continue to collect and analyze more near-miss data than ever leading the way to a safer healthcare system in New York State.

Ask the Expert

Veronica Wilbur, RN, MBA, CHC, CLNC

Question: What are IPRO and the New York State Department of Health looking for regarding resident supervision during onsite surveys?

Veronica's Response: As stated in the regulations for review, we focus on three required elements: access and availability, proactive supervision and personal supervision in the operating room. For access and availability, a determination is made based on post-graduate trainees' access to quality supervision and whether supervision is available 24/7. Next, we review medical records to determine if supervision is pro-active. We expect to see ongoing evidence in the medical record of the attending/supervising physician's oversight and management of the patient's care, as well as oversight of the care and services provided by the post-graduate trainee. We also look to see whether there is a one-to-one relationship between resident and attending documentation. The final element requires us to verify that in-person supervision of post-graduate trainees, both in the operating room and post-operatively, is evident and documented.

Questions are addressed to our experts from residency program representatives seeking practical ideas for work-hour regulation compliance. Responses are currently specific to New York State regulations; however, suggested approaches can be customized to address global work-hour mandates. Contact Veronica Wilbur, RN, MBA, CHC, CLNC, Senior Director of IPRO's Hospital Compliance Program, at (800) 233-0360, ext. 103 or vwilbur@ipro.org to find out how IPRO can assist in effectively addressing your program's compliance challenges.

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