

RESIDENCY MANUAL

2015-2016



**WRIGHT STATE UNIVERSITY
SCHOOL OF MEDICINE**

**INTEGRATED RESIDENCY IN
EMERGENCY MEDICINE
WRIGHT STATE UNIVERSITY SCHOOL OF MEDICINE**

-RESIDENT MANUAL-

FOREWORD

This manual was developed as a communication tool for the residents and faculty of this training program. Despite the considerable effort that has gone into its creation, it will be under continual revision. Supplements and updated materials will be distributed as available. We recommend an initial review of the entire manual, then using it as a first-line reference when questions arise about the residency. Note that this manual is a guide and at any time can be altered or amended to suit a particular situation at the discretion of the Department Chair and/or Program Director.

The manuals are distributed to each resident, full-time faculty, hospital directors of medical education, and each emergency department director.

Initially issued Dec. 1984

(J. Lyman/G. Hamilton)

Revised 1985, (J. Lyman/G. Hamilton)

Revised 1986, 1987, 1988 (G. Hamilton)

Revised Aug. 1990

(P.T. Doerger/J. Singer/G. Hamilton)

Revised June 1991-1998

(J. Singer)

Revised June 1999, 2000

(S. Doak)

Revised June 2001-2007

(J. Brown)

Revised January 2013

(J.R. Pickett)

Revised June 2014

(S. Rubenstein and 2014 Chiefs)

Table of Contents

TEACHING PROGRAM RESPONSIBILITIES:	7
<i>R1s</i>	7
<i>R2s</i>	7
<i>R3s:</i>	7
PART-TIME FACULTY:	7
<i>Full-Time Faculty:</i>	7
RESIDENT BLOCK ROTATIONS	8
DAGMEC SCRUB POLICY	9
CONFERENCE ATTENDANCE	10
<i>Policy:</i>	10
<i>Methodology:</i>	10
<i>Updating:</i>	10
<i>Incentive:</i>	10
Didactic Methodology.....	9
SHIFT SCHEDULING	11
<i>Intent</i>	11
<i>Calculations</i>	11
DISASTER RECALL.....	13
TABLE: CALCULATION OF ED SHIFTS.....	14
POTENTIAL WORKING DAYS IN THE BLOCK.....	14
SIGN OUT POLICY.....	14
VACATION, EDUCATION, FAMILY, AND SICK LEAVE	15
VACATION.....	15
VACATION/CME/PRESENTATION - PGY-I*	17
VACATION/CME/PRESENTATION - PGY-II*	18
VACATION/CME/PRESENTATION - PGY-III*	19
SICK LEAVE.....	19
RESIDENT BACKUP POLICY (WHAT TO DO IF YOU WILL MISS A SHIFT UNEXPECTEDLY)	20
PERSONAL LEAVE.....	20
EDUCATIONAL LEAVE.....	20
RESIDENT TRAVEL POLICY	20
<i>Reimbursement Rates & Rules</i>	20
<i>Documentation / Receipts</i>	20
<i>Travel Reimbursement</i>	21
FAMILY LEAVE.....	22
ABSENT WITHOUT EXCUSE	22
CONTRACTUAL RESPONSIBILITIES	22
EXTRACURRICULAR SERVICE (MOONLIGHTING)	232
REQUEST FOR EXTRACURRICULAR SERVICE ACTIVITY.....	25

CLINICAL SUPERVISION GUIDELINES	26
<i>On-Service (Emergency Department)</i>	<i>26</i>
<i>Off-Service (Other Rotations)</i>	<i>26</i>
COUNSELING	26
MEDICOLEGAL ISSUES	27
COMPUTER INTERNET USE	28
SOCIAL MEDIA.....	28
EVALUATION PROCESSES/FORMS.....	29
<i>ABEM In-Service Examination –.....</i>	<i>29</i>
<i>Oral Examinations –</i>	<i>29</i>
<i>Resident Lectures –.....</i>	<i>29</i>
<i>Evaluation of Clinical Experience</i>	<i>30</i>
EMERGENCY DEPARTMENT ROTATION EVALUATION CRITERIA FOR EACH YEAR IN THE INTEGRATED EMERGENCY MEDICINE RESIDENCY	30
INTRODUCTION	30
PGY-I	30
PGY-II	31
PGY-III	32
WSU EMERGENCY MEDICINE RESIDENCY PROGRAM: ANNUAL COMPETENCIES FOR EM RESIDENTS.	36
RESIDENT REVIEW COMMITTEE.....	38
<i>DESCRIPTION</i>	<i>38</i>
<i>POWERS.....</i>	<i>38</i>
<i>LETTER.....</i>	<i>39</i>
<i>REMEDICATION.....</i>	<i>40</i>
EMS ASSISTANT MEDICAL DIRECTOR	43
LONGITUDINAL EDUCATION PROGRAM IN EMS	43
EMS SHIFTS.....	46
ADDITIONAL EMS ACTIVITIES BY YEAR:.....	47
<i>PGY-1</i>	<i>47</i>
<i>PGY-2</i>	<i>47</i>
<i>PGY-3: The PRV.....</i>	<i>47</i>
ASSISTANT EMS MEDICAL DIRECTOR PROGRAM.....	49
GUIDELINES.....	49
RESIDENT EMS PHYSICIANS: LIABILITY/MALPRACTICE	50
<i>Participation in Patient Care on Scene</i>	<i>51</i>
Prehospital EMS Medical Direction	
SWAT TEAM RESIDENT PARTICIPATION	54
<i>I. TEM Direct-Support Capability</i>	<i>54</i>
<i>II. Educational Offerings</i>	<i>56</i>
<i>III. Data-Collection and Research.....</i>	<i>56</i>

IV. Coordination/Relationships.....	56
V. Initial and Ongoing Participation Requirements	57
SUBMITTED PUBLISHABLE PAPER/PROJECT	58
Clinical Duty Requirements in June for Graduating Residents.....	57
RESIDENT RESEARCH FUND SUPPORT APPLICATION	61
<i>Setting Background</i>	<i>61</i>
<i>Application and Award Process</i>	<i>61</i>
SEED GRANT PROGRAM GUIDELINES	62
PROCEDURE LOG	65
<i>INSTRUCTIONS FOR WSU EM PROCEDURE LOG</i>	<i>65</i>
<i>PATIENT /FOLLOW-UP LOG</i>	<i>66</i>
<i>REPORTING INTERESTING CASES, EKG'S, AND RADIOGRAPHS</i>	<i>66</i>
NUMBER AND TYPE OF PROCEDURES REQUIRED BY RRC.....	67
TEACHING RESPONSIBILITIES.....	68
A. <i>Bedside/clinical settings</i>	<i>68</i>
B. <i>Didactic Lectures.....</i>	<i>69</i>
INFORMATION DISSEMINATION.....	70
DEPARTMENTAL ORGANIZATION	71
DEPARTMENT CHAIRMAN	71
VICE-CHAIRMAN	72
PROGRAM DIRECTOR	73
EDUCATION COORDINATOR	75
ASSISTANT EDUCATION COORDINATOR.....	76
RESIDENT RESEARCH COORDINATOR	77
E.M. RESEARCH LABORATORY DIRECTOR	78
ICCU COORDINATOR.....	80
SPORTS MEDICINE COORDINATOR	81
SIMULATION CENTER DIRECTOR	82
EMERGENCY MEDICAL SERVICES AND DISASTER MEDICINE COORDINATOR.....	83
MEDICAL STUDENT COORDINATOR.....	84
SUPPORT STAFF	85
ROLE OF CHIEF RESIDENT	86
<i>INTRODUCTION</i>	<i>86</i>
<i>RESPONSIBILITIES</i>	<i>86</i>
<i>REWARDS</i>	<i>86</i>
ROLE OF PGY-III RESIDENT	87
SOCIAL DIRECTOR/ACTIVITIES	88
PARKING PASSES/PERMITS	89
CONFERENCES/DIDACTIC CURRICULUM: PURPOSE, GENERAL SCHEDULES.....	85
SIMULATION CURRICULUM	92
R-1 SIMULATION CURRICULUM	92
R-2 SIMULATION CURRICULUM	94
R-3 SIMULATION CURRICULUM	95

Section I: Graduate Medical Education Resident and Fellow Manual (WSUSOM)

- i. Resident & Fellow Manual: Wright State University:

<http://www.med.wright.edu/fca/gme/index.html>

- ii. Housestaff Manual: see Kettering Medical Network intranet website:

<http://intranet.ketthealth.com/kh/DeptPages/admin/html.cfm?id=11956&unit=KMCMedEd>

Teaching Program Responsibilities:

R1s

One Fifteen minute lecture in the Spring

R2s

Total of 30 minutes of lecture

R3s:

Chiefs and two R3s on teaching have helped with orientation, depending on faculty availability
Total of One hour of lecture: 30 minute lecture during teaching block, 15 minute Toxicology Case, Other 15 minute Lecture
Four 6-hr days with medical students at Cox during teaching block
One 2-hr journal club with faculty preceptor during block after teaching block

Part-Time Faculty:

1 hr of lecture time during orientation
12 hrs of lab time during orientation
1 hr of lecture time on core topics in the first six weeks of Friday conferences
Two 1-hr lectures on concentrated topics in emergency medicine
Two 1-hr resident lectures precepted on the model of the clinical practice of emergency medicine
Two 1-hr lectures on interest series in emergency medicine
One ½-hr case at Friday conference during teaching block
Two 1-hr small-group discussions for R1 YDC during teaching block
One 2-hr small-group discussion or hands-on lab for R2 YDC during teaching block
Two 6-hr days with medical students during teaching block
One 6-hr day with R1s doing simulations during teaching block
One 2-hr resident journal club precepted and hosted during block after teaching block

Full-Time Faculty:

2 hrs of lecture time during orientation
12 hrs of lab time during orientation
2 hrs of lecture time on core topics in the first six weeks of Friday conferences
4 1-hr lectures on concentrated topics in emergency medicine
4 1-hr resident lectures precepted on the model of the clinical practice of emergency medicine
Three 1-hr lectures on interest series in emergency medicine
One ½-hr case at Friday conference during teaching block
Two 1-hr small-group discussions for R1 YDC during teaching block
One 2-hr small-group discussion or hands-on lab for R2 YDC during teaching block
Two 6-hr days with medical students during teaching block
One 6-hr day with R1s doing simulations during teaching block
One 2-hr resident journal club precepted and hosted during block after teaching block

Resident Block Rotations

Resident schedules are arranged in 4 week blocks which begin on Tuesdays.

PGY-I

Orientation	1 block
Pediatric ED	2 blocks
Pulmonary	1 block
Adult E.D.	7 blocks
Trauma	1 block
GSH ICU	1 block

PGY-II

Adult E.D.	8 blocks
Selective/Hand	1 block
OB/GYN	1 block
ICCU	2 blocks
Pediatric ICU	1 block

PGY-III

Trauma	1 block
Adult E.D.	8 blocks
GSH ICU	1 block
EMS/Selective	1 block

Selective	1 block
KMC Teaching	1 block

The Program Director is responsible for oversight production of the block rotation schedule. The latest block schedule is emailed out to all residents and faculty by the Residency Coordinator.

DAGMEC SCRUB POLICY

- While wearing scrubs, personnel must comply with all other dress and appearance requirements of that institution and the Occupational Safety and Health Administration.
- Scrubs must be worn in the operating room and in any other locale when performing an invasive procedure or when engaged on a service where an invasive procedure may be likely. Personnel must comply with directives of each facility in regards to where scrubs must and must not be worn.
- At the completion of the activity that necessitated donning the scrub, the scrub must be removed and replaced by other acceptable attire.
- If the scrub cannot be immediately removed for any reason, personnel must wear an appropriate outer garment such as a white coat over the scrub. Anytime that an individual leaves the Operating Room or other areas where invasive procedures are performed and returns to that area, they must change into clean scrubs.
- Scrubs are suitable at any time should contaminated clothing necessitate a change of attire.
- Unless scrubs are being worn to replace contaminated clothing, scrubs must not be worn outside the hospital.

CONFERENCE ATTENDANCE

Attendance at the didactic series presented by this department is an essential part of the training program. The nature of the program should allow, in most circumstances, full attendance. A combination of incentives and disincentives exist to encourage compliance with the attendance policy. Conferences are Tuesdays, 7:00 a.m – 12:00 p.m. in the Dean Amphitheater at KMC.

Policy:

A cumulative attendance of 70% or greater is required to allow the resident to engage in a selective in the PGY-III year. Deviation from this minimum standard may result in disciplinary actions or a reduction of educational freedoms (such as moonlighting, selective choice, etc.). Conference attendance includes Emergency Medicine Conference on Tuesday mornings, Journal Clubs and Year Directed Conferences, and specifically arranged lectures and experiential programs. Should you be unable to attend any conferences, you should call the office or talk to a preceptor prior to your absence.

Methodology:

Attendance will be taken either by a Chief, faculty, turning point clicker or a combination there of.

Updating:

The biannual RRC letter issued in November/December and June/July, and will include a percentage tally of conference attendance, with appropriate commentary.

Incentive:

As an incentive to enlist an interest in conference attendance, the top attendees will receive appropriate recognition (best attendance per class and PGY-III best attendance for program). The announcements will be made at the Annual residency graduation.

Didactic Methodology:

The goal of this program is to educate and develop Emergency Medicine Residents into Emergency Medicine Attendings through a multidisciplinary approach. The aim of our curriculum and its continual reform is to do just that. Social media tools such as Twitter and Blogs, problem based learning techniques, traditional lectures, self-reading and EM Challenger are some of the methods that will be used by this program to achieve our Prime Directive of training residents. As a Wright State University Emergency Medicine Resident, you will be expected to take part of these methodologies. In 2014 the WSU EM curriculum was revamped and is in an evolving state. Much like this manual, the curriculum can change as the direction of the Departmental Chair, Program Director and/or the Educational Coordinator.

Shift Scheduling

Intent

Make clear guidelines to the residents, faculty and chiefs in order to define the expectations of our workload during our Emergency Department and off service rotations and to render conflict to a minimum.

Calculations

Based on our new curriculum, residents will work 200 hours per month. Those hours will be divided between 9 hour shifts, didactics and other residency activities.

Clarification

1. Current ACGME guidelines on working schedules prevail:
 - a. As a minimum, residents shall be allowed one full 24-hour period (day) in seven free of any clinical or academic responsibilities away from the institution while on an ED block. While on off-service rotations, residents shall be allowed on average one full 24-hour period from both clinical and academic activities.
 - b. While on duty in the Emergency Department, residents may not work longer than 12 continuous scheduled hours. There shall be an equivalent period of continuous time off between scheduled shifts.
 - c. Residents will not work more than 80 duty hours per week. No more than 60 hours per week may be clinical time scheduled in the ED. Duty hours comprise all assigned clinical duty time and conferences, whether spent in or outside of the educational program (i.e. EMS, SWAT), including all on-call and moonlighting hours.
 - d. Attempts will be made to limit Monday night shifts to allow for conference attendance, however RRC guidelines allow R1's to work no more than 16 hours and R2/3's to work 24 hours which will allow a 9 hour ED shift followed by 5 hours of academics.
2. Guidelines adopted in December, 1988 are reiterated:
 - a. A resident may specifically request four days during the month, including one weekend, to be days off.
 - b. No more than two Tuesdays per month should be scheduled as off days.
 - c. Residents, at the discretion of the Program Director or Chair, may be excused from clinical activities for major presentations.
3. Written excuse letters will be sent out to your rotations for the following events they are highly encouraged and NOT considered mandatory. Chiefs scheduling E.D.s will also be reminded of these events. You may take vacations during these events, but you MUST be available to attend.

Function	Avoid Shift Assignments
Orientation Picnic (June)	1st, 2nd
Christmas Party (December)	2nd, 3rd

Spring Retreat (May)	1st, 2nd
Graduation Exercise (June)	2nd, 3rd
Night Before ABEM In-Service(February)	3rd
ABEM In-Service (February)	1st
Oral Board Exams (twice, fall & spring)	1st, 2nd

- Residents may be scheduled for a shift, and be available for a portion of the shift because of an official residency function, yet the shift will be counted as a completed date. Thus, a resident may be engaged in clinical activity, but priority of the educational endeavor will supersede.

Examples include:

- ACLS exercises
- ATLS
- Friday Conferences
- Journal Club
- Various labs
- Special scheduled conferences
- Simulation labs

The above dates will be highlighted in the Conference Schedule which is distributed with monthly in your WSU mailbox. When dates change for any of these functions, the Department will notify schedulers and residents via e-mail or text message.

- Residents may request time off for department social activities but time off for one of these events counts for one of open day requests.
- EMS shifts are factored into the 200 hour/month work schedule. These dates cannot be the resident's requested day off.
- A third year resident on his/her teaching month will work the equivalent time of other Emergency Department rotations, 200hrs/month. This time will be divided between clinical shifts, and medical student precepting shifts and didactics. Clinical shifts will be at least 50% of the 200 hours, at the discretion of the GSH and the Academic chief.
- After a schedule has been made, switching shifts to facilitate personal well-being is encouraged. However, all switches **MUST** be approved by the scheduling chief resident at that site. Furthermore, when switching a shift away from an academic faculty member, that faculty member's permission should also be sought.

DISASTER RECALL

Emergency medicine is at the forefront of disaster response. Natural or man-made incidents may bring a large number of patients to the ED very suddenly, and may affect multiple hospitals in the region. In the case of such a surge of patients, there may be a need to rapidly increase ED staff. As such, residents may be recalled to a clinical site during “off hours”. The US Air Force may recall military members to the base for any number of anticipated emergencies.

A disaster recall of residents would be a rare event, and has yet to occur in this program. It is not expected that every resident remain “mission ready” every hour of the day. However, there may be some residents who are not at work or otherwise committed that may be available to supplement hospital staff during extraordinary events.

In the event of a disaster recall, residents will receive initial notification via text message. Details of where to report, or whom to contact, will be in that message. **It would generally be imprudent to leave an inpatient service** to go to a disaster, as you may already have disaster responsibilities within that service. If told to report to your clinical site, report to whatever hospital you are currently assigned during that block, whatever rotation you happen to be on. For example, during a general recall of residents to their clinical sites, residents on the Orthopedic service will report to MVH, Pulmonary will report to KMC, ICU to GSH, etc. You may instead be instructed to report to a specific hospital or to a field site, depending on the incident and resources needed.

Many residents have concerns about caring for their families during a disaster, particularly during a terrorist event. Protective gear, antibiotics, and chemical antidotes are available for all responding residents **and their families** during such an event through the Metropolitan Medical Response System, as a cache is maintained for all responders.

It is impossible to anticipate all the scenarios in which residents would be asked to respond for mass casualties. Be flexible, await instructions, and anticipate that events may evolve faster than our ability to predict them.

**TABLE: CALCULATION OF ED SHIFTS
POTENTIAL WORKING DAYS IN THE BLOCK**

	21	22	23	24	25	26	27	28
PGY-I	14	15	15	16	17	17	18	19
PGY-II	14	15	15	16	17	17	18	19
PGY-III	14	15	15	16	17	17	18	19
CHIEF	13	14	14	15	15	16	16	17

SHIFTS 9 hr

Calculations based upon:

- PGY-I working up to 50 hrs/wk
- PGY-II working up to 50 hrs/wk
- PGY-III working up to 50 hrs/wk
- Chief working up to 45 hrs/week

7

All residents will work an equivalent of 240/hrs/month that includes clinical shifts, didactics and other activities (JC, SIMs, DTEMs, EMS, etc). Chief residents will work 180 hours per month

SIGN OUT POLICY

Turning over patients is a part of being an Emergency Medicine Physician; however it must be done safely.

