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Clinical Learning
Environment Review

NATIONAL REPORT OF FINDINGS 2016

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SUPERVISION

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Issue Briefs

The CLER Program presents this series of Issue Briefs to supplement the *CLER National Report of Findings 2016*.

Each issue in the series features one of the focus areas of the CLER Program—supplementing the key challenges and opportunities highlighted in the National Report and enhancing the discussion as to their relevance and potential impact on GME and patient care.

In both the National Report and the issue briefs, the findings are based on data collected during the CLER site visits, including responses to closed-ended questions collected via an audience response system, open-ended structured interviews with the clinical site's executive leaders and leaders in patient safety and health care quality, and information gathered from the many individuals interviewed during walking rounds of the site's clinical units.

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Background

The ACGME established the CLER Program to provide formative feedback that presents graduate medical education (GME) leaders and the executive leadership of the clinical learning environments (CLEs) for GME with information on six areas of focus: **patient safety, health care quality, care transitions, supervision, duty hours/fatigue management and mitigation, and professionalism.**[1,2,3]

The *CLER National Report of Findings 2016*[4] presents information from the first set of CLER site visits to participating sites of 297 ACGME-accredited Sponsoring Institutions of residency and fellowship programs. These visits, conducted from September 2012 through March 2015, focused primarily on teaching hospitals, medical centers, and ambulatory sites that host three or more core residency programs.

In the group sessions conducted during these visits, the CLER teams collectively interviewed more than 1,000 members of executive leadership (including CEOs), 8,755 residents and fellows, 7,740 core faculty members, and 5,599 program directors of ACGME-accredited programs in the group sessions. Additionally, the CLER teams interviewed the CLEs' leadership in patient safety and health care quality and thousands of residents and fellows, faculty members, nurses, pharmacists, social workers, and other care providers while on walking rounds of the clinical areas.

OVERARCHING THEMES OF THE NATIONAL REPORT OF FINDINGS

The initial visits of the CLER Program revealed a number of findings that appeared to be common across many of the CLEs and six focus areas:

- Clinical learning environments vary in their approach to and capacity for addressing patient safety and health care quality, and the degree to which they engage residents and fellows in these areas.
- Clinical learning environments vary in their approach to implementing GME. In many clinical learning environments, GME is largely developed and implemented independently of the organization's other areas of strategic planning and focus.
- Clinical learning environments vary in the extent to which they invest in continually educating, training, and integrating faculty members and program directors in the areas of health care quality, patient safety, and other systems-based initiatives.
- Clinical learning environments vary in the degree to which they coordinate and implement educational resources across the health care professions.

In addition to serving as a basis for the overarching themes, the initial CLER visits sought to establish baseline structural and operational characteristics of the clinical sites, as well as their training practices in the six focus areas. In future cycles, the CLER Program will also seek to understand how the sites identify and prioritize areas for improvement and assess progress over time.

Supervision

A STORY FROM THE FIELD

During a CLER site visit, a nurse supervisor of an acute care patient unit noted that on occasion, during the evening shifts, she has entered a patient's room to find a lone resident struggling to complete a lumbar puncture. She noted that most of the time the residents eventually completed the procedure successfully and obtained the appropriate spinal fluid. However, she also recalled a few times where she intervened to ask the resident to stop and get assistance.

When asked about how she would know if a resident was approved to conduct the procedure without supervision, she stated that she believed in each instance the resident and the patient's attending physician were aware of the resident's abilities. She also noted that the hospital had a method for checking whether a resident was permitted to perform a procedure and that she would use this system on occasion. She was uncertain if other nurses used this system for checking.

She expressed the belief that if she or any of the other nurses had a significant concern about a resident's skills in conducting a procedure, they would likely call the patient's attending physician to check. However, she did not believe there was a comprehensive system in place to ensure prior to procedures that residents were qualified to perform them without direct supervision. Upon further reflection, she thought this was putting the patient, resident, and nurse at risk.

This story highlights the complex nature of the supervision process. In the findings from the first cycle of CLER visits, residents and fellows reported that they generally receive a high degree of supervision by senior residents and faculty physicians. However, there are times throughout the patient care experience when supervision of care is not conducted in person. The approach and management of indirect supervision is often not transparent to the other members of the health care team. In the case of this story, the nurse was left to assume that indirect supervision was appropriate. While it is not the role of other health care team members to supervise residents and fellows, it is the role of all health care team members (along with residents, fellows, and faculty members) to ensure the safety of patients at all times.

