McMaster University | Psychiatry & Behavioural Neurosciences

McMaster Psychiatry Postgraduate Program

Guidelines for Supervision of Residents During a Pandemic

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Purpose: This document outlines expectations of supervisors providing supervision of residents during a pandemic.

These guidelines have been developed in attempt to meet the educational needs of residents, while maintaining continuity of some clinical services, during the exceptional circumstances of the CoVID-19 pandemic.

Review of these guidelines should occur in the post-pandemic period, when needs of the system may be different.

Guidelines:

In the COVID-19 pandemic, it is possible, due to psychiatric faculty staffing shortages related to COVID-19 possible exposures or illness, that coverage on units may be markedly reduced. In addition, although the hospital remains ultimately responsible for staffing coverage of psychiatric units, residents may be redeployed to other psychiatric settings to assist in coverage or enhance their learning experience based on staffing shortages or changes in patient numbers.

a) Resident safety, including access to adequate PPE and space in which to safely complete work, is required in all clinical settings. PPE availability must comply with hospital requirements.

b) Supervision must be adequate for the level of the resident. This may be individualized as deemed appropriate.
    a. For senior residents:
        i. this must include access to a supervisor, either remotely or in person, to provide adequate indirect supervision of all clinical care in a timely fashion.
        ii. There must always be a staff member on site or available to attend in person in a timely manner where face to face care with patients is occurring, that being either the primary supervisor or a backup supervisor, in case of urgent need for assistance or in-person assessment.

    b. For junior residents:
        i. It is ideal, although may not always be possible, to provide some direct supervision of a junior resident's work, even during a pandemic. This can

be performed by the supervising faculty member or by a senior resident on the same service.

ii. Provision of adequate indirect supervision must occur for all patient encounters.

iii. There must always be a staff member or senior resident on site where face to face care with patients is occurring, either the primary supervisor or a backup supervisor, in case of urgent need for assistance or in-person assessment.

iv. In the instance of only a senior resident being on site, there must always be a staff member available to attend in person in a timely manner where face to face care with patients is occurring, that being either the primary supervisor or a backup supervisor, in case of urgent need for assistance or in-person assessment.

c) Although learning considerations at time may be of lower priority, every effort to ensure that residents are receiving an adequate learning/training experience should be ensured.

d) Assessment of residents must continue to occur. If on a usual clinical rotation, this will occur by means of the typical rotation ITER. If on a redeployment rotation, this will occur by means of a pandemic ITER. Supervisors are responsible for filling out the ITER in a timely fashion in keeping with PGME guidelines and providing direct feedback to residents on their work during the course of their rotation with a given supervisor.

The remainder of this document highlights considerations particular to remote supervision of residents during a pandemic scenario.

Guidelines for Remote Supervision of Residents

This may occur in two contexts:

I. Provision of virtual care, with resident and supervisor each working outside of an office setting

II. Resident working in hospital, while supervisor off-site (ie due to illness or self-isolation)

I. Remote Supervision of Residents Working from Home Performing Virtual/Phone Visits:

During the COVID-19 pandemic, outpatient psychiatric care in many settings has been transitioned to a virtual care model. This document serves as a guide for supervisors and residents in understanding their mutual roles and responsibilities in providing safe, adequately supervised patient care and supporting residents in their learning.

a) The faculty member is the Most Responsible Physician for every patient seen by residents, even when both are working separately from home.

b) Supervisors must set clear expectations for check in times during the day and the week:
    - This can include a morning check-in before seeing patients or an afternoon check-in after all cases are completed for supervision and review.
    - Supervisor and resident should have each other's cell phone or other information if immediate contact for supervision purposes should arise (ie, an urgent question or an issue of patient safety) and the supervisor should make themselves available at all times.
    - Frequency of phone or video check in with the resident should be determined by level of seniority (ie, a PGY-2 may require supervision after each new consult, but a PGY-5 may be able to review at end of day only).
    - For technical difficulties, the resident should be made aware of who to contact (ie, clinic manager, IT) or of use of alternative options to contact patients (ie, by phone).

c) Supervisors should be familiar with confidentiality, medicolegal issues, and how to put in place provisions for patient safety (ie, Form 1s) while performing telepsychiatry or video psychiatry. The supervisor's clinical or hospital setting should give guidance, and further guidance is available online from both the CPSO and the CMPA.

d) The platforms for phone/video visits must be discussed and agreed upon by resident and supervisor and be in line with confidentiality guidelines (ie, OTN and MyDovetale preferred for video visits and if these are not available, then a discussion around confidentiality differences and need for patient consent for other platforms like Zoom must be discussed).