Turning over patients to a new provider has been shown to increase the risk of preventable medical error. It is therefore recommended that you disposition (admit or discharge) as many of your patients as possible before you sign out.

- Turn over no more than 2 active patients when you leave.
- It is common courtesy to prepare discharge instructions and prescriptions as well as follow-up information on patients you are turning over whom you anticipate discharging.
- Though all results may not be in, you may have enough information to admit a patient anyway, and can make the call to the admitting consultant. Tell them what tests are pending and when you expect them back.
- Calling a consultant to see or admit a patient that was turned over to you is difficult. Be mindful of this when considering whom to turn over.

Vacation, Education, Family, and Sick Leave

Vacation

All residents receive three weeks (21 days) of vacation per academic year (July through June). A resident may take his/her vacation during most rotations after discussion with the program director and chief. No more than one week (7 days) may be taken on a one-block ED rotation at any one hospital at one time. No more than two weeks (14 days) should be taken on a two-block ED rotation at any hospital at one time. In order to determine the number of emergency department shifts worked in a month when vacation is taken, refer to the table in the shift policy.

Your vacation will start and end on a charged vacation day. If you happen to be scheduled off, you may NOT, however, take a vacation day prior and after that scheduled off hiatus; e.g., a Friday and a Monday vacation day with the weekend off -- that will be four days of vacation charged. You may, however, use your scheduled days off at the beginning or the end of your vacation stint without being charged those of days as vacation. The purpose of this restriction is to prevent abuse of the vacation policy.

The program reserves the right to restrict vacation time from being taken from a particular rotation. Please see attached specifics for each PG year.

There will be no pre-approved vacation time from the emergency rotation without prior discussion with the Chief Resident assigned to the hospital and the Educational Coordinator. To those services with clinic responsibilities, two clinics per week will be accommodated on the schedule when requested. Other responsibilities (eg. off-service conferences, Grand Rounds) must be arranged specifically with the EM Chief Resident rotating on the service. The total hour commitment to the rotation will not be reduced by outside conference or clinic responsibilities.

If no vacation is requested, the Chief Residents will accept REQUESTS for up to 4 specific days off including one week-end request and make every attempt to fulfill that request. If vacation is taken, only 2 requests for days off may be made. These requests will be honored as available on the schedule, but are not guaranteed.

ALL MISSED SHIFTS DUE TO ILLNESS OR OTHER ISSUES MUST BE REPORTED TO THE CHIEF RESIDENT ASSIGNED TO THAT EMERGENCY DEPARTMENT AND MUST BE MADE UP.

If a resident is unable to perform a scheduled shift due to illness or other emergency, the on-call resident will fill in. The resident whom the on-call resident is covering must make up the shift by covering the on-call resident's shift on another block.

Residents from off-services cannot be scheduled for night-call on those services during their emergency medicine rotation.

The clinical services need to send the approximate equivalent number of residents per month to their respective emergency departments. A variation of 1-2 residents per month is reasonable, but substantial swings in either direction is simply too disruptive for scheduling.

Each individual site (CMC, GSH, KMC, MVH) may have specific scheduling requirements. These can be clarified with the EM Chief Resident assigned to each hospital.

Procedure for vacation requests:

- a) WSU EM Leave Request Form is available online at www.new-innov.com under 'More' > 'Resources' with the resident manual or from the residency coordinator. Complete form and email to residency coordinator.
- b) Approval will be obtained from the chief resident and Program Director. You will receive an electronic copy once leave has been approved, or an explanation if your leave has been denied. Once the decision is made by the Chief Resident it will be considered final.
- c) **Vacations will not be approved if you will be gone during mandatory program didactics or activities. Vacations will not be approved until Journal Club CATS and patient follow up logs are current.**
- d) **RESIDENTS WILL NOT BE PERMITTED TO TAKE VACATION WHEN THEY ARE SCHEDULED FOR PEDS ER TIME**
- e) **All requests for vacation must be submitted 8 weeks prior to the start of that particular rotation.**

The resident coordinator will keep a log of the resident's leave time. The original request will be filed in the resident's file. If the vacation takes place in the ED, chief residents will receive a cumulative resident leave report monthly prior to preparation of ED schedules.

Vacation or CME leave should NOT be scheduled during the following activities and WILL BE DENIED:

- Biannual Oral Board Simulations (Nov & Apr)
- In-Service exam (Feb)
- Spring Retreat (Apr/May)
- The last two (2) weeks of June
- Senior Residents may NOT take vacation in June.

It is highly recommended that you NOT buy plane tickets, cruises, hotels, etc until your vacation is approved by the Program Director and Chief Residents. Do NOT assume that because your request is in that it is approved.

Vacation/CME/Presentation - PGY-I*

<u>PROGRAM</u>	<u>Vac./CME</u>	<u>Advanced Notification</u>	<u>Department Contact</u>
TRAUMA MVH	NO / NO		PETER EKEH, M.D.
MEDICINE/PULMONARY KMC	NO/ NA		JENNY FITZPATRICK, MED ED
PEDS ICU CMC	NO / NA	N/A	VIPUL PATEL, M.D.
E.D. GSH	YES / NA	8 WEEKS	EM CHIEFS
KMC	YES / NA	8 WEEKS	
MVH	YES / NA	8 WEEKS	
WPAFB	YES / NA	8 WEEKS	
CMC (R1)	YES / NA	8 WEEKS	

* All programs allow residents limited time for major presentations with approval from our Program Director.

Note: CMC ED: only two weeks vacation during the three-year residency is permitted, and may not be taken in the same academic year.

Vacation/CME/Presentation - PGY-II*

<u>PROGRAM</u>	<u>Vac./CME</u>	<u>Advanced Notification</u>	<u>Department Contact</u>
HAND GSH	NO / YES	8 WEEKS	BETH BERRETONI, M.D.
ICCU GSH	NO / NO		TIMOTHY JANZ, M.D.
OB/GYN GSH	NO / NO		JACKIE MULLENS --FP COORDINATOR
SELECTIVE #	YES/YES	8 WEEKS	JAMES BROWN, MD
E.D. GSH	YES / YES	8 WEEKS	EM CHIEFS
KMC	YES / YES	8 WEEKS	
MVH	YES / YES	8 WEEKS	
CMC (see note)	YES / YES	8 WEEKS	

* All programs allow residents limited time for major presentations with approval from our Department Chair.

Residents may take 2 weeks vacation while on selective.

Note: CMC ED: only one week a year of vacation during the three-year residency is permitted.

Vacation/CME/Presentation - PGY-III*

<u>PROGRAM</u>	<u>Vac./CME</u>	<u>Advanced Notification</u>	<u>Department Contact</u>
TRAUMA			
MVH	NO/NO	N/A	PETER EKEH, M.D.
ICCU		N/A	
GSH	NO / NO		TIMOTHY JANZ, M.D.
SELECTIVE			
WSU	YES / YES	8 WEEKS	EDWARD FIEG, D.O.
EMS			
WSU	NO/NO	8 WEEKS	JASON PICKETT, M.D.
E.D.			
GSH	YES / YES	8 WEEKS	EM CHIEFS
KMC	YES / YES	8 WEEKS	
MVH	YES / YES	8 WEEKS	
WPAFB	YES / YES	8 WEEKS	
CMC (see note)	YES / YES	8 WEEKS	

* All programs allow residents limited time for major presentations with approval from our Department Chair.

** When on selective/EMS, each rotation will only be of two-weeks duration. An absence of one week may negatively influence your education. Please seek advice from the Program Director before arranging vacation during this rotation.

Note: CMC ED: only one week a year of vacation during the three-year residency is permitted.

Sick Leave

If sick, contact the Department, Chief Resident (ED), or attending (off-service)

Each resident is allowed 15 days of sick leave per fiscal year, i.e., sick days accrue at a total of 1.25 days per month by contract. If a resident is unable to report on duty for any rotation, he/she must call the departmental office and the attending on service. For ED rotations, this should be the Chief Resident, as well as the attending on duty. If an illness requires absence for more than one day/shift, it is imperative that the same process of reporting takes place for each day/shift missed.

Sick leave is recorded by the residency coordinator. The Program Director will request a tally of sick days taken for each Emergency Medicine resident. The Resident WILL BE required to make up the shift at a later date.

Resident Backup Policy (What to do if you will miss a shift unexpectedly)

This policy will apply to the following circumstances:

1. When an Emergency Medicine Resident is unexpectedly unable to make an ED shift due to illness or other unavoidable circumstances.
2. EM residents only (off-service residents will be covered by other policy).
3. Single, isolated circumstances. In the case of anticipated extended absence from a service, arrangements will be made at the discretion of the program director.

In the case of an unexpected absence from an ED service:

1. The resident will **contact the chief resident for that particular ED** to discuss who will arrange backup.
2. Residents on the following services will be contacted, in the following order, to assess their availability to work the shift:
 - a. Any EM Resident of your choice
 - b. Hand/Selective (R2)
 - c. Senior Selective (R3)
 - d. EMS/Selective (R3)
 - e. GSH/Teaching (R3)
3. Residents on the above services **must be available by text message at all times.**
4. Clinical responsibilities and duty hour restrictions supersede the requirement to backup another resident.
5. Should none of the above residents be available, no backup will be provided.
6. A resident who is 'backed up' **will repay the resident who covered him/her** during that resident's next ED month. The shift to be covered will be at the discretion of the resident that provided coverage.

Personal Leave

Arrangements can be made individually with the Program Director for personal days off. Residents apply for this leave in the same fashion as vacation, filling out the same WSU Leave Request form. The same signature cycle is used. See section on Vacation Request.

Educational Leave

	TIME	MONEY
PGY-I	3 days	\$250
PGY-II	1 week	\$750
PGY-III	1 week	\$1000
Chiefs	1 week	\$1250

In addition to this, we will provide 50% of the registration fee for the Ohio ACEP Review Course for any Senior Residents that wish to attend.

The Department will pay ACEP dues for all residents throughout their residency training.

Resident Travel Policy

Reimbursement Rates & Rules

Residents will be reimbursed for travel according to the following guidelines. Residents not able to travel may use up to one-half of their travel allowance for the purchase of approved textbooks.

Documentation / Receipts

The IRS requires that expenses reimbursed to employees must have a business purpose and that the employee must submit proper documentation (original receipts). Currently, the items not requiring documentation are the Per Diem and the Mileage reimbursement.

Each resident must have a receipt in his/her name for travel, lodging, and registration. Each resident sharing lodging is required to obtain a receipt in his/her own name. Airfare receipts must also be in each individual's name. We will no longer reimburse residents who submit receipts in someone else's name.

Travel Reimbursement

Per Diem \$56.00 (travel times determine number of meals reimbursed)

One Meal: \$28.00 Two or More Meals: \$56.00

Lodging: up to 100% (depending on travel allowance)

Seminar Fees: up to 100% (depending on travel allowance)

Auto Travel

Personal Vehicle Mileage = 51 cents/mile

NOTE: Auto mileage will not be reimbursed for more than the cost of airfare to the same destination.

If you have questions regarding travel, please contact Shirley Foreman in the Emergency Medicine office.

Family Leave

Family leave will be arranged with the Program Director in accordance with RRC guidelines and the established policy found in the KMC house staff manual.

Absent Without Excuse

"Absent without excuse" days will be made up during the same rotation. Any absenteeism without excuse will be reported to the Program Director or his designee for review and clarification. Absenteeism is unacceptable in clinical practice and is unacceptable as part of training.

Contractual Responsibilities

It is anticipated that each resident will perform to the best of his/her capacity for the total duration of his/her contract. Each resident must fulfill his or her clinical responsibilities for the entire month of each rotation. Should a graduation exercise occur before the end of the month of a resident's last clinical rotation, the resident shall be held to his/her clinical duties as assigned by his/her scheduler. Should a resident fail to perform the assigned clinical duties, the Program Director shall make every effort to have the clinical duties "made up." If the clinical duties are not performed to the satisfaction of the Program Director, the Program Director may choose not to sign for permission for this individual to sit for the board exam.

EXTRACURRICULAR SERVICE (MOONLIGHTING)

ACGME defines moonlighting as voluntary, compensated, medically-related work which is outside the course and scope of the approved training program requirements.

The Department of Emergency Medicine Policy on Extracurricular Service supports the policy drawn up by the Residency Education Committee for all other training programs integrated with Wright State University School of Medicine. In addition, the policy adds or reinforces the following statements:

1. Neither appointment to Wright State University, Department of Emergency Medicine, nor subsequent receipt of training certificate number from the Ohio State Medical Board, in any way authorizes an individual in training to work outside the strict confines of the training program.
2. Activities outside of the educational program are not mandated and must not interfere with resident performance in the educational process, including conference attendance. Moonlighting activities must never supersede responsibilities for any resident rotation commitment. Any notification of this occurring, or unusual or unreasonable requests for scheduling will be sufficient basis for cessation of all moonlighting privileges and placing the resident on probation for the time to be determined by the Program Director.
3. Military residents are subject to regulations of the Air Force, which prohibit moonlighting.
4. For residents in good academic standing (see requirements below), moonlighting may take place beginning January 1st of the EM-II year and continue through graduation as individual Program rotation requirements allow. EM-I residents are not permitted to moonlight.
5. In order to moonlight, the following criteria must be met:
 - a. In good academic standing within the program and cannot be on remediation or probation
 - b. Meeting all competency-based goals and objectives set forth by the Program Director, including (but not limited to): Conference/Journal Club attendance >70%, completion of CAT assignments, up-to-date with all logs (procedure logs, follow-up logs, etc.) and evaluations, continued completion of weekly EM Challenger assignment, initiation and/or completion of scholarly activity and QI project, satisfactory in-service exam scores
 - c. Must have a full medical license/DEA number and professional liability coverage
 - i. NOTE: Professional liability coverage (malpractice insurance) and your DEA number through WSU EM Residency is provided only when on official duty and does not cover moonlighting activities
 - d. Receive approval from the Program Director
 - e. "Moonlighting" per se, does not include voluntary, remunerative, extracurricular nonclinically related activities, e.g., teaching advanced life support courses or other like activities.
6. The resident will complete a "Request for Extracurricular Service Activity" form and submit to the program director. This form documents the insurance coverage for the extracurricular activities.
7. A maximum of 40 hours of moonlighting is allowed per month. Furthermore, moonlighting duty hours will be cumulatively added to assigned duty hours and will not exceed those permitted by the ACGME RRC-EM requirements:

- a. Residents may not work longer than 12 continuous scheduled hours.
 - b. There must be at least an equivalent period of continuous time off between scheduled work periods.
 - c. A resident should not work more than 60 scheduled hours per week seeing patients in the emergency department, and no more than 72 hours per week.
 - d. Emergency medicine residents must have one day (24-hour period) free per each seven-day period. This cannot be averaged over a four-week period.
 - e. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.
8. Due to program rotation requirements, residents with moonlighting privileges may not moonlight while on any rotation (e.g., ICU, trauma) for which ACGME RRC-EM work hour restrictions would likely be violated.
 9. Moonlighting sites are preferable in Ohio and should be a setting with careful chart reviews. Type of practice is unrestricted, but the Emergency Department is encouraged.
 10. So as not to confuse hospital staff with the moonlighting resident's practice versus training status, residents may not moonlight within the same Emergency Department of the hospital or affiliated hospitals (e.g., Kettering Health Network hospitals) in which they are currently rotating. This stipulation does not apply to Miami Valley South Hospital since this is not a routine program teaching facility.
 11. Moonlighting residents may wear WSU EM shift attire but should not display their institutional nametag identifying them as a WSU EM resident.
 12. The moonlighting privilege will remain at the discretion of the Program Director, with advice and consent from faculty, to suspend accordingly any resident from moonlighting privileges when such activity is judged to be interfering with training and/or didactics.
 13. Breach of the above policies will result in cessation of all moonlighting and placement of a resident on probation for a minimum of six months. A second breach of conduct will be considered grounds for full resident review of performance during the training program and possible termination of the contract. A third breach will automatically result in dismissal.

REQUEST FOR EXTRACURRICULAR SERVICE ACTIVITY

Resident Name _____

Permanent Ohio License # _____

Estimated number of hours per month _____ (Maximum 40 hours)

Moonlighting Site _____ Malpractice Indemnification _____

Moonlighting Site _____ Malpractice Indemnification _____

Moonlighting Site _____ Malpractice Indemnification _____

I have read and understand the terms and implications of the Department of Emergency Medicine Policy on Moonlighting and agree to abide by them in their entirety. I understand that this activity may not interfere with my residency training and, furthermore, am aware of the ACGME RRC-EM duty hour restrictions. I understand that the training malpractice insurance and DEA registration do not cover me while moonlighting.

SIGNED _____ DATE _____

This resident is currently in good standing in the Emergency Medicine Residency Program and has completed all requirements required to be eligible to engage in patient care outside of the residency program. Permission is given to engage in moonlighting as long as the residents abides by ACGME RRC-EM duty hour restrictions and the conditions set forth in the Residency Manual.

SIGNED _____ DATE _____

Edward Fieg, DO
Director, Residency Program
WSU Department of Emergency Medicine

CLINICAL SUPERVISION GUIDELINES

Clinical supervision is divided into on-service (Emergency Department) and off-service rotations.

On-Service (Emergency Department)

1. A staff member of the Emergency Department of the hospital in which the resident is rotating is both scheduled and present in the Emergency Department. The majority of these attendings are full-time practitioners of Emergency Medicine and clinical faculty of the Department of Emergency Medicine at Wright State University School of Medicine.
2. Residents may not staff with attendings who are neither trained nor board certified in Emergency Medicine.
3. All charts of the residents are reviewed and co-signed by the Emergency Department staff.
4. The Program Director or Educational Coordinator will meet with the various ED directors and educational coordinators on an ongoing basis to insure a mutual understanding of our goals for ED rotations.

Off-Service (Other Rotations)

1. Emergency Medicine residents and the off-service attending physicians will be given the goals and objectives of all rotations. The Program Director or Educational Coordinator will maintain a dialog with off-service attendings to insure a mutual understanding of our goals for the rotation.
2. Each rotation has a hospital staff and Wright State University School of Medicine clinical faculty physician in charge. In the community hospital-based setting of WSUSOM, there is often one-to-one contact between the attending physician and the resident. A few of the rotations are shared with other residents, and though there may be graded authority, an attending physician is always in charge of the service.
3. It is the responsibility of the attending physician to complete an evaluation of the resident at the completion of the rotation. (See evaluation form Section II.) Each of these evaluations is reviewed by the resident and the Program Director.

COUNSELING

With the complexity of our setting and the stresses of graduate training in medicine, we anticipate that some of you may need some degree of counseling during your training period. This may range from intermittent discussions with the faculty about various rotations to a regular psychotherapeutic relationship with more experienced mental health personnel. More importantly, whatever you're feeling, please do not keep it to yourself. The faculty is not here to judge and punish, but rather to support and advise. Many of us have been through similar circumstances before, and sometimes the simple knowledge that you are not alone can do a great deal to make an "insurmountable" problem tolerable, particularly in the months of December and January.

We are freely available to all of you and would rather hear about an evolving difficulty with a rotation, family, friends, etc., on an early and voluntary basis, rather than be brought into some complex problem at a later date.

At the same time, we understand that there may be difficulties that you have some hesitancy in bringing to the faculty and that, on occasion, the faculty may be part of the problem/stress. For these rare circumstances, we will call upon the Chair and Program Director in the Psychiatry Department to serve as a liaison for counseling requests of psychiatric referral.

