Staten Island University Hospital

Annual Physician/Practitioner Orientation & Mandatory Training Program

Management of Patient Complaints

Supervision of Patient Care Provided by Post Graduate Trainees

North Shore – LIJ Health System, Inc.
Staten Island University Hospital

POLICY TITLE: Management of Complaints and Grievances	ADMINISTRATIVE POLICY AND PROCEDURE MANUAL
POLICY #: ADM III B 32.0 Health System # 100.12	CATEGORY: Administration
System Approval Date: 10/17/13 Site Implementation Date: 11/15/13	Effective Date: March 2008 Last Revised: 2/14/13
Prepared by: Denise McPartland, Asst. Director/PI	Superseded Policy(s)/#: N/A

GENERAL STATEMENT of PURPOSE

The purpose of this policy is to provide guidelines for a timely and effective review and response process for addressing patient grievances and complaints.

POLICY

The System is committed to the principle that all patients have the right to express complaints/ grievances about the care and services they have received or are receiving and to have those complaints/grievances fully investigated and responded to in a timely manner. Individuals acting on behalf of patients may express complaints for patients. The response to these complaints will be in be in accordance with the privacy guidelines outlined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If a quality investigation is required, any reviews are privileged under the Confidentiality of Hospital Quality Assurance (and exemption from disclosure) as set forth in the New York Public Health Law 2808-m and New York Education Law 6527(3). No patient's medical care will be compromised as a result of bringing a complaint to the attention of staff and/or a regulatory agency.

The Board of Trustees has delegated responsibility for the review of patient grievances to the Performance Improvement Committee at each site.

SCOPE

This policy applies to all members of the North Shore – LIJ Health System work force including, but not limited to, employees, medical staff, volunteers, students, physician office staff, and other persons performing work for or at North Shore – LIJ Health System.

DEFINITIONS

A "patient grievance" is a written or verbal complaint that cannot be resolved at the time of the complaint by staff present, is postponed for later resolution, is referred to other staff for later resolution, requires investigation, and/or requires further actions for resolution that is submitted by a patient, or patient representative, regarding the patient's care, abuse or neglect, issues related to compliance with CMS Hospital conditions of participation, or a Medicare beneficiary complaint related to rights and limitations provided by 42 CFR §489.

- A written complaint is always considered a grievance. Complaints received via e-mail or by facsimile are considered a grievance.
- All verbal or written complaints (including post hospital calls) regarding allegations of abuse, neglect, patient harm, or hospital compliance with CMS requirements are considered grievances.
- Whenever the patient or the patient's representative requests a response from the hospital, the complaint is considered a grievance.
- If an identified patient writes or attaches a written complaint on the patient satisfaction survey and requests resolution, then the complaint meets the definition of a grievance

A "patient complaint", for the purpose of this policy, is one that can generally be resolved by the staff present. "Staff present" includes any staff present at the time of the complaint or who can quickly be at the patient's location (i.e., nursing, administration, nursing supervisors, patient advocates, etc.) to resolve the patient's complaint.

- Patient issues with the environment, food services, amenities, TV etc. are generally considered to be complaints.
- Issues regarding billing, either written or verbal are considered complaints. However, Medicare beneficiary complaints related to rights and limitations provided by 42 CFR §489 are considered grievances.

PROCEDURE/GUIDELINES

As part of its notification of patient rights, on admission, every patient or their representative is provided the phone numbers and addresses for lodging a complaint with the appropriate regulatory agency (NYS Department of Health, Quality Improvement Organization Island Peer Review Organization, The Joint Commission, New York State Office of Mental Health and New York State Office of the Aging).

Every effort will be made to resolve any patient or patient's representative complaint as defined above as soon as possible. If a staff member is unable to provide resolution when the complaint is presented, staff of the hospital/facility/healthcare entity of the North Shore-LIJ

Health System must inform the patient and/or the patient's representative of the internal grievance process, including whom to contact to file a complaint/grievance.

