

UW GME Approved Supervision Policy Template

Revised 03/10/2022

TRAINING PROGRAM SUPERVISION AND ACCOUNTABILITY POLICY

Last updated: March 20, 2026

Please reference complete [UW GME Institutional Supervision and Accountability Policy](#) for additional definitions and background.

Department of Otolaryngology- Head and Neck Surgery (OHNS)

Washington Medical Center-Montlake (UWMC-ML)

Harborview Medical Center (HMC)

Seattle Children's Hospital (SCH)

VA Puget Sound Health Care System (VA)

Washington Medical Center-Northwest (UWMC-NW)

Responsibilities and Accountability

Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care. This information will be available through the electronic health record to residents, fellows, faculty members, other members of the health care team, and patients.

The Otolaryngology residents, fellows, and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care.

The program will provide the appropriate level of supervision for each resident based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation.

As part of their education program, residents are given graded progressive responsibility according to the individual's clinical experience, judgment, knowledge, and technical skill. Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence.

Supervision Definitions

To promote oversight of resident supervision while providing for graded authority and responsibility, the following levels of supervision are recognized:

1. Direct Supervision:
 - a. the supervising physician (attending, faculty, fellow, senior resident) is physically present with the resident and patient during the key portions of the patient interaction;or,

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- i. PGY-1 residents must initially be supervised directly with the supervising physician physically present during the key portions of the patient interaction.
 - b. the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.
2. **Indirect Supervision:**
the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.
3. **Oversight:** the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

Resident Competence & Delegated Authority

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.

The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones.

Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident/fellow.

Clinical Responsibilities by PGY-Level

PGY-1 Residents

PGY-1 residents are initially either directly supervised or *indirect supervision with direct supervision* immediately available (see definitions above). They should generally be the point of first contact when questions or concerns arise about the care of their patients. However, when questions or concerns persist, supervising residents and/or the attending physician should be contacted in a timely fashion. During this year, the residents function on multiple other services within the General Surgery training program. The details of the supervision provided for them during these R1 rotations can be found under the guidelines for General Surgery. While on the OHNS services, R1 residents participate in patient care in the outpatient clinic, inpatient areas, emergency department, and operating room. They function under institutional guidelines for non-otolaryngologic procedures. For activities specific to the specialty, they are always directly supervised, or indirectly supervised with direct supervision immediately available (for a limited number of activities outside of the operating

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room) by a more senior trainee or attending.

Direct supervision is not required for the following procedures: Phlebotomy, placement of peripheral intravenous catheters, dressing changes, suture/staple placement and removal, nasogastric intubation, Foley catheter placement, arterial puncture/catheterization, wound packing, removal of drains, wound/laceration closure, placement of ear packing/wick, nasal culture.

Note: Direct supervision should be sought for any situation involving the above if the resident is unsure or has not previously achieved basic procedural competence under the supervision of a certified resident (R2-R5), fellow or attending while on another rotation during the R1 year.

Intermediate Residents

Intermediate residents may be *directly* or *indirectly supervised* by an attending physician or senior resident/fellow but will provide all services under supervision. They may supervise PGY-1 residents and/or medical students; however, the attending physician is responsible for the care of the patient.

Senior Residents

Senior residents may be *directly* or *indirectly supervised*. They may provide direct patient care, supervisory care or consultative services, with progressive graded responsibilities as merited. Senior residents or fellows should serve in a supervisory role to medical students, junior and intermediate residents in recognition of their progress towards independence, as appropriate to the needs of each patient and the skills of the senior resident; however, the attending physician is responsible for the care of the patient.