There should be no concerns about confidentiality, as this is assumed in all of the discussions between faculty and residents. We may discuss the issue with other faculty to gain the benefits of their experience, but if requested not to do so, the issue will remain with the individual faculty member. The type of problem that becomes part of the resident's permanent record is usually that brought to them by the faculty as opposed to vice versa. If there is a particular, unique circumstance that needs recording, the faculty will give the resident fair warning before doing so. There should be no surprises in the resident record.

MEDICOLEGAL ISSUES

The potential medical-legal inquiry or action is always part of the practice of medicine. You may be the recipient of verbal comments, notification of a chart being requested by patient and/or lawyer, a letter requesting more information from legal counsel, or a subpoena.

For the uninitiated, the legal system and inquiries in regards to medical care can be quite intimidating. It is important to know that the majority of these questions are routine and do not lead further.

Procedure

In the event that any of you are contacted by any of the mechanisms listed above or others, please notify the Program Director at your earliest convenience. Early notification and discussion can do much to abate the emotional aspects of such an inquiry, and maintain a professional demeanor and perspective in exchanges with legal counsel. Please do not keep this information to yourself.

A similar request is made for any patient case in which a result occurs that may lead to legal action. Again, you are not alone in these matters and must communicate. Education about the structure and appropriate handling of dialogues with the legal profession is an important part of your training.

COMPUTER INTERNET USE

- Policies on computer use are governed by the respective institutions where the computers are located.
- Many institutions monitor computer use at their particular facility.
- Any use of the internet for pornographic, racially or sexually offensive purposes (including merely visiting websites), or for anything of a harassing nature, will result in swift disciplinary action.
- You may be held accountable for anything you view, download, upload, or post from departmental or institutional computers or networks.

SOCIAL MEDIA

- Social media sites such as Facebook, Twitter, Myspace, and “anonymous” bulletin boards are considered public. Despite some privacy measures enacted by the websites, it is not difficult to overcome these measures and discover what has been posted and by whom.
- Once you post it, it is out there forever, even if “deleted” from the site.
- Do not post anything that relates to any specific patient, facility, or department.
- It is generally bad form to bash your coworkers on such sites.
- One resident made a disparaging comment on Facebook about the patient population at a specific hospital ED. That hospital saw it, and the resident was banned from there for life.
- Some posts may be specific enough to allow family members to identify a patient, even if you do not post identifying patient information.
- Do not post anything that you would not want read by a plaintiff’s attorney during a malpractice trial to paint a picture of your character.

EVALUATION PROCESSES/FORMS

Evaluation is a critical part of marking accomplishment and mastery of the skills and knowledge areas in this residency program. Pursuant thereto there are a variety of evaluations undertaken to document this mastery. Written examinations, evaluations of resident lectures, oral examination, and evaluation of clinical experience by both faculty and the residents are components.

ABEM In-Service Examination –

This exam is given in February of each year. It allows for individual and program comparison throughout the Emergency Medicine residencies in the United States. This exam is MANDATORY. You will be excused from your rotation. You are not permitted to schedule vacation on this day.

Oral Examinations –

Oral examinations are administered once in the winter and spring of each year. These are MANDATORY. Your rotations will be contacted; you will be excused. These examinations are patterned very closely after both the format and content of the actual certifying oral examination process. The intent is to allow the faculty to evaluate resident thinking and performance "on their feet." It also provides the resident with content and format practice for the oral certification examination. This combination provides the faculty with another independent measure and evaluation of resident performance.

In the PGY-I year, each resident receives three 20-minute cases. In the PGY-II and PGY-III years, one 20-minute case and one 40-minute multiple case is presented. The residents are assessed by the criteria established by the American Board of Emergency Medicine, which includes an 8-point scale for each of seven categories including data acquisition, problem-solving, patient management, health care provided, patient relations, clinical competence, and comprehension of pathophysiology. An overall score is given each case, shared with the resident, and included as part of the permanent record for review by the RRC.

Resident Lectures –

Residents provide a substantial amount of the educational material delivered in the didactic portion of the training program. Residents are provided with faculty advisors who meet with them and help provide content structure and practices for their presentations. The faculty member will help define and draft objectives for the presentation. Based on those objectives, questions will be obtained or written to evaluate those stated objectives. The intent of these presentations is to provide good quality in-house educational experiences for the residents and to provide a portion of the didactic program for the training program in Emergency Medicine. A written evaluation by a faculty member will be provided. This evaluation will give the resident some feedback as to their ability to present material in a lecture format. The objective here is two-fold. The first objective is to provide residency based, and thereby, more focused and attentive information resources for the didactic program and two, to provide the resident with some background experience and prepared materials for the educational aspects of their future careers. (See Section VI for suggestion on lecture preparation.)

Evaluation of Clinical Experience

a. Resident evaluation of service

The resident is expected to complete a monthly statement of the clinical and education experience given on each rotation. Written comments of both clinical and personal issues are strongly encouraged. The specific form is not returned to the individual in charge of the service, but rather a tally of scores and a summary statement of written comments are sent yearly. This is to allow resident freedom in describing their experience. Documentation may be requested if particularly difficult circumstances were encountered. E-mailed monthly.

b. Service evaluation of resident

At the end of each month evaluations are available for review on New Innovations. You are REQUIRED to sign these evaluation forms. The evaluation is a consensus opinion and assembled by daily evaluations from academic and clinical faculty. It is strongly recommended that written comments be included to support the assessment. The residents do receive a copy of this report, but it should not preclude an honest, objective, appraisal of strengths and weaknesses. Neutral or "semi-good" comments are discouraged when a specific area has not been evaluated. A reference to "not applicable" is preferred.

Any questions/comments about the forms or specific comments about a resident performance that is preferentially not placed in writing should be communicated directly to the Program Director.

Evaluation must be linked to an anticipation of change if difficulties have been revealed. You are assessed and graded to encourage your own growth and development. It is incumbent on each resident to respond openly and willingly to comments and criticisms made to them.

5. Mid-Year Program Evaluation

By January of each year, an extensive evaluation form is distributed to each resident. The form thoroughly reviews all of the components of the training program, allows a grading of rotations, as well as individual clinical faculty, and encourages overview comments about the tone and direction of training. Signing the form is optional.

The faculty has these materials tallied, the comments assembled, and utilizes the information as a major focus of their spring faculty retreat. From this assessment, the Program and Associate Directors determine appropriate changes to be made in the training program and spend the next two to three months working to implement them. The new curriculum, both rotational and didactic, is then presented to the residents during the May full departmental retreat. This assessment and the faculty's response has been an integral part component of the evolution of this training program and full participation is strongly encouraged.

Evaluations

Many of the evaluations are now completed electronically and are e-mailed monthly to the resident directly.

Copies of all Evaluations, daily and monthly, can be found in New Innovations under More > Resources.

It is YOUR responsibility to sign your monthly evaluations in New Innovations.

EMERGENCY DEPARTMENT ROTATION EVALUATION CRITERIA FOR EACH YEAR IN THE INTEGRATED EMERGENCY MEDICINE RESIDENCY

Introduction

The following year-directed lists are the result of a consensus process that included both residents and faculty. The purpose is to give practical goals for the emergency department (on-service) rotation. They will clarify the expectation of performance from the resident's perspective, and improve the criteria for evaluation used by the faculty. The goals are different for each postgraduate year, and represent a graded responsibility.

PGY-I

Data Gathering

Perform an adequate history and physical examination related to the chief complaint, as observed and checked by the attending physician.

Use of Laboratory/Radiology

To demonstrate cost effective laboratory ordering selection and awareness of ancillary test costs.

Diagnostic Analysis

To be able to recite appropriate diagnostic possibilities for each clinical problem seen. This is to emphasize the etiologies of the presenting complaint. To develop an appropriate assessment plan for each chief complaint of a patient seen.

Therapeutic Intervention

To recognize presentations/circumstances threatening to life and limb, and begin prompt initial stabilization. That stabilization will include reporting such a circumstance to the attending physician.

General Medical Knowledge/Presentation

To accurately and concisely present patients to attendings and consultants (usually less than two minutes). To demonstrate data base expansion through independent reading.

Discharge/Follow-up

To formulate appropriate discharge plans and communicate to patient family. To develop regular demonstrated follow-up of admitted patients and selected discharged patients by the use of the Follow-up Book.

Charting

To demonstrate an ability to clearly document and communicate on the chart in legible handwriting or by dictation/transcription. This would include Hx, PEX, Clinical Course in ED, Assess, and Plan.

Procedure/Technical Skills

To perform under observation basic emergency department procedural skills including minor wound care and suturing, regional and local anesthesia, arterial puncture, defibrillation, oral and nasal

endotracheal intubation, peripheral and central venous access, orthopedic splinting, NG/lavage tube placement, bladder catheterization.

Interpersonal Skills

To demonstrate effective communication skills with peers, patients, families, attendings, private attending staff, and other ED personnel.

Attitude and Motivation

To begin EMS assistant medical advisor activities, by using EMS day.

Patient Management Skills

To demonstrate an ability to manage two patients simultaneously. (One of who may be seriously ill.)

Orientation

To become familiar with the physical structure, equipment locations, and chart/patient flow patterns of the emergency department. To learn the functions of all the personnel assigned in the emergency department. To observe basic telemetry communication skills, in cooperation with the attending physician.

PGY-II

Data Gathering

To perform an adequate history and physical examination related to the chief complaint, as observed and checked by the attending physician.

Use of Laboratory/Radiology

To demonstrate cost effective laboratory ordering selection and awareness of ancillary test costs.

Diagnostic Analysis

To develop assessment and management plans for each patient seen and discussed.

Therapeutic Intervention

To recognize presentations/circumstances threatening to life and limb, and begin prompt initial stabilization. That stabilization will include reporting such a circumstance to the attending physician.

General Medical Knowledge/Presentation

To accurately and concisely present patients to attendings and consultants (usually less than two minutes). To demonstrate data base expansion through independent reading.

Discharge/Follow-up

To formulate appropriate discharge plans and communicate to patient family. To develop regular demonstrated follow-up of admitted patients and selected discharged patients by the use of the Follow-up Book.

Charting

To demonstrate an ability to clearly document and communicate on the chart in legible handwriting or by dictation/transcription. This would include Hx, PEX, Clinical Course in ED, Assess, and Plan.

Procedure/Technical Skills

To be able to give a rationale for, and complications of, any emergency department procedure undertaken. To expand emergency department procedural skill experience into the remainder of skills listed in the course content. These skills to include but not limited to: plastic repair, venous access with introducers using the guidewire technique, peritoneal lavage, thoracostomy, thoracotomy, pericardiocentesis, extensor tendon repair.

Interpersonal Skills

To assume a "team captain" role in multiple and cardiac arrest patients. To demonstrate effective communication skills, as observed by faculty, in discussing critical situations and sudden death with family and friends.

Attitude and Motivation

To expand on role as EMS advisor, as per job description.

Patient Management Skills

To demonstrate an ability to manage multiple patients (up to four) simultaneously. Up to two of them critically ill (with faculty supervision readily available).

To be able to effectively manage "difficult" psychiatric patients. (With faculty supervision readily available.)

Orientation

To become aware of and respond to the flow of patients in the emergency department. As an opportunity is available, to attend emergency department group meetings during the month assigned, to attend surgical M&M at the hospital assigned, and to attend the medical morning report at the hospital assigned.

Teaching Skills

To develop clinical teaching skills including off-service resident, medical students, and EM PGY-I education.

PGY-III

Data Gathering

Perform an adequate history and physical examination related to the chief complaint, as observed and checked by the attending physician.

Use of Laboratory/Radiology

To demonstrate cost effective laboratory ordering selection and awareness of ancillary test costs.

Diagnostic Analysis

To develop assessment and management plans for each patient seen and discussed.

Therapeutic Intervention

To recognize presentations/circumstances threatening to life and limb, and begin prompt initial stabilization. That stabilization will include reporting such a circumstance to the attending physician.

General Medical Knowledge/Presentation

To accurately and concisely present patients to attendings and consultants (usually less than two minutes). To demonstrate data base expansion through independent reading.

Discharge/Follow-up

To formulate appropriate discharge plans and communicate to patient family. To develop regular demonstrated follow-up of admitted patients and selected discharged patients by the use of the Follow-up Book.

Charting

To demonstrate an ability to clearly document and communicate on the chart in legible handwriting or by dictation/transcription. This would include Hx, PEX, Clinical Course in ED, Assess, and Plan.

Procedure/Technical Skills

To be able to give a rationale for, and complications of, any emergency department procedure undertaken. To expand emergency department procedural skill experience into the remainder of skills listed in the core content.

Interpersonal Skills

To assume a "team captain" role in multiple and cardiac arrest patients. To demonstrate effective communication skills, as observed by faculty, in discussing critical situations and sudden death with family and friends.

Attitude and Motivation

To expand on role as EMS advisor, as per job description.

Patient Management Skills

To develop and demonstrate the ability to manage multiple patients (greater than four) simultaneously and efficiently.

Orientation/Administrative Skills

To develop administrative skills by handling administrative problems in the emergency department. These should be selectively referred by the attending.

Teaching Skills

To assume leadership in the teaching role to include those listed in Year II plus PGY-IIs, nursing in-service.

WSU Emergency Medicine Residency Program: Annual Competencies for EM Residents

1. **ACGME Milestones:** Recently the ACGME changed their evaluation process to include milestones. the EM Milestones are a matrix of the knowledge, skills, abilities, attitudes, and experiences that should be acquired during specialty training in Emergency Medicine. The EM Milestones will provide a basis for six-month evaluations for EM residents. The Milestones Project was a Joint Initiative of the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Emergency Medicine. Copies of the milestones can be found in New Innovations.
 - a. **The Milestones can be found on the new innovations under More > Resources**
2. Remediation of Deficiencies per the RRC (see next section): Individualized remediation plans will be developed depending on the needs of a specific resident. The plan will contain specific, measurable objectives for the resident to perform until remediation is no longer required. The following general approaches will be taken for specific competency areas:
 - a. **Patient care:** Residents will be given specific formative feedback of clinical care provided in the ED using the SDOT. Areas that are identified as below expectations will require repeated direct observations until the resident meets or exceeds expectations. In addition, residents will be required to meet with their advisors and to have remedial sessions using oral case simulations, or review of patient charts generated by the resident. Residents will have the opportunity to work through standardized resuscitation cases at the simulation lab. If deficiencies are noted in performing emergency procedures, residents will be required to perform these procedures in laboratory simulations under the supervision of faculty until performance of the procedure is satisfactory.
 - b. **Medical Knowledge:** Residents will be given feedback during semi-annual evaluations and using the SDOT on their emergency medicine knowledge base. If medical knowledge is judged below expectations, the program director will develop a monitored self-study program for the resident. This may take the form of discussion of readings, articles, administration of test questions, etc., all that are monitored by the program director or his designee. The results of the annual in-training examination will be provided to each resident and discussed at the semi-annual evaluations.
 - c. **Practice-based Learning and Improvement:** Elements that are related to PBL&I in resident portfolios will be assessed during semi-annual evaluations and, if deficiencies are identified, residents will be assigned specific exercises for remediation. This may take the form of chart stimulated recall, review of M&M cases, assignment of evidence-based medicine exercises, and development of critically appraised topics. Evaluation of research performed and lectures given in the core curriculum conferences will be reviewed with specific suggestions for improved teaching.
 - d. **Interpersonal and Communication Skills:** Residents will be given specific formative feedback of clinical care provided in the ED using the SDOT and shift evaluations. Areas that are identified as below expectations will require repeated direct observations until the

resident meets or exceeds expectations. Residents will discuss with their program director appropriate behaviors and these will be reviewed at the next semi-annual evaluation. Resources are available through the medical school for training in communication skills.

- e. **Professionalism:** Residents will be given specific formative feedback of clinical care provided in the ED using the SDOT and shift evaluations. Areas that are identified as below expectations will require repeated direct observations until the resident meets or exceeds expectations. Residents will discuss with their program director appropriate behaviors and these will be reviewed at the next semi-annual evaluation. The residents have been given the EM specific competency objectives and are expected to follow them.

- f. **Systems-based Practice:** Residents will be given specific formative feedback of clinical care provided in the ED using the SDOT. Areas that are identified as below expectations will require repeated direct observations until the resident meets or exceeds expectations. Residents will discuss with their program director appropriate behaviors and these will be reviewed at the next semi-annual evaluation. In addition, residents will be required to meet with their advisors and to have remedial sessions using oral case simulations, or review of patient charts generated by the resident. Residents will have the opportunity to work through standardized resuscitation cases at the simulation lab.

RESIDENT REVIEW COMMITTEE

DESCRIPTION

The Residency Review Committee is a committee chaired by the Program Director. Other committee members include full-time faculty. The RRC meets biannually, in December and June/July.

The primary purpose of the Residency Review Committee is to individually evaluate each resident on a biannual basis. The RRC attempts to evaluate the residents in each of six categories: affective domain, cognitive domain, motor skills, interpersonal skills, objective measurements, and overall performance. These evaluations are based on the monthly rotation evaluations, objective testing, observations by faculty, and observations by other individuals including the chief residents and clinical faculty.

The Residency Review Committee may also meet at other times during the year at the request of the Department Chairman and Program Director. The primary purpose for calling such a session of the RRC would be to discuss and evaluate the resident on an urgent basis, when such an evaluation cannot be delayed until the next scheduled RRC meeting.

POWERS

The RRC makes a biannual status report with recommendations to each resident, and through group discussion and its biannual letter, makes recommendations to the Program Director. In performing their duties, the RRC members follow the general guidelines for WSUSOM Integrated Graduate Medical Education Program as listed in Section I of this Resident Manual. These guidelines may include, but are not limited to:

- Resident and Fellow Duties
- Resident and Fellow Responsibilities
- AMA Principles of Medical Ethics
- Risk Management
- Due Process
- Guidelines for Outside Employment
- Completion of Medical Records

Policies specific to the individual hospitals and the program in Emergency medicine are also included in RRC deliberations.

In cases of concern, the RRC can recommend to the Program Director the following:

1. At the second year and above leave, limitation, denial, or cessation of extracurricular service ("moonlighting").
2. **PROBATIONARY STATUS** - which includes cessation of all extracurricular service privileges, and requests a remediation program to be initiated between the resident and the Program Director (or designee).

3. Any of the status listed under the Wright State University Due Process policy (Section I, pp. 12-16). These may include Academic Demotion, Non-Advancement, or Non-Reappointment, Non-Academic Suspension or Termination.
4. Emergency Suspension will be under the authority of the Program Director, who will notify the RRC members. Due Process procedure will be followed.

LETTER

The letter from the RRC follows a format that has been designed to give a complete overview of the resident's performance. The six components of the letter are detailed below. Each resident receives individual attention.

1. **Patient care** - Patient care that is timely, effective, appropriate, and compassionate for the management of health problems and promotion of health.
2. **Medical knowledge** - Medical knowledge about established and evolving biomedical, clinical and cognate sciences and the application of this knowledge to patient care.
3. **Practice-based learning and improvement** - Evaluation of quality of patient care, appraisal and assimilation of scientific evidence, and improvements in patient care.
4. **Professionalism** - A commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.
5. **Interpersonal skills** - Interpersonal and communication skills that result in effective information exchange and teaming with patients, their families, and other professionals.
6. **System-based practice** - Demonstrating through actions an awareness of health care systems and the ability to effectively mobilize system resources to provide optimal care.

Each resident will meet twice annually with the Program Director to discuss his/her performance. The Department Chair may choose to attend the meetings. At the end of the meeting each resident will receive a copy of his/her evaluative letter and sign the document. This evaluation letter is written by the Program Director and documents the resident's progress and performance, and includes specific recommendations for continued development.