I. Handling Patient Grievances

1. Every effort will be made to respond to all grievances within 7 days upon receipt indicating the hospital/facility/healthcare entity's contact person, the steps taken on behalf of the patient to investigate the complaint, the results of the complaint process, and the date of completion.
    a) If a response cannot be completed within that timeframe, the patient or patient's representative will be informed, via phone call or written letter that the grievance is under review through the grievance resolution process and a written response will be sent within 30 business days of receipt of the original grievance.
    b) If a response cannot be sent within 30 business days of receipt of the grievance due to the complexity of the grievance or extenuating circumstances in the resolution process, the patient or patient's representative will be informed of the delay, via phone call or written letter, and a written response will be sent as soon as possible but not to exceed 60 business days from receipt of original grievance.

- Written grievances addressed/directed to Administration at the Health System Corporate Office or any member of Administration within a hospital/ facility/healthcare entity of the North Shore-LIJ Health System will be initially acknowledged with a phone call by the Administrator or designee to the complainant.

- Written grievances, that are clinical in nature, received at the North Shore-LIJ Health System Corporate Office / Office of the President / Office of the Chief Medical Officer / Office of the Chief Nurse Executive will be forwarded to the Institute for Clinical Excellence and Quality. The Institute for Clinical Excellence and Quality will acknowledge receipt of the grievance and forward the grievance to the appropriate site for review and response. The site named in the grievance is responsible for review of the grievance and a copy of these findings will also be sent to the Institute for Clinical Excellence and Quality for response to the complainant.

- Written grievances, that are not clinical in nature, received at the North Shore-LIJ Health System Corporate Office/ Office of the President/ Office of the Chief Medical Officer / Office of the Chief Nurse Executive will be forwarded to the appropriate facility/individual for acknowledgement of receipt, review, and response to the complainant.

2. Grievances with regard to quality of care issues received via facsimile or e-mail from the North Shore-Long Island Jewish Health System public website can be acknowledged via e-mail. However, a written response letter will be sent as described above with the findings and the resolution. It is the current practice of the North Shore-Long Island Jewish Health System that no resolution letters will be sent via e-mail.

3. All written and verbal grievances known to be related to participation in a research study that are received at a hospital/facility/healthcare entity of the North Shore-LIJ Health System, must be reported to the North Shore-LIJ Institutional Review Board (IRB), as per the IRB's reporting requirements. If the IRB receives a grievance from a research subject, it should be reported to the Institute for Clinical Excellence and Quality.

4. Written and verbal grievances concerning improper disclosure, access, release or use of medical record information, and any privacy-related complaint will be referred to the Compliance and Privacy Director of the applicable facility for review, resolution, and response and will be entered into the Health System Complaint and Compliment Tracking Database or other applicable database.

5. Representatives from an insurance company, patient advocacy agency, and/or other third party with a request for patient information regarding a patient complaint/grievance should be informed that under state laws and regulations no patient information will be discussed and/or forwarded without a signed Authorization for Release of Health Information Pursuant to HIPAA by patient or patient representative.

6. Complainants who express dissatisfaction with the response will have their issues re-reviewed and another letter will be sent after re-review along with information concerning the right to contact a regulatory agency. Telephone numbers and addresses will be included. Also, a patient/family meeting may be offered to further clarify the situation and provide a learning opportunity for both the patient/family and the staff. These scheduled meetings may include the Executive Director, Associate Executive Director Quality Management, Medical Director, Chief Nursing Officer or designees and others as appropriate.

7. In the situation where the hospital/facility/healthcare entity has taken appropriate and reasonable actions to resolve a grievance, the patient or patient's representative remain unsatisfied with the resolution, the facility may consider the grievance closed for the purposes of these requirements.

8. All grievances will be entered and closed in the Health System Complaint and Compliment Tracking Database or other applicable database.

9. On a quarterly basis, an internal audit review will be conducted to assure that the intent to provide resolution in a timely manner is being achieved.