Levels of Supervision for Common Specialty Clinical Activities and Invasive Procedures

Please list each clinical activity/procedure by PGY-level, with specific CPR Level of Supervision language:

Clinical Activity/Procedure	Resident level (PGY)	Location	Supervision Level
Fiberoptic endoscopy	PGY 1	Hospital, ED, Clinic	Direct (until competence)
	PGY 1-2	Hospital, ED, Clinic	Indirect with direct supervision available. The endoscopies of R1 residents are recorded for review.
	PGY 3-5	Hospital, ED, Clinic	Oversight
Anterior nasal pack	PGY 1	Hospital, ED, Clinic	Direct

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Clinical Activity/Procedure	Resident level (PGY)	Location	Supervision Level
	PGY 2	Hospital, ED, Clinic	Indirect with direct supervision available
	PGY 3-5	Hospital, ED, Clinic	Oversight
Biopsy of superficial head/neck lesions	PGY 1	Hospital, ED, Clinic	Direct
	PGY 2	Hospital, ED, Clinic	Indirect with direct supervision available
	PGY 3-5	Hospital, ED, Clinic	Oversight
I&D wounds/abscess	PGY 1	Hospital, ED, Clinic	Direct
	PGY 2	Hospital, ED, Clinic	Indirect with direct supervision available
	PGY 3-5	Hospital, ED, Clinic	Oversight
Drainage of peritonsillar abscess	PGY 1	Hospital, ED, Clinic	Direct
	PGY 2	Hospital, ED, Clinic	Indirect with direct supervision available
	PGY 3-5	Hospital, ED, Clinic	Oversight
Tracheostomy tube change	PGY 1	Hospital, ED, Clinic	Direct
	PGY 2	Hospital, ED, Clinic	Indirect with direct supervision available
	PGY 3-5	Hospital, ED, Clinic	Oversight
Micro-otoscopy with cerumen removal	PGY 1	Hospital, ED, Clinic	Direct
	PGY 2	Hospital, ED, Clinic	Indirect with direct supervision available
	PGY 3-5	Hospital, ED, Clinic	Oversight

Direct supervision by a qualified senior resident (R4-R5), fellow or attending is required for all other invasive otolaryngologic procedures not listed. All surgical procedures performed in the operating room must be directly supervised by a fellow or attending. Direct supervision by a fellow or attending is required for all procedures on pediatric patients less than 5 years of age.

Circumstances and Events in which Supervising Faculty Member (s) MUST be Contacted

1. Any change in patient status, including significant vitals instability.

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2. Admission of patient.
3. Patient leaving hospital AMA.
4. Patient transfer to higher acuity (ICU, Telemetry, etc.).
5. Significant neurologic changes.
6. Intubation/CODE event, death.
7. Change in status of free flap, limb-threatening event (loss of pulses, etc.).
8. Unplanned loss of drain.
9. Hematoma, excessive drain output.
10. Significant wound dehiscence.
11. Medical/treatment error.
12. Any request by other providers for attending notification.
13. Consultation/care regarding immunosuppression.
14. Complex decision making around initiation of new therapies, procedures for diagnosis or treatment (IR, scan, antibiotics, etc.).
15. Direct supervision is requested or a Patient Advocate is involved for any reason.

Supervision of Consults

Residents may provide consultation services under the direction of supervisory residents including Fellows. The attending of record is ultimately responsible for the care of the patient and thus must be available to provide direct supervision when appropriate for optimal care. Information of the attending, fellow and senior residents on call is available to residents, faculty members, and hospital staff through department Intranet in addition to the paging operator who has the up to date call schedule.

Residents performing consultations on patients are expected to communicate electronically/verbally with their supervising attending at the following time intervals: daily as directed by the clinical context for acute consults. More frequent communication may be required based patient acuity, complexity, and the resident's level of training. Stable consults may have intermittent follow up by the consultant team and less frequent updates.

Emergency Procedures

It is recognized that in the provision of medical care, unanticipated and life-threatening events may occur. The resident may attempt any of the procedures normally requiring supervision in a case where death or irreversible loss of function in a patient is imminent, and an appropriate supervisory physician is not immediately available, and to wait for the availability of an appropriate supervisory physician would likely result in death or significant harm. The assistance of more qualified individuals should be requested as soon as practically possible. The appropriate supervising practitioner must be contacted and apprised of the situation as soon as possible. An example of this may be an emergency surgical airway that must be performed immediately before a supervising physician arrives.