REMEDICATION

At its biannual meeting, the Resident Review Committee may advise that a resident receive remediation. Forms of remediation include:

1. Data base improvement - this activity is recommended for either general or specific knowledge deficiencies demonstrated by the resident. In cooperation with the Program Director and Education Coordinator, a program of evaluation, lecture, reading, simulation and re-evaluation is usually set up over a 3-6 month period. This program takes considerable effort and supersedes all outside activities of the resident, including moonlighting.
2. Psychosocial - if there are perceived attitudinal problems, the resident is referred to the Program Director, who in cooperation with the Education Coordinator, attempts to outline the problem and work with the resident to remedy it. Referral to psychiatric support may be a part of the requirement. A specific time period of usually 3-6 months is given to allow for alteration of the perceived difficulty. Lack of improvement and/or unwillingness to participate in this program may be grounds for leave of absence or termination of contract. This is a difficult circumstance, but residents will not be graduated who will not clearly represent the training program, practice quality emergency medicine, or contribute to the specialty.

The resident must understand the necessity to maximize their experience from what is presently being offered in the didactic and clinical settings. A psychosocial problem can be a very difficult one to handle, but there will be a sincere effort directed toward improving and solidifying our response. At the same time, there will be less tolerance for disinterest or lack of attempt to remedy change on the part of the resident.

WRIGHT STATE UNIVERSITY
BOONSHOFT SCHOOL OF MEDICINE
INTEGRATED RESIDENCY IN EMERGENCY MEDICINE

Clinical Competency Committee (CCC)
(Revised 1 July 2013)

As part of ACGME requirements for resident evaluation, the Program Director for Emergency Medicine has appointed the following members of the Program core faculty to the Clinical Competency Committee, IAW ACGME CPR Section V.A.1.a.

Members:

1. James E. Brown, MD (Department Chairperson and Associate Program Director)
2. Ray TenEyck, MD (Department Vice Chairperson)
3. Roy Johnson, MD (Assistant Program Director)
4. Edward L. Fieg, DO (Program Director, CCC Chairperson)

Meetings:

The CCC will formally review all resident evaluations semiannually. The CCC is scheduled to meet twice annually, in June and December.

Responsibilities:

When applicable, the CCC will prepare and assure the reporting of milestones evaluations for each resident semiannually to ACGME (ACGME V.A.a.b.(1)(a)).

The CCC will use the following metrics to evaluate resident performance:

- Rotation evaluations
- End of shift reports
- Multi-rater evaluation by peer
- Multi-rater evaluation by patients
- Multi-rater evaluation by healthcare team member
- Teaching skills evaluation
- Handoff evaluation
- Simulation Lab observation evaluation
- QI project summary or evaluation
- Scholarly activity progress or evaluation
- Program compliance requirements (patient follow-ups, conference attendance, in-training exam, CATs, EMChallenger scores/activity, patient encounters per hour, procedure logs, etc.)
- Mock Oral Board Exams
- Self-assessment
- Patient care outcomes

The CCC will advise the Program Director regarding resident progress, including promotion, remediation and dismissal. Based upon consensus, the Program Director will update each resident's milestones and advise the resident accordingly, semiannually.

Longitudinal Education Program in EMS

The longitudinal EMS curriculum spans over the three years of residency training, and each year builds on the previous. Many experiences in the PGY-1 and PGY-2 years are prerequisites to the PGY-3 EMS rotation.

PGY-1

The resident gains hands on experience in the field on ride along shifts to understand how prehospital care differs from emergency care in the hospital, and how prehospital care affects the continuum of patient care.

PGY-2

The resident obtains experience in scene command, extrication, and disaster response.

PGY-3

The resident performs field response on critical calls and participates in a variety of QA and administrative activity. This facet of the program is to develop the emergency physician as a medical director for municipal EMS agencies, as well as embrace the role of the physician in the field.

There are several other options open to allow you to explore the realm of EMS. If you are interested in fully appreciating the stresses of EMS, we can arrange for you to ride along during a full 24-hour shift with several area departments. You are invited to attend the Greater Miami Valley EMS Council Meetings, which decides area wide issues. Finally, for those of you interested in aeromedical operations, ride with an aeromedical (helicopter) service in Dayton or elsewhere.

If you have had previous EMS experience, this will be an introduction to EMS in the Greater Dayton area. If you have not been involved with emergency care in the field up to this time, your "squad days" may be especially interesting. In either case, it is hoped that you will view this as an opportunity both to teach and to learn. EMTs, paramedics, and other emergency care workers can benefit greatly from your knowledge. You can have a significant impact on the quality of emergency care, both here, and in whatever locale you choose to practice.

You, on the other hand, will spend much of your career dealing with patients whose conditions have been affected (positively or negatively) by EMS personnel. It is critical for you to know as much about the prehospital care system, its environment, working conditions, and capabilities.

The program outlined above is the minimum requirement for all emergency medicine residents. Involvement with EMS departments above and beyond the requirements is strongly encouraged. The Department encourages resident activity with local DMAT, USAR and SWAT organizations. However, these endeavors are above and beyond all other training program requirements.

EMS Assistant Medical Director

The purpose of the Resident Advisor Program is to provide the Emergency Medicine resident physician with a first-hand exposure to pre-hospital care of emergency patients and to serve, with the established medical advisor, as a medical resource person for the squad. All first-year residents participate in the Observer Program. Each PGY-II and PGY-III Emergency Medicine resident will be assigned to a squad, hopefully in proximity to the resident's place of residence. Specific areas of involvement and interaction may vary from squad to squad, but the following are suggested activities:

The Resident Advisor is encouraged to:

1. Contact the medical advisor and the EMS Coordinator of the squad to introduce himself (herself) and discuss the EMS activities of the squad.
2. Ride with squad members on the squad day of E.D. rotation months. Monthly contact with the squad should be maintained, even when on off-service rotations. See "Participation in Patient Care on Scene" attachment.
3. Meet periodically with the squad medical advisor/EMS coordinator/members for run review sessions.
4. Participate in Continuing Education programs:
 - a. attend training sessions as an observer or evaluator.
 - b. prepare and present lectures on appropriate topics. Package lectures on 20 topics are available through Department.
 - c. forward appropriate medical literature to squad members.
 - d. be available as a resource person as particular medical problems or questions arise.
5. Help coordinate, with hospital EMS coordinators, follow-up of patients of particular interest transported to hospitals.
6. Help the WSU Department of Emergency Medicine keep abreast of EMS developments and EMS literature.
7. Other specific areas of involvement are outlined in the Resident Squad Advisor Activities packet. (See Section VI EMS/Squad Activities.)

The squads are encouraged to:

1. Orient the Emergency Medicine resident to Emergency Medical Services Systems (EMSS) and the functions of pre-hospital care providers.
2. Provide the Emergency Medicine resident with training in pre-hospital care techniques and the proper use of specialized equipment.

3. Orient the Emergency Medicine resident to extrication technique.
4. Encourage squad members to periodically do clinical time in the E.D. with the Emergency Medicine resident.

It is hoped that the increased interaction between squad members and Emergency Medicine residents will be a valuable learning experience for all involved and increase the quality of emergency medical care in the Dayton area. Periodic assessment of the frequency, quality, and commitment to continuance of this relationship will be performed by the Department. It is an essential part of the Emergency Medicine education in this program.

The Department encourages resident activity with local DMAT, U&SAR and SWAT organizations. However, these endeavors are above and beyond all other training program requirements.

In the even a resident member of one of those teams is offered the opportunity of participation or deployment which conflicts with other residency requirements, contact for permission will be made with both the Program Director and the director of the service with which it conflicts. The Program Director will virtually always grant permission. However, it is the resident's responsibility to obtain permission from the director of the service in question themselves.

If necessary, the Program Director will contact the service director in question to "lobby" for permission as well.

EMS Shifts

PGY 1 residents will be required to complete ride alongs with various EMS departments to total 10 pre-hospital patient encounters. Please set these up prior to your ED rotations and arrange with the assigned chief so that you are not working on a particular day.

PGY-1s who serve as assistant medical director for an EMS department may choose to do their ride shifts at that department instead of the other services we are now using. Example: Howells works with Vandelia, so he did his ride shift there instead of Huber or Dayton.

When and with what departments you would like to complete your ride alongs is your choice.

MVH ED	KMC ED	GSH ED	CMC ED	WPMC ED
Dayton FD	Kettering FD	Huber Heights	Xenia FD	Fairborn FD
Station 14	Station 32	FD	Station 31	10am-8pm
2213 N. Main St.	250 W. Dorothy	Station 22	225 E. Main St.	Station 4
3pm-11pm	Lane	7008 Brandt Pike	3pm-11pm	444 W. Funderburg Rd.
DFD contact:	8am-4pm	8am-4pm	XFD contact:	Station: 937-754-3095
Lt. Jack Mix	KFD Contact:	HHFD contact:	Capt. Jason Kinley	Station 1
937-333-3146	BC Nick Hosford	Misty Hall	937-602-7112	495 N. Broad St.
Jack.Mix@daytono.hio.gov	937-296-3237	937-233-1564	emstraining@ameritech.net	Station: 937-754-3078
	Nicholas.Hosford@ketteringoh.org	mhall@hhoh.org		FFD contact: Batt.
				Chief Adam Howard
				937-479-5482
				BC Adam Howard
				adam.howard@ci.fairborn.oh.us

Residents are responsible for completing the "visitors identification" form, and returning it to the medic at your respective EMS agency. We will NOT be completing waivers/release/waive of liability forms

If you have had previous EMS experience, this will be an introduction to EMS in the Greater Dayton area. If you have not been involved with emergency care in the field up to this time, your "squad days" may be especially interesting. In either case, it is hoped that you will view this as an opportunity both to teach and to learn. EMTs, paramedics, and other emergency care workers can benefit greatly from your knowledge. You can have a significant impact on the quality of emergency care, both here, and in whatever locale you choose to practice.

You, on the other hand, will spend much of your career dealing with patients whose conditions have been affected (positively or negatively) by EMS personnel. It is critical for you to know as much about the prehospital care system, its environment, working conditions, and capabilities.

There are several other options open to allow you to explore the realm of EMS. If you are interested in fully appreciating the stresses of EMS, we can arrange for you to ride along during a full 24-hour shift

with several area departments. You are invited to attend the Greater Miami Valley EMS Council Meetings, which decides area wide issues. Finally, for those of you interested in aeromedical operations, ride with an aeromedical (helicopter) service in Dayton or elsewhere.

EMS time is accounted for in all ED blocks, all 3 years. The PGY-2 and PGY-3 residents have EMS experiences that are not as regimented as the PGY-1 ride along shifts. This EMS time may be used for EMS activity as an assistant medical director, SWAT training or activity, mass gathering events, participation in regional, state, or national EMS meetings, EMS research, EMS teaching opportunities (CAP Lab), Emergency Vehicle Operations Course (EVOC), ride along shifts with Dayton FD supervisors, or other training opportunities necessary for participation in the Physician Response Vehicle program prior to the PGY-3 year. It is expected that all residents spend time involved in EMS activity during every ED block, as this time is designated to do so instead of another ED shift. If the resident does not have a scheduled activity at the start of the month, the EMS director will involve them in teaching for EMS.

Additional EMS activities by year:

PGY-1

- Completion of the Incident Command System courses ICS-100 (Introduction to the Incident Command System) and ICS-200 (ICS for Single Resources and Initial Action Incidents), preferably before beginning orientation. These courses are free, self directed and available online: <http://training.fema.gov/EMIWeb/IS/courseOverview.aspx?code=IS-100.b>
<http://training.fema.gov/EMIWeb/IS/courseOverview.aspx?code=IS-200.b>
- Online medical control course- This course is a 4 hour block to teach the resident how to give orders through telemetry to EMS agencies and the various legal and ethical obligations associated therewith.
- One mass gathering event (X-Fest, USAF Marathon, Nutter Center concert, Downtown Revival Festival, political rally, etc.)
- Emergency Vehicle Operations Course (EVOC)

PGY-2

- Completion of the Incident Command System courses ICS-700 (National Incident Management System: An Introduction) <http://training.fema.gov/EMIWeb/IS/courseOverview.aspx?code=IS-700.a>
- Vehicle extrication course. This four-hour block is scheduled around April at Kettering Fire Department. The resident will learn basic approach to extrication and how to work around rescue scenes safely. The resident will don full turnout gear and rip cars apart with hydraulic tools.
- One mass gathering event (X-Fest, USAF Marathon, Nutter Center concert, Downtown Revival Festival, political rally, etc.)

PGY-3:

- One two week block rotation dedicated to EMS.
- Duties include the following, however will be left to the discretion of the EMS Director:
 - Perform training at Dayton FD stations. The resident should develop a single 1-hour class for EMS on a topic of the resident's choosing. This should be delivered to all 3 shifts during the resident's EMS block.

- Attend regional and state EMS meetings to include the Regional Physicians Advisory Board (RPAB), Greater Miami Valley EMS Council (GMVEMSC), and the Metropolitan Medical Response System (MMRS).
- Teach at regional EMS conferences such as Critical Thinking in EMS, Ohio Association of EMS, and others as opportunities present themselves.
- Participate in regional disaster drills.
- Other activities at the guidance of the EMS Director

Assistant EMS Medical Director Program Guidelines

I. Contact squad EMS Director

II. Contact medical advisor

It is expected that each resident will contact these individuals (EMS coordinator and medical advisor(s)) by July 31. Initial contact may be by telephone, but it is hoped personal contact can be established soon thereafter. These individuals have been informed of your participation and are expecting your call.

As each resident becomes more involved with his/her organization, and with the advent of the squad day (see below), it is hoped that the resident will communicate with these individuals on a monthly basis (even if not on an ED rotation).

III. Review regional protocols

A copy of the pre-hospital care standing orders/protocols is provided to all resident advisors. It is expected that the resident advisor be familiar with these protocols prior to the first ED rotation. It is a prerequisite to communicating via radio with pre-hospital care providers. Each hospital has established individual policies regarding residents' handling radio calls - consult the resident manual.

IV. Training session

The resident advisor is encouraged to develop an EMS level presentation within the first six months of involvement. The specific topic can be agreed upon after discussion with the squad EMS coordinator and medical advisor. DEM support is available for preparing handouts and slides/overheads. The DEM is building an EMS program library - please obtain faculty approval before producing your A-V material so duplicates can be made.

V. Run review sessions

Run reviews should be conducted with your department on a scheduled basis. Basically, the review should look at documentation of presenting complaint, physical assessment, treatment, time sequence, and the completeness of the documentation.

Also, while in the EDs, contact the hospital EMS coordinator to review their run review procedures.

VI. Mechanism for follow-up

Just as we in emergency medicine appreciate follow-up on patients we see, so do prehospital care providers appreciate follow-up on their patients, particularly those admitted to the hospital and those who expire. Some feedback is already provided by the hospital EMS coordinator.

Encourage your squad members to contact you if there is a particular patient about whom they would like more information. Every local hospital has a full time EMS Coordinator who can help you find that information. Also, consider giving the squad follow-up on fatalities, including information regarding extent of injuries discovered at autopsy. The county coroner can be contacted for this information.

Resident EMS Physicians: Liability/Malpractice

Several squads have asked us about the abilities of the emergency residents who are working with the squads and what the liability (malpractice) considerations are. The issues have been discussed with Dr. Hamilton and Marshall Kapp, J.D., M.P.H., WSUSOM.

The primary responsibilities of the resident advisors, as outlined in the program guidelines distributed earlier, are to participate in continuing education programs, meet periodically for run review sessions, and ride periodically with the medics. The resident advisors are all licensed to practice medicine in the state of Ohio: PGY-I residents with a temporary license to practice within the residency; PGY-II and PGY-III residents with a permanent medical license.

The activities of the resident advisors in the field appear to be of specific concern. The residents may function as a physician in this setting, including participating in patient care and prescribing treatment. PGY-III residents are able to assume medical control, in cooperation with the on-line ED physician. As this is a recognized function of the residency, the residents are covered by the liability (malpractice) coverage of the residency program. Should any situations arise in the field that the resident needs guidance with, he will establish radio contact with the ED physician to discuss the situation (as the medics normally do, and as the resident would if he were physically in the ED). The presence of the resident advisor with the medics should not preclude routine radio/telemetry communications with the Emergency Departments. The residents are all expected to be familiar with the Montgomery County paramedic operating protocols which can be found here: .

The question of the resident advisors responding directly to the scene of a medical emergency has also been raised. Because this relationship is being entered into on a voluntary basis (by both the squad and resident), and because the physician is not receiving, nor does he expect to receive, enumeration from the squad or the patient, the resident advisor would also be covered by the emergency care liability legislation (Good Samaritan Act) in Ohio (ORC 2305.23, 4731.90, and in principle, 2305.231), the same as the medical advisor is covered.

Participation in Patient Care on Scene

The resident squad advisor may choose to participate in patient care with their respective squads on any of three levels.

1. Passive observation - in this role the resident functions solely as a passive observer to learn about prehospital emergency care as provided by their squad.
2. Assistance in patient care - the resident assists in patient care at the request of the EMTs or paramedics, or when the resident feels the patient may benefit from his assistance. In this role the resident does not assume medical control, and all patient care activities performed by the resident will be within the confines of the squad's standing orders or orders from the on-line physician. Resident assistance in patient care should be commensurate with the resident's level of expertise and training. Assistance in patient care may include activities ranging from attachment of electrode leads and lifting patients to performing endotracheal intubation and obtaining IV access.
3. Assumption of medical control - PGY-II and PGY-III residents are able to assume medical control on scene, in cooperation with the on-line physicians. The EMTs and paramedics on scene should be explicitly informed that the resident is assuming medical control.

Prehospital EMS Medical Direction

The purpose of the EMS rotation is to develop your skills in prehospital EMS medical direction. There are several aspects of being a medical director that will be discussed during this rotation.

1. Emergency medical care outside the hospital environment.
2. EMS provider levels, capabilities.
3. EMS System types.
4. Brief history of EMS in the United States.
5. Responsibilities of the Medical Director.
6. Quality Assurance.
7. Protocol Development.
8. Medicolegal aspects of prehospital care.
9. Hiring, disciplinary action, termination of employees.
10. EMS in nontraditional environments: Tactical EMS, Wilderness EMS, Disaster EMS.
11. Initial and continuing education of EMS providers.

Reading of Accidental Death and Disability: The Neglected Disease of Modern Society is recommended to residents. This document created the impetus for a national EMS system.

http://www.nap.edu/catalog.php?record_id=9978

Syllabus

The EMS rotation is scheduled around your selective, so meeting times with the EMS Director are flexible. Plan to meet at least four times during the rotation. To develop your skills in prehospital EMS, specific projects are planned as follows:

- I. Resident Presentation. Residents will complete an EMS educational project, such as a lecture which will be presented to local EMS, as well as a video lecture that will be posted online for local EMS to log in, watch, and obtain relevant CEUs.

This lecture should be at least one hour long, and can use any combination of powerpoint, video, and hands on training (though hands on training will not be available for the online course takers, obviously, so time can be filled with whatever is appropriate). Residents may work together on this project. Project requirements include:

- A. Presentation should be a minimum of one hour up to two hours in length.
- B. Presentation should include objectives for the learner as required for CEU credit.
- C. Presentation should include a ten question quiz that the medics will complete for credit for the online lecture.
- D. Presentation should reference standing orders used locally, view at link below:
<https://www.gmvemsc.org/documents/2008ParamedicTrainingManualwcovers.pdf>

- II. Resident Paper. Residents are required to develop a paper the medical load including mission threat analysis, choosing one of the following scenerios:
 - A. Remote wilderness rescue mission.
 - B. Mission trip to Africa
 - C. Offshore boat trip out of USCG reach
 - D. Manhunt in the woods for armed suspect
 - E. Rock concert aid station
 - F. Active shooter in a high school
 - G. Take an example of a non-medical transport vehicle and perform a paper exercise of how to convert this into a patient transport vehicle.
 - H. Medical threat assessment includes diseases or conditions you expect to be prevalent in a given environment. For example, waterborne illness in remote locations, heat illness during hot weather operations, arthropods of interest in certain field situations, etc.