10. Reports on grievance investigations, resolutions, and corrective actions will be regularly reported at the Performance Improvement Coordinating Group and the Medical Board. Each site will track and trend data to be utilized as a measure of performance indicators and take actionable steps to improve quality patient care and patient experience. Periodic summary reports will be provided to the Committee on Quality by the Institute for Clinical Excellence & Quality and at the System Service Excellence Council and internal committees as appropriate.

II. Handling Patient Complaints

1. All complaints will be reviewed, responded to and resolved by the "staff present". Whenever possible, staff is empowered to immediately resolve complaints and to offer appropriate service recovery. If the staff member receiving the complaint cannot immediately resolve the issue, the staff member will escalate the complaint to the appropriate staff member for resolution.

2. Resolution will be determined based on a mutually agreed upon decision or the complainant will be informed of the grievance resolution process in which all stated requirements would apply.

III. Record Maintenance

1. The designated department of the hospital/facility/healthcare entity will maintain a grievance file including:
    a. A copy of the original complaint, or a report of the original complaint, if verbal, that was conveyed to a staff member.
    b. A copy of the investigation, findings, recommendations, and actions taken.
    c. A copy of the written response letter to the complainant.

2. If a quality review was required based on the nature of the grievance, the quality reviews will be maintained in a separate quality file by the designated quality/personnel department and would fall under the protection of the NY Public Health Law 2805-m and NY Education Law 6527(3).

3. The Compliance and Privacy Director for the applicable facility will maintain a complete file of all privacy cases including:
    a. A copy of the original complaint, if written, or a report of the original complaint, if verbal, that was conveyed to a staff member.
    b. A copy of the hospital's investigation report including findings, recommendations, and actions taken.

c. A copy of the response, if written, or a summary of the response given, if verbal.

REFERENCES to REGULATIONS and/or OTHER RELATED POLICIES

- Health Insurance Portability and Accountability Act
- Health Insurance Portability and Accountability Act of 1996, as revised 8/2002, 45 CFR § 164.501
- 10 NYCRR § 766.1 (Patient's Rights)
- 10 NYCRR § 763.2 (Patient's Rights)
- 10 NYCRR § 405.7 (Patient's Rights)
- Joint Commission Standard APR .09.01.01
- Joint Commission Standard RI .01.07.01
- CMS COP Patient's Rights § 482.13 (a) (2)
- NY Public Health Law 2805-m and NY Education Law 6527(3)

CLINICAL REFERENCES

APPROVAL:	
System P&P Committee	3/11/08; 10/12/10; 1/31/13; 8/29/13 (Provisional); 9/26/13 (Final)
System PICG Committee	3/27/08; 10/28/10; 2/14/13; 10/17/13
SIUH MEC	3/1/13; 11/4/13

Versioning History:
March 2008
October 2010
February 2013

North Shore – LIJ Health System, Inc.
Staten Island University Hospital

POLICY TITLE: **Occurrence Reporting**	**ADMINISTRATIVE POLICY AND PROCEDURE MANUAL**
POLICY #: ADM I 13.0 **Health System # 100.04**	**CATEGORY: Administrative**
System Approval Date: 11/20/14 **Site Implementation Date:12/15/14**	**Effective Date: 4/95** **Last Revised: 5/12**
Prepared by: Institute for Clinical Excellence and Quality	**Superseded Policy(s)/#:** N/A

GENERAL STATEMENT of PURPOSE

To establish a standardized method for the recording and reporting of Occurrences, as defined below; to ensure that an appropriate record is made and maintained with respect to any unusual event involving a patient or visitor, that the correct personnel are informed of such events; and that the facility collects, maintains and reports information in accordance with its obligations under state and federal law.

POLICY

- All Occurrences shall be promptly reported on an applicable Occurrence Report Form or on the electronic tracking and trending software. It is the responsibility of every employee/volunteer to immediately report to his/her supervisor any Occurrence.

