Resident Supervision
Attending Physician Responsibilities
for Physician, Dental, Optometry and Podiatry Residents

“Supervising Practitioner”
(synonymous with “Attending”): Responsible for all care in which interns, residents or fellows are involved.

“Resident”
refers to all physician, dental, optometry, and podiatry residents and fellows, regardless of training level.

“Documentation”
is the health record entry that clearly demonstrates the involvement of the supervising practitioner.

Four types of documentation of resident supervision:
1. Attending’s progress note or other entry into the patient health record.
2. Attending’s addendum to the resident admission or progress note.
3. Co-signature by the attending implies that the attending has reviewed the resident note or other health record entry, and absent an addendum to the contrary, concurs with the content of the resident note or entry. Use of EHR function “Additional Signer” is not acceptable for documenting supervision and is not the same as co-signature.
4. Resident documentation of attending supervision includes the name of the attending with whom the case was discussed, a summary of the discussion and a statement of the attendings oversight responsibility (e.g., “I have seen and discussed the patient with my attending, Dr. X, and Dr. Y agrees with my assessment and plan” or “I have discussed the patient with my Attending Dr. X and Dr. X agrees with my assessment and plan”), or at a minimum, the responsible attending should be identified (e.g., “The attending of record for this patient encounter is Dr. X”).

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.

An independent note, addendum to the resident’s note, or resident note with description of attending involvement. Co-signature of resident note by attending alone is not sufficient documentation.

Observation Patients
The level of supervision depends upon the unit where the patient is being held (e.g., ICU, inpatient ward, or emergency department). Residents will contact the attending on-call for patients being discharged before being seen by the attending.

A summary of the discussion between the resident and Attending must be documented in the resident’s note (for patients not seen by the attending prior to release). An independent note or addendum to a resident note is required when the attending evaluates the patient in person. Co-signature of the note is not sufficient.

Home Visits
Residents must have training in handling emergency situations and in-home health policies. PGY-1 residents must be accompanied by an attending. For other PGY-level residents, the attending must be readily available via phone. Home visits must be followed by a discussion between the attending and the resident.

Any of the 4 types of documentation is acceptable.

Telemedicine/Telehealth
Please refer to the OAA Intranet for current recommendations and rules.

• Real-time Videoconferencing: The attending must be in the general vicinity and available to the resident for direct supervision without delay, as if the patient were being seen in a clinic.
• Store and forward telehealth: The resident reviews the material with or without the attending present, and the attending reviews the same material. The interpretations and reports on all images and pathology specimens must be verified by the attending. Residents must receive feedback on their interpretations.
• Home telehealth: Attendings are expected to exercise general oversight of the care provided by residents. Residents must consult with the supervising practitioner regarding any changes in a home telehealth patient’s status or proposed changes in the treatment plan.
• Tele-ICU coverage (remote): The local ICU attending is responsible for supervising residents-on-duty. Residents are expected to write all orders on patients whom they are covering. Tele-ICU practitioners may act as consultants to the residents, but not as their supervising practitioners.

Any of the 4 types of documentation is acceptable.
Depending upon the clinical situation, 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 to determine the appropriate type of documentation.

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.

An Attending progress note, Attending’s addendum to the resident’s note, or resident documentation of attending involvement. Co-signature of resident note 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.

Any of the 4 types of documentation is acceptable.

Outpatient: Discharge
Attending will ensure that discharge from a clinic is appropriate.

Any of the 4 types of documentation is acceptable.

Inpatient: Admission
Attending must physically meet, examine and evaluate the patient within the time frame specified in the Medical Center Bylaws, not to exceed the end of the next calendar day after admission, including weekends and holidays.

An attending admission note or addendum to resident note documenting findings and recommendations regarding the treatment plan within the time frame specified in the Medical Center Bylaws, not to exceed the end of the next calendar day after admission, including weekends and holidays. Subsequent visits: Any of the 4 types of documentation is acceptable.

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).

Attending independent note, co-signature of the discharge/transfer note and/or the discharge instruction note. If patient is transferred from one service to another, the accepting attending should treat the patient as a New Admission. If the same attending is responsible for the patient across different levels of care, transfer documentation is not required. The Attending must co-sign a discharge summary.

(PGY-1) residents must have on-site supervision at all times by either an attending or a more advanced resident, with an attending being available on-call. On-site supervision for PGY 1 residents is required for Night Float and ‘Over Cap’ Admissions.

Inpatient: Continuing Care
Attending must be personally involved in ongoing care.

Any of the 4 types of documentation, at a frequency consistent with the patient’s condition and principles of graduated levels of responsibility and consistent with the medical staff bylaws.

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.

An admission note or addendum to the resident’s admission note is required within the timeframe specified in the Medical Center Bylaws, not to exceed the end of the next calendar day after admission, including weekends and holidays. Subsequent visits: Any of the 4 types of documentation is acceptable.

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).

Attending independent note, co-signature of the discharge/transfer note and/or the discharge instruction note. If patient is transferred from one service to another, the accepting attending should treat the patient as a New Admission. If the same attending is responsible for the patient across different levels of care, transfer documentation is not required. The Attending must co-sign a discharge summary.

Consultations (Inpatient, Outpatient, Emergency Department)
When residents are involved in consultation services, the consultant attending is responsible for supervision of these residents.

Any of the 4 types of documentation is acceptable.

Radiology/Pathology
Radiology or pathology reports must clearly identify the responsible supervising practitioner.

Routine Bedside & Clinic (Non-OR) Procedure (e.g., LPs, central lines, centeses, I&D, skin biopsy)
Complexity and risk dependent supervision and documentation; principles of graduated levels of responsibility apply.

Resident writes procedure note that includes the attending’s name. Any of the 4 types of documentation is acceptable.

Non-routine, Non-bedside, Non-OR Procedure (e.g., cardiac cath, endoscopy, invasive radiology)
The attending must authorize the procedure and be physically present in the procedural area.

Any of the 4 types of documentation: attending’s name is required, and degree of involvement is encouraged.

Surgery / OR Procedures

Except in emergencies, the attending surgeon must evaluate each patient pre-operatively.

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 written in the timeframe specified in the Medical Center bylaws, not to exceed the end of the next calendar day after admission, or the day before the OR procedure. Use appropriate note title. Informed Consent must be obtained according to VA policy. Attending level of involvement is documented in the VistA Surgical Package. Post-op documentation is 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 / 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 / procedural room, observes and provides direction to resident.
- Level D: Attending in OR Suite, Immediately Available Attending is physically present in 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.