- III. Develop a brief (2-3 paragraph) article or "guest column" for JEMS Magazine, EMS Magazine, or GMVEMSC newsletter.
...OR...
Do a CAT of one article germane to EMS from current literature. This may satisfy the above requirement for a publishable article or guest column. This may also be submitted as one of your other CAT requirements.

- IV. Attend relevant GMVEMSC meetings or RPAB meetings. Residents will be sent a separate email that lists the meetings that would be of importance.

- V. QI cases.
Residents will be given QI cases to review at scheduled meetings.

If you have any questions, please contact the EMS Director at any time.

SWAT Team Resident Participation

Providing medical support to police Special Weapons and Tactics (SWAT) teams gives the emergency physician valuable experience in providing prehospital care in austere, hostile, or nonpermissive environments. Participation in tactical medical support of law enforcement teams is voluntary. If you wish to participate in SWAT team related activity, notify Dr. Springer.

I. TEM Direct-Support Capability

Medical Care: As a participating emergency medicine resident physician, you will be assigned to a specific team, with whom you will work throughout your residency. Your point of contact will be the team's Attending Physician. You are expected to attend training with the team whenever possible; training does not supersede your other residency duties, but will count as fulfillment of your EMS ride-along duty. Once you have established a pattern of active participation with the team, you are expected to participate in operations whenever possible; operations do not supersede your other residency duties.

Your duties as a Tactical Medical Provider will include provision of care under fire and tactical field care, tactical evacuation, care during sustained and continuous operations, medical surveillance and preventive field care, and the medical pre-planning and provision of ongoing medical intelligence. Should a tactical team member require hospitalization or other outside medical care, whether or not related to performance of duty, you are expected to provide medical advocacy serving as a liaison with the team member, his family, and his department.

You are expected to observe safe practices while on operations or training. Equipment may not be provided to you by the team with which you are assigned. To provide a minimum standard of safety, tactical medical equipment will be provided by the Division of Tactical Emergency Medicine (DTEM). You are responsible for proper storage and care of your equipment. Equipment will be inspected quarterly by the Division Director. If you and another resident are assigned to the same team, you will be responsible for deciding with whom the gear is stored. You will be asked to sign for all gear issued. The following gear is available, and may be supplemented by your own personal gear if desired:

- Ballistic vest: Level IIIA
- Kevlar helmet
- Ballistic goggles
- Knee pads
- Chemical, biological, radiological, nuclear (CBRN) Mask and filter
- NARP High-Risk Warrant Medical Bag
- "Boo-boo" bag: for minor injury/illness

Please double check to ensure all equipment is in operational order prior to and following operations and training. Let Cassie Browning know immediately if there are any issues with damaged, missing, or otherwise impaired equipment. Should any of medical gear be used, replace it on your own or with replacement materials provided at Cox. If replacement materials are needed let Cassie know immediately. Should any of the ballistic materials (vest or helmet) sustain damage, whether from a

projectile, shrapnel, incendiary device, significant abrasion, or other significant mechanism, let Cassie know immediately so the gear may be inspected for viability. Should the mask be used for training or operations, please notify Cassie of the agent used and duration of exposure, so the filter may be replaced when appropriate.

The teams working with DTEM use different uniforms, and often have separate uniforms for training and operations. As such, uniform purchase is the responsibility of the individual resident. Uniforms may be purchased through Shirley Foreman, and you may use your academic money towards purchase. At a minimum, you should be willing to purchase the following:

- 1 or 2 sets flight suit, battle dress uniform, army combat uniform, or other
- 1 pair 6-8" waterproof combat boot (Danner, 5.11, Magnum, or other)
- 1 pair Nomex gloves or operator glove
- 1 Gore-Tex rainsuit

The default uniform for DTEM is the OD green Nomex flight suit with NARP Med Patch and black combat boot.

Participation does not confer you with police powers, and you are not to be armed unless appropriately trained and authorized to be so by the team. Maintenance of weapons certification will be your responsibility and that of the tactical team.

Clinical Oversight: Provision of medical care through DTEM is a function of the Wright State University Department of Emergency Medicine (DEM) Residency Program and as such is under the direct or indirect supervision of the attending physician. Should you have any questions, concerns, or feel uncomfortable with any clinical decision-making, notify the attending physician and team commander immediately. You may also contact the Division Director or Assistant Director for Operations at any time.

Documentation: Clear documentation is essential for operations. It allows quality assurance, medico-legal protection, and data collection for research. To simplify the process, you will be provided with paperwork to track your participation, as well as document any treatment you may provide. A metallic clipboard/box will be provided for each team. Should you be lacking any of the listed documents, let Cassie Browning know immediately. The documents may also be downloaded from the DTEM website: <http://www.med.wright.edu/em/dtem.html>. The following documents are contained in the clipboard/website:

1. **Incident Report Form:** You are to fill out an incident report form following every training session, exercise, mission or other operation in which you participate. The form should be returned to Cassie Browning at Cox within 48 hours of completion of activities.*
2. **Casualty Report Form:** You are to fill out a casualty report form following any treatment you provide during a training session, exercise, or mission, or other circumstance. No patient identifiers are to be used. The form must be returned to Cassie Browning at Cox within 48 hours of completion of activities.* ‡
3. **TCCC Casualty Care Card:** You may use this to rapidly document casualty assessment and care administered. Oftentimes the card will be transferred over to transporting EMS;

however, should you retain the copy, it should be submitted immediately to the attending physician or team commander. The TCCC Casualty Care Card does not replace the need to fill out a Casualty Report Form.

- 4. Medical Threat Assessment:** You may use this form to develop your team's medical plan during training or operations. You may use as much of the form as relevant/necessary. Although it is not mandatory to return the form, for operational security it is recommended the form either be shredded or submitted to Cassie Browning at Cox for storage following use.

*Operational security remains of paramount concern. Therefore, all paperwork you complete should be considered confidential and handled carefully. Should security concerns dictate that you do not hand in any form in a timely manner (for example, a dry hit during warrant service), the delay must be explained after the fact to the Division Director.

‡In any case where there is patient contact that warrants submission of a Casualty Report Form, a copy of the form should also be given to the corresponding Team Leader.

II. Educational Offerings

Non-Physicians: The DTEM currently hosts several Tactical Emergency Medical Support (TEMS)-focused classes for law-enforcement and tactical medics. Residents participating in DTEM activities may be asked to assist in teaching one or several of these classes. All relevant course materials will be reviewed in advance, and all classes are taught under the direct supervision of an attending physician. Non-physician education is overseen by the Division Assistant Director for Operations.

Physicians: The DTEM plans on hosting TEMS-focused classes for physicians interested and/or active in tactical medicine. Classes will also be designed and taught to teach EM resident physicians relevant TEMS skills and knowledge, and to teach military residents TCCC. Residents participating in DTEM activities may be asked to assist in teaching one or several classes. Physician education is overseen by the Division Assistant Director for Academics.

III. Data-Collection and Research

As one of the mission components of DTEM is determining and disseminating best evidence and practices for TEMS education and clinical care, it is imperative that documentation be maintained as directed above. Additionally, should you have an interest in TEMS-related research it may be done in conjunction with the Division Assistant Director for Academics and the DEM Director of Scholarly Works.

IV. Coordination/Relationships

National Center for Medical Readiness (NCMR): NCMR has hosted classes directed towards law enforcement and TEMS, and will continue to do so in conjunction with the DTEM. Ongoing collaborations with Calamityville provide additional opportunities for cutting edge training. You will have ample opportunity to both participate in and teach such endeavors. Be aware that, although there is frequent collaboration between them, NCMR and DTEM are separate entities with a differing chain-of command.

Center for Immersive Medical Education and Research (CIMER): Simulation is playing an increasing role in TEMS training, and residents will have opportunities to participate in and develop TEMS simulation scenarios.

Tactical Resident Interest Group (TRIG): TRIG meetings are held quarterly. Participation in TRIG is expected by residents active in the DTEM. TRIG meetings provide not only opportunities for camaraderie but also for learning and teaching. TRIG events may be attended by residents and medical students who are not active in TEMS but interested. Active residents will be able to share their experiences.

V. Initial and Ongoing Participation Requirements

Any resident with an interest in TEMS is welcome to attend TRIG functions. However, not all residents are accepted by the DTEM. A vetting process is in place to ensure participants have the requisite knowledge, skills, abilities, and attitudes to function in the tactical out-of-hospital environment. As such:

1. Resident participation is restricted during the R1 year. Interested R1 residents may begin to attend team training in the company of an attending or upper level resident in the second half of the academic year. Exceptions may be made in cases where the resident has extensive operational experience in the TEMS environment.
2. Prior to attending any operations or training without an attending present, the resident needs approved TEMS or TCCC training OR prior TEMS experience OR OJT side-by-side with an attending (or operationally skilled resident) for @ least 3 months. Again, exceptions may be made in cases where the resident has extensive operational experience in the TEMS environment.
3. Residents active with DTEM will attend at least 50% of TRIG meetings.
4. Should a resident experience academic difficulties at any time in their training, the DEM Program Director may suspend them from DTEM activities for a period of 3-6 months, with review at the end of that period.
5. Without exception, any and all resident involvement with DTEM, to include education, training and operations support, team assignments, and research is at the discretion of the DTEM faculty and DEM Program Director.

SUBMITTED PUBLISHABLE PAPER/PROJECT

It is the opinion of the WSU/EM faculty that submission to a journal of a paper of publishable quality be part of the requirement for graduation from the Emergency Medicine Residency Program. The skills developed by use of library services, literature review, paper organization and outline, writing and revising, and going through the process of submission and editorial review, are all considered an important part of resident experience. Examples of acceptable papers are:

1. Primary research paper, either basic or clinical. This can be retrospective or prospective.
2. Review paper. This paper should be an extensively research and thorough coverage of a topic pertinent to emergency medicine.
4. Case report. This can be a single report or a series, but must include a well-researched discussion. Being a co-author on one of the case conferences (CPC's)
4. Simulation Case
5. Other. At the discretion of the Program Director and Director of Scholarly Activities.

Editorials, book reviews, and letters to the editor are all useful and important forms of written expression, but will not fulfill the above requirement.

It is recommended that the type of paper and subject be selected near the end of the PGY-I or beginning of the PGY-II year. The faculty mentor you are assigned at the beginning of the residency will be the first contact for all ideas. Any of the faculty members can serve as resources. The Director of Scholarly Activity will meet with you biannually beginning the R2 year. Your status will be recorded on your biannual RRC letters.

The Director of Scholarly Activities is responsible for the ultimate approval of your scholarly activity. The Director of Scholarly Activity will perform the initial and final reviews of your manuscript. The manuscript will then be distributed to the remainder of the academic faculty and chief residents. Their critic should be incorporated into the "submission draft".

The submission draft shall be placed in the format as demanded by the journal where you intend to submit. The submission draft and the cover letter (or electronic confirmation) shall be provided to the Director of Scholarly Activity. When proof of submission has taken place, the Director of Scholarly Activity will notify the Program Director that you have satisfied the program requirements. In order for you to receive a graduation certificate at the time of graduation exercise, you must complete this process by April 15th of your R3 year. Submissions beyond that date do not guarantee a certificate at graduation. Delayed submission beyond the date of graduation may jeopardize your capacity to sit for the ABEM written examination.

The decision on acceptance, acceptance with revision or rejection will come to you from the journal. You are encouraged to approach the Director of Scholarly Activity to aid you in completing the

necessary changes and/or resubmission to another journal. You have worked hard to accomplish the submission and the program would encourage you to pursue maximal efforts to get your manuscript published. You do not need to be published to satisfy the scholarly requirement.

Clinical Duty Requirements in June for Graduating Residents

Senior residents rotating through an Emergency Department in the month of June will be scheduled as if they are on vacation after the 3rd Friday in June (graduation). In other words, they will be scheduled accordingly and released at 8:00 am on this third Friday. Though tempting, no resident will be allowed to break departmental or RRC policy regarding shifts on consecutive days. In order to receive full credit for the month, no senior resident may take additional time off (vacation or otherwise) in June. Any resident violating such policy of no more than six days in a row will forfeit their early release date.

Residents who are on off-service rotations in which we have control of the schedule, such as Administration, EMS, some selectives, and the Teaching month will enjoy a similar early release. All rotation requirements, however, must be fulfilled prior to this release date. Otherwise, they will be released at such time that they have satisfactorily fulfilled all rotation requirements

Residents who are rotating on the Miami Valley trauma service or in the ICU at GSH may be required to remain the entire month. Exceptions to this will be considered on a case-by-case basis in conjunction with the Miami Valley trauma service and Dr. Janz. The final decision, however, will rest within this department.

RESIDENT RESEARCH FUND SUPPORT APPLICATION

Setting Background

The Resident Research Fund has been in existence since 1984. To date, it has been completely supported by donations from faculty and alumni. Its purpose is to foster resident research interest and effort by supplying "seed money" support for resident-generated research projects. Research support money requests from faculty and alumni maintains this fund. Each project is developed with the assistance of one of the clinical or full-time faculty.

Application and Award Process

1. The resident comes up with a research idea. These ideas may come from discussions with others, reading, modifications of known research activities or faculty suggestions. As always, the hardest part is getting started.
2. The resident discusses the research idea with the research coordinator and one other faculty member and/or chief resident. The discussion with the research coordinator is important to maintain an overview of the total research activity of the department. Discussion with another individual also is important for an additional opinion and generation of interest for assistance at the faculty level.
3. The resident and faculty member draft a one or two paragraph summary of the research proposal. This proposal will be reviewed by the research coordinator to determine if it is ready for faculty review at the faculty meeting.
4. The application for Resident Research Fund monies is available from the Resident Research Coordinator. A copy is included on the following pages. At the end of the budget information section, the request for the specific amount of money from the Resident Research Fund should be made. Requests for research monies have ranged from \$200 to \$1200.
5. Once the application is completed with the assistance of the faculty member, copies will be distributed to the full-time faculty and chief residents. At the next faculty meeting, the proposal and financial requests will be discussed and three outcomes may result:
 - a. the proposal may be returned for more information, research restructure, or budget revision.
 - b. the proposal may be accepted and the requested monies awarded. Acceptance will be by simple majority vote of the faculty and the chief residents in attendance at the meeting. The chief residents may cast two votes between them. Each faculty has one vote. A tie will be decided by the departmental chairman.
 - c. the proposal may be denied by the same process as in (b). A written explanation will be supplied to the resident if this should occur. This explanation will be written by the research coordinator.
6. Once the proposal is accepted, a budget number will be assigned through the Departmental Administrative Assistant. The monies will be available to the resident for the specific project for the time until graduation from the training program. Quarterly project status and budget

reports will be submitted to the departmental chairman by the resident with the assistance of the faculty member.

- 7. This policy will be reviewed annually and changes made as necessary based on experience.

SEED GRANT PROGRAM GUIDELINES

PURPOSE

The Emergency Medicine Seed Grant Program is to provide funds for residents to carry out research projects. These projects may be epidemiological, clinical, or basic science; performed by survey, in a hospital or other patient-care setting, or in the laboratory. Our primary criteria for funding focuses on the experience the resident will receive in research-study development and performance.

ELIGIBILITY

All residents in the Department of Emergency Medicine at Wright State University School of Medicine are invited to apply. The resident must be the principal investigator on the project and be primarily responsible for the development of the project oversight of data acquisition and analysis of the results.

The Resident Research Coordinator must endorse the proposal. The endorsement indicates that the application is sufficiently developed to be reviewed by the entire departmental faculty.

PROPOSAL

The proposal **must** include these sections:

1) An abstract of no more than 200 words.	Limit Section 1 to 1 page .
2) A research plan (not including bibliography).	Limit Section 2 to 3 pages .
3) A budget and budget justification for funds requested.	Use NIH Form Page 4-DD.

If the proposal involves several investigators, one person must be identified as the principal investigator.

ASSURANCES

Applicants using human subjects, animals, biohazards, radioactive materials, or recombinant DNA must submit appropriate forms to Research and Sponsored Programs (RSP) in 122 Allyn for institutional review. Institutional approval at the university **and** affiliated hospital(s) must be granted before funds are dispersed. Call the Research and Sponsored Programs Office at 775-2425 for appropriate university forms.

DEADLINE

There is no deadline. Applications may be submitted at any time.

BUDGET

Generally, awards ranged from several hundred to \$1500. Allowable costs include supplies, travel required to complete the project, staff and students' salaries. Research funds cannot be used to pay salaries of residents or faculty. In general, purchase of equipment is discouraged. If specific

equipment is needed, collaborative arrangements with other departments or facilities would be encouraged.

REPORTS

Quarterly reports outlining the funds used and current status/progress of the project are to be submitted to the department chairman. This should include any submissions or publications that have resulted from this work.

Publications which have resulted from this work should acknowledge the Department of Emergency Medicine Resident Research Fund.

DEPARTMENT OF EMERGENCY MEDICINE
SEED GRANT PROGRAMS
Application Guidelines

Instructions: Complete this form and submit with your application. Please type.

Principal Investigator Name: _____

Rank: _____

Signature: _____

Co-Investigator Name: _____

Department: _____

Rank: _____

Signature: _____

[Note: If more than two faculty are involved, list their names and department on a separate sheet.]

Project Title: _____

Amount Requested: _____

Endorsement of Departmental Resident Research Coordinator

PROCEDURE LOG

Hospitals are beginning to require residency programs and/or prospective staff members to confirm competency in performing certain technical procedures prior to granting staff privileges. The procedure log will allow us the opportunity in an easy format to document and retrieve this data. The log will also be available to evaluate rotations and locations in reference to availability of opportunities for procedures. The log has become an RRC requirement.

INSTRUCTIONS FOR WSU EM PROCEDURE LOG

Procedures are logged using New Innovation's Residency Management Suite. This is web-based and can be accessed from any Internet-connected computer and mobile device via the new innovations application. Procedures should be entered in a timely fashion; i.e., procedures completed during the month's rotation should be entered by the end of that month. Reports will be printed and submitted to the Program Director to be included with your 6-month RRC evaluation.

There have been a few questions about which procedures are recordable and which ones don't "count." In short, any procedure that is done, attempted, assisted—whether on live patient, dead patient, cadaver, or an animal—can and should be recorded in your log. This includes, but is not limited to, procedures that are done at Wright-Patterson Trauma Resuscitation Lab, procedures performed on cadavers during Cadaver Lab, procedures performed during ATLS, PALS, Airway Lab, Splinting Lab, and Suturing Lab. Additionally, all procedures that were attempted but were not successful as the education received from such failures is often superior to the education received from a successful procedure.

The RRC in Emergency Medicine has listed an average number of key procedures that Residents should perform. This list is attached and Residents should meet or exceed the numbers listed by graduation. Failure to perform and record an adequate number of each of these may be grounds for remediation or extension in training.