- Patient related Occurrence Reports are the property of the facility and are prepared specifically for use by the Quality Management Department as an integral part of the facility's Quality Assurance program. Such reports are privileged and confidential, and protected from disclosure under N.Y.S. Education Law § 6527 and N.Y. S. Public Health Law § 2805-m as well as under the Federal Nursing Home reform Act, 42 U.S.C. § 1396r(b)(1)(B)(ii).

SCOPE
This policy applies to all members of the North Shore – LIJ Health System workforce including, but not limited to, employees, medical staff, volunteers, students, physician office staff, and other persons performing work for or at North Shore – LIJ Health System.

DEFINITIONS

Occurrence: An unusual event involving a patient, employee or visitor, such as, but not limited to suspected injuries resulting from medical care, accidents resulting in suspected personal injury or damage to persons, property or hospital property, and safety/security events. Examples of patient occurrences include, but are not limited to: falls, any medically unexpected outcome, medication errors, accidental burns, wrong-site surgery, unauthorized leave by patients, reports of inappropriate conduct by a member of the healthcare team, and allegations or neglect.

PROCEDURE/GUIDELINES

1. When an Occurrence involves physical injury or suspected physical injury, the individual involved should be promptly examined by a physician/designee.

    a) Patient Occurrences: The attending physician should be notified promptly of the Occurrence. The patient should be examined by their attending physician or designee. All patient occurrences should be fully documented in the patient's medical record by both the patient care services staff and the physician who examined the patient. The objective findings and assessments of the patient, as well as follow-up action, must be documented in the Medical Record. Occurrence Reports should not be filed in a patient's medical record. Chart documentation should not include that an Occurrence Report Form was filed.

        a. Patient Occurrence Forms: The form or electronic tracking and trending software should be completed for any Occurrence by the person or healthcare team member who first learned of or has the best knowledge of the Occurrence. The completed report should be submitted to the Quality Management Department for review. As applicable, other departments may be notified such as Corporate Compliance, Corporate Risk Management and the Office of Legal Affairs.

    b) Visitor Occurrences: Visitors shall be offered the opportunity to receive care in the Emergency Department (ED) (e.g. to be examined). If the individual involved in the Occurrence refuses to be examined by a physician, this refusal must be documented on the Occurrence Report Form.

        a. Visitor Occurrence Forms: The form should be completed by the healthcare team member who first learned of or has the best knowledge of the Occurrence. A completed Visitor Occurrence Report should be submitted to the facility's Security Department for review and reporting through the facility's Environment of Care (EOC)/Safety Committee. In the absence of Security, forms should be forwarded to facility leadership for review and routing. A copy of the visitor Occurrence Reports shall also be forwarded to Corporate Risk Management.

2. Employees, medical staff members, contracted staff, volunteers, and students involved in possible work-related injuries or exposure should follow the procedure outlined in the Human Resources Policy and Procedure Manual; Part X; Section 1 (Employee Health Services).

3. The Security Department shall also be notified of any loss, property damage or incident related to security/safety issues so that an applicable security report can be completed. Trends shall be reported to the EOC/Safety Committee. Completed reports are retained in the Security Department. Security will forward a copy of these reports to Corporate Risk Management.

REFERENCES to REGULATIONS and/or OTHER RELATED POLICIES

- NYSDOH 405.6 Regulations
- Joint Commission 2014 Hospital Accreditation Standards PI.01.01.01; EC.02.01.01
- Administrative Policy# 100.65 Serious Adverse (Sentinel) Event Policy

CLINICAL REFERENCES

N/A

FORMS

N/A

APPROVAL:	
System Administrative P&P Committee	1/11/11; 4/26/12; 10/30/14
System PICG/Clinical Operations Committee	1/27/11; 5/24/12; 11/20/14
SIUH MEC	12/7/11; 5/7/12; 12/1/14

