POLICY ON RESIDENT SUPERVISION
General Psychiatry Residency Program
DEPARTMENT OF PSYCHIATRY
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Section I. Introduction
Careful supervision and observation are required to determine the psychiatry residents’ abilities to obtain and interpret psychiatric data and to manage patients. Because they are not licensed independent practitioners, psychiatry residents must be given graded levels of responsibility while assuring quality care for patients. Supervision of psychiatry residents should be graded to provide gradually increased responsibility and maturation into the role of a judgmentally sound, technically skilled, and independently functioning credentialed psychiatrist.

Section II. Definitions
The following definitions are used throughout the document:

Resident – a professional post-graduate general psychiatry resident, child and adolescent psychiatry resident, geriatric psychiatry fellow, psychosomatic medicine fellow, or addiction psychiatry fellow
Licensed Independent Practitioner (LIP) – a licensed psychiatrist who is qualified by a state board of medical examiners to practice psychiatry or their subspecialties independently

Medical Staff – an LIP who has been credentialed to provide care in psychiatry, or its subspecialties by a hospital

Staff Attending – the immediate supervisor of a resident who is credentialed for specific procedures, activities which are being supervised.

Section III. Purpose

This policy establishes the minimal requirements for psychiatry resident supervision in teaching hospitals of The University of Texas Health Science Center at San Antonio (UTHSCSA). A UTHSCSA teaching hospital may have additional requirements for resident supervision pertaining to that hospital. The psychiatry, child and adolescent psychiatry, geriatric psychiatry, psychosomatic medicine and addiction psychiatry training programs may have requirements for their attendings and residents.

Section IV. Procedures

A. Psychiatry residents will be supervised by licensed, credentialed medical staff of the UTHSCSA teaching hospital in which they are attending. The staff attendings must be credentialed in each hospital for the specialty care or subspecialty care and diagnostic and therapeutic procedures that they are supervising. In this setting, the supervising staff attending is ultimately responsible for the care of the patient.

B. The UTHSCSA Psychiatry Resident Program Directors define policies to specify how residents progressively become independent in specific patient care activities while still being appropriately supervised by medical staff. The Department of Psychiatry resident supervision policies are in compliance with
Joint Commission, ACGME, and UTHCSA policies on resident supervision, delineate the role, responsibilities and patient care activities of residents, and delineate which residents may write patient care orders. Progressive independence from supervision occurs with the advancement through the PGY1-PGY4 years. At the beginning of training all cases are directly discussed and checked out with a supervisor. As the resident progresses through the PGY2 year, uncomplicated cases can be managed by the resident without immediately checking out the case with the supervisor on site. Continued graduated progression of less supervision, if so approved by the Program Director and after feedback from faculty, occurs with an increasing number of cases during PGY3-PGY4 years, wherein an increasing percentage of patient cases are allowed to depart from the treatment site before direct review by the site attending. The approved process for residents to see patients independently will be depicted and monitored locally by directly informing the site supervisor and ancillary site personnel.

C. The Psychiatry Resident Program Director determines if a resident can progress to the next higher level of training.

Section V. Supervision of Residents in the Inpatient Setting

A. The attending staff has the primary responsibility for the medical diagnosis and treatment of the patient. Residents may write daily orders on inpatients in whose care they participate. These orders are implemented without the co-signature of a staff physician. It is the responsibility of the resident to discuss their orders with the attending staff physician. Residents will follow all local teaching hospital policies for how to write orders and notify nurses, and they will follow verbal orders policies of each patient care area.

B. Descriptions of residents’ competencies by site and year of training are depicted in the Goals and Objectives provided for each training site.
C. Staff supervision of care for hospitalized patients is documented in the psychiatry inpatient record. The documentation requirements below are minimal requirements and may be more stringent if required by the UTHSCSA teaching hospital. Required documentation for residents and staff:

In accordance with hospital policies, staff must document in writing concurrence with the following: admission, history, physical examination, assessment, treatment plan, orders regarding major therapeutic decisions (such as “do not resuscitate” status), or when any major change occurs in the patient’s status (such as transfer into or out of an intensive care unit). Documentation, in writing, by residents must also be in accordance with hospital policies.

Section VI. Supervision of Residents on Inpatient Consult Service

All inpatient consultations performed by residents will be documented in writing, with the name of the responsible staff consultant recorded. The responsible staff consultant must be notified verbally that day by the resident doing the consult. The attending staff has the primary responsibility for the psychiatric diagnosis and treatment of the patient. The consulting staff is responsible for all the recommendations made by the consultant resident.

Section VII. Supervision of Residents in Outpatient Clinics

All outpatient services provided by residents will be conducted under the supervision of a staff attending. The staff provider will interview and examine the patient at the staff’s discretion, at the resident’s request, or at the patient’s request. The staff attending has full responsibility for care provided, whether or not he/she chooses to verify personally the interview. The Outpatient Clinic experience occurs in the PGY3 and PGY4 year. Since the resident has had decision-making experiences as a PGY1 and PGY2, outpatient encounters occur with less direct supervision to encourage more clinical independence. For example, off site college mental health clinics do not have a supervisor on site although an attending physician is available by phone.
Additionally, bimonthly office supervision occurs with the resident to discuss the ongoing college clinic caseload. Initially all cases are discussed retrospectively, but after three months, select difficult cases are the focus of supervision, with less complex cases managed by the resident.

**Section VIII. Supervision of Residents in the Emergency Service**

Supervision of residents assigned to Emergency Service (Psychiatric Emergency Service) as a PGY2 follows the model for the in-patient consultation service. Supervision of residents assigned to the Emergency Service (Psychiatric Emergency Service) as a PGY3 and PGY4 follows the model for the outpatient clinics with graduated progression of less supervision over time.

**Section IX. Additional Issues**

A. Changes to resident supervision guidelines may be altered during the year by the Program Director.

B. Interpretations to resident supervision guidelines will be made by the Program Director.

C. The Program Director makes decisions for progression, unless by exception, based on evaluations from other faculty.