Special attention should be paid to the recording of the resuscitations and ultrasound procedures. The definition of both "resuscitation" by the RRC is anything but clear. The interpretation of "resuscitation" by most Emergency Medicine Residencies in this program is, any patient that is in any way unstable qualifies. More specifically, any patient that requires intervention in airway breathing or circulation should be considered a resuscitation. These patients would include patients requiring basic or advanced airway techniques such as bag valve mask, nasopharyngeal airway, or even simple improvement of patient's position to attain adequate airway patency. Also, any patient that is hypotensive or significantly tachycardic and requires fluid bolus would be considered unstable and, in the interpretation of the RRC, a resuscitation. Another reasonable interpretation of "resuscitation" is any patient that requires emergent and timely intervention such as thrombolysis, dialysis, or aggressive bronchodilator therapy. With the advent of the new ultrasound curriculum, certification will be available upon graduation, provided that one passes the written and practical exams, as well as generates adequate documentation of ultrasound exposure. The governing bodies of Emergency Medicine (ACEP, SAEM, ABEM), as well as this program, still differ in opinion as to what this number should be. Therefore, I urge you all to aggressively seek out and document ultrasound exposure. (This

includes exams performed during Ultrasound Labs.) The best opportunities for these, obviously, are at WPAFB ED, WPAFB OB Clinic, and while on the surgery/trauma services at MVH. I anticipate the minimum number that will be required when our certification criteria are finalized will be a number well over 50 exams, and may well include requirements that a minimum number of each type of exam (trauma, abdominal, pelvic, renal, etc.) be done.

Keep in mind that the purpose of thorough procedural log documentation serves two purposes. First, it documents for the RRC that this training program offers residents adequate exposure to various procedures. Secondly, it provides your future employers with the same. We frequently receive requests for procedure logs of senior residents who are applying for positions, and this may be required by your employer for credentialing.

PATIENT /FOLLOW-UP LOG

You are to track a minimum of 10 patients during each ED monthly rotation with the exception of the PGY-III teaching month, where the minimum is reduced to 5 patients secondary to working a reduced number of shifts. See form page 68a.

At least 3 of these patients are to be inpatients (those admitted to the hospital) and 3 outpatients.

REPORTING INTERESTING CASES, EKG'S, AND RADIOGRAPHS

For the development of morbidity and mortality, as well as publishable reports, it is extremely important that you consider each patient you treat in the context of its potential teaching value.

Number and Type of Procedures Required by RRC

Procedure	RRC Requires
Intubations	35
Cardioversion/Defib	10
Chest tubes	10
LPs	15
Cardiac Pacing	6
Laceration Repair	50
Vaginal Delivery	10
Central Venous Lines	20
Bedside U/S	150
Conscious Sedation	15
Adult Medical Resus	45
Adult Trauma Resus	35
Peds Medical Resus	15
Peds Trauma Resus	10
Cricothyrotomy	3
Pericardiocentesis	3
DPL	3
Dislocation Reduct	10
Closed Fx Splint	20

TEACHING RESPONSIBILITIES

The teacher often learns as much or more than the student. Teaching responsibility is an integral part of the educational experience of the residency training program. Residents are expected to teach at all levels in the clinical and didactic setting, and, in turn, they should demand an educational experience from both on- and off-service faculty. The following are the minimal areas in which the resident is expected to actively and willingly participate:

A. Bedside/clinical settings

1. Peers/underclassmen in emergency medicine - the concept of graded responsibility of education is a cornerstone of graduate medical education. You are expected to set an education-oriented role model for residents in years behind you and, in appropriate circumstances, for your peers and/or faculty. You must maintain a questioning curiosity that allows you to maintain the lifelong learning mentality that is essential in emergency medicine.
2. Rotating residents - as these resident are future consultants, an investment of time and intellect will reap improved interaction and mutual acceptance. Avoid condescension and rigidity. There are often many ways to solve the problem. At the same time, don't be bluffed and give away authority when circumstances dictate otherwise.
3. Medical students - the emergency medicine experience is often one of the best for the fourth-year medical students. It is a unique circumstance in which they have 24 hour one-on-one supervision in the care of the undiagnosed patient. Future Emergency Medicine residents, as well as Cooperative Consultants, come from these early interactions. Give them the best experience you can. PGY-IIIs will also devote a month to medical student teaching (see Section V, Resident).
4. Nursing staff - explanations and discussions of activities and treatment plans are an important component of maintaining a good physician-nurse relationship. They have much to offer your education, and a 2-way dialogue should be maintained at all times.
5. Pre-hospital care - It is recommended that you meet as many pre-hospital care personnel coming into the emergency department as possible. Discuss the initial findings of the patient, treatment given, and results to date. Any compliment or critique should be given at that time; the latter in private. The relationship of mutual respect is absolutely necessary for this system to work, and education is a primary tool for maintaining that respect.
6. Patients - this is obviously the most important, but often neglected, group in terms of medical education. It is preferable to do your own teaching during the years of this training program rather than turning the final discussion over to the nursing staff. You must avoid jargon, anticipate patients' questions, and even offer a little mini-test before discharge to make sure they understand your instructions. Your skills as an educator will never be better served.

B. Didactic Lectures

1. Resident lectures - you are expected to give lectures each year as part of the departmental didactic program. In addition, all Residents will periodically make case presentations at conference. The details for developing these lectures is listed in Section VI of this manual under Resident Lectures - Guidelines/Preparation.
2. Fourth-year medical student program - see Resident Medical Student Teaching Month, Section V.
3. ACLS/PALS - the department has a number of commitments to medical students, residents, and the community for teaching ACLS/PALS. You are taught as providers in your orientation and as instructors an ACLS within the first six months of your first year; PALS instructor status is completed in the second year. The required sessions in which you will be requested to participate include a modified ACLS given to the new MS-III's as part of the Clinical Preparation Clerkship each July. ACLS/ PALS for our own and other residents is taught during orientation. These are the official commitments of the department. You may be requested to participate in other teaching sessions.
4. Pre-hospital care personnel - as part of your assignment as a resident squad advisor, you will be expected to actively teach your assigned squad.
5. The PGY-III's undertake the role of teacher as they lead the PGY-I YDC.
6. Teaching training given - to assist in fulfilling the expectation of quality teaching by the residents, the training program contains a series of lectures/experiences in educational design and technique. The following are presently available; others will be added as developed.
 - a. Each resident is given advice in advance of and a critique after their resident lecture. (See Section VI - Lecture Preparation.)
 - b. Instructional technique is part of the ACLS instructor course.
 - c. Bedside teaching skills are demonstrated during the Emergency Medicine rotation, as well as during discussions in the M&M conference.
 - d. Teaching skills will also be part of the PGY-III year directed conferences.

INFORMATION DISSEMINATION

Because of the widespread nature of the Department, we make every effort to insure that all residents and faculty are informed of Departmental activities, offerings, schedule changes, and other newsworthy items. It is imperative that each resident maintain an up-to-date address and phone number within the departmental offices.

The information is disseminated in a number of different manners.

- A. Text message. Urgent messages, such as cancelled classes, changes in class start time, or disaster recall will be disseminated via text to your cell phone. It is very important that you provide us with a current cell phone number for this reason.
- B. Telephone - You may be contacted via telephone for additional urgent information. It is very important that you provide us current home and cell phone numbers.
- C. Written Communication
 - 1. E-Mail. All residents, faculty, and support staff are issued Wright State University e-mail accounts and are expected to use them. The uniformity of these accounts assist with reliability of communication. If you have another account, it is necessary that you forward your Wright State University e-mail account to that address. **A great deal of important information is sent to you via email, and it is therefore important that you read it.**
 - 2. Department of Emergency Medicine Update. This quarterly newsletter contains a variety of information assembled by the Chair, Program Director, and other faculty.
 - 3. Conference call. The monthly schedule of Friday afternoon, PGY, and Special Conferences. **Check this every month, as schedule changes will appear here first.**
 - 4. Resident mail slot. There is a department mailbox in Cox Heart Institute with a slot for each resident. Materials not picked up at the Friday conference or coming in during the interim are available in this slot during office hours.
 - 5. Resident mailings. Apart from the mail slot, there are still a number of items that are mailed to your home, e.g., contracts. Therefore, an up-to-date mailing address is essential.

DEPARTMENTAL ORGANIZATION

DEPARTMENT CHAIRMAN

Vertical Structure: Responsible to Dean, School of Medicine; oversees all of Department's faculty and support staff.

Basic Responsibility: Manage and continue to develop a Department committed to scholarship.

- Specifics:**
1. Recruit, retain, and promote faculty members with proven excellence in teaching, research, and professional service.
 2. Encourage faculty development.
 3. Formally evaluate individual faculty members on a yearly basis and document the faculty's teaching ability, clinical knowledge, and scholarly contributions.
 4. Review and update the written responsibilities of individual faculty members for supervision of residents, teaching, administration, and research.
 5. Review and update policy manuals on a yearly basis.
 6. Negotiate and secure adequate financial commitment to:
 - a. Direct and supervise a highly competitive community-based Residency in Emergency Medicine.
 - b. Support faculty development.
 - c. Support scholarly research at all levels.
 7. Maintain membership in national organizations and seek leadership roles in order to promote institutional philosophy and departmental identity.
 8. Maintain partnership with the University community and make efforts to facilitate the University's stated mission.
 9. Foster multidisciplinary relationships with other departments within the University and the emergency medicine departments at other universities.
 10. Participate in supervision of Fellow, especially when orientation is faculty development, clinical excellence, etc.
 11. Assist Program Director in maintaining constructive ties with each of the clinical teaching sites.

VICE-CHAIRMAN

Vertical Structure: Directly responsible to the Chairman.

Basic Responsibility: Assume functions of the Chair in the Chairman's absence.

- Specifics:**
1. Chair any committee activity when requested by the Chair.
 2. Sign documents when requested by the Chair.
 3. Complete external survey instruments or distribute to others within the department.
 4. Write letters for external awards (AOA), SAEM, Academy of Medicine, etc.).
 5. Attend committees and ceremonies at the request of the Chair.

PROGRAM DIRECTOR

Vertical Structure: Directly responsible to the Chairman.

Basic Responsibility: Function as the source of vision and operations director of the Residency.

- Specifics:**
1. Foster a sense of Resident identity within the Medical School.
 2. Project the interest and activities of our Department as a functioning member of the SOM Residency Education Committee and the Dayton Area Graduate Education Consortium (DAGMEC).
 3. Participate in institutional policy-making within all medical facilities to the extent necessary to assure proper implementation of the Residency Program.
 4. Maintain suitable relationship with participating hospitals, Director of Medical Education offices, and Emergency Department Groups that participate in the Residency.
 5. Maintain dialogue with the RRC and provide necessary documentation for continued accreditation of the Emergency Medicine Residency.
 6. Chair the Residency Review Committee, Interviewing Committee, and Resident Selection Committee.
 - a. Provide written documentation at least semi-annually of the Resident's knowledge, skills, and professional growth in Emergency Medicine.
 - b. Lead the recruitment effort.
 - i. Screen all incoming applications.
 - ii. With secretarial staff support, schedule interviews.
 - iii. Provide ranking list.
 - iv. Interface with the military concerning military ranking and recruitment.
 - c. First call for counseling and individual resident concerns.
 7. Analyze the curriculum on an annual basis and, with the Chair and faculty, supervise beneficial alterations in the program.
 8. Establish Chief Resident positions, and maintain guidelines and assistance as necessary.
 9. Coordinate annual scheduling of block rotation.

10. Monitor block rotations via monthly review of block rotation forms and assure secretarial support, exchange of goals and objectives package.
11. Plan and implement a department specific orientation.

EDUCATION COORDINATOR

Vertical Structure: Responsible to Chairman.

Basic Responsibility: Develop core curriculum.

- Specifics:**
1. Work with Program Director to develop and maintain an innovative and high quality didactic curriculum and evaluation of that curriculum.
 2. Maintain suitable relationship with participating hospitals and Emergency Department Groups participating in the Residency.
 3. Participate as a member of committees (for example, the Residency Review Committee, Interviewing Committee, and Resident Selection Committee) at the request of the Program Director.
 4. Participate as the representative to the KMC Transitional Residency Committee.
 5. Modify and distribute Mid-Year instrument, collate and distribute the responses to faculty for discussion at the Spring Faculty Retreat.
 6. Organize the scheduling of the PGY-I didactic ultrasound course.

ASSISTANT EDUCATION COORDINATOR

Vertical Structure: Responsible to Program Director.

Basic Responsibility: Develop core curriculum.

Specifics: Works with the Educational Coordinator to develop and maintain an innovative and high quality didactic curriculum and evaluation of that curriculum.

RESIDENT RESEARCH COORDINATOR

Vertical Structure: Responsible to the Chairman.

Basic Responsibility: Coordinate resident research activities and assist in development of Department research planning and activity.

- Specifics:**
1. Maintain independent research activity.
 2. Work with the Chair to promote research activity of faculty and residents, act as a clearing house for research ideas, and be the resource person for research ideas, activities, available facilities, and funding sources.
 3. Oversee activity of resident(s) during the selective in cooperation with the Research Laboratory Director.
 4. Provide information for research section of ED Update, as requested by Research Laboratory Director.
 5. Work with Laboratory Director to improve and maintain Cox Laboratory space.
 6. Maintain research bulletin board.
 7. Work with Educational Coordinator and Laboratory Director to maintain annual research forum.
 8. Maintain appropriate accounting of Department Resident Research Funds.
 9. Actively seek and support efforts to maintain and obtain extramural funding for research.
 10. Oversee activities of Research Fellow in coordination with Research Laboratory Director.
 11. Maintain direction of Journal Club.
 12. Participate as a member of the Residency Review Committee, Interviewing Committee, and Resident Selection Committee.

E.M. RESEARCH LABORATORY DIRECTOR

Vertical Structure: Directly responsible to the Chairman.

Basic Responsibility: To service as operating manager of EM laboratory and resource for research activity in the Department.

- Specifics:**
1. Medical students
 - a. Assist in the medical school teaching activities of the Department of Emergency Medicine, which include lectures and basic/advanced cardiac life support courses.
 - b. Limited teaching responsibilities to the Basic Science Department.
 - c. Research principles/techniques to interested student - voluntary or paid.
 2. Biomedical Ph.D. students - As they become available, activities/responsibilities will be discussed with Chair.
 3. Residents
 - a. Coordinate with Resident Research Coordinator the resident research selective. This includes participation in selective evaluation of resident and selective revision as necessary.
 - b. Assist in resident research projects.
 - c. Provide didactic presentation/materials on research design and implementation for residents, as requested.
 - d. Work with Education Coordinator, Resident Research Coordinator to continued Annual Research Forum.
 4. Faculty - Assist in teaching research related material to faculty. This could include research design, research equipment, statistical analysis, etc.
 5. Emergency Medicine Research Fellow - Responsibility for work with Resident Research Coordinator to divide supervision of Research Fellow's activities.
 6. Research Responsibilities - The Laboratory Director will be responsible for continued development and refinement of the department's research program. This would include:

- a. Procurement of intramural and extramural funds for self for Emergency Medicine related research. Assist in procurement of funds for residents and faculty.

This would include accounting of Department research funds and grants directed toward Cox Laboratory.

- b. Responsibility for development, direction, and operations (including budget) of basic science laboratory.
- c. Collaborative effort with MRI and PET. Center personnel.
- d. Assistance in writing manuscripts for publication.
- e. Liaison between basic science departments and the Department of Emergency Medicine regarding research.
- f. Maintain own active research projects.
- g. Oversee activity of laboratory research assistant(s).

7. Communication

- a. The Director will represent the activities/concerns of the laboratory to the Chair and faculty at the bimonthly faculty meeting.
- b. The Director will develop a monthly report of research activities in cooperation with the Resident Research Coordinator for inclusion in the ED Update.
- c. Financial concerns/requests regarding the laboratory or research will be discussed with the Chair.

ICCU COORDINATOR

Vertical Structure: Directly responsible to the Chairman.

Basic Responsibility: Organize and structure the ICCU rotation at Good Samaritan Hospital.

- Specifics:**
1. Periodically revise and edit the ICCU goals and objectives, and ICCU manual.
 2. Coordinate and participate in academic teaching rounds of ICCU patients.
 3. Coordinate and participate in rotation lecture series designed for the ICCU rotation.
 4. Coordinate and participate in 24-hour faculty coverage and consultation for resident ICCU staff.
 5. Implement the MS-IV ICCU selective at GSH. Track and tally the medical student evaluations from ICCU rotations with the assistance of the Educational Secretary. This will include developing/monitoring the timely submission of these documents to the Office of Student Affairs.
 6. Intervene in resident-medical staff conflicts.
 7. Actively participate in monthly ICCU Committee meetings at GSH.
 8. Offer recommendations concerning administrative duties of the ICCU at GSH.
 9. Offer assistance in critical care nursing education.
 10. Participate as a member of the Residency Review Committee, Interviewing Committee, and Resident Selection Committee.

SPORTS MEDICINE COORDINATOR

- Vertical Structure:** Responsible to Chairman.
- Basic Responsibility:** Coordinate Sports Medicine residency selective, wilderness medicine education and postgraduate fellowship advocate
- Specifics:**
1. Work with Program Director to develop and maintain an innovative and high quality didactic & clinical curriculum and evaluation of that curriculum.
 2. Maintain suitable relationship with participating hospitals and Emergency Department Groups participating in the Residency.
 3. Encourage, organize and supervise resident coverage of sporting events, to include high school football, wrestling, and track and field; and organize and supervise resident participation in athletic pre-participation physical exams.
 4. Encourage and supervise resident research in sports medicine (especially that which is pertinent to emergency medicine).
 5. Work with the Fellowship Director to ensure the fellow receives high quality clinical and didactic education.
 6. Work with the Sports Medicine Fellow to deliver didactic lectures to the emergency medicine residents on clinically relevant sports medicine topics.
 7. Serve as an intermediary to maintain good communication between the Program Director, Department Chair, and the Sports Medicine Fellowship Director.
 9. Participate as a member of committees (for example, the Residency Review Committee, Interviewing Committee, and Resident Selection Committee) at the request of the Program Director.

SIMULATION CENTER DIRECTOR

Vertical Structure: Directly responsible to the Chairman.

Basic Responsibility: Planning, writing, directing and conducting the simulation-based portions of the residency curriculum.

- Specifics:**
1. Assess resident learning objectives and milestones which can be best met with or supported by simulation-based programs.
 2. Develop a year-appropriate resident curriculum of core simulation-based curricular material.
 3. Procure models, supplies and equipment needed to conduct high-quality simulation experiences.
 4. Program simulation cases addressing the learning objectives and milestones for each year of the residency.
 5. Create documents (paper or electronic) to support simulation cases and documentation of milestone accomplishments for each resident.
 6. Conduct simulation-based training for all emergency medicine residents and assist other faculty with simulation-based components of their curricula.
 7. Facilitate a comprehensive debriefing process for all simulation sessions which encourages reflective learning and opportunities for additional practice when needed.
 8. Mentor simulation-based research for residents including researched focused on completing residents' required scholarly projects.
 9. Conduct additional simulation sessions and create new simulation modules to meet additional educational requirements identified by individual residents or as identified by the program director or other faculty.
 10. Track and document individual resident milestones accomplished within the simulation-based curriculum.

EMERGENCY MEDICAL SERVICES AND DISASTER MEDICINE COORDINATOR

Vertical Structure: Responsible to Chairman.

Basic Responsibility: Oversees the department's involvement in the pre-hospital community and for delivery of EMS education to resident physicians, medical students, and EMS providers.

1. **Specifics:**

This position represents the DEM on the Greater Miami Valley EMS Council, the State of Ohio Regional Physicians Advisory Board, and on any applicable Greater Dayton Area Hospital Association committees (regional domestic preparedness).