Versioning History:
1/2011
5/2012

STATEN ISLAND UNIVERSITY HOSPITAL
GRADUATE MEDICAL EDUCATION POLICY & PROCEDURE MANUAL

SUBJECT: The Supervision of Patient Care Provided by Post Graduate Trainees	MANUAL CODE: GME VII-5
EFFECTIVE DATE: November 2004	SUPERSEDES: February 2003

POLICY:
Post Graduate Trainees (also referred to in this policy as "residents") may perform treatment procedures only under the supervision of a licensed, independent practitioner (in this policy the term "physician" also refers to dentist), on the Hospital's Attending staff or other physician credentialed to provide the specific treatment/procedure, in accordance with applicable law and accrediting requirements, as well as Hospital, Medical Board, and Clinical Department By-laws, rules, regulations, policies and procedures and delineation of privileges. Each Hospital inpatient, outpatient and emergency area patient shall be under the care of a licensed, independent health care practitioner who is a member of the Hospital's Medical Staff who bears ultimate responsibility for the patient's care.

PURPOSE:
Appropriate supervision of postgraduate trainees shall be provided and documented in the medical records of patients.

APPLICABILITY:
Post Graduate Trainees (members of the Graduate Staff) and physicians on the Attending Staff (referred to in this policy as "Attendings" or "Attending Physicians").

PROCEDURE:
General Rules (see also the section to follow: Special Requirements for Specific Patient Care Settings).

Definitions: For the purposes of this policy, the following terms, when capitalized, have the following meaning:

"General Supervision" means the treatment/procedure is furnished under the Supervising Physician's overall direction and control, but the Supervising Physician's presence is not required during the performance of the procedure/treatment. The Attending of record, however, has the continuing responsibility for the patient.

"Direct Supervision" means that the Supervising Physician must be in attendance with the patient and the resident while supervising the performance of the treatment/procedure.

Supervising Physician: unless otherwise stated in this policy, a Supervising Physician may be any of the following:

1. the patient's licensed Attending Physician or other responsible Physician credentialed to perform the treatment/procedure to be supervised;

2. for postgraduate trainees in the acute care specialities of anesthesiology, family practice, dentistry. medicine, obstetrics, pediatrics, psychiatry and surgery (see additional requirements below for surgery), Direct Supervision may be provided by: a) physicians who are board certified or admissible in the respective specialty in which the resident is a trainee, or b) physicians who have completed a minimum of four postgraduate years in training in the respective specialty. When residents are rotating to other services they will be under the supervision of the attending physician responsible for the service.

3. when Attending Physicians are immediately available by telephone and readily available on-site when needed, Direct Supervision of routine hospital care and procedures may be carried out by postgraduate trainees who are in their final year of postgraduate training or have completed at least three years of postgraduate training.

Responsible Individuals: Responsibility for ensuring proper supervision of postgraduate trainees and documentation thereof rests with the Department Chairs acting for the Board of Trustees, Chief Medical Officer and Medical Board. The Medical Board is responsible for ensuring compliance with policies for proper supervision and documentation of the supervision throughout the Hospital.

Delineation of Privileges: Each trainee's delineation of privileges must specify the treatments/ procedures he/she may perform under the Supervising Physician's a) General Supervision and b) Direct Supervision. The delineation of privileges may, but need not, also specify the treatments/ procedures that may be performed under the Supervising Physician's Direct Supervision.

On-Call Coverage by Telephone: Whenever an Attending is providing on call coverage via telephone, there shall be telephone calls as necessary between the Attending and the on-site Supervising Physician.

SUBJECT: The Supervision of Patient Care Provided by Post Graduate Trainees, Page 3	MANUAL CODE: GME VII-5
EFFECTIVE DATE: November 2004	SUPERSEDES: February 2003

DOCUMENTATION

General rules: No patient can be treated without a medical record being established and kept. The Supervising Physician must document in the patient's medical record whenever the Supervising Physician: 1) provides Direct Supervision of the resident's treatment/procedure, or 2) actually performs the treatment/procedure.