This story provides an example of the complex interaction between patient care and GME supervision when residents and fellows are performing procedures under indirect supervision. Notably absent in the nurses' description of patient care is clarity as to the role of nursing and other clinical care providers in assuring that indirect supervision is appropriately applied at the time of care. There was a lack of explicit systems allowing other care providers to participate effectively in assuring that supervision was appropriate.

The *CLER National Report of Findings 2016* presents data on three major areas of supervision: perceptions of potential vulnerabilities; awareness of the situations in which residents and fellows require direct supervision; and the potential impact on patient safety. The sections that follow highlight several examples of the detailed information found in the National Report and expand upon the areas identified to be challenges and opportunities.

Selected Findings

Figures 1 and 2 present data based on group interviews with residents and fellows, and conversations with nurses on walking rounds of numerous clinical areas.

Across CLEs, nearly all of the residents and fellows reported that they knew what they are allowed to do with and without direct supervision–a median of 100 percent (Figure 1).[a]

In most CLEs (90.3 percent), the nurses interviewed on walking rounds reported that they primarily rely on trust rather than clear and objective methods for determining whether an individual resident is allowed to perform specific patient procedures without direct supervision (Figure 2).[b]

Appropriate supervision is critical to patient safety. These findings illustrate the inconsistency of CLEs to provide nurses and other clinical staff members with explicit and accessible systems that provide detailed information on the level of supervision required of residents and fellows when performing patient procedures.

Figure 1

Percentage of residents and fellows who reported knowing what they are allowed to do with and without direct supervision: Distribution across CLEs

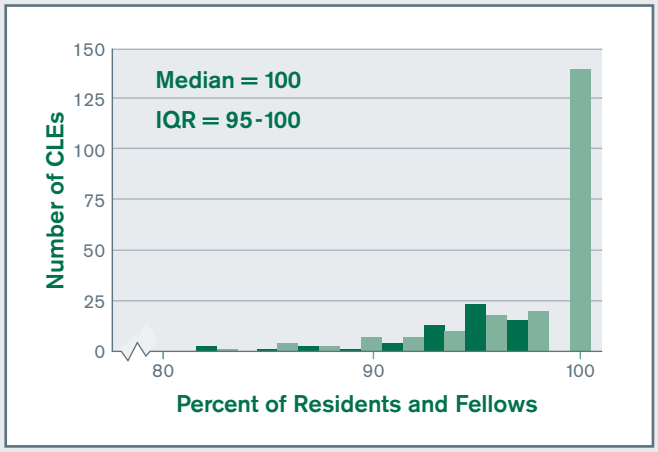
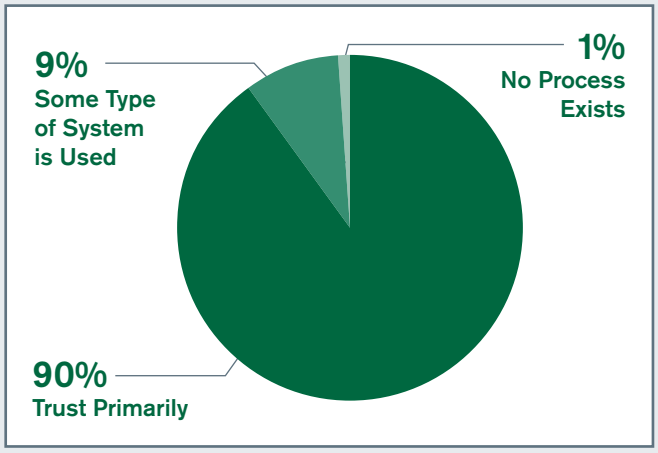


Figure 2

Percentage of CLEs by mechanism used for identification of resident and fellow competency to perform clinical procedures, as reported by nurses



[a] Distribution includes 90% or more of the 297 CLEs.

[b] Results based on 90% or more of the 297 CLEs.

Challenges and Opportunities

For the National Report, the members of the CLER Evaluation Committee reviewed aggregated data and selected three to four key findings to highlight and discuss. The following section expands upon the information presented in the National Report to include additional findings and a more in-depth discussion regarding the potential impact on patient care and resident and fellow education.