The coordinator serves as liaison with fire departments serving as clinical sites for the residency program.

2. **Qualifications**

This position is to be filled by an emergency medicine specialist physician, preferable with pre-hospital expertise and experience. ABEM board certification in Emergency Medical Services is preferred.

MEDICAL STUDENT COORDINATOR

Vertical Structure: Directly responsible to the Chairman.

Basic Responsibility: Direction and sustaining interest of faculty members toward medical student education.

- Specifics:**
1. Organize and implement mechanisms for fourth-year student rotation in Emergency Medicine.
 - a. Coordinate the resident teaching month.
 - b. Update curriculum, orientation, presentation schedule, and evaluation mechanisms for the MS-IV rotation.
 - c. Track and tally the medical student evaluations from emergency medicine rotations with the assistance of the Educational Secretary. This will include developing/monitoring the timely submission of these documents to the Office of Student Affairs.
 - d. Initiate remediation activities with students as necessary.
 - e. Actively maintain and promote constructive relationships with our individual teaching sites.
 2. Participate in Biennium 1, Biennium 2 Committee activities of the School.

SUPPORT STAFF

Administrative Assistant - Operations – Alaine Dunn

Facilitates overall administrative affairs of the department under the direction of Dr. Brown.

Administrative Assistant - Finance - Shirley Foreman

Administratively responsible for budget/fiscal operations and business functions of the Department under direction of Dr. Brown

Med. Student Coordinator – Lynn DeWine

Coordination of Fourth Year Medical Student Selective, Patient follow-up logs, Procedural Logs, Rotation Evaluations; ABEM In-service exam

Resident and Recruitment Coordinator – Chris Kraft

Responsible for resident recruitment and resident operations per the Program Director

Research Coordinator – Nancy Andrews

Responsible for Conference Call, Journal Club. Research Grant proposals, Visiting Professor/Specialist and Oral Board Simulation.

Department Secretary – Cassandra Browning

Department Phone; maintain database program personnel, Website innovation and maintenance; assist with recruitment and public relations, publisher of department newsletter.

ROLE OF CHIEF RESIDENT

INTRODUCTION

The Department of Emergency Medicine has established five Chief Resident positions at the PGY-III level. Four of the chiefs are involved with the various community hospitals (Kettering Health Network, Good Samaritan Hospital, Miami Valley Hospital, Children's Hospital, WPAFB Hospital). The fifth chief is the Academic Chief and is responsible for helping the Academic Coordinator and Clerkship Director with the teaching month as well as curriculum development. The purpose of these positions is to accelerate educational development and promote academic interest. Individuals selected for this position are volunteers who have demonstrated a particular interest in academic Emergency Medicine. It is the faculty's desire to promote this interest by offering educational and administrative responsibility, as well as increased faculty contact. The basis for selection includes academic standing, expressed interest, demonstrated interpersonal skills, participation and performance to date in academic endeavors, and career goals.

RESPONSIBILITIES

1. The Chief Resident must be perceived as a role model in the residency, particularly by the PGY-Is and IIs. It is anticipated that both a high profile and appropriate demeanor will be maintained during the year.
2. The Morbidity and Mortality Conferences will be organized by the chief residence.
3. Regular attendance at the Tuesday afternoon Departmental faculty meetings will be maintained. In this context, the resident will participate in the faculty development courses as well as the continued assessment and adjustment of the training program. A much better understanding of Departmental organization and policy should be obtained from this experience. The chiefs will also attend the annual faculty retreats.
4. The residency has responsibilities for a number of teaching activities. These include paramedics, nurses, off-service residents, and emergency physicians. Though other residents will participate, the Chief Residents will be expected to take an active role in the teaching activity of the Department. Every effort will be made to give feedback on the resident teaching skills during these presentations. In counterpoint to our teaching encouragement, make sure you don't over-commit. Too many "yeses" can make for a stressful, un-fun year.
5. The Chiefs perform scheduling of residents on ED rotations.

REWARDS

1. Most importantly, selections to this position should be considered its own reward. We view this position as an opportunity for enhanced academic growth.

2. To recompense for the time involved in the above activities, the Chief Residents will be scheduled 2 fewer shifts than other PGY-3 residents during the Emergency Department rotation.
3. The position may be listed on your curriculum vitae.
4. Promotion will be assisted by increased faculty exposure in the areas of research and education.

ROLE OF PGY-III RESIDENT

The PGY-IIIs are an invaluable resource that in years past have been overlooked. In the more traditional university setting, PGY-IIIs are the dominant teacher of less-experienced residents. We rely on the PGY-III to be important contributors to the education of fellow residents and medical students.

Below are the formal teaching activities of the PGY-III resident during the Teaching Month:

1. **MSIV Teaching:** The PGY-III resident is required to spend 5 hours per each medical student doing bedside teaching time. This time is over and above any overlap that might occur with the student during scheduled clinical shifts. The resident is not to have “ownership” of the patients during these shifts (no note-writing, etc.). If there are two resident assigned to the teaching month, then each resident will do a similar number of hours and the students will benefit from twice as much teaching time. This request will be tracked by mid and end month queries of the medical students, and the teaching resident will submit to the Medical Student Coordinator (Dr. Stacey Poznanski) their tally of time spent with each student. The teaching resident is also responsible to attend and assist with the four scheduled MSIV didactic sessions. The student hours and the resident hours will be corroborated. Failure to fully complete this teaching time obligation will result in teaching time being scheduled while on other services. This is an extremely important part of our obligation to the medical school, as well as an opportunity for bedside education on the part of the PGY-III resident.
2. **PGY-I Teaching:** The PGY-III resident will give a minimum of 5 hours teaching-time per each PGY-I rotating in an emergency department during the PGY-IIIs teaching month. This is a critically important opportunity for the PGY-IIIs to share their knowledge and experience with PGY-Is in a teaching capacity. Fulfilling this requirement will be checked by a mid-month and end-month discussion with the PGY-I residents as well as the PGY-III resident submitting a tally of teaching time to the coordinator of the teaching month (Dr. Stacey Poznanski). These items will be corroborated. Failure to fulfill an adequate amount of teaching time with PGY-III residents will be remedied by makeup hours being scheduled during another rotation.
3. **Conference Lecture:** On the fourth conference day of each teaching month, the teaching resident is responsible to give a 30 minute lecture. The topic will be assigned. The teaching resident is to collaborate with the faculty mentor for the month to create the lecture.

4. **Journal Club:** The Teaching Resident will be required to be the discussion leader for the journal club that occurs the month following his/her teaching month. The mentor will be the assigned faculty with whom the teaching resident works throughout the teaching month.

SOCIAL COMMITTEE

Volunteers from the second-year resident class are encouraged to form a social committee. The purpose of this committee is to create events with the goal of getting residents/faculty and their families together in a setting outside of the conference/hospital setting. A budget of approximately \$200 is made available per event with a maximum of 5 events. Previous activities have included canoe trips, pool parties, picnics, etc.

In addition, the Department has three regular events that you are strongly encouraged to attend:

1. The Welcoming picnic in the last week of June.
2. The Departmental Christmas party in mid-late December.
3. Resident graduation in mid-June.

The social side has obvious benefits. One quickly finds that much more than emergency medicine can bind this group together. Suggestions are welcome to enhance the above.

SUGGESTED CALENDAR OF EVENTS

July	Pool Party
August	Canoe Trip
September	Labor Day Picnic
October	Halloween Party
November	Turkey Bowl
December	*Christmas Party
January	New Years
February	"Where's the Sun" Party
March	Zoo Trip (Cincinnati or Columbus)
April	Reds Game
May	Spring Retreat
June	*Resident Graduation *Welcoming Picnic

*Organized by faculty

PARKING PASSES/PERMITS

A. Good Samaritan Hospital

Hospital ID cards are issued during Orientation Week at Security. Keep these cards through your entire residency - if you misplace or lose your ID, you must pay for a new one from Security. The ID card will let you gain access to the physician parking garage on Philadelphia Drive. Your ID card is also used to obtain free meals from GSH's cafeteria.

B. Kettering Medical Center

Parking for Emergency medicine conferences as well as ED shifts are in the Parking garage located in the front of the main entrance. You will need your ID badge to swipe out of the garage when leaving. ID cards are also used for meals, with a \$250 maximum per month.

C. Sycamore Medical Center

Parking at Sycamore Hospital does not require an ID. Follow the signs to the physician parking.

D. Miami Valley Hospital

Parking at Miami Valley Hospital can be either in the Apple Street Garage or the parking garage on Wyoming Street. ID card is required.

E. Wright-Patterson AFB

Two months prior to your first rotation at the AFB, you must complete paperwork for security reasons. The Residency Coordinator will supply this information to you in advance, and once completed, will mail it to the AFB ED Coordinator.

F. Children's Hospital

When rotating at Children's Hospital, the resident will be assigned parking passes/decals on his/her first day of service through the Medical Education Department. There is a large parking lot at the north side of the hospital off of Valley Street. An ID card is required. At night, the parking garage may be used.

CONFERENCES/DIDACTIC CURRICULUM: PURPOSE, GENERAL SCHEDULES

The didactic curriculum is an essential part of your education. It covers the full range of core topics in Emergency Medicine, and is structured to complement and reinforce your clinical experience. The policy on conference attendance is in Section II. The conferences for this year will be:

1. Emergency Medicine Conference (Tuesday morning 7:00a – 12:00p)

This weekly conference follows the core curriculum and consist of a mix of active case-based small group learning as well as lectures presented by Emergency Medicine full-time faculty, clinical faculty, outside faculty, and residents.

2. Morbidity and Mortality (once per month)

30 to 60-minute conference run by Chief Residents which emphasizes errors in clinical care with lessons to be learned from them. Sources of cases will be from integrated institutions.

3. Visiting Professor Series (as available)

An every other month event in which faculty from other EM training programs or with interest/ability in EM is invited to speak and meet residents. Usually fit into EM conference, though other arrangements may be made.

4. Year-Directed Conferences

This is an additional 2-hour monthly conference given by the Emergency Medicine faculty to each class. Its purpose is to emphasize selected topics that are of particular importance to a specific year. The conferences are presented in the following manner:

PGY-I	Approach to chief complaints
PGY-II	Emergency Medicine Procedures
PGY-III	Administration

5. Journal Club (Every fourth Tuesday)

A monthly meeting designed to allow residents to become facile with the medical literature. These will occur either during conference time or in the evening at a site picked by the host. See Section VI for specifics on scheduling and subject matter.

6. Toxicology presentation

- a. One 15-minute presentation each month by the PGY-III resident. A signup sheet is provided.

7. In-service Review

- a. During the month of February, the Education Chief, with the assistance of faculty and RIII's, will lead the residents through high-yield lectures and questions similar to those seen on the in-service/board exams. This will take place during conference time.
8. EM Challenger
 - a. Every resident will be provided with access to EM Challenger, an online question bank designed to help prepare for the in-service exam as well as board certification exam. Residents are expected to complete the question bank by 31 Dec of the R2 year. Failure to do this may result in relinquished moonlighting privileges.
9. Simulation
 - a. Throughout residency, R1-RIII's will be required to participate in the simulation lab. This will be scheduled by Nancy Andrews. Please see "Simulation Curriculum" for further details.
10. The following laboratory experiences will occur as scheduled by the education coordinator:
 - a. Airway lab
 - b. Wound care lab
 - c. Splinting lab
 - d. Anatomy course
 - e. Ultrasound course
 - f. Extrication course
 - g. Online medical control course

Simulation Curriculum

Rules of engagement for the CIMER simulation lab – The goal of all simulation sessions is to help prepare all students to assess and treat real patients by providing a safe environment to practice and demonstrate the knowledge, skills, and attitudes required to provide care in the emergency department (ED). Simulation does not completely replace bedside teaching, but it provides a means of shortening the steep part of the learning curve in a setting in which the care of a real patient is not at stake. As such, we will frequently bring each student to the edge of his/her envelope of competency without purposefully allowing any student to flail. When necessary, a consultant, attending or senior resident will call in or drop in to help reset the direction if a student becomes completely lost. In addition, most cases of actions/inactions leading to patient deterioration will be reversible with correction of inappropriate/neglected actions. All students are encouraged and expected to have the reference materials they use in clinical settings with them in the simulation lab. They are expected to refer to decision rules, look up doses of medications, and contact support services normally available in the real clinical setting (e.g. pharmacy, consultants, poison control) as they are needed. Despite the expectation that patients will become very ill in the simulation lab, students are expected to complete the steps in assessment and confirm data as they normally would with a real patient. To support this expectation, they can be assured that patients won't suddenly deteriorate or die while they are taking the correct steps (unfortunately we can only make this guarantee while in the simulation lab).

R-1 Simulation Curriculum

Orientation

- a. Task training – This section consists of instruction on 4 common emergency procedures including airway control, lumbar puncture, central IV line placement, and tube thoracostomy. The airway section includes basic airway support, tracheal intubation and rescue airway devices. Each section consists of viewing the accompanying video from the NEJM series of videos in clinical medicine followed by supervised practice of the procedure on a high-fidelity task trainer. Each resident is given a blank assessment checklist for each skill following completion of the station to assure that he/she knows the criteria which will be used for assessment during the skills demonstration session.
- b. Resuscitation team leader – This section involves a focused response to a cardiac arrest or a peri-arrest situation using the high-fidelity mannequins and the lab's emergency department setting. Each resident serves as the team leader in one of four scenarios and as a team member in the other three scenarios.
- c. Skills demonstration – This section provides each resident the opportunity to demonstrate his/her skill in each of the five areas of instruction during the orientation month. Each resident completes a start-to-finish demonstration of each of the task training skills to a faculty in a one-on-one setting and then leads a resuscitation team consisting of a standardized set of nursing personnel. Each resident needs to demonstrate the skill to complete each task by criteria on the checklists provided after the training sessions. The global assessment used during the sessions is to the standard of faculty comfort of allowing the resident to perform the procedure in a busy emergency department with supervision "from a distance".

Hybrid case-based simulations applying procedure skills

This session provides the capstone experience for the orientation month. It consists of four patients presenting one-at-a-time with an undifferentiated chief complaint. In addition to introducing the residents to the approach to ED patients from triage to disposition, the cases require the use of one of the tasks they have trained on during the orientation period. In some instances (tube thoracostomy and cardioversion) the procedures are performed on the computer operated mannequin. In the other two, a hybrid approach is used in which they transition to a task training model to complete the procedure (lumbar puncture and central line placement).

Clinical Teaching Simulation

This session involves two students; the R-1 gains additional experience in the approach to the patient presenting to the ED with an undifferentiated chief complaint and the R-3 who practices his/her role as a clinical teacher. The R-1 initially assesses the patient, gathers initial data, initiates a treatment plan and presents the patient to an R-3 who serves as the clinical supervisor. Following completion of the simulation the case is debriefed from both the perspective of the patient care and that of the clinical teaching.

Individual Simulation – Set 1

This series provides a controlled environment to provide R-1s with specific feedback on strengths and opportunities for improvement in their approach to patients presenting with undifferentiated complaints to the ED. The series includes 3 separate patient encounters and one task training demonstration.

The three patient encounters are designed to demonstrate the resident's level of development in the approach to the undifferentiated chief complaint patient in the ED. This includes, but is not limited to:

- Approach to the patient
- Initial assessment
- Data gathering
- Team management
- Development of and refinement of a differential diagnosis
- Problem solving
- Decision making regarding when the patient has received maximal benefit in the ED and requires discharge or referral to another level of care.
- Presentation to the provider assuming care

Each resident has a standardized team consisting of staff members of the CIMER team. The debriefing following each case-based scenario emphasize the particular case as well as trends seen during the serial cases.

The task training skill consists of demonstrating either tube thoracostomy or central line placement and the purpose is to ensure the resident maintains familiarity with the procedure if he/she has not had an opportunity to perform the procedure (on real patients) since the orientation session.

Individual Simulation-Set 2/Interprofessional Education

As with the first set, this series provides a controlled environment to provide R-1s with specific feedback on strengths and opportunities for improvement in their approach to patients presenting with undifferentiated complaints to the ED. The series also includes 3 separate patient encounters and one task training demonstration. The biggest difference from the first set is that as of 2013, these cases are conducted as interprofessional education simulations. As such, to the extent possible, the R-1 serve as a team leader in an ED with a staff of senior nursing students from the WSU College of Nursing and Health instead of CIMER staff. Each of the three case-based simulations is debriefed using the criteria listed for set-1. In addition, nurse faculty address nursing skills. Overall, an emphasis is placed on medical team skills. In preparation for this session, both the residents and the nursing students complete a one-hour interactive session consisting of the TeamSTEPPS® Essentials course material.

The task training skill involves demonstration of either tube thoracostomy or central line placement and the purpose is to ensure the resident maintains familiarity with the procedure if he/she has not had an opportunity to perform the procedure (on real patients) since the orientation session.

Resuscitation Practice Simulations

Once a month 3-4 R-1s are scheduled to practice their response to focused arrest or peri-arrest scenarios for an hour immediately preceding Friday core curriculum conferences. Each resident take a turn serving as the team leader for one scenario and as a team member for the remaining scenarios. Debriefings focus on ACLS and resuscitation team leader principles.

R-2 Simulation Curriculum

Interprofessional Education Simulations

These sessions consists of two series of three cases each. They incorporate senior nursing students from WSU College of Nursing and Health for one series and senior nursing students from Kettering College Nursing School for the second series. As such, the R-2 serves as a team leader in an ED with a staff of senior nursing students. Each resident-nurse team participates in one simulation per series and observes the two remaining simulations. All debriefings are conducted with the full group. During each simulation, the observers are tasked with recording three good actions and three opportunities for improvement demonstrated by the group being observed in the lab. Both series involve challenging case-based simulations representing atypical presentations of life threatening conditions or high-risk, low-frequency conditions. Each of the three case-based simulations is debriefed based on the physician's core competencies and milestones. In addition, nurse faculty address specific nursing skills. However, the overall emphasis is placed on medical team skills. In preparation for this session, both the residents and the nursing students complete a one-hour interactive session consisting of the TeamSTEPPS® Essentials course material.

Intensive Care Units Simulations

This session is designed for just-in-time training provided to each R-2 the week prior to his/her initial ICU rotation at Greene Memorial Hospital. In preparation for the lab, the residents are sent a series of nine ventilator management cases written by Dr. Janz. During the simulation, the resident manages two patients requiring skills not utilized as frequently in his/her ED work. In the process of managing the two patients, the resident will need to place a central intravenous line. A hybrid simulation is utilized with a central line task trainer, central line kit, full sterile PPE, and an ultrasound machine. Respiratory therapy and nursing roles are fulfilled by a standardized team of CIMER staff.

Pediatric Simulations

This series provides a spectrum of four pediatric cases varying from basic PALS cases to more complicated pediatric pathology. These cases incorporate use of the Broselow tape along with the Broselow bag/cart as well as calculating medication doses with specific instructions designed to assure the correct dose is given by nursing personnel (role played by other residents). Each resident takes a turn serving as the team leader for one scenario and as a team member for the remaining scenarios. Debriefings include all participants.

Resuscitation Practice Simulations

Teams of 3-4 residents make up teams to practice the response to focused arrest or peri-arrest scenarios. The cases are more complicated than the R-1 cases, but incorporate the same basic ACLS principles. Each resident take a turn serving as the team leader for one scenario and as a team member for the remaining scenarios. Debriefings focus on ACLS, resuscitation team leader principles, and discussion of recent literature addressing advances in resuscitation theory.