The Supervising Physician must document in the patient's medical record whenever the Supervising Physician: 1) reviews and agrees with the trainee's history, examination, laboratory findings, assessment or plan of care or, 2) disagrees with the trainee's history, examination, laboratory findings, assessment or plan of care (in which case the Supervising Physician must ensure that the patient's care is provided in accordance with the Supervising Physician's assessment and plan of care). For the purposes of this policy, a countersignature alone shall not constitute adequate documentation of Supervising Physician involvement.

Residents participating in LCME approved training programs may write orders under general supervision provided by the Teaching Attending Faculty (licensed, independent practitioner). Attending Physicians are not restricted from writing orders, but in a teaching setting they should complete their teaching supervision for the residents as recommended by the ACGME-RRC, by direct communication, telephone calls or progress notes rather than by writing orders.

Emergency Treatment: Emergency treatment provided by the resident pending the arrival of the Supervising Physician shall be documented by the resident, including the nature of the emergency, the treatment provided by the resident and the contact with the Attending Physician. The Supervising Physician also shall document the emergency condition and his/her assessment of the treatment provided.

Solicitation or Acceptance of Payment: No postgraduate trainee may solicit or accept payment on his/her behalf or on behalf of third parties (e.g. Hospital or Attending Physicians). No Attending may suggest that a postgraduate trainee solicit or accept payment from a patient. Solicitation or acceptance of such payments (or suggesting such solicitation or acceptance) is grounds for disciplinary action, including summary dismissals. Payment to the Hospital for services
rendered should be made directly to the Hospital in accordance with Hospital policies and procedures.

Department Chair and Program Director Responsibilities: the assurance of proper supervision of postgraduate trainees by Department Chairs and Program Directors will include:

1. the establishment and review of policies and procedures for the Clinical Departments that describe appropriate supervision of postgraduate trainees in accordance with applicable law, accrediting requirements and this policy;

2. Ensuring that the trainee successfully complete the treatment/procedure under Direct Supervision before he/she may perform the treatment/procedure under General Supervision, and documentation for changes in the trainee's delineation of privileges throughout the year (e.g., when the trainee's privileges have been revised upward or downward from the standard PG-level delineation); and

3. ensuring that supervision is provided at all times for the postgraduate trainees in accordance with applicable Medical Staff and Hospital By-laws, policies, rules, regulations and protocols, including this policy.

Medical Executive Committee Responsibility: The Medical Executive Committee, or a committee thereof, will:

1. at least annually review and approve recommended delineation of privileges proposed by Clinical Departments for their postgraduate trainees;

2. at least annually review and approve appropriate policies and procedures of all Clinical Departments related to supervision of postgraduate trainees;

3. at least annually (through the Hospital Performance Improvement or Risk Management Programs and GME Committee, as appropriate) monitor and supervise compliance by the Clinical Departments with such policies and procedures.

Supervision Requirements for Specific Patient Care Settings: In addition to the institution-wide requirements set forth in this policy, requirements for supervision and its documentation in various patient care settings are as follows:

Bedded Areas: Documentation by Attending Physicians of patient care in bedded areas shall at a minimum occur within 24 hours of the admission of the patient and occur at intervals in accordance with appropriate standards of care, within the specific specialty. Supervising Physicians must review and confirm or disagree with subsequent continuation or progress notes written by postgraduate trainees.

Operating Rooms: (includes all areas where surgery is performed, including ambulatory surgery): supervision by Attending Physicians of the care provided to surgery patients by postgraduate trainees must include as a minimum:

1. Direct Supervision by the Attending Physician of all surgical procedures requiring general anesthesia or an operating room procedure. The Attending Physician must be present during the critical portions of the procedure. The trainee, if credentialed, may provide the care of the non-critical portions of the procedure. The trainee, if credentialed, may provide the care of the non-critical portions under General or Direct Supervision and the record (perioperative record) must accurately reflect the portions where the Attending was present. In addition, the Attending must be immediately available within the Hospital;

2. preoperative examination and assessment by the Attending Physician and documentation according to this policy; and

3. at least daily postoperative examination and assessment by an Attending Physician and documentation according to this Policy (if the patient is not an inpatient, then at each visit).