Across most CLEs, residents, fellows, and faculty members reported an overall culture of close supervision within the GME community. CLEs also faced challenges of under- and over-supervision. Many faculty members and program directors perceived that external factors contribute to a culture of over-supervision that impeded resident and fellow readiness for clinical practice after training.

- The most common reason given for concerns regarding over-supervision related to the Centers for Medicare and Medicaid Services (CMS) billing rules and medical liability concerns.

Across most CLEs, there were residents and fellows who reported that they have personally experienced—or had witnessed peers in—clinical situations in which they felt there was inadequate supervision.

Few CLEs provided nursing and other clinical staff members with systematic resources that allowed them to check an individual resident's or fellow's required level of supervision when performing a patient procedure.

- Across CLEs, nurses rarely used an objective source to verify that an individual resident or fellow had been approved to perform a procedure without direct supervision. When residents and fellows performed procedures without direct supervision, nurses primarily relied on familiarity, trust, year of training, or, when available, the presence of a senior resident, fellow, or attending physician.
- Occasionally, CLEs indicated that they had an objective source to check whether a particular resident or fellow is permitted to do a procedure without direct supervision. When an objective source existed, it was frequently found to be incomplete or out-of-date, or the nurses were not aware of its existence or how to access it. Often, the objective source described resident or fellow procedural ability by year of training and did not provide information specific to individual residents and fellows.

Some program directors reported having managed issues related to resident supervision within the past year, some of which contributed to patient safety events. In general, the CLEs' patient safety and quality leaders indicated that they did not actively monitor the supervision of residents and fellows except retrospectively, after a patient safety event had occurred.

- During the CLER visits where patient safety events related to supervision were identified, the residents and fellows, faculty members, program directors, GME leadership, patient safety leadership, and executive leadership varied in their knowledge of these events.
- Generally, across CLEs, the issue of supervision was viewed as the responsibility of the GME community.

Across CLEs, faculty members, program directors, patient safety leadership, and GME leadership identified patient care vulnerabilities related to supervision that were specific to the CLE, while executive leadership varied in their knowledge of issues related to supervision.

Examples of vulnerabilities mentioned include:

- When there are fewer attending physicians present on site, such as nights, weekends, and holidays
- When the resident or fellow is uncertain about when to seek support from the supervising attending physician
- When the resident or fellow is uncomfortable with contacting a specific supervising attending physician
- When the supervising physician is unavailable because of competing demands of other acute patient care situations and back-up supervision is not readily available

Across CLEs, nursing and other staff varied in their awareness of when and how best to engage faculty members or CLE administration when they had concerns regarding supervision.

Across CLEs, many residents and fellows, faculty members, and program directors expressed the belief that the majority of patients would not know the differences between the roles of residents, fellows, and attending physicians on their health care team.

Discussion

The issues of appropriate supervision relate primarily to patient safety and quality of care and the ability and ease in which all patient care providers—from the residents, fellows, and their faculty members, to other clinical care providers and patients—can help to preserve a safe environment while allowing the profession of medicine to train the next generation of physicians. Central to this issue is the need for a culture in which anyone is able to raise concerns about appropriate supervision.

The findings illustrate the inherent difficulty that CLEs have in achieving the appropriate level of supervision, an issue that is necessarily complicated by the need for different degrees of supervision at different stages of training. It is essential that CLEs explicitly address some of the well-known challenges to supervision, such as how supervision is managed late in the evening, early in the morning, and on weekends and holidays.

It was noteworthy that over-supervision was identified as a challenge in many CLEs across different specialties and services lines. Over-supervision of residents and fellows can have the negative consequence of producing physicians who are unprepared for independent practice. Billing requirements, payment policies, and regulatory and accreditation rules may be influencing CLEs and residency programs to place significant restrictions on the amount of patient care that residents and fellows can perform without direct supervision. Much of the concern about over-supervision appears to be related to how the CMS guidelines for teaching physicians, interns, and residents are being interpreted and implemented within various CLEs.[5] Within CLEs, teaching faculty members often refer to these issues to explain why they are present with their residents or fellows during procedures at all times throughout their training, while also recognizing that this may be adversely impacting their residents' or fellows' abilities to gain the necessary confidence in preparing for independent practice.

With regard to under-supervision, the findings suggest that often the only interface between GME and the CLE's patient safety and health care quality department happens after a major patient safety event has occurred. Patient safety and quality departments could benefit from working with GME to develop proactive monitoring of physician learners. Any proactive monitoring system would likely be underutilized unless the CLE clearly communicates expectations regarding use of this information in the daily workflow of clinical care for all members of the clinical team.

