Resident Supervision

Attending Practitioner Responsibilities

For all care in which interns, residents or fellows are involved. Documentation of all patient encounters must identify the supervising practitioner attending and indicate the level of involvement.

Four types of documentation

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**
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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 24 hours of admission. (No exceptions for weekends or holidays).

**Inpatient: Continuing Care**
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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.)
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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) plus any of the 4 types of documentation daily.

**Inpatient: Discharge or Transfer**
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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](#).

**Outpatient: New Patient Visit**  
(includes Emergency Dept. visits)  
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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**  
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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**  
([table of contents](#))

Attending will ensure that discharge from a clinic is appropriate.

**Documentation:** Any of the [4 types](#) of documentation.

**Surgery / OR Procedures**  
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Except in emergencies, 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.
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)

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)
(table of contents)

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

provided by: **Department of Veterans Affairs**

Veterans Health Administration
Office of Academic Affiliations

Reference: VHA Handbook 1400.1 Resident Supervision
March, 2009