Emergency Services:

A responsible supervising Attending Physician must be physically present for both pediatric and adult Emergency Department patients.

With respect to psychiatric patients in the Emergency Department, an on-call attending psychiatrist must be immediately available by phone, and available to come to the ED within approximately 30 minutes, if needed, 24 hours/day, 7 days/week. In addition, certain circumstances mandate the automatic on-site evaluation by the on-call attending psychiatrist where: a) the patient has inflicted physical damage to self or others; b) the patient has made a suicide attempt within the preceding 30 days. All decisions concerning the treatment and disposition of psychiatric patients in the Emergency Department will require the involvement of the attending physician by appropriate documentation in the record.

Critical Care Units: An Attending Intensivist is physically present in the hospital to provide appropriate supervision as needed in any critical care unit.

Behavioral Sciences: Any patient seen by residents or students will be directly reviewed at the bedside by a supervising psychiatrist from the Department of Behavioral Sciences. The supervising psychiatrist will be Board Certified or Board Eligible and take full responsibility for any care rendered by those trainees. In all cases, a progress note will be written by the supervising psychiatrist for all visits made by trainees.

Obstetrics & Gynecology: An Attending Physician must be physically present in the Hospital for on-site supervision at all times.

Ambulatory Care Sites: Each Department Chair will designate one person in the Department (usually the Ambulatory Program Director) to be responsible for ensuring that an Attending Physician ("Preceptor") is physically present at each session to supervise residents in accordance with Hospital policies and procedures, applicable law and accreditation requirements. Each Department Chair will ensure that either the resident carries on his/her person or the site administrator of each ambulatory site has the list of treatments/procedures that may be performed by the residents of the Department and the Preceptor must ensure that the resident is practicing within those parameters. The Program will provide the site manager a schedule of the resident's sessions and the Preceptor for each session. Records of Preceptor schedules must be maintained whenever they are responsible for the supervision of residents. Whenever Preceptors are responsible for the supervision of residents at an ambulatory care site, an attendance record must be kept for supervision.

Radiology and Diagnostic Studies: The Attending Physician must review every film/tracing, diagnostic study or specimen and every interpretation with the postgraduate trainee and document this review according to this policy.

The Attending Physician must personally supervise all "interventional" and "high risk procedures" (as defined in the Clinical Department's policies and procedures and delineation of privileges).

Endoscopy Suites: An Attending Physician must Personally Supervise the entire viewing portion of each endoscopy procedure.

Off-Site Doctors' Office: Clinical Departments may assign postgraduate trainees to rotate to Doctors' Offices, provided that the Department Chair ensures that there is a document which is first approved by the hospital GME Committee describing the nature of the rotation; that the rotation is limited to clinical activities within the scope of the resident's delineated clinical privileges at the Hospital; that the resident is directly supervised by an Attending Physician; and the Attending Supervision is documented by an attending note in the patient record.

(Note: Occurrence of urgent or emergent situations may preclude the Attending Physician from direct participation in the decision-making regarding patient care. In such circumstances, the Supervising Physician shall concur in the decision, and the Attending Physician shall be notified as soon as possible. Responsibility for such decisions made in absence of consultation with the responsible Attending Physician resides with the involved postgraduate trainees and the Supervising Physicians.)

Reviewed:

Mark Jarrett, M.D.	Chairman, Graduate Medical Education	Date
Al Glover	Executive Vice President & COO	Date
Anthony Ferreri	President & CEO	Date
Albert Accettola, Jr., M.D.	President, Medical & Dental Staff	Date
John Shall	Chairman, Board of Trustees	Date