Faculty Supervision Assignment

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Faculty supervision assignments exist for the duration of the clinical rotation, and therefore are of sufficient length to assess the knowledge and skills of each resident/fellow and to delegate to the resident the appropriate level of patient care authority and responsibility.

Supervision of Handoffs

Residents are expected to conduct professional, safe and articulated handoffs whenever there is a transition of care from one resident or team to another. Prior to the handoffs, a senior resident will round with the team in order to clarify all on call orders, procedures, and “if then” scenarios that may come up for each patient. Residents are instructed in the process and expectations for handoffs during annual orientation which is reinforced every quarter at “sign-out” dinners. Department provides for these face-to-face sign-out dinners every quarter with required attendance. These dinners help residents rotating onto a new service to understand the nuances of that service and the inpatient care provided at that site. Senior residents are responsible for overseeing the accuracy of the information relayed at these dinners.

Residents conducting hand-offs are expected to use structured verbal and electronic processes for patient transfers between services and locations. Otolaryngology residents use iPAASS that was updated to incorporate current EPIC workflow (Feb 2026). See Addendum I.

ADDENDUM 1

UW OTOLARYNGOLOGY RESIDENCY PATIENT HANDOFF

STANDARD FORMAT: I-PAASS (ENT-Adapted)

I — Illness Severity

- Stable
- Watcher
- Unstable

P — Patient Summary

- **MRN/ Name / Age / Gender:** _____
- **Location / Site:** _____
- **ENT Dx:** _____
- **OR Date:** _____
- **Key Procedure(s):** _____
- **Comorbidities:** _____

Example: ** Name, MRN, Hospital bed ** 72 yo F with history of BOT SCC who is admitted s/p TORS and ND 2/3/26. PMH: HTN, a fib, depression

AIRWAY (MANDATORY)

- Native airway & amount of O2 support
- Tracheostomy (fresh trach: yes no; size: ___ / cuff up down; ventilatory status: on vent trach collar)
- Laryngectomy – STOMA ONLY

Emergency airway plan: Are they maskable? Are they intubatable from above? Prior intubation history (View size ETT laryngoscope used)? Back-up size trach?

Example: FRESH TRACH. 6.0 cuffed shiley with cuff up on the vent. IF decannulates: 1.) replace trach with same size, 2.) Replace with downsized back-up trach, 3.) If unable to replace trach, patient is maskable and intubatable from above – Grade 2a view with a C-MAC and previously intubated with a 6.5 ETT

A — Action List

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(Specific, time-based tasks)

- _____
- _____
- _____

Example:

- Follow-up AM labs
- BID neck packing with Dakins soaked krelex
- Remove JP drain when output < 10
- XR Pharyngogram scheduled for 2/13/26

S — Situation Awareness / Contingency Plans

If → Then

- **Bleeding:** _____
- **Respiratory distress:** _____
- **Flap concern:** _____
- **Other:** _____

S — Synthesis by Receiver

- Read-back completed
- Questions addressed

ENT-SPECIFIC ADD-ONS (Use as Needed)

Post-Op Head & Neck / Flap

- Flap type & anastomotic vessels: _____
- POD #: _____
- Doppler: Yes No
- Needle poke: BRB in ____ seconds
- Positioning / tie precautions: _____

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- Airway: _____

Drains

- JP # / location: _____
- Output concern threshold: _____
- Removal criteria: _____

Consult Coverage

- Pending consults: _____
- Re-checks needed overnight: _____

PRIMARY ATTENDING

Name: _____
Escalation instructions: _____

HANDOFF RULES

- ✓ Verbal + electronic handoff
- ✓ Quiet, interruption-free
- ✓ Airway ALWAYS stated
- ✓ When unsure → CALL
- ✓ Answer all oncoming teams' questions

8/2018, 3/2021, 4/2022, 9/2022, 3/20/2026