e) Residents performing phone visits should be instructed to use a hospital/clinic phone if conducting the visit from a clinic setting and should be instructed to turn off caller ID if using their personal cell phone for privacy purposes.

f) It may be desired by the supervisor or the resident to do a shared visit, when both the faculty member and resident are present to interview a patient or observe each other. Phone and video platforms can offer this capability and should be utilized as a form of direct supervision.

g) Teaching can still be provided even if residents and faculty are working remotely, and the supervisor may wish to use daily supervision or set aside other times for teaching. Video platforms may lend themselves to teaching to facilitate increased engagement on both sides.

h) Faculty should review resident documentation from offsite as appropriate and must have remote access to Dovetale or other EMR as dictated by the site to complete this.

Residents are required to learn based on "graded responsibilities". A resident would not be expected to demonstrate all of outpatient psychiatry competencies at the beginning of their training. However, by the end of their training, psychiatry residents should be consistenly demonstrating significant compentency in this setting, thereby functioning at the level of a Junior Consultant. However, given that virtual care is new to many, extra support may be required for the first few weeks providing care in this manner.

II. Remote Supervision of Residents Working in Hospital Provided by Faculty Off-Site (due to Illness or Self-Isolation):

In the COVID-19 pandemic, it is possible, due to psychiatric faculty staffing shortages related to COVID-19 possible exposures or illness, that coverage on units may be markedly reduced. Although it is the responsibility of the hospital to ensure units are appropriately staffed and covered, it may be deemed possible or necessary for some staff to work from home. In this case, residents may be physically in the hospital working on acute units with supervision provided primarily by remote supervision.

In this case, staff supervision should function similarly to the model of supervision provided in PES. Within the PES supervision structure, a teaching framework is used that is similar to a clinical teaching unit (CTU) model. In this model, the medical care of the emergency psychiatry patient is the function of the team comprised of a supervising staff psychiatrist, senior and junior residents, and allied health professionals.

a) The faculty member supervising the resident in the inpatient or C/L environment is the Most Responsible Physician for every patient seen by residents.

b) All teams that are supervised by a remote faculty member MUST include a senior resident comfortable with the clinical setting. This would include having worked in this setting before and/or having completed a rotation in this setting prior (ie, a PGY-4 resident supervised remotely on C/L must have completed their core C/L rotation).

c) Safety must remain a priority at all times. Supervisors are expected to ensure that residents with whom they are working with have been oriented to the safety features, processes and policies of the unit(s) on which they will be working. This can be completed remotely, by an on-site faculty member, or by a member of the nursing or allied health staff, as deemed appropriate.

d) Supervisors and residents must set clear and mutual expectations for check in times during the day and the week:
    - This must include a morning check-in before seeing patients and an afternoon check-in after all cases are completed for supervision and review.
    - Additional check ins can be scheduled based on cases and need.
    - Supervisor and resident should have each other's cell phone or other information if immediate contact for supervision purposes should arise (ie, an urgent question or an issue of patient safety) and the supervisor should make themselves available at all times.

e) Notwithstanding the above, should there be an urgent need for a psychiatrist to supervise the resident in person due to the nature of a certain case, there MUST be a back-up psychiatric faculty on site who can respond to an urgent resident need. This faculty member MUST attend in person to a resident request, although a conversation can occur with the offsite faculty and onsite resident, which then includes the onsite faculty to determine if in-person presence is required.

f) Teaching can still be provided even if residents and faculty are working remotely, and the supervisor may wish to use daily supervision or set aside other times for teaching. Video platforms may lend themselves to teaching to facilitate increased engagement on both sides.

g) Residents must review every case with the supervising psychiatrist before moving forward with the disposition plan. The level of detail reviewed should be appropriate for that required for the particular clinical setting.

h) Faculty should review resident documentation from offsite as appropriate and must have remote access to Dovetale or other EMR as dictated by the site to complete this.

Appendix A: Example of a Virtual Visit Consent Form

*this example of a virtual visit consent form is from recommendations of the OMA.

Virtual Visit Consent Form

Patient Name: _____

Physician Name: _____

Date: _____

Informed verbal consent was obtained from this patient to communicate and provide care using virtual and other telecommunications tools. This patient has been explained the risks related to unauthorized disclosure or interception of personal health information and steps they can take to help protect their information. We have discussed that care provided through video or audio communication cannot replace the need for physical examination or an in person visit for some disorders or urgent problems and patient understands the need to seek urgent care in an Emergency Department as necessary (from OMA).

Physician signature: _____ Date: _____