Advanced Disaster Support Course Simulations

Teams of 5-7 residents practice their response to disaster related situations using case-based simulations which focus on the principles incorporated in the Advanced Disaster Life Support (ADLS) Course. Each resident takes a turn serving as the team leader for one scenario and as a team member for the remaining scenarios. Debriefings focus on discussion of the simulations from the perspective of the ADLS DISASTER (Detection, Incident command, Safety/Security, Assess hazards, Support, Treatment/Triage, Evacuation, and Recovery) paradigm.

R-3 Simulation Curriculum

Clinical Teaching Simulations

This session involves two students; the R-1 gains additional experience in the approach to the patient presenting to the ED with an undifferentiated chief complaint and the R-3 who practices his/her role as a clinical teacher. An R-1 initially assesses the patient, gathers initial data, initiates a treatment plan and presents the patient to the R-3 who serves as the clinical supervisor with clinical teaching responsibilities in addition to patient care responsibilities.

Following completion of the simulation the case is debriefed from both the perspective of the patient care and that of the clinical teaching.

Interprofessional Education Simulations

These sessions consists of two series of three cases each. They incorporate senior nursing students from WSU College of Nursing and Health for one series and senior nursing students from Kettering College Nursing School for the second series. As such, the R-3 serves as a team leader in an ED with a staff of senior nursing students. Each resident-nurse team participates in one simulation per series and observes the two remaining simulations. All debriefings are conducted with the full group. During each simulation, the observers are tasked with recording three good actions and three opportunities for improvement demonstrated by the group being observed in the lab. Both series involve the most challenging case-based simulations representing atypical presentations of life threatening conditions or high-risk, low-frequency conditions. Each of the three case-based simulations is debriefed based on the physician's core competencies and milestones. In addition, nurse faculty address specific nursing skills. However, the overall emphasis is placed on medical team skills. In preparation for this session, both the residents and the nursing students complete a one-hour interactive session consisting of the TeamSTEPPS® Essentials course material.

Advanced Procedures Simulations

This session is designed to provide senior residents the opportunity to perform high-risk, low-frequency procedures (e.g. transvenous pacemaker wire placement and pacing, pericardiocentesis, or perimortum C-section). Although some of these items are included in their procedure logs it is common for a resident to not encounter an opportunity to perform these procedures in actual patient care during a three-year residency. The procedures are incorporated in cased-based simulations utilizing high-fidelity mannequins to ensure residents have the opportunity to practice making the decision to perform the procedures as well as practicing the psychomotor skills involved in completing the procedure. A hybrid simulation is utilized with the appropriate task trainer needed to perform each of the procedures. One resident serves as team leader for each scenario and as a team member in the remaining scenarios. However, after the case-based scenario for each procedure, all residents individually complete the procedure which is the subject of the case.

Pediatric Simulations

This series provides a spectrum of four pediatric cases varying from more complicated pediatric pathology to special case scenarios (e.g. neonatal resuscitation and non-accidental trauma). These cases incorporate use of the Broselow tape along with the Broselow bag/cart as well as calculating medication doses with specific instructions designed to assure the correct dose is given by nursing personnel (role played by other residents). In addition, they have an opportunity to complete specific tasks (e.g. umbilical vein catheter placement, umbilical cord pulse palpation, mobilizing appropriate resources to address suspected child abuse). Each resident takes a turn serving as the team leader for one scenario and as a team member for the remaining scenarios. Debriefings include all participants.

Emergency Medicine Resident Goals and Objectives: Pediatric Intensive Care Unit Rotation, Dayton Children's Hospital:

<p>Patient Care</p>	<p>The resident will demonstrate the ability to assess clinically ill patients and assess acuity level</p> <p>The resident will demonstrate the ability to quickly determine immediate critical care interventions necessary to stabilize emergency patients</p> <p>The resident will demonstrate the use of clinical information, supplied paramedic information, medical records and information from other hospitals/emergency departments</p> <p>The resident will demonstrate the use of clinical information gathered from history and physical exam, to develop patient's acuity level and management plan</p> <p>The resident will demonstrate appropriate disposition on a timely basis on patients with both high and low acuity problems</p> <p>The resident will recognize and describe functional disorders and develop appropriate management/treatment disposition</p> <p>The resident will demonstrate an understanding of appropriate use of medical/surgical consultants for patients presenting with a vast variety of clinical scenarios</p> <p>The resident will show the ability to interview and assess patients in often difficult and stressful situations presented in the Emergency Department</p> <p>The resident will demonstrate the ability to rapidly assess acuity level often based on very limited information</p>
---------------------	---

	<p>due to altered mental status and/or poor patient cooperation</p> <p>The resident will develop a knowledge and proficiency in critical care procedures to stabilize emergency patients including endotracheal intubation, central line placement, lumbar puncture, NG tube placement, Foley catheter placement, ABG draw, etc.</p> <p>The resident will assimilate a variety of ancillary data to assist in developing patient management plan including laboratory testing, EKG, x-rays, ultrasound and computerized tomography</p> <p>All procedures will be performed under the direction and supervision of the attending emergency physician</p> <p>Complete medical records and documentation pertinent to this patient encounter</p>
<p>Medical Knowledge</p>	<p>Will demonstrate knowledge in the evaluation of a variety of x-rays and recognition of pathologic findings for but not limited to the following radiographs: chest, abdominal series, C-spine, pelvis, upper and lower extremities, and head CTs</p> <p>The resident will demonstrate an understanding and knowledge in basic invasive monitoring, mechanical ventilation, ECMO, hemodialysis, procedural sedation and other intensive care unit procedures</p>
<p>Practice-Based Learning and Improvement</p>	<p>The resident will demonstrate the appropriate use of consultants to assist in developing management plan</p> <p>The resident will demonstrate an understanding of the urgency for consultative follow-up or re-evaluation as part of an overall management plan</p>
<p>Interpersonal Communication Skills</p>	<p>The resident will demonstrate the</p>

	<p>ability to communicate effectively and succinctly with patients and family who have had no previous doctor/patient relationship with resident</p> <p>The resident will develop trust and confidence of patient and family in limited time frame through professional sensitive interactions</p> <p>The resident will discuss management plan and disposition with patient and family members and discuss any concerns to alleviate patient anxiety</p> <p>The resident will review and discuss clinical/ancillary findings with patient and/or family prior to definitive disposition</p> <p>The resident will demonstrate the ability to communicate effectively with emergency staff including nurses, medics, attending physicians, clerical staff, and consultants to develop a coordinated approach to efficient and effective patient care</p>
<p>Professionalism</p>	<p>The resident will interact professionally toward patients, families, colleagues, and all members of the health care team</p> <p>The resident will accept and demonstrate a professional responsibility as the primary care provider for patients under his/her care</p> <p>The resident will have an appreciation of the social context of illness</p> <p>The resident will demonstrate knowledge and application of the ethical concepts of confidentiality, consent, patient autonomy, and justice</p> <p>The resident will demonstrates integrity, altruism, and avoidance of conflict of</p>

	<p>interest</p> <p>The resident will demonstrates self-awareness to identify methods to manage personal and professional sources of stress and burnout</p>
Systems Based Practice	<p>The resident will show the ability to develop cost effective strategies, evaluating and managing patients particularly those with low acuity levels</p> <p>The resident will gather information from wide variety resources including friends, family, other physicians and hospitals, EMS personnel, co-workers and /or other nursing personnel</p>

Emergency Medicine Resident Goals and Objectives, Pediatric Emergency Medicine Rotation, Children’s Hospital:

Patient Care	<p>The resident will demonstrate the ability to assess clinically-ill patients and assess acuity level</p> <p>The resident will demonstrate the ability to quickly determine immediate critical care interventions necessary to stabilize intensive care unit patients</p> <p>The resident will demonstrate the use of clinical information, supplied paramedic information, medical records and information from other hospitals/emergency departments</p> <p>The resident will demonstrate the use of clinical information gathered from history and physical exam, to develop patient’s acuity level and management plan</p> <p>The resident will demonstrate appropriate disposition on a timely basis on patients with both high and low acuity problems</p> <p>The resident will recognize and</p>
--------------	--

	<p>describe functional disorders and develop appropriate management/treatment disposition</p> <p>The resident will demonstrate an understanding of appropriate use of medical/surgical consultants for patients presenting with a vast variety of clinical scenarios</p> <p>The resident will show the ability to interview and assess patients in often difficult and stressful situations presented in the Emergency Department</p> <p>The resident will demonstrate the ability to rapidly assess acuity level often based on very limited information due to altered mental status and/or poor patient cooperation</p> <p>The resident will develop a knowledge and proficiency in critical care procedures to stabilize emergency patients including endotracheal intubation, central line placement, lumbar puncture, NG tube placement, Foley catheter placement, ABG draw, etc.</p> <p>Will have the opportunity to perform minor surgical procedures including suturing, skin stapling, burn management, incision and drainage, and wound management/debridement</p> <p>The resident will assimilate a variety of ancillary data to assist in developing patient management plan including laboratory testing, EKG, x-rays, ultrasound and computerized tomography</p> <p>All procedures will be performed under the direction and supervision of the attending emergency physician</p> <p>The resident will perform initial evaluations followed by a presentation</p>
--	--

	<p>with the supervising Emergency Department attending and develop a work-up treatment plan based on this assessment</p> <p>Consult the appropriate service necessary for patients that require admission or further consultation</p> <p>Complete medical records and documentation pertinent to this patient encounter</p>
Medical Knowledge	<p>The resident will demonstrate knowledge in the evaluation of a variety of x-rays and recognition of pathologic findings for but not limited to the following radiographs: chest, abdominal series, C-spine, pelvis, upper and lower extremities, and head CTs</p> <p>The resident will demonstrate knowledge in basic orthopedic procedures</p> <p>The resident will demonstrate knowledge in the basics of wound care management, disposition and appropriate follow-up</p> <p>The resident will demonstrate an understanding and knowledge in basic Ophthalmologic and ENT procedures including slit lamp evaluation, foreign body removal, nasal packing, epistaxis control and emergency laryngoscopy.</p>
Practice-Based Learning and Improvement	<p>The resident will demonstrate the appropriate use of consultants to assist in developing management plan</p> <p>The resident will demonstrate an understanding of the urgency for consultative follow-up or re-evaluation as part of an overall management plan</p>
Interpersonal Communication Skills	<p>The resident will demonstrate the ability to communicate effectively and succinctly with patients and family who have had no previous doctor/patient relationship with resident</p>

	<p>The resident will develop trust and confidence of patient and family in limited time frame through professional sensitive interactions</p> <p>The resident will discuss management plan and disposition with patient and family members and discuss any concerns to alleviate patient anxiety The resident will review and discuss clinical/ancillary findings with patient and/or family prior to definitive disposition</p> <p>The resident will demonstrate the ability to communicate effectively with emergency staff including nurses, medics, attending physicians, clerical staff, and consultants to develop a coordinated approach to efficient and effective patient care</p>
Professionalism	<p>The resident will interact professionally toward patients, families, colleagues, and all members of the health care team</p> <p>The resident will accept professional responsibility as the primary care provider for patients under his/her care</p> <p>The resident will demonstrate appreciation of the social context of illness</p> <p>The resident will demonstrate knowledge and application of the ethical concepts of confidentiality, consent, patient autonomy, and justice</p> <p>The resident will demonstrate integrity, altruism, and avoidance of conflict of interest</p> <p>The resident will demonstrate self-awareness to identify methods to manage personal and professional sources of stress and burnout</p>

Systems Based Practice	<p>The resident will show the ability to develop cost effective strategies, evaluating and managing patients particularly those with low acuity levels</p> <p>The resident will gather information from wide variety resources including friends, family, other physicians and hospitals, EMS personnel, co-workers and /or other nursing personnel</p>
------------------------	---

GSH ICU Guidelines/RoEs

Sign out and Orientation

Sign out is at 0900 in ICU (3rd floor). The ICU resident phone is x3087. The overnight residents and family practice resident write the progress notes for the day. We admit /transfer as many patients as we are called for, but the cap is usually 10 patients (plus or minus depending on ICU census or if there are a lot of interesting patients that we can learn from). There are EPIC ICU templates for consult notes, H&Ps and daily progress notes. Just copy them from the offgoing resident on your first day and have them show you where they are. They can also show you how to set up your ICU patient list, to include patients on 3600 (ICU) and 3900 (CVICU). For patients that are DNR CC or without much change in their daily plan, you can stop writing progress notes daily as it will not add much to your education and most of the attendings will write their own notes anyways. Medical students will usually see 1-2 patients each morning and write notes, you have to cosign their notes and write your own also.

Scheduling

The EM R3 will make the resident and medical student schedule. For the upper level residents, this can either be everyone works q3 for the entire block, or you can schedule several q2s in a row and give each R2, R3 a block of 5 or 6 days off during the rotation. Just discuss it with each other the month prior to starting the ICU block. According to the ACGME and RRC rules, R2s and R3s can be assigned to a maximum of four call nights in any seven-day period. This can only be done one week per month. Basically no more than four q2s in a row. This has to be in accordance with the 80-hour weekly limit, averaged over four weeks.

The EM R2s and R3 will divide up the 28 day block and usually work 9-10 24 hr shifts (0900-0900), but you are usually there later than that signing out patients and attending lecture if Dr. Janz is there, usually out no later than 1100. The EM R1 works 12 hour shifts, 2 weeks of days (0600-1800) and 2 weeks of nights (2200-1000), with at least 1 day off per week. The Family practice resident works weekdays from 0700-1700 (they have conference Wed afternoons, and will have a few family medicine calls they take and will be gone for those, as well as be gone for interviewing medical students during interview season). Medical students usually work weekdays from 0700-1700 and will take 6 or 7 24 hr calls with the upper level resident.

Pulmonary Groups:

-Their call schedules and pager numbers are on the GSH home site under schedules, Physician on call.
-When consulting specialists for patients, either review their chart to see what provider/group they have seen in the past, or else ask the attending what group they prefer to use (e.g. Nephrology, Cardiology, Surgery, ID, etc...)

1. Dayton Lung and Sleep Medicine

- Dr. Khan, Malik, Ambrose, Quadri, Pracha, and Darwich (the main group we follow)
 - During the week, each attending follows the patient's they admitted while on call (for the most part). This does switch around quite frequently though.
 - On weekends, usually one attending from the group sees everyone
 - No formal rounds. If you can catch them, round with them. They have a wealth of knowledge. If you cannot find them, read their notes or page them for info.
 - Their call schedule and pager numbers are on the GSH Physician schedules website.
 - Dr. Malik and Khan like to teach on rounds and will ask you to look topics up from time to time and give a brief presentation

2. Dayton Pulmonary and Critical Care

- Dr. C. N. Reddy
 - Doesn't take call much, but we will typically admit for him and sometimes follow his patients but not always.

3. Dayton Respiratory Care

- Dr. Patel, Yunger, Allan, Pacia, Goyal
- We admit for them and follow their patients, except Dr. Pacia, she will let us admit her patients, but usually prefers to follow her own patients
- Dr. Patel usually rounds between 0700-0730 on weekdays and likes you to follow all of his patients, he will do walking rounds and does like to teach
- Dr. Allen will also give short presentations from time to time if you ask him and is extremely smart and likes to teach (a lot of bedside US, echos, etc...)
- Dr. Goyal and Yunger are both very nice and will ask you to admit and manage their patients if they are interesting and if there is educational value to you following them.

****** We follow a cap of ten patients day-to-day (plus or minus) but we are expected to admit/transfer ALL patients that the attending physician asks us to, to the ICU/CVICU and attend to ALL patients for whom a nurse calls you for help, even if it is not one of the 10 patients we are "following" or writing notes on. If there is an issue that you are not comfortable making a decision on, call the attending physician for help. Dropping patients within the 10 in order to pick up a patient of higher interest requires discussion with the attending/APRN to ensure continuity of care and avoid disturbing established relationships (patient satisfaction issue). ******

Procedures

This is a procedure heavy rotation. You will have ample opportunities to intubate, place central lines, arterial lines, hemodialysis catheters, LPs, set up vents, run codes, etc... You are not required to call the attending before you do a procedure as long as you are comfortable with the procedure and it is in the patient's best interest. Make sure to get the interns and medical students involved with procedures also.

The SonoSite US and GlideScope/C-mac are located in the charge nurses station, available 24/7. Clean and put back once you are done using it. Line cart is in the supply room next to the charge nurses station and has everything you need for lines/tubes, etc...

Lectures

Dr. Janz comes 2-3 times/week to lecture around 1000 in the ICU conference room. Days will vary, he usually gives you a heads up a few days in advance. You are expected to come, even on your day off. Please text/call other residents/medical students on the team to let them know if they are off so they can be present.

Order sets

Every patient new to the ICU (ED admit or transfer) gets the ICU admission order set in addition to the base order set.

Other order sets that should be used depending on the patients' conditions are:

-Sepsis orderset

-DKA/HHS orderset

-Subq insulin orderset (usually ordered when patient has a diet)

-Insulin infusion orderset (usually ordered if pts blood glucose is over 200 when NPO)

- CVA orderset
- Post TPA orderset
- Pulmonary orderset (COPD, Asthma, PNA, etc...)
- Mechanical Vent orderset (if patient intubated)
- Potassium replacement orderset
- PICC orderset
- Restraint orderset
- PE orderset
- Heparin drip orderset
- Induced hypothermia orderset

Transferring patients to the floor

You can transfer a patient without consulting the attending as long as they are stable. They remain on the attending's list and they will follow them out on the floor. Beside the transfer order (GSH transfer), include the floor they will be going to and if they need telemetry. Ask the nurses to help guide you with what floor will be appropriate for your patient.

Codes

Code blue team is the Family resident team on call. If you are not busy, go to the code blues because they can always use help with procedures, brainstorming, and management. Some are more comfortable than others, so be sure to help teach, fill in gaps, and direct care if in the patient's best interest. Most (but not all) of them will come to the ICU if they make it, so it can give you a head start on the patient. We are required to respond to ALL Code Blues in ICU and CVICU. Nurses will usually give you a call if patient is not doing well or about to code.

Nurse Practitioners

Jason and Emily are the APRNs of the unit. Jason usually works three 12 hr night shifts a week (1800-0600), typically Sunday-Tuesday. Emily works three 12 hr day shifts a week (0600-1800). They work with all of the groups admitting and doing procedures. They help to share the workload. They do not write daily notes but they do write H&Ps and consult notes. It is a crap shoot when they get called or when we get called. Two additional APRNs are in orientation allowing for 6 days/nights out of 7 coverage. Melissa is the Critical Care APRN and manages unit quality, clinical processes, as well as the other ICU APRNs. The APRNs are responsible for the quality of all ICU patients and serve as a constant in the unit as residents rotate. Don't hesitate to ask them questions.

Food

The cafeteria hours are 0630-1900. But opens again at night from 0130-0330. You can find extra food in the Family Resident Lounge or can request access to Surgeon's Lounge next to ICU for food/scrubs (have to go down to security in basement and fill out the required paperwork, we have standing authorization letter allowing us access if requested).

Conference

As of now, we are expected to have continuous 24/7 coverage in the ICU by an EM R2 or R3 resident. Conference is only excused for approved vacation and we can not take vacation on ICU months.

Call Rooms

The ICU call room and medical student call room are located on 3rd floor of the old building, the offgoing resident should give you a quick orientation and keys for the ICU call room.

Miscellaneous

Change the battery on the phone as needed. Fresh batteries for the phone are by the tele monitors behind the HUC.

The HUC prints off an ICU patient room assignment sheet for both day and night shifts with the patients nurses Spectra link number and other useful phone numbers. Just ask the HUC for a sheet when you come on shift.

If you get a McAfee Drive encryption screen on the computer:

username is: Shared

password is: Pr3mier