Comprehensive solutions for appropriate supervision of, and delegation of authority and responsibility to, residents and fellows within CLEs require ongoing attention and monitoring. This responsibility, while centered within GME, needs to include regular review by the executive leadership of the CLE. The findings suggest that solutions to resident supervision are currently managed within the context of the GME program, and sometimes by the GME leadership. However, supervision issues, if viewed and shared within the larger context of the CLE, may provide opportunities for more comprehensive approaches to challenges of faculty member availability related to under-supervision or faculty member concerns about risks and liability as related to over-supervision.

Issues of appropriate supervision are seldom simple and require careful oversight by faculty members. Due to the complex nature of clinical care, other members of the clinical team need to be involved in ensuring adequate supervision in a role that is supportive of faculty members and their residents and fellows. Such support requires information on the need for and type of supervision for each resident and fellow to be available to faculty members, supervising residents and fellows, and non-physician clinical staff members in an accessible and timely manner. It also requires that such information be reliably used to support clinical care.

The general lack of a well-defined role in supervision for clinical care providers other than physicians is an important finding, as appropriate supervision is central to patient safety. Health care in today's complex clinical care environment is a team effort. Much of a resident's experience in providing patient care happens in concert with other associated clinical providers. However, in many CLEs, the role of these other clinical providers in supervising residents and fellows is at best unclear. At this time, only teaching physicians have the responsibility for assessing the clinical competency of the residents and fellows. In the context of patient care, many other clinical providers could, with proper input and information, assist the GME community in ensuring the appropriate level of supervision. Defining such a role cannot be done informally. Appropriately incorporating other associated clinical providers in addressing issues of resident and fellow supervision will require interprofessional discussions and eventual alignment as to what the roles and obligations should be, as well as the appropriate tools to support staff members' efforts.

The finding that most residents, fellows, faculty members, and program directors believe that the majority of patients would not know the differences between their roles and responsibility raises concerns. It should be noted that, during this set of CLER visits, the site visitors did not directly speak with patients, so there was no direct means of confirming these beliefs. However, the finding needs to be further investigated as patients and their families, like other associated clinical providers, are often with the trainees at times when there is no attending physician present. They need to know how and who to contact if they have concerns regarding their care.

Conclusion and Next Steps

The ultimate goal of GME is to provide resident and fellow physicians with the clinical experiences necessary to acquire the knowledge, skills, and abilities that they need to deliver the safest and highest quality patient care. In order to achieve this, residents and fellows need appropriate supervision throughout their training. Providing close direct supervision provides the necessary comfort and assurance to minimize issues of patient safety for patients receiving care from residents and fellows in training. However, it is essential that residents and fellows are given the opportunity to provide care under indirect supervision to ensure that they develop into physicians who can practice independent of the training environment, and have the skills to ensure they deliver safe patient care over the 30 or more years of their clinical careers.

Patient care billing requirements, payment policies, and regulatory and accreditation rules may be influencing CLEs and residency programs to place restrictions on the amount of patient care that residents and fellows can perform without direct supervision. When this occurs, it impedes the ability of residents to progress from direct supervision through indirect supervision to successful independent practice at the completion of training. Addressing this set of issues will require a new national discussion to identify the best ways to manage these competing needs to ensure safe high quality care and the best possible GME experience.

The CLER Program findings demonstrate that residents and fellows believe that, in general, they are well supervised and know what they are allowed to do without direct supervision. It should be noted that this cycle of CLER visits was not designed to ascertain whether the residents' and fellows' beliefs about supervision are consistent with the beliefs of other members of the health care team, as well as their patients' views on supervision. The findings suggest that information about the required level of resident and fellow supervision may not be easily accessible to other members of the GME community (e.g., other residents or fellows) or other members of the clinical care team. To optimize patient safety, other members of the patient care team need to know the specific expectations for supervision of each individual resident and fellow, and need to act if there appears to be a need for closer supervision. Based on the findings from the first CLER National Report, it appears that engaging the GME community and the CLE's leadership in joint conversations to address the challenges regarding supervision of residents and fellows has the potential to greatly benefit patient care.

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5 Guidelines for Teaching Physicians, Interns, and Residents, CMS, ICN 006347, February 2015, Washington, DC.

Acknowledgments

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